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This title has three volumes:

Volume 1: Executive Summary

Volume 2: Analysis

Volume 3: Transcripts (Volume 3 is further broken out into sections by City.)

Commissioners: Kenneth R. Drysdale
 Heather DiGregorio
 Dr. Bernard Massie
 Janice Kaikkonen

Thank you to the thousands of volunteers across Canada who worked tirelessly to make the hearings possible.

VOLUME TWO



- | Analysis
- | Recommendations
- | Conclusions
- | Commissioners Statement



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7. Analysis

Introduction

Following is the analysis, commentary, and recommendations as put forward by the Commissioners. To facilitate the analysis and review, the information has been divided into various broad areas as follows:

CIVIL

- Legal, policing, policy, regulatory, human rights, emergency preparedness, government, private-public partnerships, anti-trust, monopolies, private corporations;

SOCIAL

- Media, family, faith, education, community, service delivery, societal coercion;

ECONOMIC

- Impacts related to financial matters at all levels—personal, family, corporate—and governmental expenditures and debt, government actions; and

HEALTH

- Medicine, research, pharmaceuticals, regulating and safety monitoring, patient relations, doctor-patient relationship, industry health, messaging, incentives, regulatory collusion.

Each of the categories listed above cannot be fully appreciated independently of each other. Each category is only a part of the much larger whole of the information presented, and specific subject areas cross categories. This reflects the intersectionality of all areas that were considered.

7.1. Civil

7.1.1. Canada's Justice System

Introduction

The Commission heard testimony regarding the role that Canada's justice system played in the pandemic response.

Based on the testimony, the Commission has serious concerns about the state of the rule of law in Canada, the real or perceived failure of Canadian courts to protect Canadians from government and administrative overreach, and the neutering of the *Charter of Rights and Freedoms* in the face of a government-declared emergency.

James Kitchen (Saskatoon, SK; Vancouver, BC)

Leighton Grey (Saskatoon, SK)

Bruce Pardy (Toronto, ON)

Lt. Col. David Redman (Red Deer, AB)

Myriam Bohémier (Québec City, QC)

Luc Harvey (Québec City, QC)

Maurice Gatien (Ottawa, ON)

The preamble to the *Canadian Charter of Rights and Freedoms* (the Charter) affirms clearly that Canada itself is founded upon the principle of the rule of law:

Whereas Canada is founded upon principles that recognize the supremacy of God and the rule of law² . . .

The rule of law is so fundamental to our nation that it is recognized as a pillar of the country in our Constitution.

The rule of law means that the law applies equally to all—including people and the government. It means that no person is above the law, regardless of wealth, race, or personal characteristics. It means that the government itself is bound by the law and cannot act with impunity. The rule of law rejects political influence and popularity, and ensures that each person is treated in the same way in the eyes of the law. The rule of law is of utmost importance to a functioning democracy and is a fundamental principle in the Canadian justice system.

² *Canadian Charter of Rights and Freedoms*, preamble.

The NCI (National Citizens Inquiry) heard repeatedly about the rule of law during testimony. Sadly, the erosion of the rule of law during COVID was a recurring theme of the testimony from legal experts as well as lay witnesses.

The rule of law is not only important to ensure that a justice system functions correctly; the rule of law is equally important to maintaining the confidence of Canadians in their justice system. When the rule of law is subverted, Canadians perceive fundamental unfairness to themselves and their loved ones. This breeds resentment and mistrust and can undermine the very functioning of democracy.

In some ways, the justice system can be seen as a pressure valve on society. It is a place where people who feel wronged can bring their grievances to be heard and resolved. The actions of a court in: (1) hearing a grievance, (2) placing it into context with the other side, and (3) rendering a decision with careful reasons are of utmost importance. Even when the result is not the desired outcome, the mere fact that the process has been conducted fairly can provide relief and understanding to the participant.

However, when members of society lose trust in the justice system's ability to fairly resolve problems, the resulting frustration and grief can become problematic. When people lose faith in their ability to solve problems through the justice system, the risk that they may take matters of justice into their own hands increases significantly.

The NCI heard extensive evidence that Canadian courts have failed to uphold the rule of law, and failed to instil confidence in the system. The Canadian courts' response to the impact of COVID measures on Canadians has led to a breakdown in confidence and an erosion of trust in the Canadian legal system. One legal expert who represented many Canadians in lawsuits involving the pandemic measures described his experiences in Canadian courts as consistently being on the visiting team.³

A perception that the government has the advantage in court runs contrary to the rule of law--whether or not the perception is true. Sadly, the testimony heard led the Commissioners to conclude that the advantage was not only perceived; the advantage actually existed. Counsel repeatedly asked legal experts during their testimony if they were aware of any case in Canada where a person had success against the measures and mandates, and not one single lawyer could name such a case in the entire country.

Canadians have been left with the feeling that there is no person to protect them from government overreach. This is worrisome evidence of a breakdown of the rule of law..

The Legislative, Judicial and Executive Functions

Canada's legal system is comprised of three branches: three branches: the legislative, judicial, and executive.

³ Testimony of Leighton Grey, Saskatoon.

Most Canadians are familiar with the legislative and judicial branches. The legislative branch consists of parliament and each provincial legislature, where elected representatives enact laws. The judicial branch is the system of courts where Canadians go to resolve legal disputes (An extensive discussion of the courts and their role during the pandemic is below.).

What most Canadians are not aware of, however, is the power and reach of the executive branch within Canada and the important role that it played in Canada's pandemic response. During the pandemic, much of the rule-making power in Canada coalesced into the executive, which resulted in unelected public health officers across the country ruling as petty tyrants, without accountability or oversight.

The Administrative State

Canadians relied on their institutions to serve them during the pandemic. Critical institutions failed, and public policy suffered.

The NCI heard testimony that this partly resulted from an overgrowth of the administrative state, whereby unelected bodies are delegated significant regulation-making and decision-making powers over Canadian citizens. The size of Canada's administrative state has been growing, and at the same time, Canadian courts have been paying more and more deference to the powers of unelected administrative bodies. This has resulted in a perfect storm, where unelected officials have powers over Canadians, which are largely unchallenged-able in court, and are not subject to oversight through an election.

In Canada, there are three distinct branches that make up the government and state: (1) the elected legislatures, (2) the courts, and (3) the administration. The separation of powers between the branches is intended to protect individuals by ensuring that excessive power does not become concentrated in any one branch.

The only branch that is elected, and thus accountable to the people, is the legislative branch, which, in Canada, is made up of the federal Parliament and the legislatures of each province. The second branch, the courts, is made up of judges who are chosen by the legislature and thereafter have tenure until retirement. Each of the legislatures and the courts are well-known institutions, with well-understood functions in Canadian society. The third branch, however, is not highly visible and is mostly not a consideration to Canadian citizens. However, its power over the lives of Canadians has been growing steadily, and this was revealed during the pandemic.

The purpose of legislatures is to create laws by passing statutes. However, the NCI heard that legislatures have been increasingly "passing the buck" by creating statutes that do not create new laws or rules, but instead delegate rule-making to various unelected administrative bodies. Once such power has been delegated, an unelected administrative body is then empowered to make rules and exercise decision-making powers that impact Canadians. These administrative bodies, however, lack accountability to citizens through civic elections.

The result is that the unelected administration of Canada makes rules that have a profound impact on Canadian citizens. This has become the case for a large number of rules that apply, on a day-to-day basis, to Canadians. It became particularly evident during the pandemic. One example was the health authorities of each province: The public health authority of each province in Canada was empowered to make profoundly restrictive rules limiting Canadians' freedom of movement, association, and expression. The officials making these rules were unelected and thus felt free to impose whatever measure made sense from the perspective of protecting everyone from one thing only—infection by COVID-19. The NCI was not made aware of a single health authority that took any other consideration into account. At the same time, the NCI heard considerable testimony (documented throughout this report) about the devastating harms that public health measures caused on Canadians and their society, as well as the fact that health authorities surely had early knowledge about the true risk profile of the COVID-19 virus on different parts of the population.

When rule-making and decision-making are delegated to the unelected administrative state, a gap in accountability is created. This gap has grown alongside the growth of the administration itself, as a result of Canadian courts' decisions that provide great deference to administrators who act within their area of expertise. (See the section below titled "The Standard of Review in Judicial Applications.")

During the pandemic, the unaccountable administrative state made far-reaching decisions in the name of the "public good." Individual rights that are purportedly guaranteed under the *Canadian Charter of Rights and Freedoms* became subverted to this purpose. Courts supported the decisions, often without requiring the administration to actually demonstrate the benefits of their actions, on the basis that protecting the public was the administrative state's area of expertise. This set a dangerous precedent.

While the most obvious example of this was the public health orders, the administrative state's power to subvert rights on the premise of "protecting the greater good" was evidenced across many areas of Canada, including the professional bodies that regulate various health professions.

The harms that arose from Canada's response to the pandemic demonstrated the dangers of allowing an administrative state to govern and make rules on the premise of protecting the public. The purpose of the *Canadian Charter of Rights and Freedoms* is to ensure that Canadian fundamental rights and freedoms are not subverted by the government, and yet the administrative state appears to have found a way around them, with less scrutiny by a court than would arguably arise if such infringements were inflicted by laws passed in a legislature.

The NCI heard testimony that this subversion could be addressed through creating legislation that enshrines a non-delegation doctrine, as some U.S. states have done. The NCI recommends that this be studied for potential application in Canada. Additionally, the NCI recommends legislated changes to the standard of deference paid by Canadian courts to decisions of the administrative state (which is set out in more detail under the section below titled "The Standard of Review in Judicial Applications").

Public Health Authorities

The public health authorities in Canada and its provinces took on a regulatory role in an unprecedented manner.

The Commission heard that in Nova Scotia, the Minister of Health issued public health orders under the authority of the provincial health legislation. The first order was made on March 24, 2020, and it underwent 97 iterations, being renewed every two weeks until July 6, 2022. The final order remained in place at the date of the Truro, Nova Scotia hearings. Among the things that were ordered by the public health authority in Nova Scotia were protocols and directives mandating masks and vaccines in certain settings and for certain activities.⁴

In Québec, the Commission heard that initially a 10-day public health emergency was declared. However, it was repeatedly renewed and changed. Different rules were enacted in each district, and the rules became so complex that even a legal practitioner who was specializing in the area could not keep up. Because the rules were not legislation, there was no central location for a person to learn what was being imposed at any particular time.⁵

In Alberta, the Premier effectively deputized the Public Minister officer, providing her with the power to make pandemic measures as public health orders.⁶ By declaring an emergency under the *Public Health Act* instead of the *Emergencies Management Act*, the province of Alberta avoided having to implement the Emergency Preparedness Plan that it had spent decades creating and preparing. Instead, the public health authority made orders on the fly, without the benefit of the emergency planning that was well developed and ready to go.

Surprisingly, the Commission heard testimony that when the Alberta Public Health Officer was cross-examined in a court action, she admitted that the public health orders that she made were at the instruction of, and contained the will of, the Cabinet, and not her own. In this way, the government appeared to delegate the power to impose pandemic measures to a health expert, but in reality, the measures were political and made by politicians.

This stunning admission underscores the problems that can occur when matters are delegated by the government. The politicians were able to avoid public criticism for the measures they imposed by providing them under the guise of their medical expert. The courts, in turn, gave excessive deference to the public health authorities, believing them to be making orders based on their expertise.

⁴ Submission of Truro counsel on day 3—after Scott Spidle and before Jessica Blauvelt.

⁵ Myriam Bohémier, Québec City hearings.

⁶ Lt. Col. David Redman, Red Deer hearings.

That this happened in Alberta is a clear demonstration of why reform is needed in the area of judicial deference. The Commission recommends that legislation be implemented requiring that administrative bodies whose decisions are subject to the standard of reasonableness be required to demonstrate their expertise and how it was applied to reach the decision. Absent such demonstration, the decision cannot be reasonable.

Colleges of Physicians and Surgeons

The Commission heard evidence that the governing bodies over doctors in each province created internal guidelines and directives in respect of doctors' ability to practise medicine during the pandemic.

Patrick Phillips (Truro, NS)

Michael Alexander (Toronto, ON)

James Kitchen (Saskatoon, SK; Vancouver, BC)

Natasha Gonek (Ottawa, ON)

The Commission heard that colleges in Canada had taken these steps:

- Restricted doctors from making public statements that contradicted public health information concerning lockdowns, masks, and vaccines;
- Restricted doctors from prescribing certain drugs—notably ivermectin, zinc, and vitamin D—to patients in order to treat COVID-19;
- Restricted doctors from writing mask and vaccine exemptions for patients;
- Suspended a chiropractor from practising due to failure to mask;
- Disciplined a doctor who refused to get a COVID-19 vaccine due to religious beliefs.

Doctors who did not follow these instructions were subject to investigation and discipline by the College of Physicians and Surgeons of Ontario (CPSO).

There is legislation in each Canadian province establishing self-regulating bodies for doctors (each a college), which is an administrative body that regulates the practice of medicine. In Ontario, the legislation provides that the colleges have two aims: (1) to prevent patient harm, and (2) to establish standards of practice and competence for the profession. The college is required at all times to act in the public interest. But how is the public to know whether or not the college is, indeed, acting in the public interest?

The Commission heard evidence that the colleges governing health professions are private, not-for-profit entities formed for the purpose of being a self-governing body for professions under the applicable health legislation. They are funded by member fees, and their functions are to govern the regulated members in a manner that protects and serves the public interest. Main activities include providing direction and regulation of the practice of medicine and regulating members, establishing standards of practice, approving programs of study, and establishing, maintaining, and enforcing standards for registration and continuing competence.

The separation of the governing colleges from the government itself is intended to serve the public: independent and free from government influence. During the pandemic, however, such separation disappeared. The NCI heard testimony that regulatory bodies took up the government message and instead of independently considering their path, adopted and reinforced the government measures with zeal.

Lawyers across the country described case after case of professional discipline by professional colleges governing doctors, nurses, chiropractors, and others.⁷

One lawyer described defending doctors, and some nurses, who were prosecuted by their colleges for “spreading misinformation.” The charges were that the doctors harmed the public by spreading misinformation about COVID-19. Licences have been suspended and may be permanently revoked.⁸ Another lawyer described a doctor who was disciplined for prescribing an off-label prescription drug (a practice that is explicitly allowed),⁹ and another doctor who was disciplined for failure to vaccinate (where the doctor’s refusal was based on a religious belief).¹⁰

Freedom of expression among doctors was jettisoned, and colleges required that doctors not speak publicly against public health policies and recommendations. The Ontario college published this requirement on its website as a “statement.” It was not passed as a resolution, it was not a policy established by the college, it was not in the legislation, nor was it a government directive. Nonetheless, the colleges prosecuted doctors for violating this statement, using their power to investigate and prosecute.

⁷ James Kitchen, Saskatoon hearings. Michael Alexander, Toronto hearings.

⁸ Michael Alexander, Toronto hearings.

⁹ The NCI heard testimony from multiple witnesses that once Health Canada approves a medication, any doctor can prescribe it on an off-label basis. The ability to prescribe off-label is allowed because approved medicines come with a side effect profile and doctors can assess the risks of prescribing it in an off-label manner. See for example, Michael Alexander, Toronto hearings.

¹⁰ James Kitchen, Saskatoon hearings.

The NCI heard testimony that the prosecution of doctors by their colleges, highlighted faults in the system, revealed a lack of transparency in the governance process, and facilitated a chronic abuse of authority by the college system. During the pandemic, the medical colleges sought uniformity in medical messaging and treatment, while squashing dissent and questions among doctors.

Under the law, a college cannot prosecute a doctor without reasonable and probable grounds that the doctor has committed professional misconduct. During the pandemic, the colleges took the novel position that doctors were not permitted to publicly disagree with statements or guidelines from the college or public health authority. This was described as extraordinary. Doctors who violated this new rule were subject to not only investigation and prosecution but also search and seizure of their offices and medical records.

The following questions have yet to be answered:

- In whose interest did the colleges act when they directed members to convey ONLY the government and health authorities' messaging?
- How could colleges so freely interfere in the patient-practitioner relationship in directing the treatment of patients?
- Should regulators be allowed to censor their membership and prevent them from speaking publicly?
- Who oversees the regulators?

The Commission heard that the colleges engaged in fear based communication—threats of, and actual, discipline—as well as discouraging open discussion and research into best clinical practices.

In the end, the professional colleges simply adopted government messaging and imposed it on their members, when the government did not demonstrate that it was acting in the public interest.

The failure of professional colleges to act independently and ensure that their actions were indeed in the public interest reveals a serious governance issue. An independent, multidisciplinary inquiry into the governance of professional colleges, particularly in the medical field, is warranted.

Recommendations

Based on the witness testimony and the preceding discussion regarding Canada's justice system and its actions during the pandemic, here are 10 recommendations for improvements:

- A. **Uphold the Rule of Law:** Reiterate and reinforce the importance of the rule of law in Canada's justice system, emphasizing that all individuals, including the government, are subject to the law.

- B. **Review and Rebuild Confidence in Courts:** Conduct a thorough review of the Canadian courts' handling of pandemic-related cases and their impact on the rule of law. Rebuild public confidence in the justice system by addressing concerns raised during the pandemic.
- C. **Separation of Powers:** Reassert the separation of powers among the legislative, judicial, and executive branches, ensuring that each branch functions independently within its prescribed role.
- D. **Limit Executive Authority:** Examine and reform the extent of executive authority during emergencies, ensuring proper checks and balances to prevent unelected officials from making far-reaching decisions without accountability or oversight.
- E. **Non-Delegation Doctrine:** Study the implementation of a non-delegation doctrine in Canada, similar to some USA states, to ensure that legislative powers are not unduly delegated to unelected administrative bodies.
- F. **Accountability of Administrative Bodies:** Enact legislation that requires administrative bodies to demonstrate their expertise and rationale for decisions, particularly when those decisions infringe on individual rights.
- G. **Public Health Authorities Oversight:** Establish a clear framework for oversight of public health authorities' decision-making processes during emergencies to balance public health needs with individual rights and freedoms.
- H. **Transparency in College Governance:** Conduct an independent, multidisciplinary inquiry into the governance of professional colleges, especially those governing medical professionals, to ensure transparency, independence, and accountability in their decision-making. The activities of the colleges must adhere to the Charter of Rights and Freedoms.
- I. **Freedom of Expression for Healthcare Professionals:** Safeguard healthcare professionals' freedom of expression, while ensuring that they provide accurate and evidence-based information to the public.
- J. **Protecting the Patient-Practitioner Relationship:** Review the ability of regulators to interfere in the patient-practitioner relationship, ensuring that professional judgment remains independent and guided by the best interests of the patient.

These recommendations aim to address the concerns raised in the discussion and promote a more balanced, accountable, and transparent approach to governance and decision-making during public health emergencies in Canada.

7.1.2. The Response of Canadian Courts

Introduction

The Commission heard testimony regarding the role that Canada's court system played in the pandemic response.

Based on the testimony, the Commission has serious concerns about the impact of court pandemic measures and the excessive deference paid by the courts to administrative bodies such as public health authorities and professional colleges. The Commission recommends an independent inquiry be conducted into the court's response.

The Role of Canadian Courts

Canadian courts have an interesting dual role in that they must both: (1) enforce the laws created by the government; and (2) protect Canadians from unconstitutional laws created by the government. In practice, courts actually spend the vast majority of time enforcing and implementing laws. It is rare for courts to be called upon to consider whether laws are appropriate or constitutional in the first place. For this reason, one could wonder whether some courts forget, or are not comfortable with, their role as constitutional guardians who must stand up to the government in defence of citizens.

The imbalance of power between the government and its citizens, however, means that the courts' role in reining in legislative overreach and preventing rights violations by government bodies (and others) is critical. When the government enacts laws or takes actions that violate the constitutional rights of Canadians, there is no mechanism for protection other than the courts. This is particularly so when the government's actions are supported by (or, at least, not stopped by) the majority of Canadians.

In an elected democracy, the government can create laws that are popular with the voting majority, but which may harm individuals or minority groups. For this reason, one of the primary purposes of the Constitution, minority populations from the tyranny of the popular majority. The courts, through their tenure and independence, play a critical role in such protection. The courts are the only institution in the country that are empowered to stop government actions from harming the people. Despite this, the NCI heard compelling evidence that Canadian courts did not hold up their expected role for Canadians.

The NCI heard significant criticisms from legal experts about the lack of protection from the courts in responding to pandemic measures that violated the rights of Canadians. The courts paid deference to the government in its action, which is inconsistent with the rule of law, and the requirement that the government be subject to the law in the same way as its citizens. Among the many complaints heard by the NCI was that Canadian courts:

- participated in the prosecution of religious leaders whose alleged crimes are supposedly protected under the principle of freedom of religion and worship;

- gave unquestioned and unwarranted deference to the decisions of administrative bodies that censored medical providers;
- supported the medical system in denying life-saving care to a Canadian on the basis that she would not consent to a COVID injection, despite there being no medical reason for the requirement, and the fact that she could demonstrate evidence of strong natural immunity to COVID;
- supported the government and employers in denying Canadians the right to work and the right to receive Employment Insurance;
- avoided difficult decisions under the doctrine of mootness; and
- did not require governments to demonstrate the supporting proof of the benefits of their policies outweighing the risks, and even took judicial notice of public health positions as unquestioningly true.

These actions by the courts have eroded Canadians' trust in the judicial process, and have left many feeling hopeless.

Court Shutdowns and Delays

One of the first pandemic responses was to close Canadian courts. The NCI heard that virtually all Canadian courts completely shut down from April to June 2020 (except for emergency matters). Thus the Canadian justice system came to a standstill, delaying cases and creating backlogs. One is reminded of the old maxim: "Justice delayed is justice denied." The shutdown of courts caused Canadians to lose access to justice as an immediate result.

Upon reopening, many courts implemented the very public safety measures that were being challenged as unconstitutional. Virtual court hearings were required in many cases, which denied complainants their ability to be seen and heard by a judge in person. Mask requirements, and even vaccine passports, were imposed.

The fact that courts imposed the same measures as the rest of society without questioning their efficacy or justification was unbefitting of courts that are supposed to be independent and in control of their own process. Additionally, adopting government measures without question created an implicit bias against anyone who questioned or opposed those measures. For example, if a person wanted to dispute a ticket for refusal to wear a mask, they would be required to attend court in a mask and would be heard by a masked judge who insisted that everyone in his or her presence also wear a mask. It is difficult to see how a person coming to court in that situation could expect a fair and unbiased hearing about whether the masking ticket was reasonable or lawful.

For this reason, courts should not simply accept public health mandates, even in cases of public health emergencies. Canadian courts should have conducted an independent review of the impact of such measures on their own ability to provide justice. As part of this review, Canadian courts could have required the government to demonstrate how the benefits of the measures outweighed the harms. This review could be conducted now, and is recommended to be adopted as part of each court's process going forward in cases of public emergencies.

In Alberta, a small business applied to court for an injunction to stop business closures. Instead of recognizing the immediate harm that the business was asserting, the court allowed the government six months to prepare its evidence and delayed issuing a decision. At the time of the Saskatoon hearings (April 2023), the decision had still not been issued from the court despite the application being made in December 2020.

In these ways, Canadians experienced a lack of access to justice at a time when they felt they needed the courts.

The Courts Paid Undue Deference to the Government

A former judge who testified to the NCI described the Canadian courts' approach to pandemic cases as, "If the government makes a policy, then who are we to question it?"¹¹

Judicial deference to government COVID policy was a consistent theme heard by the NCI across the country. Courts were reluctant to question public health messaging. Instead, the NCI heard that courts assisted in effectively creating a public health authority that could not be questioned, as public health recommendations were accepted by the courts without any verification or testing. This approach was inconsistent with the rule of law.

In Manitoba, when churches arranged for outdoor or car-based worship services, the police came and arrested the organizers and some attendees for violating the gathering restrictions.¹² The courts, instead of requiring the government to demonstrate the necessity of the gathering restrictions in those circumstances, especially in light of the extreme violation of Charter rights caused by such restrictions, paid deference to the government's actions. This left citizens with the perception that there was no point in going to court to defend themselves.¹³

¹¹ Brian Giesbrecht, Winnipeg hearings.

¹² Tobias Tissen, Winnipeg hearings.

¹³ Brian Giesbrecht opinion, Winnipeg hearings.

In an Ontario family law case, a couple came to court with a dispute over whether to vaccinate a child.¹⁴ The mother brought evidence from experts who discussed the risks versus benefits of vaccination, while the father pointed to the Ontario public health recommendation to vaccinate all children in that age group. The motions judge took significant time to review the evidence from both parents and concluded that the mother, who had sole custody of the child, could make the decision not to vaccinate.

The father appealed this decision to the Ontario Court of Appeal. The Appeal court overruled the decision and held that the lower court should have accepted the provincial health authority's recommendation.

The NCI heard that this approach caused the burden of proof to shift in cases involving the government. Thus, Canadian courts appeared to give the benefit of the doubt to the government and required ordinary citizens to disprove the government's conclusions, even where they negatively impact or infringe upon their protected rights. A dangerous precedent is being set.

The Canadian approach could be compared with the U.S. courts, where pandemic measures were repeatedly struck down by the courts. The NCI heard evidence that U.S. courts have struck down a requirement that all air passengers wear face masks and have struck down several vaccine mandates.

The courts' excessive deference and failure to question the governments' measures has led to a crisis of confidence in the judicial system. If courts simply take the government's position at face value, then what is the purpose of having a court at all? There is nobody else in the country that can require the government to justify imposing such draconian measures on its citizens. If the courts refuse to do this, then what is their purpose?

The Commission heard evidence that Canadians trust their institutions and have a general belief that institutions that exist to further the public good should not be questioned. This helps to explain why Canadian courts gave so much deference to public health authorities and administrative bodies such as medical colleges. The danger with holding such a belief, however, is that well-meaning courts can actually participate in harm and the violation of rights by not holding institutions to a high standard.

In order to ensure that Canadian courts properly require the government to justify infringement of Canadian rights, judges need to be selected for, and have confidence in, their ability to hold the government to account and make principled decisions. This is especially so when the decisions are unpopular.

[The Standard of Review in Judicial Review Applications](#)

In Canada, government and administrative decisions can be reviewed by a court through the judicial review process. A person who wishes to challenge a government decision, therefore, may

¹⁴ *J.N. v. C.G.*, Ontario Court of Appeal.

apply to court to have it struck or reversed. The judicial review process is a critical part of maintaining the rule of law in Canada, as it ensures that the government is not above the law in making decisions that affect its citizenry.

The NCI heard testimony that the standard of review applied by courts in the judicial review process is problematic, cumbersome, overly deferential, and applied inconsistently and incorrectly. During the pandemic times, the judicial review process was engaged by Canadians to review a wide array of decisions including:

- disciplinary decisions of Colleges of Physicians and Surgeons suspending doctors' licences,
- the decision of the Alberta Minister of Health to close businesses.

The Supreme Court of Canada has established two standards of review that can apply in the judicial review of a decision: (1) correctness, and (2) reasonableness.¹⁵ In general, the standard of reasonableness is presumed to apply in all judicial reviews unless there is a question of law that requires the stricter standard of correctness. It is not always evident which standard of review is appropriate to review a particular decision.

The difference between the standards of review is critical, however, as the standard of review that is applied dictates the level of deference that will be given by the court to the decision-maker who issued the decision under review. Under the standard of correctness, there is virtually no deference given, and a court can feel free to substitute its own view about the correctness of the decision. By contrast, under the standard of reasonableness, a court must only review whether a decision was reasonable, meaning that a reasonable person could have reached the decision based on the facts before them.

The standard of reasonableness comes from the Supreme Court of Canada case of *Vavilov*. This case requires courts to give deference to administrative bodies that are operating within their field of expertise. The Commission heard evidence that the result of this decision has been that no citizen has a chance of successfully overturning a decision or measure when this standard applies. By way of example, Jeffrey Rath testified that the Alberta Chief Medical Officer Dr. Hinshaw, made statements that were negligent, delusional, and not based on facts. For example, Mr. Rath testified that Dr. Hinshaw stated that a person who had received an AstraZeneca vaccine as their first dose was fine to receive a Moderna or Pfizer vaccine as their second dose, despite the fact, according to Mr. Rath) that this was never studied, tested, or proven. Despite this, the reasonableness standard of review requires a court to give her the benefit of the doubt.

¹⁵ *Vavilov v. R.*, Supreme Court of Canada.

The standard of review also applies to court cases challenging the disciplinary decisions of Colleges against their doctors.¹⁶ Each province has a college that regulates the medical profession and has the power to discipline doctors. This is similar for most medical professions. The disciplinary measures can involve reviewing allegations of professional misconduct, levying fines, and suspending or revoking licences to practise. Where a disciplinary decision is made to suspend a doctor's licence, this can be subject to a judicial review in court.

The NCI heard evidence in respect of a judicial review involving a doctor whose licence to practise medicine was suspended. The court essentially applied the wrong standard of review by allowing excessive deference to the administrative tribunal. Allowing deference to administrative bodies such as medical colleges is extremely concerning, particularly where decisions are made that affect a person's ability to work and earn a living. The Commissioners recommend that rules or legislation be enacted that would apply the standard of correctness to disciplinary decisions of professionals, thus ensuring that such persons are entitled to an independent review of disciplinary measures in a court of law.

Failure to provide for meaningful judicial review of disciplinary decisions encourages the application of poor standards by administrative tribunals. This is particularly problematic given the significant impact that such decisions have on the affected member.

The NCI further heard that there is no right to appeal in Ontario where the college's decision to suspend a doctor's licence is upheld upon judicial review. In effect, therefore, a doctor has to request permission from the Ontario Court of Appeal to have his or her appeal heard. This is extremely concerning because such a doctor is effectively prevented from earning a living. This type of deprivation should be entitled to review by a higher court. The Commissioners therefore recommend that rules or legislation be enacted expressly allowing for appeals to the Ontario Court of Appeal of a judicial review involving the suspension of a doctor's right to practise his or her profession.

Judicial Notice

The doctrine of judicial notice is a principle of common law where a court can take judicial notice of a fact without the need of supporting evidence. Taking judicial notice of a fact is supposed to be extraordinary.

The Commission heard that in the past, courts would only take judicial notice of facts that involve no controversy whatsoever. However, in recent years, the upper courts of appeal in Canada have begun to expand the concept.

¹⁶ Michael Alexander, Toronto hearings, day 2.

The problem with taking judicial notice of facts is that the practice throws the requirement for true evidence out and substitutes a court's own view of fact, regardless of the actual evidence presented in court. This practice undermines the principle of Canada's adversarial system, whereby each side of a lawsuit is entitled to present their evidence, and the judge adjudicates between them.

The Commission heard that in court cases involving pandemic measures, government lawyers would ask the court to take judicial notice of facts such as (1) the severity of the pandemic, and (2) the necessity of the government measures. The problem is that the cases before the court often challenged those exact facts. The practice of judicial notice, therefore, deprived Canadians of their ability to challenge the actions of their government.

Curiously, the one case in which a court refused to take judicial notice of the pandemic and the risks of COVID-19 was when inmates of a correctional facility applied to get out of jail. In that case, the court stated it could not take action to protect inmates from COVID without evidence and that judicial notice was not sufficient. Thus, the perception by members of Canada's legal community is that the practice of judicial notice was expanded in favour of government actions but never to support the rights of individuals.

Mootness

The doctrine of mootness is an old principle of common law that experienced resurgence in the courts during pandemic times. Essentially, mootness arises when a legal issue that is proceeding before the courts becomes moot, in that it is no longer a live issue. When an issue is moot, a ruling by the court is considered to be hypothetical only, and thus courts do not wish to waste valuable time and resources reaching a decision that will have no real impact.

It is only in rare and exceptional cases that a court will render a decision on an issue that has become moot. Typically, the issue must be of great importance and the principles to come out of the decision would be of great precedential value, regardless of the mootness in the particular circumstance.

The NCI heard that government lawyers defending cases of government violations of Charter rights consistently argued mootness as their first position in court. They were assisted in this by the slow movement of justice in Canada, which meant that by the time many cases reached a hearing in court, the particular measure or mandate had been suspended or removed. That meant it no longer applied and that any decision in favour or against it would technically be moot.

One might have expected that cases involving severe violations of Charter rights due to pandemic measures would be of such importance that courts would rule on it anyway. Instead, courts sheltered themselves from making difficult decisions by claiming mootness, even when restrictions were ever-changing or were suspended with the explicit threat of being re-invoked.¹⁷

¹⁷ See, for example, the case against the federal government's COVID vaccine mandate for air and rail travel.

Because mootness is a principle of common law, it can be modified or overturned by legislation. It would be appropriate to legislate parameters to the doctrine of mootness, including a prohibition on mootness when the case involves a violation of Charter rights.

Judicial Independence

Because Canadian courts make decisions that have power over citizens and government alike, it is imperative that members of the courts have independence and are not beholden to the government of the day. In principle, judicial independence is laudable and necessary. In practice, it is much more difficult to achieve.

Judges are human, they are citizens of Canada, and they are products of Canadian society. They are former lawyers who have practised law in a particular area, have their own lived experiences, and have formed views which have shaped their biases (conscious and unconscious). They are not untouchable paragons of virtue and fairness who have appeared out of nowhere to rule benignly over questions of law. Thus, perfection in our judicial selection is simply not possible.

In Canada, judges are not elected by the people but are instead appointed by the ruling political party. Once appointed, a judge has tenure essentially for life, meaning that his or her position cannot be threatened even upon issuance of an unpopular decision. Once appointed, judges are free to decide cases without fear of retribution.

In the event that a judge issues an incorrect or controversial decision, there are several levels of appeal through which more judges (often panels containing multiple judges) review the decision. The highest level of appeal is the Supreme Court of Canada. Judges at appellate levels in Canada have themselves been selected (or appointed) by the government, on the theory that they have demonstrated impartiality, competence, and expertise in making fair and reasoned judgments.

In theory, judges are free to make principled decisions that are unpopular and to strike down government actions that infringe constitutionally protected rights and freedoms. In practice, however, the NCI heard that judges were often fearful of COVID, held the same fear-driven views that were propagated daily in the news media, and were not open to or receptive of information that ran contrary to public health messaging.¹⁸

The NCI heard evidence that in Canada, judges are selected after being vetted by a judicial selection committee, which reviews the candidates to ensure their competence and quality. The ultimate selection and appointment to the bench, however, is made by the government.¹⁹ Thus the judicial appointment process is inherently political.

¹⁸ James Kitchen, Saskatoon hearings.

¹⁹ James Kitchen, Saskatoon hearings.

The NCI heard evidence that judicial selection in Canada has been shifting “to the left,” meaning that more judges are being appointed who favour government, and fewer are chosen that value individual rights. Over time, this has shifted judicial decision-making towards government deference and away from protecting citizens from their government. The effects of this shift became particularly apparent during COVID.²⁰

There is a perception by some Canadian legal experts that the judicial appointment process in Canada is flawed. In this respect, there were two main criticisms: (1) any system with government appointments is inherently going to reflect political bias; and (2) in Canada, the federal government is responsible for appointing judges of each province’s superior and appellate courts.

Judicial Appointments Versus Elections

One of the main criticisms of the judicial appointment process is that the judiciary will necessarily be made up of people who have been selected by politicians. There is a question, therefore, of whether appointees are selected because they align with, or may be disinclined to challenge, the views and positions of elected politicians. This may reduce the likelihood that courts will rule against the government to protect the citizenry as judges may have been selected for the very reason that they are pro-government.

Some may take comfort from the fact that in a democratic system, the government (at least in theory) changes fairly often, and thus, any bias in judicial appointments should balance out to some extent. What comfort can be taken, however, if one political party or, indeed, ideology dominates the Canadian landscape for a sustained period of time? And what comfort can be taken by citizens whose political interests are unpopular and are thus never reflected in the elected politicians of the country?

The NCI heard submissions from counsel that Canada’s system of government selection and funding the judiciary could be perceived as inconsistent with the rule of law. Other jurisdictions have addressed this issue by providing for elections of judges by direct and popular vote of the citizenry, at least for some levels of court. While elections appear appealing as an antidote to the issues that can arise from a political appointment process, they also carry downsides. For example, we noted above that a court’s role can be to protect minorities from the tyranny of the majority. However, where a judge has been elected by a majority of the citizenry, he or she may align with the majority’s oppressive actions or be disinclined to rule in protection of the unpopular minority.

Whether or not judges should be elected at some levels in Canada, there are certain practices from the U.S. election system that could fit in with the Canadian appointment system and enhance its process. For example, an open debate with public hearings during the judicial appointment process would provide more transparency and might help to alleviate some of the political bias in appointments. This would be particularly appropriate when appointing judges to appellate levels.

²⁰ James Kitchen, Saskatoon hearings.

It is clear that no system is perfect, and there are advantages and drawbacks to appointments versus elections. For this reason, the NCI believes that the judicial appointment process should itself be reviewed by a panel or inquiry—with the benefit of a wide range of experts, academics, and experienced practitioners—to determine if reform is needed to the system of judicial appointments.

Federal Appointments of Provincial Judges

In Canada, each province has its own set of courts, while Canada maintains a set of federal courts. Many Canadians would be surprised to learn (indeed, several of the NCI Commissioners were also surprised to learn) that the federal government appoints the judges of the superior and appellate courts of each province. When this is combined with the lifelong tenure of judges, it is not difficult to see that this practice can be perceived as providing a significant amount of control over the provinces by a centralized federal government.

It is common and expected in a large country like Canada that different regions have different priorities and ideas about the proper governance of the nation. The confederation of provinces and the separation of powers in the Constitution are intended to allow the provinces autonomy over their own affairs, while also providing for a centralized federal government to coordinate on certain national matters of importance to all.

The confederation is not intended to provide for a federal government that rules over the provinces, nor would that be appropriate, given the substantial separation of constitutional powers. Moreover, given the disproportionate distribution of population across the provinces, it has long been clear that the powers of the federal government tend to be dominated by the interests of the most populous provinces. This begs the question, then: why does the federal government have appointment power over judges that are making the most fundamental rights decisions in each province?

The NCI heard testimony from legal experts recommending that provinces be entitled to appoint their own judges, albeit with appropriate selection processes and corresponding judicial advisory committees. This suggestion makes sense to the Commissioners. However, given the fundamental importance of the judicial selection process, our recommendation is that this should form part of the overall justice system inquiry that should be conducted.

The Judiciary Cannot Act in Tandem with the Government Prosecution Service

The Government of Canada is responsible for law and order, as well as enforcing its laws and regulations. This means that in addition to selecting and funding the judiciary, the government also employs and funds the police and prosecution services in Canada. Government responsibility for all these functions can a perception of a conflict of interest (if not an actual conflict of interest).

The priority of the police and prosecution services is to enforce government laws against people. It is the government that directs them in carrying out their functions. While some may view the role of police and prosecution as achieving the “correct” result under the law, the NCI heard submissions that, in practice, the police and prosecution do not act as protectors of citizen rights. To the contrary, government lawyers appear in court to defend the position of the government. This was particularly so in cases involving pandemic measures.

In effect, the Department of Justice is Canada’s largest law firm, with unlimited resources, prosecuting cases and lawsuits in favour of the government’s laws and decisions. Individual Canadians who seek redress or protection from the courts face a significant imbalance of power and resources.

For this reason, the independence of the judiciary is of utmost importance. Citizens must not have the perception that the entire justice system is stacked in favour of the government, particularly when it comes to violations of their guaranteed rights and freedoms.

Moreover, Canadians should have access to resources when their cases involve violations of Charter rights and freedoms, particularly in a novel setting.

[Societal Pressure on the Judiciary](#)

There is no doubt that the uncertainty and fear that accompanied the introduction of the pandemic in 2020 impacted judges as well as everyone else. Members of the judiciary are members of society and share in the same pool of information provided by the news media as the rest of the country. The societal pressure that was imposed on Canada at large was bound to be felt by some, if not the majority, of judges as well. Additionally, since most judges are older, it is perhaps understandable that some would have been fearful for their own personal safety from the virus.

The NCI heard from a former judge²¹ who described how societal pressure in previous times has impacted judges in their decision-making. He noted that in the 1980s, there was a “satanic panic” that swept North America. Allegations of satanic ritual abuse against children were rampant. There was very strong societal pressure on police and judges to “believe all children,” which resulted in the wrongful conviction of many people. In the aftermath of the panic, it was discovered that many children had been coached to make false abuse claims.

Similarly, spousal abuse got a lot of attention when society began to recognize that it was a real problem. The increased attention was appropriate, but the pendulum swung too far, and there was strong pressure on judges to “believe all women.” Any judge who found in favour of an accused husband or who didn’t accept all allegations of a wife was strongly criticized, sometimes by an Appellate court who oversaw the original judgment.

²¹ Brian Giesbrecht, Manitoba hearings.

Judges are human and cannot help but be impacted by societal pressures of the day. The NCI cannot recommend that judges be replaced with unemotional robots who are immune to societal panics. Nor would that necessarily be positive, as it is important for judges to have a strong sense of sympathy and fairness that comes from being a human being. However, it is very important to select judges who demonstrate an ability to be impartial during times of strong pressure and who are similarly able to set aside their own personal views on controversial topics and remain open-minded. The political appointment process tends to undermine this, as each government would like to appoint judges who share their approach. For this reason, the NCI recommends that there be an independent selection process that involves members of each political party as well as lay citizens.

The Role of Chief Justices

Each court in Canada has a chief justice, whose function is to administer the court, in addition to being a judge. While the chief justice does not have power over any of the individual judges on a court, he or she does have the ability to select which judges on his or her court will hear which cases. Thus, the case-assignment process actually provides a chief justice with significant influence over the ultimate decisions of a court.

The NCI heard testimony that a large number of court cases were taken up directly by the chief justices of each court and that these tended to result in pro-government decisions. There is a perception that many of the older, more rights-focused judges may have been excluded (deliberately or coincidentally) from cases involving the infringement of Charter rights.²²

Despite this perception, it is not recommended that governments legislate measures to direct chief justices in their duties, as this would encroach on judicial independence. It is recommended, however, that case-assignment practices of the courts be included as an item to be examined as part of an inquiry by the courts themselves.

Fear Felt by Legal Practitioners

The rule of law requires a functioning legal system in all ways. Just as important as an independent judiciary is the ability of Canadians to access legal advice and for lawyers to be able to provide such advice in a free and independent manner.

²² James Kitchen, Saskatoon hearings.

The legal profession was not immune from the fear felt by many other professionals in other disciplines across the country. One lawyer who gave advice to members of groups that protested government measures testified that he felt fear of reprisal and prosecution simply for providing his legal services.²³ Once the federal government enacted the *Emergencies Act*, he understood that any person who participated in providing assistance to any person who protested could have their property seized, have their bank account frozen, be fined, or be arrested. In response, he withdrew thousands of dollars in cash from his bank account. He also began to meet his clients clandestinely, in dark parkades and without cell phones.

These reactions may seem extreme, but considering the fact that people were, in fact, arrested and had their bank accounts frozen under the *Emergencies Act*, this was not an unreasonable response. As a legal representative of participants in the protests, he was fearful that he would be targeted. He further testified that although he had no evidence of the government intercepting his solicitor-client privileged communications, he considered it to be very possible.

Another lawyer testified that a complaint was filed against him at the Law Society²⁴ after he criticized the court for its pandemic measures. Such criticism, when done respectfully and academically, should be welcomed in a free society, not punished. The complaint resulted in an investigation by the governing body and was ultimately dismissed as having no basis. However, the mere act of reporting and investigating a lawyer in this circumstance will serve as a disincentive to other lawyers who may wish to speak out. When speaking up to protect freedoms puts your career on the line.

Canada should not be a country in which lawyers are fearful to criticize the court or to provide legal services to Canadian citizens who protest against their government. Lawyers being in fear of losing their licence to practise law when they speak up is an indication of a failure of a free democracy. Legal providers being in fear for their own safety in representing protesters is an indication that Canada is not governed by the rule of law. If the rule of law prevailed, lawyers would not be afraid of their government.

Lawyers should not have to fear for their careers or their safety when performing roles in the justice system. Without fundamental protections for lawyers, the rule of law cannot survive. Even if vindicated at the end of the day, the mere act of threatening the livelihood of lawyers has a chilling effect. Our society should welcome open discourse and should specifically protect those who criticize any branch of the government.

The ability to challenge the government during times of Charter violations and to obtain legal assistance in doing so is critical to maintaining our functioning democracy.

²³ Robert Ivan Holloway, Winnipeg hearings.

²⁴ The Law Society of each province is the governing body for lawyers and is responsible for licensing lawyers to practise law, as well as disciplining those who breach the code of practice.

Recommendations

Following are recommendations to improve the situations described under each of the separate headings.

A. Protection of Constitutional Rights

- **Judicial Review:** Reinforce the role of Canadian courts as constitutional guardians by actively engaging in judicial review of government actions, especially those that may infringe upon Canadians' constitutional rights.
- **Robust Assessment:** Develop a rigorous and evidence-based assessment process for cases involving rights violations, ensuring that the burden of proof is not disproportionately placed on individuals. Courts should critically evaluate government actions.

B. Access to Justice and Court Shutdowns

- **Timely Responses:** Implement measures to ensure that court closures, especially during emergencies like the pandemic, do not result in undue delays in access to justice. Develop contingency plans for virtual proceedings, and prioritize cases with immediate consequences.
- **Independent Assessment:** Courts should independently assess the impact of public health measures on their ability to provide justice. Review the necessity and effectiveness of measures like mask requirements and vaccine mandates in a courtroom setting to ensure fair hearings.
- **Public Engagement:** Involve legal experts, practitioners, and the public in discussions about maintaining access to justice during crises.

C. Judicial Deference to the Government

- **Balanced Review:** Encourage a balanced and impartial review process for government policies and actions, rather than automatically deferring to the government's position. The burden of proof should not unfairly rest on individuals or groups challenging government decisions.
- **Comparative Analysis:** Consider international precedents, such as the approach taken by courts in the USA, where pandemic measures were subject to rigorous legal scrutiny. Analyze and learn from the experiences of other jurisdictions when addressing similar issues.
- **Transparency and Accountability:** Promote transparency in court decisions, ensuring they include clear reasoning and explanations for rulings, especially in cases that involve significant rights infringements. This helps build public trust and understanding.

D. Crisis of Confidence in the Judicial System

- **Public Education:** Launch educational initiatives to inform the public about the role of courts in safeguarding constitutional rights, especially during emergencies. Promote an understanding of the court's duty to question government actions and protect citizens.

- **Judicial Independence:** Emphasize the importance of judicial independence in preserving the rule of law and protecting individual rights. Judges should be selected and trained to have confidence in their role as independent arbiters of justice.
- **Public Engagement:** Create opportunities for the public to engage with the judicial system, such as public consultations or information campaigns. This can help demystify the legal process and foster public participation.

These recommendations aim to strengthen the Canadian judicial system's ability to protect citizens' rights, maintain access to justice, and enhance public trust during times of crisis. Implementing these measures would help ensure that courts fulfil their dual role of enforcing laws, while safeguarding constitutional rights effectively.

E. The Standard of Review in Judicial Review Applications

The *Vavilov* standard of review that pays excessive deference to the decisions of unelected administrative officials prevented Canadians from meaningful access to justice and review of their cases. This was particularly egregious where Canadians were fighting for their rights to bodily autonomy, to work, and to participate as free citizens in society.

The Commission recommends that:

- Legislation be enacted to amend the standard of review in cases where the rights of citizens have been affected. This could be implemented in the applicable *Interpretation Acts* and in the applicable *Bills of Rights*.
- The burden of proof should be placed on the administrative body to demonstrate reasonableness in cases where the rights of citizens are affected.
- Statutory protections should be removed for the decisions of health officers to the extent that they cause harm to persons.

F. Judicial Notice

- The Commission recommends that legislation be enacted to set strict parameters on the use of judicial notice by courts. Judicial notice should never be allowed in respect of evidence that is being challenged. The normal rules of evidence require a party who asserts a fact to prove that fact. This rule underlies the rule of law and should not be relaxed, even in times of emergency.

G. Mootness

- **Legislate Parameters:** Consider legislation to modify or limit the doctrine of mootness, especially when cases involve violations of Charter rights. This could include prohibiting mootness in such cases.

- **Timely Hearings:** Address the issue of slow-moving justice by implementing measures to expedite hearings, ensuring that cases are heard before measures or mandates are suspended or removed.

H. Judicial Independence

- **Diverse Selection Committee:** Ensure that the judicial selection committee includes members from various political parties and lay citizens, not just the government, to minimize political bias.
- **Transparent Appointment Process:** Implement a more transparent judicial appointment process, including public debates and hearings, especially for appellate judges, to reduce political bias and enhance fairness.

I. Judicial Appointments Versus Elections

- **Independent Review Panel:** Establish an independent panel or inquiry composed of experts, academics, and experienced practitioners to review the judicial appointment process. Evaluate whether reforms, such as introducing elections at certain levels, are necessary.
- **Balancing Appointments:** Ensure that appointments reflect a balance of judicial independence and government accountability.

J. Federal Appointments of Provincial Judges

- **Provincial Appointment Authority:** Consider devolving the appointment of provincial judges to the provinces, while maintaining appropriate selection processes and advisory committees to safeguard quality and independence.

K. The Judiciary Cannot Act in Tandem with the Government Prosecution Service

- **Enhance Judicial Independence:** Promote and protect the independence of the judiciary, particularly in cases involving government actions, to ensure that citizens have faith in the fairness of the justice system.
- **Resource Allocation:** Allocate resources to support citizens in cases involving violations of Charter rights and freedoms, ensuring they have access to legal representation.

L. Societal Pressure on the Judiciary

- **Impartial Selection:** Emphasize the importance of selecting judges who demonstrate the ability to remain impartial, open-minded, and fair during times of societal pressure.
- **Non-Partisan Selection:** Promote a non-partisan selection process aimed at minimizing political influence when appointing judges who possess strong principles to uphold laws as they are written, while also emphasizing fairness.

M. The Role of Chief Justices

- **Review Case-Assignment Practices:** Encourage courts to review their case-assignment practices to ensure fairness and balance in the decisions made, particularly regarding Charter rights.

N. Fear Felt by Legal Practitioners

- **Support Legal Professionals:** Ensure that legal professionals can perform their roles in the justice system without fear of career repercussions or threats to their safety.

These recommendations aim to uphold the principles of justice, fairness, and the rule of law, while addressing the specific challenges outlined in each section. Implementing them may require legislative changes, policy reforms, and a commitment to preserving judicial independence and protecting the legal profession's vital role in society.

7.1.3. Labour Law and the Failure of Unions

Discussion

The Commission heard evidence that thousands of unionized employees across the country lost their jobs or were put on unpaid leave as a result of the vaccine mandates. Union members had an even harder time fighting this than non-unionized employees, because under the law they cannot bring direct actions against their employer in court and instead must rely on their union to fight for them.

Unionized employees are largely shut out of the courts and must seek recourse for workplace wrongs through their union, which is the gatekeeper of the grievance process. But what is a person to do when the union itself fails to take up his or her defence—or worse, acts against the employee to enforce compliance with the problematic mandates?

Under the law, union members do not have the right to sue their employer directly. This is because union members are part of a collective agreement, under which they contract out their rights to the union. In turn, the union is obligated to represent the employee against his or her employer. Thus, unionized employees depend solely on their union to fight for their employment rights.

The Commission heard that many unions failed to advocate for their members in defence of the vaccine mandates. Some unions told employees that they must comply with the mandate if they were unable to qualify for an exemption. The Commission heard that one union refused to fight for its member because it had received a legal opinion supporting the employer's right to impose a mandate.

Some employees attempted to bring human rights complaints without the assistance of their union. These applications were denied on the basis that the court had no jurisdiction. This left employees at the mercy of unions that were uninterested in defending them.

The Commission heard evidence that a group of employees in British Columbia had filed a claim against unions for failure to represent them against their employers. The employees had a difficult time finding a lawyer who would represent them, and the time and expense related to this type of suit is extensive.²⁵

The result is that a large number of Canadian unionized employees had no ability to have a court adjudicate on the applicability of mandates nor to consider the safety of the vaccines being imposed.

Recommendations

Based on the testimony concerning labour law and the challenges faced by union members during the pandemic, these recommendations were formulated to address these issues:

²⁵ Philip Davidson, Vancouver hearings, day 1.

- A. **Legislation to Protect Union Members:** The Commission recommends that legislation be adopted to include ensuring the protection of union members where the member asserts
- that Charter rights have been violated as a result of actions of the employer or the union, and
 - a grievance against his or her employer that the union fails to, or refuses to, defend.
- B. **Review and Strengthen Labour Laws:** The government should review labour laws to ensure that they provide adequate protection to both unionized and non-unionized employees during health emergencies like the pandemic. This should include mechanisms for addressing workplace issues related to mandates and safety concerns.
- C. **Enhance Union Accountability:** Labour laws should be amended to hold unions more accountable for representing their members effectively. This could involve regular assessments of a union's performance in advocating for its members' rights during crises. Unions should be required to demonstrate that they are acting in the best interests of all of their members.
- D. **Ensure Union Transparency:** Unions should be transparent about their decision-making processes and actions during crises. Members have a right to know how their union is advocating for them. Transparency can help build trust between members and their unions.
- E. **Access to Legal Recourse:** Labour laws should be revised to allow union members to have access to legal recourse in cases where their union fails to adequately represent their interests. This could include the ability to bring direct actions against employers under certain circumstances, such as when the union refuses to take up their case.
- F. **Legal Aid for Union Members:** Governments should consider providing legal aid or support to union members who need to take legal action against their union or employer. This would help level the playing field for employees who find themselves in such situations.
- G. **Mediation and Dispute Resolution:** Establish mediation or dispute resolution mechanisms specifically tailored to labour disputes arising from health emergencies. This can provide a more efficient and cost-effective way to address employer-employee issues than lengthy court battles. Reasons for decisions must be made public.
- H. **Educate Union Members:** Unions should play a proactive role in educating their members about their rights and the grievance process. Well-informed members are better equipped to hold their unions accountable and make informed decisions during crises.
- I. **Encourage Collaboration:** Governments, unions, and employers should work together to develop clear guidelines and protocols for dealing with workplace issues during health emergencies. Collaboration can help prevent conflicts and ensure the best interests of workers are protected.

- J. **Whistleblower Protections:** Strengthen protections for whistleblowers within unions and workplaces. This can encourage employees to come forward with concerns without fear of retaliation.
- K. **Public Inquiry:** Consider launching a public inquiry into the specific challenges faced by unionized employees during the pandemic. This can help identify systemic issues and inform policy changes.

These recommendations aim to address the shortcomings in labour laws and union representation highlighted during the pandemic. They seek to strike a balance between protecting individual employee rights and maintaining the integrity of collective bargaining agreements.

7.1.4. The Constitution

The Constitution is the supreme law of Canada.²⁶ The main parts were enacted in 1867 and 1982. *The Constitution Act, 1867*,²⁷ created Canada as a country, and the *Constitution Act, 1982*, created the *Canadian Charter of Rights and Freedoms* (the Charter).

Since the Charter is part of Canada's Constitution, it forms part of the supreme law of Canada, and governments are therefore not permitted to pass laws that violate the rights that it guarantees.

Canadians were surprised, therefore, when the governments' responses to COVID not only appeared to violate many of the rights that are guaranteed under the Charter but that the courts supported the government in such violations.

There is a reason that Canada (and many other countries) have enacted constitutional protection for individual rights and freedoms. Governments are not infallible, and institutions cannot be trusted on their own to protect individuals. History has demonstrated that even the most advanced societies can enact oppressive measures and trample on the rights and freedoms of some of their members. Canada is not necessarily immune from this, and its government actions should not be immune from scrutiny.

There is no doubt that many of the government measures in response to COVID violated Canadians' rights and freedoms under the Charter, including:

- freedom of thought, belief, opinion, and expression (s. 2(b));
- freedom of peaceful assembly (s. 2(c));
- freedom of association (s. 2(d));
- the right to move to and take up residence in any province (s. 6(2)(a));
- the right to pursue the gaining of a livelihood in any province (s. 6(2)(b));
- the right to life, liberty, and security of the person (s. 7);
- the right to be secure against unreasonable search or seizure (s. 8);
- the right not to be arbitrarily detained or imprisoned (s. 9);
- the right not to be subjected to any cruel or unusual treatment or punishment (s. 12);
- the right to be equal before and under the law (s. 15); and

²⁶ *Constitution Act, 1982*, being schedule B to the *Canada Act 1982* (UK), 1982, c 11, section 52(1).

²⁷ Formerly the *British North America Act, 1867*, 30-31 Vict., c. 3 (U.K.).

- the right to equal protection and equal benefit of the law without discrimination based on race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability (s. 15).

The rights under the Charter, however, are not absolute. Section 1 of the Charter provides that the rights and freedoms are guaranteed to Canadians. However, it also provides that the rights and freedoms are subject to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

The NCI heard from counsel and witnesses that courts essentially relied on section 1 of the Charter to excuse the governments' violations of Canadians' rights and freedoms. During COVID, it appeared that every government response was justifiable under section 1, no matter how fundamentally it affected Canadian individuals.

NCI was not made aware of any case in which a court tested the government's reasons for infringing the rights and freedoms of Canadians. To the contrary, counsel brought a decision to the NCI's attention where a Court of Appeal lambasted a lower court judge for not relying on public health authorities, while noting that many courts have taken judicial notice of the safety and effectiveness of the COVID-19 vaccines.²⁸ To have a decision at the appellate level pay this much deference to the government is of great concern.

Canada is not a country that is founded on the principle of the collective over the individual. To the contrary, Canada's constitution provides that Canada is founded on the rule of law, and it guarantees the rights of individuals. The courts' deference to the government in its pursuit of policies that favoured public health, and the protection of the health system over the health of individuals, runs contrary to the rule of law.

Canadian courts' support of the governments' pandemic measures have set the dangerous precedent that individuals do not have rights during a crisis. This represents a fundamental change in the relationship between citizens and their government. Prior to the pandemic, individuals and government were equal under the law. The government had powers, such as to govern and protect the nation. The citizens, however, equally had power through their guaranteed rights and freedoms.

The precedent appears to have been set now that, during a crisis, the government has all the power, and the citizens can no longer assert their rights and freedoms. If this is accepted, then the government will be incentivized to characterize more and more circumstances as crises in order to assert power over the people.

When Canada adopted the Charter in 1982, it appeared to guarantee certain fundamental rights and freedoms to each individual in Canada. Multiple experts, however, testified to the NCI that the protection of the Charter has turned out to be illusory, with one lawyer asserting that it only took 40 years for the Charter to be subverted by the government.

²⁸ See the cases cited in *J.N. v. C.G.*, 2023 ONCA 77, at para. 20.

The pandemic exposed that the *Canadian Charter of Rights and Freedoms* is weak. It failed to protect Canadians' basic rights and freedoms during a time when governments imposed the most broad and draconian measures on society.

The importance of the Charter, however, cannot be understated. It is those people who bring cases to court challenging government actions that open the door to information and bring wrongs to light.

Loss of the Right to Freedom of Expression

Public policies and pandemic measures enacted across Canada were viewed by many as an assault on the rights and freedoms of citizens. The NCI heard that Canada's principles and values stem from classical liberalism, which has an extraordinary history over 1000 years; at its core is the assumption that people are born free.²⁹ The government's role is to serve the people. It is not the ruler of the people, and it is not above the law. The state is not privileged under the law; instead, it is bound by it.

Of all of the rights that were violated under the Charter, the NCI heard that the freedom of expression was the most essential, and its violation was the most impactful. Medical professionals were instructed not to speak out against public health messaging and were disciplined by their governing bodies if they did. Scientists were dismissed from their positions, dropped by media outlets where they had previously spoken, and censored on the Internet.

Freedom of expression, belief, and conscience is the cornerstone of a liberal democracy. It is not an accident that it is the first fundamental freedom described in the Canadian Charter. Freedom of expression and tolerance of diversity of opinion fosters respectful debate. Through this, innovation is fostered, and society improves.

The Canadian justice system did not support Canadians' freedom of expression where it conflicted with the public health messaging of the government. This was coupled with undue deference to government officials who had unfettered discretion to enact rights-violating measures that went unchallenged by the courts.

The Legality of COVID Injection Mandates

The Commission heard evidence from many Canadians who were required to take a COVID-19 vaccine in order to keep their job. Sadly, the Commission heard from many who were injured as a result.

²⁹ David Leis, Winnipeg hearings.

There is a considerable amount of legislation in Canada that requires employers to keep employees safe. During the time of the pandemic, employers relied on public health guidance to implement measures to keep employees safe. Presumably this is how employers who imposed mask and vaccine mandates justified these measures³⁰.

In determining whether an employer should be held accountable for harm that may have occurred as a result of a workplace vaccine mandate, the Commission heard from a workplace safety professional that three questions should be asked:

1. Was the employer required to implement the mandate at law?
2. Was it legal to implement the mandate?
3. Did the employer do the requisite due diligence to ensure the safety of employees as a result of the mandate?

The Commission further heard there is extensive legislation that applies to employers that should have prevented them from imposing a mandate, both legally and as a result of performing proper due diligence. Among these is the *Canada Labour Code*, provincial health and safety legislation, a *Genetic Non-Discrimination Act*, and the *Criminal Code*.

Despite the extensive regulatory framework that exists in Canada to protect employees from workplace hazards and dangers, vaccine mandates were implemented in many workplaces and people were harmed as a result.

Recommendations

The Commission recommends that legislation be enacted prohibiting employers from imposing vaccine mandates on employees.

- A. **Canada should establish** an independent review of its judicial appointment process.
- B. **The federal and provincial courts** should conduct a national inquiry into their response to pandemic measures, including a review of:
 - a) What role did the court play in protecting the rights of individuals?
 - b) What role should the court play when a government imposes vast rights-violating measures?
 - c) Should the government have the ability to impose pandemic measures on courts and the judiciary?
 - d) What level of independence do the courts have over their own process in implementing publicly recommended or ordered measures?

³⁰ Ryan Orydzuk, <https://rumble.com/v2kb5pu-a-passion-for-occupational-health-and-safety-ryan-orydzuk-testimony-day-2-s.html>

- e) Should guidelines or best practices be adopted for case assignment, particularly in cases that involve alleged violations of Charter rights?
- C. **Judges in provincial courts** should be appointed by provincial governments and not the federal government. This recommendation is subject to review as part of the overall review of the judicial appointment process.
- D. **The judicial selection** process should involve a review by a panel that involves a wide array of citizens and legal experts with different political views and backgrounds. Recommendations for appointments should be made public.
- E. **Canada should establish a fund** to pay for legal services for Canadian citizens who bring cases against the government for a violation of Charter rights or who are defending prosecutions that violate Charter rights. Further study could be undertaken to determine the structure and principles governing the fund. Some fundamental principles should include:
 - a) The fund is governed/overseen by a board which has equal representation from constitutional scholars, lawyers, government representatives, academics, and citizens.
- F. **Canada and the provinces** should legislate parameters for mootness, including a prohibition on mootness when a case involves a violation of the Charter rights of an individual.
- G. **An independent inquiry should** be conducted into the response of the medical colleges in each province, including a review of
 - a) What role did the college play in protecting the rights of its members?
 - b) What role should the college play when a government makes recommendations for medical practice?
 - c) Should there be specific limits placed on the powers of the colleges?
 - d) What regulations can be put in place to assure that the colleges adhere to the *Canadian Charter of Rights and Freedoms*?

7.1.5. Undermining Democratic Institutions

Introduction

The Commission heard evidence that Canada's democratic processes were interrupted and undermined during the pandemic.

Rick Nicholls (Toronto)

Stéphane Hamel (Québec City)

Testimony that Politicians Were Pressured to Vaccinate Against Their Will

It is fundamental to Canada's democracy that elected representatives must be able to participate in the legislative affairs for which they were elected, without undue interference.

Rick Nicholls was a member of the Ontario Legislature from October 2011 to June 2022. He served three terms and was elected as a member of the Progressive Conservative Party. During his time, he was an opposition shadow cabinet minister and deputy speaker of the opposition, and deputy speaker for the legislative assembly.

Elected members of the provincial legislatures serve at the pleasure of the people. While he was a sitting member of the legislature:

- at caucus meetings, the chief medical officer of Ontario and other doctors gave presentations to the members about the new vaccines. He asked questions about the efficacy and safety,
- some colleagues were supportive, but others would not entertain his vaccine hesitancy,
- Premier Ford himself called Mr. Nicholls and asked him to "do me a favour" and get vaccinated,
- he received a call from a Progressive Conservative Party pollster, a campaign chair for the re-elect Doug Ford campaign (who is a lobbyist for pharmaceutical companies), threatening him to get vaccinated within 72 hours or be removed from the Progressive Conservative caucus.

Mr. Nicholls instead declared publicly that he would not get vaccinated. Later that day, a press release was issued by the party removing Mr. Nicholls from the Progressive Conservative caucus. Mr. Nicholls sat as an independent member of the legislature for a while before joining the Ontario Party.

How can the public be confident that their elected representatives are able to serve their interests if they are threatened and coerced to "go along" with something they either disagree with or are hesitant about?

Testimony that Politicians Were Pressured to Not Dissent

The Commission heard testimony from Stéphane Hamel, one of the founders of the Québec provincial political party, the Coalition Avenir Québec (CAQ). In 2020, he was the president of the CAQ, which was the governing party of the province.

When the pandemic measures were first discussed and introduced, he questioned them but understood that it was important not to put doubt in the mind of the population during a time of crisis. However, as more data and information was coming out, he had more questions. The executive of the CAQ cautioned him against speaking out, warning him that it was important for the entire population to be on the same page due to the dangerous virus.

When the CAQ began discussing the implementation of a vaccine pass, Mr. Hamel wrote a letter to the party stating he did not agree with the measure and that he would oppose it. Ultimately, he expressed his position on his personal social media page. The CAQ accused him of not following the party's constitution and not being in solidarity with the party. They unanimously voted to remove him from the party.

Thus, Mr. Hamel was removed from his political party for criticizing its position, and his voice was silenced. Not only was he silenced, but the party made an example out of him to ensure that there would be no other opposition. If the elected members of a political party cannot speak their minds, the political process is undermined.

Testimony that the Normal Passing of Legislation Was Undermined

The pandemic gave Parliament and provincial legislatures an opportunity to subvert the normal democratic process of passing legislation by passing legislation that gave themselves (and the administration) powers that would not normally be acceptable to the public. Parliament and the legislatures took the opportunity to change their own procedures and adopt practices such as virtual attendance and voting, and extended sessions into evenings when most were not in attendance.

Rick Nicholls testified that in respect of the vaccine measures, he repeatedly challenged the Health Minister in the legislature, as more and more boosters were recommended and the response was always the same—that it's "safe and effective" and we have to protect others.

Bills are first discussed in caucus. The minister presenting it makes a presentation in caucus, and the other members can ask questions. Then it gets presented in the legislature for readings, amendments, debate, and a vote.

The timing of readings changed during the pandemic. For example, when the *Emergencies Act* was implemented in Ontario and the government wanted to extend the emergency, the legislature called for third reading on a Wednesday evening, when very few MPPs were around and not many were attending in person. He hurried to attend and asked to remove the provisions that give immunity to pharmaceutical companies. His changes were not accepted, and the legislation was passed.

During the pandemic, insufficient time was given to review and understand proposed bills. Debate was started immediately, and the party dictated how each MPP should vote. Members were given talking points on how to present the bill to their constituents and convince them to support the bill. Members were pressured to not show up for a vote if they would not vote to support it. When one person secretly voted against a bill, they were removed from caucus.

Recommendations

- A. **Informed Consent:** Political parties should enshrine the principle of Informed Consent into party rules and constitutions, guaranteeing each member the freedom to make their own decision and to be free from coercion or mandates to receive a medical treatment.
- B. **Protection of Elected Representatives' Independence:** The parties should adopt regulations to protect the independence of elected representatives so that elected officials are able to express their views and concerns freely without fear of retribution from their own political parties.
- C. **Whistleblower Protections:** Clear whistleblower protections for politicians and party members who raise concerns about government actions or policies should be established, with protections extending to all levels of government and including all elected officials at all levels of government.
- D. **Transparency and Accountability:** Decisions by political parties, municipalities, and school boards should be transparent. Parties should be required to provide clear reasons for any actions taken against their members. This includes publicizing party decisions and disciplinary actions.
- E. **Strengthen Party Democracy:** Encourage internal party democracy by allowing members to openly debate and express dissenting opinions on significant issues, especially during crises like a pandemic.
- F. **Reform Legislative Procedures:** Review and reform legislative procedures, particularly during emergencies, to ensure that there is sufficient time for members to review and debate bills. Emergency legislation should not bypass the regular legislative process.
- G. **Public Consultation and Accountability:** Ensure that significant decisions related to public health measures and emergencies are subject to public consultation and accountability. Decisions should be based on a transparent and evidence-based approach.
- H. **Protection of Parliamentary Sessions:** Protect the integrity of parliamentary sessions by maintaining regular working hours and ensuring that important votes are conducted when a significant number of members are present.

- I. **Review Emergency Powers:** Review and assess the powers granted to governments during emergencies, such as those under the *Emergencies Act*, to ensure that they are not overly broad and they respect democratic principles. Consider legal mechanisms for parliamentary oversight.
- J. **Education on Legislative Processes:** Educate elected representatives and the public about legislative processes and the implications of emergency measures. This includes training for politicians on their roles and responsibilities during crises.
- K. **Independent Oversight:** Consider the establishment of an independent oversight body or commission to monitor and evaluate government actions during emergencies, ensuring that democratic principles are upheld.
- L. **Protection of Opposition Rights:** Strengthen the rights and protections of opposition parties to allow them to effectively scrutinize government actions, especially during emergencies. This includes timely access to information and the ability to hold the government accountable.
- M. **Public Inquiry:** Consider launching a public inquiry to investigate the undermining of democratic institutions during the pandemic. The findings of such an inquiry can inform necessary reforms.

These recommendations aim to safeguard democratic institutions, protect the independence of elected representatives, and ensure that decision-making during emergencies is transparent, accountable, and based on democratic principles.

7.1.6. International Law

International law is different from a country's own domestic law because it does not represent binding and enforceable rules that are imposed by a government over its people. Rather, international law is a series of principles that are agreed to among countries. When Canada signs a treaty with another country (or countries), it is agreeing to abide by the principles set out in the treaty. However, if Canada does not abide by the terms of the treaty, there are very limited avenues by which the other country can seek to enforce it.

This does not mean that international law can have no effect. In Canada, the Supreme Court of Canada has confirmed that customary international law is adopted into Canadian law. It has further stated that the *Canadian Charter of Rights and Freedoms* should be presumed to provide at least as great a level of protection as is found in the international human rights treaties to which Canada is a party.³¹

The NCI heard international law testimony that raised the following two important issues:

- on the one hand, Canada's vaccine measures violated Canada's obligations under international human rights law; and
- on the other hand, new developments in international health law may result in Canada becoming, in the event of another declared pandemic, bound to implement intrusive and harmful health measures that arguably violate the principles of international human rights law.

Witnesses

Gail Davidson (Vancouver)

James Corbett (Ottawa)

Canada's Vaccine Measures and International Human Rights Law

The premise of international human rights law is to guarantee fundamental rights and freedoms to all individuals in the world. Human rights are inherent rights that people have simply as a result of existing. Some examples of human rights are the right to life itself, and the rights to food, education, work, health, and liberty.

There is a significant body of international law that is intended to guarantee fundamental rights and freedoms and which prohibits the restriction of some rights, while conditionally allowing the temporary restriction of others in specific situations.

The right to health is a human right. A lot of work has been done in international human rights law to ensure that the right to health is properly protected from government actions.

³¹ Gail Davidson testimony, Vancouver hearing.

Despite this, the NCI heard testimony that the measures imposed by Canada and its provinces during COVID-19 imposed, promoted, and allowed the suspension or restriction of health rights, as well as other rights that are guaranteed by international human rights law. In particular, Ms. Davidson testified about the measures that were taken to compel and coerce Canadians to submit to COVID-19 vaccination by restricting and suspending the rights of unvaccinated persons (Vaccine Coercion Measures).

Vaccine coercion measures were undertaken by nearly every level of government. Each of the provinces adopted actual vaccine passports, restricting unvaccinated persons from accessing most places. Municipalities adopted bylaws in support. The federal government restricted unvaccinated persons from flying and travelling by train, which is the functional equivalent of a vaccine passport for travel. The federal government also required the use of the ArriveCan app when entering Canada, which was designed to show proof of vaccination in order to avoid a quarantine order.

That these vaccine coercion measures were harmful to Canadians was evident from the abundant testimony of Canadians who suffered job losses, family rifts, social shaming, depression, and isolation as a direct result.

Vaccine coercion measures violated Canadians' rights to Informed Consent, right to be free from coercion, and right to be free from medical or scientific experimentation.

The right to Informed Consent, which includes the right to refuse treatment and withdraw consent, is an "essential right" that is protected by multiple international conventions to which Canada is a party, such as:

- United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT);
- United Nations International Covenant on Civil and Political Rights (ICCPR); and
- United Nations International Covenant on Economic, Social and Cultural Rights (ICESCR).

The NCI reviewed an excerpt from Canada's report to the Committee Against Torture in 2020, wherein Canada explicitly sets out the principles of Informed Consent, and found it to be so compelling that it will be reproduced in its entirety here:

For consent [to medical treatment] to be considered valid, it must be provided voluntarily by a person capable of providing consent and it must refer to the treatment and provider who will perform or undertake the treatment. Consent must also be informed, meaning that certain issues must be discussed with the patient prior to consent being obtained, such as material, expected consequences of the proposed treatment, special or unusual risks of the treatment, alternatives to treatment (and their risks), the likely consequences if no treatment is undertaken, and the success rates of different/alternative methods of treatment. The principle of respect for autonomy, at least in part, underpins the right to Informed Consent.³²

Notably, the right to Informed Consent is also protected under Canada's domestic law, through the *Canadian Charter of Rights and Freedoms*, as an essential part of security of the person.

In Canada, a serious abrogation of Informed Consent was accomplished, in part, through coercion of those persons who did not wish to receive a COVID-19 vaccine. Under international law, coercion is akin to torture or ill treatment, which is prohibited. Freedom from torture has been enshrined in the UNCAT and the ICCPR. The right to be free from coercion is arguably a right that cannot be violated under any circumstances. Despite this, Canadians were subjected to a government-led program with the aim of coercing every single Canadian to receive an injection of a COVID-19 vaccine. That the vaccines were an unknown substance whose safety profile was not understood, which have been shown to cause injury to many Canadians, and for which Informed Consent arguably could not be given, has been demonstrated (see section 7.6 of this Report). Those Canadians who did not wish to receive a COVID-19 vaccine but were coerced into receiving this medical treatment—whether it be to keep their job, to conform to family or social pressure, to travel, or for any other reason—had their right to be free from coercion violated.

Ultimately, when a person's right to Informed Consent is violated as a consequence of being coerced to take a novel medical treatment with no long-term safety profile, the result is that the person has become a subject of experimentation. Freedom from experimentation became a widely recognized human right after the atrocities of World War II when the international community established the Nuremberg Code.³³ The purpose of the Nuremberg Code was to ensure that no human would ever again be subject to non-consensual experimentation. It is easy to see that the prohibition against non-consensual experimentation is fundamental, because it is essential to each person's right to life, freedom from torture, and security of the person.

³² Information received from Canada on follow-up to the concluding observations on its seventh periodic report, CAT/C/CAN/FCO/7, 16 April 2020 at paras 15, 17, 23.

³³ The Nuremberg Code 1947 at para. 1. The Nuremberg Code 1947 was derived from the decision of the Nuremberg Military Tribunal in *United States v. Karl Brandt et al.* which identified ten conditions prohibiting non-consensual medical experimentation on human subjects.

While the vaccine coercion measures are not comparable to the atrocities that led to the creation of the Nuremberg Code, the Code surely covers all human experimentation and not just when it reaches extreme levels. Nor does the principle require a comparative analysis of just how bad one human experiment was as opposed to another. Any experimentation that is non-consensual and has the potential to cause harm is a serious violation of this human right. This is supported by the fact that the right to be free from experimentation is enshrined in the UNCAT and the ICCPR and is a right that cannot be violated under any circumstances.

The administration of COVID-19 vaccines was an experiment on a nationwide scale. The vaccine coercion measures were justified in many minds by the fact that the COVID-19 vaccines had been approved by Health Canada, creating the perception that their safety had been proven. However, as the NCI has discovered, the approval of the COVID-19 vaccines did not require the manufacturers to demonstrate that they were safe or effective. Instead, the Government of Canada ordered millions of COVID-19 vaccines and created a backdoor approval process to ensure that they became available as quickly as possible. The reality is that the safety of the COVID-19 vaccines was not known at the time that they began to be administered to Canadians, and many Canadians were severely injured and killed as a result. The NCI has determined that the safety of the COVID-19 vaccines was not known, and thus their administration to the population of Canada was the very definition of experimentation.

The vaccine coercion measures were not compliant with international human rights law, were applied to rights that cannot be restricted, were not proportional or temporary in nature, and were not supported by the information and debate necessary to assess their lawfulness.

Other Pandemic Measures and International Human Rights Obligations

The seriousness of the violation of rights caused by the vaccine coercion measures should not overshadow the myriad of other human rights that were violated as a result of government responses to the pandemic.

The Universal Declaration of Human Rights (UDHR)³⁴ states that all humans have the following rights:

- Equality and non-discrimination (articles 1, 2);
- Movement (article 13);
- Assembly and association (article 20);
- Work and free choice of employment (article 23);

³⁴ *Universal Declaration of Human Rights*, GA Res. 217(III), UN GAOR, 3d Sess., Supp. No. 13, UN Doc. A/810 (1948).

- Education (article 26); and
- Participation in cultural life (article 27).

These rights were all violated, to some extent, by various government measures such as lockdowns, business closures, school closures, border restrictions (interprovincially and internationally), and vaccine passports.

The NCI heard that some human rights are derogable, meaning that they can be violated in certain circumstances. It is generally acceptable to infringe upon derogable rights during an emergency where violations are necessary to protect other rights and maintain the rule of law. However, any such violations must be lawful, legitimate, necessary, proportional, and temporary.

In the early days of 2020, lockdown orders appeared to be an acceptable breach of certain human rights, since Canadians were led to believe that the emergence of the COVID-19 virus had created an emergency pandemic. Businesses and schools closed, seniors' homes went into lockdown, and hospitals closed services in order to free up resources in preparation for the onslaught of COVID-19 patients that were expected.

However, within a few short months, it became clear to doctors and hospital workers that there was no onslaught of COVID-19 patients needing critical care. It became clear that the risks of severe outcomes were age-stratified, meaning that the virus posed a serious risk only to the elderly and those with multiple co-morbidities who were in poor health. Despite this knowledge, Canadian governments continued to impose restrictions that violated human rights arbitrarily against entire populations.

Around mid-2020, therefore, and perhaps late 2020, the restrictions ceased to be proportional to the threat posed by the virus to the public at large. Nor were the measures temporary. Prior to the introduction of the COVID-19 vaccines, lockdowns and closures were triggered based on test-case numbers published by the public health authorities. Ignoring the fact that the NCI heard testimony that the case numbers were outright false in at least some cases, the tests themselves have been shown to the NCI to be unreliable in detecting actual rates of active infections.

When the COVID-19 vaccines became available, the government's message was that the restrictive measures would only stop once everyone became vaccinated. The measures then became focused on unvaccinated people, singling them out for discrimination and poor treatment. Governments and the media actively demonized unvaccinated individuals as being responsible for the continuation of the restrictive measures. This continued despite the fact that as early as the fall of 2021, the public health authorities knew that vaccinated people were continuing to contract and transmit the virus to others.

Ultimately, the violation of human rights caused by the measures may have been justifiable under international law in the early days of the pandemic. However, the continued violations of Canadian human rights year over year do not satisfy any definition of *temporary*.

The various governments of Canada should have disclosed the information necessary to justify the measures that violated human rights and opened up opportunities for debate.

Canada Has a Duty to Investigate and Provide Redress for Human Rights Violations

As a party to various human rights treaties and a member of the United Nations, Canada has an obligation to protect human rights and prevent violations thereof. Where violations of human rights are alleged, Canada has an obligation to take action against those responsible and to provide victims with access to effective remedies.

The NCI heard that Canada has a vaccine-injury compensation program. However, of the many vaccine-injured Canadians that testified, precious few had been accepted into the program. A large number were in the process of being approved and had been waiting for months or more. Many were unable to access the program at all as a result of a refusal by doctors to diagnose their injury as vaccine-related.

Canada has failed in its duty under international law to provide effective remedies to those harmed by the various pandemic measures.

Canada has also not undertaken any meaningful investigation into the violation of human rights that occurred as a result of the pandemic measures. A full public inquiry into Canada's pandemic measures—properly funded, independent, and with the power to compel testimony, is still needed.

Once a proper inquiry and investigation has occurred, Canada must identify those responsible for human rights violations and hold them to account. The number of victims is large, and to date, remedies have been effectively denied.

Looming Obligations for Canada to Implement International Health Law

The NCI heard testimony that there are significant developments underway under the auspices of an international organization called the World Health Organization (WHO) which have the potential to impact Canada's ability to (1) define a pandemic; (2) declare a pandemic; and most importantly (3) control its response to the next pandemic.

Canada's ability to control its own response to a pandemic is critical to ensuring that public health measures are in line with its laws, including the Constitution. Additionally, and from a more practical point of view, it is vital that Canada retain its ability to develop localized responses based on its own circumstances, as opposed to broad-brush measures dictated from an unelected foreign source that has no accountability to the Canadian people.

The WHO was founded as a specialized agency in 1948 with the noble goal to promote health and the attainment of the highest level of health of all peoples. Its purpose is to act as the directing and organizing authority on international health work. Canada is a member of the WHO.

The NCI heard testimony that the WHO is evolving into an organization that is less about promoting health and more about controlling the public health actions of its member countries. The problem with allowing the WHO to dictate health measures within any particular country is that each country may have its own view of what *health* is and the means by which health is to be promoted. The importance of this has been demonstrated over and over again in the NCI's weeks of testimony, which has laid bare a myriad of health problems that were created by Canada's pandemic response.

The NCI heard testimony that there are two initiatives currently underway under the WHO:

1. The implementation of a new WHO Convention, Agreement, or Other International Instrument on Pandemic Preparedness and Response (Pandemic Convention); and
2. An amendment of preexisting International Health Regulations.

The Pandemic Convention would be implemented under the WHO's Constitution, which grants its governing body the power to adopt conventions or agreements within the competence of WHO. Any such convention or agreement that is ratified will oblige each member of the WHO (including Canada) to adopt the convention—unless they notify the WHO of their objection within 18 months. The NCI heard that this means that the Pandemic Convention will be automatically adopted by Canada unless an official objection or reservation is filed.

The creation of this new Pandemic Convention is not a public process. It is being negotiated behind closed doors and will not be revealed to the public until complete. Some hearings have been conducted to allow input from accredited institutions about what the convention should include, but there is no process in place to allow for people to dispute whether the process itself is necessary.

An initial draft of the Pandemic Convention was unveiled earlier this year, and it contains concerning features such as

- increased tools for surveillance, and
- obligations for states to tackle false, misleading misinformation or disinformation.

Without knowing the details of how these will be defined in the Pandemic Convention, this indicates that the WHO is anticipating measures to violate individual privacy and censor dissenting voices as being a standard part of the next pandemic response. However, these types of measures have been identified by witness after witness in front of the NCI as causing severe harm.

The *International Health Regulations* are a product of decades of work between countries. Originally developed to address only six specific diseases, sweeping amendments and reform were adopted after the SARS hysteria of 2003 to take into account new and novel diseases that may appear in the future. These most recent changes introduced the concept of a declaration of a "public health emergency of international concern" (PHEIC). The declaration of a PHEIC is done by the WHO.

A declaration of a PHEIC opens up powers of the WHO—which can include NATO (North Atlantic Treaty Organization) “boots on the ground” to enforce quarantines and deliver medical aid. It also can create obligations on countries to purchase medical treatments, such as vaccines. The NCI heard that certain studies have concluded that serious conflicts of interest have already been found in respect of the 2009 declaration of a PHEIC for swine flu and the requirement for countries to purchase swine flu vaccines.

The NCI heard that Canada is already under an international obligation to comply and actively assess their compliance with the *International Health Regulations*.

In addition to Canada’s existing obligations under the *International Health Regulations*, sweeping changes are now being proposed that include:

- eliminating the concept of respect for the dignity, human rights, and freedoms of persons from the principles of the *International Health Regulations*;
- giving WHO greater authority over surveillance and monitoring of health threats;
- giving the WHO the authority to declare an “intermediate public health alert,” as opposed to a PHEIC;
- granting the WHO the power to change its medical and non-medical recommendations to respond to a PHEIC from non-binding recommendations to binding;
- working with partners to establish a global health certification network, which would verify the vaccination status of travellers; and
- expanding the scope of regulations to cover not just demonstrable, ongoing health emergencies but to cover all risks that have the potential to impact public health.

With the implementation of these two processes, we see an unprecedented attempt at shifting the responsibility for Canada’s public health to a foreign unaccountable body. And while it is true that Canada is a sovereign nation that ultimately has control over its responses to public health situations, these new processes may provide cover for politicians that are motivated to implement unpopular measures that affect the Canadian people.

The existing international health infrastructure under the WHO and the *International Health Regulations* explains why Canada and most of the Western world appears to have followed the same plan and implemented the same measures in response to COVID-19. This one-world approach to health responses actually has the potential to cause greater damage. It turns out that in hindsight, the measures enacted were not the correct response. Thus, the danger of coordinating responses under one umbrella is that a disaster could, in fact, be magnified instead of mitigated.

The results of these proposed changes appears to be the concentration of power over public health into fewer hands.

While international coordination of public health measures sounds like a noble and laudable goal, Canada should not cede its sovereignty, nor its ability to manage its own circumstances, to a foreign, unelected body. Because health issues and outcomes vary depending on each region's unique circumstances, international coordination of health responses should be voluntary and recommendatory only.

Moreover, it is difficult to reconcile Canada's potential new obligations under the Pandemic Convention and the *International Health Regulations* with Canada's obligations under International Human Rights law (discussed above under the section entitled, "Canada's Vaccine Measures and International Human Rights Law").

Recommendations

Based on the information provided in the testimony and other considerations, here are some recommendations on what Canada could do concerning international laws and treaties, especially in the context of the COVID-19 pandemic and potential future health crises:

- A. **Pandemic Convention:**³⁵ The NCI recommends that Canada register immediate reservation against the Pandemic Convention and the amendments to the International Health Regulations once they are put forth by the WHO to allow time for proper consideration of the initiatives and their potential impact on Canada. At the same time, Canada should conduct a public inquiry and consultation into the benefits and risks of both its current obligations under the WHO, and the proposed Pandemic Convention and proposed amendments to the *International Health Regulations*.
- B. **Review and Comply with International Human Rights Law:** Canada should thoroughly review its COVID-19 response measures in light of international human rights law. It should ensure that measures taken during the pandemic—such as vaccine measures, lockdowns, and restrictions on movement—consider international human rights standards. If any violations are identified, corrective actions should be taken.
- C. **Strengthen Informed Consent:** Canada should reinforce the importance of Informed Consent, especially in the context of medical treatments like vaccines. It should ensure that individuals have access to comprehensive information about medical treatments, including potential risks and benefits, and have the right to refuse treatment without coercion.
- D. **Enhance Vaccine Injury Compensation:** Canada should assess and improve its vaccine injury compensation program to make it more accessible to those who have suffered harm due to vaccinations. This should include a transparent, streamlined claims process, and increased transparency.

³⁵ https://apps.who.int/gb/inb/pdf_files/inb3/A_INB3_3-en.pdf (accessed 2023)

- E. **Conduct a Comprehensive Inquiry:** Canada should initiate a comprehensive and independent public inquiry into its pandemic response measures. This inquiry should have the authority to compel testimony and access relevant information. It should identify responsible parties for any human rights violations and recommend appropriate remedies.
- F. **Monitor WHO Developments Closely:** Canada should closely monitor and participate in negotiations related to the World Health Organization's Pandemic Convention and amendments to the *International Health Regulations*. It should advocate for transparency, respect for national sovereignty, and the protection of individual rights in these international agreements.
- G. **Protect National Sovereignty:** Canada should maintain its sovereignty over public health decisions. While international coordination can be valuable, it should not infringe on Canada's ability to tailor its responses to its unique circumstances. Any international agreements should be voluntary and non-binding.
- H. **Balance Health and Human Rights:** Canada should strike a balance between public health measures and human rights. While protecting public health is crucial, measures taken during health emergencies should be lawful, legitimate, necessary, proportional, and temporary. Canada should avoid disproportionately infringing on human rights.
- I. **Promote Transparency and Debate:** Canada should ensure that information relevant to pandemic measures is disclosed to the public, allowing for informed debate and discussion. Public health measures should be debated openly in democratic forums, allowing for diverse perspectives to be considered.
- J. **Provide Redress for Victims:** Canada should ensure that victims of human rights violations, including those resulting from pandemic measures, have access to effective remedies. This includes compensation for losses and harm suffered due to these violations.
- K. **Engage with Civil Society:** Canada should engage with civil liberties organizations, human rights advocates, medical professionals, and other relevant stakeholders, including the public, to ensure that responses to health crises are well-informed and respectful of human rights.

These recommendations are aimed at ensuring that Canada's responses to health emergencies uphold international human rights standards, protect individual freedoms, and safeguard national sovereignty, while promoting public health. It's important for Canada to strike a balance between these critical considerations in its domestic and international actions.

7.1.7. Coercion Does Not Equal Consent

Introduction

The principle that coercion does not equal consent is universally accepted as true in the case of sexual activity. It is hard to see how it is not equally as true when it comes to providing a medical treatment such as a vaccine—even more so when the medical treatment is a novel treatment with no long-term safety or effectiveness data.

Discussion

Coercion refers to the use of tactics like pressure, trickery, or emotional force to get someone to do something they otherwise do not want to do. Consent is not freely given if a person is pressured or threatened to agree to something.

What is surprising is how easily Canadians and their courts accepted coercive government actions in pursuit of getting every person injected with the same substance, regardless of a person's medical history or risk for serious disease from COVID-19. The hard-won principle of "my body, my choice," gained by feminists after years of fighting for the rights of women to control their own bodies, vanished during the second year of the pandemic. It was replaced with a constant drumbeat by public officials, supported by the media, of safe and effective, which was accompanied by politicians and public figures stating that measures would not be lifted unless everybody "did their part."

Canadians who hesitated to get vaccinated were branded as anti-vaxxers, despite having voluntarily received every other vaccine, recommended by public health, in their lives. Politicians encouraged people to blame the unvaccinated for the restrictive measures that stopped them from getting back to normal. Those who had taken the COVID-19 vaccines felt morally superior and validated in scorning those who didn't "do the right thing." Public shaming became a societal norm.

Witness after witness took the NCI stand and proclaimed, "I am not an anti-vaxxer," at the same time as refusing to take a COVID-19 vaccine. Why did they feel the need to make such a proclamation? Because Canadian society had devolved to the point where open denigration of the unvaccinated was permitted and even encouraged.

Coercion was applied in virtually every aspect of Canadians' lives. Workplace mandates caused many to accept a COVID-19 vaccine who didn't want one. People who supported their families simply couldn't afford to lose their jobs. The NCI heard from many witnesses that they or a loved one felt compelled to take the injection, under the threat of losing their livelihood. This does not resemble freely given consent.

Vaccine passes were designed to encourage vaccination by denying the unvaccinated access to everything not deemed essential. Thus, people were denied access to their own children's schools and sports events, to their vulnerable relatives in long-term-care homes, and to basic services such as gyms, restaurants, and movie theatres. The message was clear: If you want access to these people/things that you like/love, you must submit to vaccination. This is not freely given consent.

Vaccine passes were required for businesses, such as liquor stores in some provinces, that are frequented by vulnerable people. This ensured that persons with addiction problems would get vaccinated in order to gain access to their drug. At the same time, support services such as Alcoholics Anonymous had been locked down, ensuring that alcoholics had only one path: vaccination. Taking advantage of people's vulnerabilities in this way was shocking and un-Canadian.

How did this principle that coercion does not equal consent become forgotten? Was it overlooked or deliberately buried?

The NCI heard testimony that legal opinions were obtained by some employers who implemented vaccine mandates in the workplace. Since we did not have the benefit of reviewing any of these opinions, we can only guess at how lawyers could justify the coercive nature of workplace mandates. One legal expert testified to the NCI that vaccine passports would likely not be viewed as breaching Charter rights, since each person technically had the right to refuse a vaccine. The reasoning being that even if exercising the right to refuse resulted in a loss of the ability to work, travel, or generally participate in society, then this was a voluntary choice. Presumably, this type of reasoning was used to support the mandates.

This likely explains how much of Canadian society appeared to easily adopt the view that choices have consequences, in order to rationalize the coercive measures applied to unvaccinated people. However, it begs the question of where the line is between a voluntary choice and coercion. Wherever that line lies, it is difficult to see how the threat of losing your ability to financially support yourself and your loved ones could be anything but coercion.

If the loss of your job wasn't enough of a coercive force, the Government of Canada further increased pressure by declaring that employment insurance would be denied to those who lost their jobs due to a refusal to get vaccinated. This ensured there was no financial safety net for those who accepted job loss as the consequence of their decision not to receive a COVID-19 vaccine.

The employment insurance program in Canada is designed to be a safety net for Canadians. It is not a voluntary program; employees must pay into it. In return for a deduction off of every paycheque, employees expect that they will receive financial assistance in the event of job loss. Virtually every witness who testified about losing their job due to a vaccine mandate also testified that they were denied employment insurance benefits. The denial of these benefits served only one purpose: to cause as much financial pressure as possible on Canadians to accept a COVID-19 vaccine. This is not freely given consent.

Instead of using scientific evidence to convince people of the benefits of the COVID-19 vaccines, governments discussed vaccine hesitancy as something distasteful and used it as a wedge issue to turn Canadians against each other. The government could have engaged in a campaign to encourage vaccination by, for example, demonstrating that increased vaccination rates would result in, or were resulting in, better health outcomes. Instead, governments openly admitted that vaccine measures were aimed at modifying behaviour.³⁶

Moreover, the NCI discovered that the data published by health authorities was dishonest when comparing vaccinated against unvaccinated persons in areas such as infections, hospitalizations, and deaths. It was discovered that health authorities continued to count people as “unvaccinated” for 14 days following an injection. In this way, all infections, hospitalizations, and deaths in that 14-day window were attributed to unvaccinated people—despite occurring in people who had received a COVID-19 vaccine. At the same time, the people in this 14-day window had higher rates of COVID infection, hospitalization, and death than people who had received no COVID-19 vaccine. Publishing skewed data in this dishonest way led people to conclude that they should get vaccinated. Soliciting consent based on dishonesty is inherently coercive.

The Government of Canada’s intent to push vaccination on every member of its population appears to have its origins early in the pandemic, before any vaccines existed at all. Natasha Gonek testified that in 2020, prior to the existence of any COVID-19 vaccines, the Government of Canada created the Immunization Partnership Fund. This initiative was funded with \$45.5 million for the stated purpose of helping Canadians make informed vaccination decisions. Some of the specifically targeted groups for the project were newcomers to Canada and pregnant women. This leads to the troubling question: How much effort and study did the Government of Canada put into determining the coercive steps it could impose on Canadians?

The problem with the “choices have consequences” position can be easily demonstrated by applying it to other situations, such as coercion to participate in sexual activity or coercion to undergo reproductive sterilization. It is easy to see why you cannot threaten someone that they might lose their job if they refuse to engage in sexual activity. Why, then, was it okay to threaten people’s jobs over an injection?

³⁶ The NCI watched video evidence from press events in both British Columbia and Newfoundland and Labrador, wherein government officials acknowledged that their measures were aimed at changing behaviour, as opposed to creating better health outcomes.

The pressures felt by those who didn't want a COVID-19 vaccine were demoralizing and dehumanizing. Witness after witness testified about feeling alone, isolated, depressed, and dejected. Many described having suicidal thoughts. People testified about being banned from family and social events, being threatened by neighbours, being shamed at work, being attacked on social media, and being denied contact with grandchildren, parents, grandparents, and other family. Many spoke of pressure from friends and family to "do the right thing," imparting a moral judgment on their personal medical decision. One witness was told that she had "blood on her hands."³⁷

Institutes of higher education and colleges imposed the same measures as many workplaces, requiring a COVID-19 vaccine not only to attend classes in person but also online classes. The denial of online access was intended to coerce students to get vaccinated. By denying them any access to education at all, post-secondary students were forced to either give up their education goals or submit to vaccination. This was coercion.

The Government of Canada made the vaccine mandates the main issue in a snap election called in the fall of 2021. Shortly after the election, the government announced the implementation of vaccine mandates for travel, both domestic and international. In the world's second-largest country (by area), a vaccine requirement for planes and trains amounted to an inability for Canadians to travel for work and to visit family. Canadians were also effectively prevented from leaving their country by these measures, as the only land border is with the United States, which had imposed a vaccine mandate for entry.

The Prime Minister of Canada cruelly announced that unvaccinated people would not be able to sit on planes next to vaccinated people, to the cheers of a crowd of people. At this same time, it was already known that vaccinated people could transmit the COVID-19 virus to other vaccinated people. This inconvenient fact went unacknowledged so that pressure on the unvaccinated could continue.

Governments across the country embarked on a coercive mission to get every Canadian vaccinated, regardless of whether they wanted it or not. Any person who resisted vaccination faced the denial of basic rights and freedoms that were allowed to other Canadians. The restrictions were designed to make life difficult until people submitted to vaccination. No measure was too strong. Ultimately, the only step that wasn't taken was holding people down and forcing an injection into their arm.

When did coercion become acceptable in Canada? Will the vaccine measures and mandates go down in history as a grave societal mistake? How long will it take before Canadian politicians, media, and the courts recognize the harms and indignity that were inflicted on people in the name of a novel medical treatment?

³⁷ Kristen Nagle, Ottawa hearing.

The testimony of Canadians at the NCI cries out with the pain suffered as a result of coercion in the name of COVID-19 vaccines. In the end, we were unable to discern any justification for the coercive vaccine measures. The governments of Canada should apologize to each and every Canadian who was harmed, and commit to never employing such measures against the Canadian population again.

Testimonial Examples of Coercion

Patients who had experienced vaccine injury, as confirmed by a physician, were contacted by public health authorities who recommended that they take another COVID-19 vaccine. (Dr. Patrick Phillips, Truro, NS)

A patient who required an organ transplant was taken off the surgery waitlist due to her refusal to accept the COVID-19 vaccine. She did accept re-vaccination of all childhood vaccines and had proof of COVID antibodies. Despite this, the doctors refused to perform her surgery unless she consented to a COVID-19 vaccine. The NCI has learned that she has since passed away. (Sheila Lewis, Ottawa, ON)

People who were suspended or fired from their jobs as a result of vaccine mandates at work, most of whom were also denied any employment insurance benefits:

- **Cathy Careen** (Truro, NS)
- **Vonnie Allen** (Truro, NS)
- **Terry LaChappelle** (Truro, NS)
- **Amie Johnson** (Truro, NS)
- **Sabrina McGrath** (Truro, NS)
- **Joe Behar** (Truro, NS)
- **Janessa Blauvelt** (Truro, NS)
- **Linda Adshade** (Truro, NS)
- **Katrina Burns** (Truro, NS)
- **Tami Clarke** (Truro, NS)
- **Oliver Kennedy** (Toronto, ON)
- **Victoria McGuire** (Toronto, ON)
- **Lynn Kofler** (Toronto, ON)
- **Sean Mitchell** (Toronto, ON)

- **Cindy Campbell** (Toronto, ON)
- **Kimberly Snow** (Toronto, ON)
- **Greg Hill** (Toronto, ON)
- **Ksenia Usenko** (Toronto, ON)
- **Dr. Eric Payne** (Toronto, ON)
- **Jason Kurz** (Toronto, ON)
- **Scarlett Martyn** (Toronto, ON)
- **James Erskine** (Winnipeg, MB)
- **Sean Howe** (Winnipeg, MB)
- **Devon Sexstone** (Winnipeg, MB)
- **Jessica Kraft** (Winnipeg, MB)
- **Michelle Malkoske** (Winnipeg, MB)
- **Cindy Stevenson** (Saskatoon, SK)
- **Ryan Orydzuk** (Saskatoon, SK)
- **Elodie Cossette** (Saskatoon, SK)
- **Bridgette Hounjet** (Saskatoon, SK)
- **Chantel Kona Barreda** (Saskatoon, SK)
- **Jody McPhee** (Saskatoon, SK)
- **Jacques Robert** (Red Deer, AB)
- **Scott Crawford** (Red Deer, AB)
- **Babita Rana** (Red Deer, AB)
- **Grace Neustaedter** (Red Deer, AB)
- **Suzanne Brauti** (Red Deer, AB)
- **Darcy Harsch** (Red Deer, AB)
- **Philip Davidson** (Vancouver, BC)

- **Dr. Chris Shaw** (Vancouver, BC)
- **Aurora Bisson-Montpetit** (Vancouver, BC)
- **Lisa Bernard** (Vancouver, BC)
- **Dr. Ben Sutherland** (Vancouver, BC)
- **Zoran Boskovic** (Vancouver, BC)
- **Camille Mitchell** (Vancouver, BC)
- **Josée Belleville** (Québec City, QC)
- **Jérémie Miller** (Québec City, QC)
- **Gary Lalancette** (Québec City, QC)
- **Jean-Philippe Chabot** (Ottawa, ON)
- **Captain Scott Routley** (Ottawa, ON)
- **Laurier Mantil** (Ottawa, ON)

A woman had a stroke after her first injection of a COVID-19 vaccine. She was advised to get a second dose and that if she had concerns about having another stroke, then she should get it before her prescription for blood thinners ran out. She was denied a medical exemption from the second dose by her physician. She therefore lost her job. (Leigh-Anne Coolen, Truro, NS)

People who testified that they felt coerced to take the vaccine to keep their employment, comply with rules to visit or care for a loved-one, to travel or to attend school:

- **Peter Van Caulart** (Truro, NS)
- **Ellen Smith** (Truro, NS)
- **Josephine Fillier** (Truro, NS)
- **Marc Auger** (Toronto, ON)
- **Prof. Heather Church** (Toronto, ON)
- **Carley Walterson-Dupuis** (Winnipeg, MB)
- **Steven Kiedyk** (Winnipeg, MB)
- **Charlotte Garrett** (Saskatoon, SK)
- **Krista Hamilton** (Saskatoon, SK)

- **Joelle Valliere** (Red Deer, AB)
- **Michelle Ellert** (Red Deer, AB)
- **Madison Lowe** (Red Deer, AB)
- **Jennifer Curry** (Red Deer, AB)
- **Serena Steven** (Vancouver, BC)
- **Shawn Muldoon** (Vancouver, BC)
- **Mélissa Sansfaçon** (Québec City, QC)

Tragically, almost every person who testified that they were coerced to take the injection also reported that they had suffered an injury as a result.

Recommendations

The report highlights various instances of coercion and its impact on individuals' decisions regarding COVID-19 vaccination. To address these issues and mitigate the failures of the system, here are eight recommendations:

A. Protect Individual Rights

- **Legislation Against Coercion:** Introduce legislation that explicitly prohibits coercive tactics, whether by employers, educational institutions, or any other entity, in relation to medical treatments, such as vaccinations. Ensure that individuals have the freedom to make informed choices without undue pressure.

B. Transparency and Accountability

- **Require Organizations to Provide Legal Basis of Mandates Imposed:** Conduct a comprehensive review of the legal opinions obtained by employers who implemented vaccine mandates. Ensure these opinions align with fundamental principles of consent and individual rights. Publish these legal opinions for public scrutiny.

C. Access to Education and Work

- **Online Learning Options:** Ensure that individuals who choose not to get vaccinated have access to online education, especially in institutes of higher education, to avoid coercion through denial of educational opportunities.
- **Job Protection:** Enact legislation to protect employment insurance benefits for individuals who choose not to get vaccinated. Losing employment due to vaccine refusal should not lead to financial hardship.

D. Informed Decision-Making

- **Factual Communication:** Government and public health authorities should communicate drug information transparently and factually. Encourage vaccination through education, emphasizing the benefits of vaccination rather than resorting to coercion.
- **Accurate Data Reporting:** Ensure accurate reporting of COVID-19 data, including vaccine effectiveness, and avoid any manipulation or misrepresentation that may lead to coercion.

E. Address Vulnerabilities

- **Support Vulnerable Groups:** Recognize and support vulnerable populations, such as those with addiction issues, with strategies that do not resort to coercion. Ensure they have access to essential services and support networks.

F. Independent Oversight

- **Ombudsman or Commission:** Establish an independent body, like an ombudsman or commission, to investigate cases of coercion and violations of individual rights related to vaccination. Provide a channel for individuals to report coercion and seek redress.

G. Avoid Political Exploitation

- **Ethical Political Discourse:** Encourage ethical political discourse around public health measures, including vaccinations. Ensure that political campaigns do not exploit vaccination issues or use coercion for political gain.

H. Rebuild Trust

- **Public Apology:** Governments should issue public apologies to individuals who felt coerced into vaccination and acknowledge the harms caused by these coercive measures. Rebuilding trust should be a priority.

These recommendations aim to strike a balance between promoting vaccination for public health and respecting individual rights and choices. They seek to prevent coercion, protect individual freedoms, and rebuild trust between the government and its citizens, especially in the context of medical treatments like vaccines.

7.1.8. Emergency Planning & Plan Execution

Introduction

An essential role of any government is to plan for and act appropriately during times of national or regional emergencies. This function of government has been recognized in Canada for decades, and in the 1950s the federal government established a training college to provide emergency training courses and to foster training and cooperation in emergency situations between federal, provincial, and territorial governments.

Emergency response training is still provided by the federal government through the Canadian Emergency Management College.

On their website, Public Safety Canada³⁸ states the following:

Natural disasters, pandemics, cyber incidents and terrorism can all cause emergencies in Canada. Emergencies can quickly escalate in scope and severity, cross jurisdictional lines, and take on international dimensions. Emergency management planning can save lives, preserve the environment and protect property by raising the understanding of risks and contributing to a safer, prosperous, sustainable, disaster resistant, and resilient society in Canada.

Emergency management is a core responsibility of the Government of Canada and a collective responsibility of all federal government institutions. This is why Public Safety Canada is taking steps to promote a coordinated approach and more uniform structure to the management of emergencies by providing guidance to federal government institutions on how to develop emergency management plans. A coordinated approach to emergency management planning will strengthen the Government of Canada's capacity to prevent, protect against, respond to, and recover from major disasters and other emergencies.

The "Emergency Management Planning Guide" supports federal institutions in meeting their responsibilities under the [Emergency Management Act](#) to prepare and maintain mandate-specific emergency management plans. The Guide provides the framework for federal government institutions to undertake mandate-specific all-hazards risk assessments and planning activities within all four integrated functions of emergency management:

- [mitigation/prevention](#),
- [preparedness](#),
- [response](#), and
- [recovery](#).

³⁸ Public Safety Canada, Government of Canada. <https://www.publicsafety.gc.ca/cnt/mrgnc-mngmnt/mrgnc-prprdss/mrgnc-mngmnt-plnng-en.aspx>. (accessed October 31, 2023)

The Government of Canada has a federal policy for emergency management, as set out on the following website:

<https://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/plc-mrgnc-mngmnt/index-en.aspx>

According to the federal policy for emergency management:³⁹

The federal government is responsible for emergency management at the national level in its exclusive jurisdictions and on lands and properties under federal responsibility. Provincial and territorial governments exercise responsibility for emergency management within their respective jurisdictions except where legislation allows for direct federal intervention or for shared responsibility. If any emergency threatens to overwhelm the resources of a province or territory, federal institutions may respond to the request or if an emergency has a national implication. A provincial request for assistance during an emergency indicates that the province requires federal support to achieve an objective. While the province may indicate the specific resources and capabilities required, in most instances federal departments and agencies will need to define the appropriate response. Federal institutions can also make preparations in advance of anticipated need or request for assistance from a province or territory.

In researching how the provincial governments have integrated their own emergency response programs, a number of provincial programs were reviewed.

The government of Manitoba's website includes a copy of [The Emergency Measures Act](#) which sets out the responsibilities of the provincial and municipal governments in case of an emergency.

Other provincial governments and territories in Canada have similar legislation to deal with emergencies.

In Ontario, the legislation is called the [Emergency Management and Civil Protection Act](#)

In Alberta, the legislation is called the [Emergency Management Act](#).

It is imperative, following the implementation of emergency plans during the COVID-19 pandemic, to evaluate the emergency measures undertaken to evaluate their effectiveness in mitigating the risks associated with the COVID-19 outbreak, and to determine whether or not the steps taken actually adhered to the legislation at all levels of government as set out by the various legislations.

To undertake this task, the Commissioners have relied on the testimony of various witnesses who appeared at the hearings.

³⁹ Section 2. Preamble, 2.3 subsection. (accessed October 31, 2023)

Testimony Concerning Emergency Planning & Plan Execution During Pandemic

Direct testimony was received from witnesses concerning the actions of the various levels of governments during the COVID-19 emergency or pandemic.

Witnesses included the following:

Lieutenant Colonel David Redman

Canada Deviated from Strategic Pandemic Response

Lt. Col. Redman testified that most provinces and territories in Canada approach emergencies in a similar way. The emergency measures organizations in Canada are tasked with responding to all manner of emergencies in Canada, while mitigating the effects of the emergency on the totality of Canadians' society.

Every province and territory in Canada had a pandemic plan prepared prior to the declaration of the COVID-19 pandemic in March of 2020.

<https://pandemicalternative.org/index.php/resources/11-resource-pandemic-plan>

The following was taken from the Pandemic Alternative Website, as presented by Lt. Col. Redman:

Pandemic Plans from around Canada

Pandemic plans listed on the Government of Canada website

<https://www.canada.ca/en/public-health/services/flu-influenza/pandemic-plans.html>

Alberta's Influenza Pandemic Plan (2014)

<https://open.alberta.ca/dataset/c89245b6-a7fc-4c24-be87-c2686341ffb5/resource/a652811e-42f2-4c0d-90af-54e0e759e05e/download/2014-albertas-pandemic-influenza-plan-apip-march-2014.pdf>

British Columbia's Influenza Pandemic Plan (2014)

<https://www.crd.bc.ca/docs/default-source/emergency-pdf/bc-pandemic-influenza-consequence-management-plan.pdf?sfvrsn=0>

Manitoba's Influenza Pandemic Plan

https://www.gov.mb.ca/asset_library/en/documents/influenza/Pandemic_Overview.pdf

Newfoundland's Pandemic Plan (2007)

<https://www.gov.nl.ca/hcs/files/publichealth-pandemic-complete-pandemic-web.pdf>

New Brunswick's Influenza Pandemic Plan (2006)

https://www2.gnb.ca/content/dam/gnb/Departments/ps-sp/pdf/emo/Pandemic_Planning-e.pdf

Northwest Territories' Pandemic Guide (2020)

https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/hss_pandemic_guide_and_checklist.pdf

Nova Scotia's Influenza Pandemic Plan (2013)

https://novascotia.ca/dhw/cdpc/documents/Respiratory_Response_Plan_for_Public_Health.pdf

Nunavut's Pandemic Path (2020)

https://gov.nu.ca/sites/default/files/nunavuts_path_final_framework_-_eng_sm.pdf

Ontario's Influenza Pandemic Plan (2013)

http://www.health.gov.on.ca/en/pro/programs/emb/pan_flu/pan_flu_plan.aspx

Prince Edward Island's Pandemic Plan

https://www.princeedwardisland.ca/sites/default/files/publications/pandemic_influenza_contingency_plan.pdf

Québec's Influenza Pandemic Plan (2006)

<https://publications.msss.gouv.qc.ca/msss/fichiers/2005/05-235-05a.pdf>

Saskatchewan's Influenza Pandemic Plan (2009)

<https://www.homelesshub.ca/sites/default/files/vmd0jm0k.pdf>

Yukon Territory's Influenza Pandemic Plan (2020)

<https://yukon.ca/sites/yukon.ca/files/cs/cs-yg-pandemic-coordination-plan.pdf>

None of the provincial or federal governments fully utilized the recommendations contained in those existing plans.

The COVID-19 pandemic response was flawed from the very beginning in the following ways:

- The responses did not take into account the emergency pandemic plans that had already been created;
- The overall goal of the pandemic response was incorrect. The stated goal was to “protect the healthcare system.” A more appropriate goal should have been to minimize the impact of the virus/disease on all of society.
- The government did not utilize the preexisting emergency response apparatus that existed at all levels of government. Each province and territory had professional people trained in planning for implementing and monitoring an integrated response to any and all emergency situations.

- All emergency responses in Canada are to be under the direct control and supervision of elected officials. During the COVID-19 pandemic, control and authority of all aspects of Canadian society were handed over to non-elected bureaucrats within the healthcare area. These individuals were not elected, and had no substantive actual training in coordinating a response to an emergency situation.
- Fear and terror were used to control the population.
- The government representatives did not express confidence in their plan, nor did they express an overall plan to the population.
- No new surge capacity was constructed within the medical system, and the government took steps to eliminate normal services in order to free up resources. This resulted in lack of medical services for the overall population, including cancellation of care, diagnosis, and treatment of disease and injuries.
- A major planning mistake was bringing people infected with COVID-19 into existing hospitals, thereby potentially infecting the entire facility and staff. If COVID-19 had indeed been the deadly pathogen that we were told, separate treatment centres should have been set up to isolate COVID patients from the existing system that was needed to provide general healthcare.
- The sharing of resources across jurisdictions is a normal function during emergencies, but this practice was discouraged and demonized during the COVID-19 pandemic. The media used any hint of this to make the case that the healthcare system was overwhelmed.
- The government appeared to be unaware of what was going on in the healthcare system and in society overall. The measures that had initially been implemented were not adjusted based on the actual situation being experienced on the ground. An example of this might be that although it was understood as early as March of 2020 that different population groups had different levels of risk and outcomes from COVID-19, resources were expended needlessly in groups that had little or no risk from dying of COVID-19.
- Pandemics are “public emergencies,” not “public health emergencies.” The Premier of every province should have established a task force made up of major public sector ministries to lead, coordinate, and support the efforts. In no instance should public health have been put in the lead of the emergency plan and its overall execution across the entire society. The coordinating agency EMO (emergency measures organization) should have been in charge of the entire response across all societal sectors, this would have guaranteed a balanced and considered response.
- Those who developed and implemented the government response did not fully understand the economic and social impacts of the mitigative measures and attempted to minimize these impacts.

- Continuity of all services and businesses should have been a priority, with assistance being provided to those areas which were actually prevented from accomplishing their tasks.
- No considerations were given to the protection of individual rights and freedoms.
- Government and public health messaging failed to address and manage fear, and instead stoked and inflamed it.
- A realistic cost-benefit analysis was never carried out for each of the measures undertaken so that all effects of the proposed measures could be analyzed.
- Non-pharmaceutical interventions had previously been studied and most were determined to be non-effective; however, they were implemented without consideration of previous experience or reasons given for why they would be appropriate for this particular pandemic.
- No written plans were ever issued by the government or the media to the public so that citizens could make informed decisions.
- Government and media collaborated to promote a certain narrative without consideration of the actual known facts and information.
- Both the government and media developed a narrative which demonized persons who had tested positive for COVID-19 and/or were demonstrating symptoms of COVID-19.
- A recovery plan was never developed or implemented to address the widespread damage that had been done to Canadian society.
- Seventy-three per cent of all reported COVID-19 deaths occurred in long-term-care facilities. This is a controlled and contained population which should have effectively been addressed in a focused way.
- Medical professionals, who were asked during their testimony, had no training or awareness of any pre-existing influenza pandemic plan.

Conclusions

The Canadian response to the COVID-19 pandemic failed in all major areas of emergency response management.

Emergency response was put in the hands of unelected health officers, and elected officials abrogated their legislated responsibilities.

Emergency response planning and implementation must be carried out from the bottom up, since the circumstances of any emergency vary based on actual conditions on the ground.

Federal authorities implemented emergency plans across the country, as opposed to only providing support to local emergency plans.

Despite the existence of detailed pandemic response plans, the government response to the COVID-19 pandemic ignored most of these pandemic response plans.

Existing emergency measures personnel and procedures were not utilized during the pandemic.

The government pandemic plan did not evaluate the overall collateral effects of the measures implemented.

The pandemic measures imposed by government did not take into account the evolving situation.

Recommendations

Based on the totality of the witness testimony, the following recommendations are presented:

- A. **Emergency measures organizations** (EMOs) must be in charge of planning, implementation, and recovery from any and all “emergencies.”
- B. **Public health officials** should never be put in charge of emergency response. They should be a critical component of the planning but should never be charged with running a response.
- C. **Emergency Management Act** powers must supersede the powers of the various public health officers. The public health officers must come under the authority of the emergency management agencies.
- D. **Elected officials** must remain in charge of all emergency measures.
- E. **Follow existing emergency plans.**
- F. **Make sure all emergency plans** are publicized and the contents well known by stakeholders in all affected areas.
- G. **Require mandatory training** of emergency response personnel.
- H. **Follow all emergency measures** legislation in each jurisdiction.
- I. **Emergency planning** must be driven from the bottom up.
- J. **Federal government should not** be leading emergency response. They should be limited to supporting the requirements of the local authorities.
- K. **Media and government cannot be allowed to collude** to present a pre-approved information campaign.
- L. **The consultation process** should involve the public, and the comprehensive plan to tackle the pandemic emergency should be regularly, consistently, and promptly communicated to the public.

- M. **In any future emergencies**, the government should focus on mitigating public fear and anxiety rather than resorting to fear and terror as a means to secure compliance.
- N. **Require mandatory cost-benefit analysis** of any and all emergency measures considered and/or imposed.
- O. **Require transparency in decision-making.**
- P. **Support open public discourse**, without censorship.
- Q. **Require a mandatory recovery plan** to fix the collateral damage done by the pandemic measures.
- R. **Require a mitigation plan** for all societal damage done by the pandemic measures.
- S. **Establish regulations to ensure** that the elected officials are never sidelined or abrogate their powers to unelected bureaucrats.
- T. **Commission an independent study** which is required to include members of the emergency measures organizations from across Canada.
- U. **Rebuild emergency response** organizations across Canada.

7.1.9. COVID-19 Pandemic Mandates in the Workplace

Introduction

Many of the witnesses described how their employers, including both government and private industry employers, mandated certain “public health measures” during the pandemic.

These measures included such things as:

- Mandated vaccines
- Face masks
- Social distancing
- Work from home

A number of these industries may have been regulated by the federal government, such as railways or airlines, but many businesses were not.

The Canadian government mandated COVID-19 vaccines for all federally regulated employees and travellers on October 30, 2021.

<https://www.canada.ca/en/treasury-board-secretariat/news/2021/10/backgrounder-Covid-19-vaccine-requirement-for-the-federal-workforce.html>

A list of the departments and industries affected can be found in schedules I and IV. See links below:

[Schedule I](#)

[Schedule IV](#)

According to the Government of Canada, this order included approximately 267,000 employees.

Provincial and territorial governments also enacted similar requirements for their employees. The timelines for implementation varied by jurisdiction, as did the scope of the mandates.

Within the provincial and territorial jurisdictions there was a mixture of requirements ranging from mandatory vaccinations to required COVID-19 testing.

Witness statements indicated that many employers, both public and private, enacted face masking, social distancing, and work-from-home programs as early as March of 2020. Compulsory COVID-19 genetic vaccine requirements were generally put in place in the fall of 2021, and they were maintained for approximately one year.

Testimony Concerning COVID-19 Mandates in the Workplace

Private companies unilaterally imposed mandates on workers outside of their existing labour contracts, based on a wholesale adoption of the Government of Canada's or Provincial or Territorial health directives.

Most workers complied with the face masking, social distancing, and work-from-home programs.

Witness testimony primarily focused on those workers who refused to comply with the mandatory vaccine regulations.

Testimony indicated that when a worker refused to take the mandated vaccines, they were dismissed either for cause or for, in many instances, insubordination. Many were put on extended indefinite leave without pay, and were thus denied the ability to receive employment insurance benefits.

Being placed on leave without pay for non-compliance with a unilaterally imposed change in employment conditions is normally considered "constructive dismissal." It is unclear how the actions of these employers has not been defined as constructive dismissal.

On the Government of Canada website, the definition of *constructive dismissal* is provided.

<https://www.canada.ca/en/employment-social-development/programs/laws-regulations/labour/interpretations-policies/constructive-dismissal.html>

According to the Government of Canada:

The phrase "constructive dismissal" describes situations where the employer has not directly fired the employee. Rather the employer has failed to comply with the contract of employment in a major respect, unilaterally changed the terms of employment, or expressed a settled intention to do either, thus forcing the employee to quit. Constructive dismissal is sometimes called "disguised dismissal" or "quitting with cause" because it often occurs in situations where the employee is offered the alternative of leaving or of submitting to a unilateral and substantial alteration of a fundamental term or condition of his/her employment. Whether or not there has been a constructive dismissal is based on an objective view of the employer's conduct and not merely on the employee's perception of the situation.

It is the employer's failure to meet its contractual obligations that distinguishes a constructive dismissal from an ordinary resignation. The seriousness of the employer's failure as well as the amount of deliberation apparent in its actions are also important factors.

The employer's action must be unilateral, which means that it must have been done without the consent of the employee. If it is not unilateral, the variation is not a constructive dismissal but merely an agreed change to the contract of employment. Generally, if the employee clearly indicates non-acceptance of the new conditions of employment to the employer, there has been a constructive dismissal only if the employee leaves within a reasonable (usually short) period of time. By not resigning, the employee indicates his/her acceptance of the new conditions of employment.

Many witnesses described how they asked their labour unions to intercede on their behalf and that the unions would not take up the cases of their union members who were laid off, fired, or constructively dismissed.

Unionized workers had no access to individual review by human rights agencies due to their pre-existing union agreements.

Witnesses described how they attempted to get exemptions to the mandates, based on medical or religious beliefs, and that in most instances their requests were denied.

Many of the witnesses who testified before the Commission were unsuccessful in actions against their employers based on constructive dismissal. Although the definition noted above is from the federal government and is based on the provisions of the *Canada Labour Code*, similar such provisions exist in the provinces and territories throughout Canada.

Workers who had legitimate concerns about the COVID-19 genetic vaccines were faced with a limited set of devastating choices, if they were to stand true to their own convictions. These choices included being terminated, early retirement, forced retirement, or voluntary resignation.

Scarlett Martyn

Impact of Vaccine Mandates

Scarlett Martyn was an advanced care paramedic with special training in disaster response (Heavy Urban Disaster Team). She was first suspended and then terminated for "willful misconduct and jeopardizing workplace health and safety," after 24 years of service. This was based on her refusal to be vaccinated for COVID-19. She had evidence that confirmed she had natural immunity to COVID-19 and did not require an injection.

Ms. Martyn described a toxic work environment within the health service after the vaccines became available. This toxic environment extended to health care workers within the system and toward patients who were seeking service.

The impact of the vaccine mandates on the readiness and capacity of the Canadian Armed Forces was discussed by Catherine Christensen during her testimony.

Catherine Christensen

Canadian Military Decimated

Ms. Christensen testified that the Canadian Armed Forces lost an estimated 3000 to 5000 personnel due to the mandatory vaccination policy, out of a regular force of 68,000. This was the highest loss of personnel since World War II.

Ms. Christensen stated that the cost to the Canadian Armed Forces exceeded \$3 billion in loss of training, experience, and expertise. This did not include costs to the members.

She further discussed the toxic environment that was promoted and created within the Canadian Armed Forces against the unvaccinated, which she claimed continued.

Laurier Mantil

Balancing Pregnancy and Safety

When her employer instituted a vaccine mandate in the fall of 2021, she was pregnant, so she did not want to get the vaccine. She applied for an exemption on the basis of human rights. She did not get laid off for non-compliance, as prior to the employer-ruling, she went on maternity leave. Her other co-workers who did not comply were terminated.

Camille Mitchell

Pharmacist Camille Mitchell's Testimony on Vaccine Mandates in Healthcare

Based on her 26-year experience as a pharmacist, she had decided she did not want to take the vaccine. At the time of the vaccine mandates, she was working in the hospital pharmacy. Due to her refusal to get vaccinated, she was terminated from her hospital position, which she held for nine years. Prior to being terminated, she applied for an exemption under a declaration of faith. The employer did not acknowledge the declaration of faith.

Although she found new employment at a community pharmacy, she had to re-certify to administer injections, and she believed testifying before the Commission put her employment at risk under Bill 36.

Zoran Boskovic

Lost Job Due to Vaccine Mandates

He was working for the provincial government as a forester at the time of the COVID-19 vaccine mandates. He had been infected with and recovered from COVID-19 in the summer of 2021. His employer brought in a mandatory COVID-19 vaccine policy in the fall of 2021. Both he and his wife applied for a medical exemption due to previous infection and natural immunity. His application was denied.

He was put on three months leave without pay, and then he was terminated. He was terminated by the province on the same day that the federal government removed their vaccine mandate for federal workers.

He was denied employment insurance benefits. He took early retirement after being terminated, and his pension benefits are at a reduced rate.

Dr. Ben Sutherland

Lost his Position at Fisheries and Oceans Due to Non-Compliance with Vaccine Mandates

Dr. Sutherland was a research scientist at the department of Fisheries and Oceans. During much of the pandemic, he was working from home. He had a medical condition and asked if the vaccines had been tested on people with his condition. It had not been tested. He tried to get an exemption from the vaccine mandate from his doctor, based on his pre-existing condition, but was denied.

He tried to get support from his union, but the union would not support him.

He was terminated on November 15, 2021. There were some issues surrounding the termination; the employer told him he was suspended without pay, but on his record of employment was code M. He was able to get employment insurance.

According the Government of Canada website:

Code M–Dismissal or suspension

Use Code M when the employer initiates the separation from employment for any reason other than layoff or mandatory retirement (that is, the employee is leaving the workplace because he or she has been dismissed by the employer). Also use this code when the employee is suspended from their employment.

James Jones

Vaccine Mandates, Workplace Bullying and Wife Suicide

Mr. Jones' wife was subject to a vaccine mandate at BC Transit. The mandate was not imposed by government regulation, but a vaccine mandate was adopted by company management. His wife did not want to take the vaccine because they were wanting to get pregnant. Mr. Jones and his wife had done research on potential side effects due to the vaccines and had serious concerns.

They attempted to apply for an exemption to the mandatory vaccine, based on their concerns with safety. His wife was bullied and coerced from all sides at her work, including from her union, which would not support her.

Eleven days after being terminated from BC Transit for not complying with the vaccine mandate, she took her own life.

Philip Davidson

BC Public Service Employee Testimony on Job Loss Due to Vaccine Mandate

Philip Davidson worked for 14 years in the BC Public Service, in various policy positions. Once the pandemic was declared, many of the staff in their office worked from home.

In the summer of 2021, there was a lot of talk in the office about requiring vaccine passports (BC Vaccine Card). This was implemented on September 13, 2021.

The BC provincial government implemented a requirement for all persons to be vaccinated to enter the BC Legislature.

Mr. Davidson had serious concerns about having to disclose his private health and vaccine status. He said the BC ministry's communicable disease prevention plan (October 4, 2021) stated that the ministry could not inquire as to vaccine status. Despite this, the BC Public Service issued a policy that required disclosure of vaccine status.

He refused to disclose his vaccination status and was terminated for cause.

Employees who were terminated started a support group, in order to advocate on behalf of the employees. He estimated approximately 2000 to 3000 people were either terminated or took early retirement due to the vaccine mandate.

Darcy Harsch

Job Loss and Medical History Testimony on Vaccine Hesitancy and Employment

At the time of the pandemic, Darcy Harsch was working with adults with disabilities. Prior to the pandemic, he had a stroke and was disabled. As a result, he did not want to take an experimental vaccine.

He observed vaccine side effects in his co-workers, which contributed to his concern.

His workplace required him to reveal vaccine status, and he refused, so he was put on unpaid leave for approximately one year. His employer told him that he was not eligible for employment insurance, so he did not apply for employment insurance until the fall of 2022.

Suzanne Brauti

Job Loss Due to Denied Religious Exemption Request

She was working for the Government of Canada, in 2019. When the pandemic occurred, she was still in training. Due to the pandemic, she completed her training at home, and then worked at home for approximately one year.

The federal government implemented a vaccine mandate in the fall of 2021. She submitted a request for an accommodation due to religious beliefs. She had filed all the information requested but was denied her accommodation and was put on leave without pay.

She sent in a freedom-of-information request concerning how the government decided to deny her request. She felt that the information showed that she was not fairly assessed and filed a human rights complaint.

She has not been supported by her union.

Grace Neustaedter

Early Retirement: A Nurse's Testimony on Vaccine Pressure in the Workplace

Grace Neustaedter worked as a nurse for 41 years and has a master's degree in nursing, working as a specialist in the area of women's health.

Based on her experience as a nurse, she had serious concerns with regard to the speed that the vaccines were being developed, and she had done significant research into the vaccine's safety. She tried to have discussions concerning the vaccine safety, but co-workers were extremely close-minded. In fact, staff were vocally criticizing unvaccinated patients in public.

When vaccine mandates were imposed, she applied for a religious exemption, and there was no response.

She spoke to her union and was told that only one religious exemption had been allowed.

Some staff were allowed to continue to work from home, but she was not.

She went on stress leave and then medical leave, and finally she took early retirement.

In addition to employment issues, she and her husband were shunned by friends, family, and her family doctor.

She testified that she did not know anyone who had died from COVID-19 but that she knew several people who died from the vaccine.

Sierra Rotchford

A Paramedic's Account of Emergency Calls and Mandate-Impact on Ambulance Services

Sierra Rotchford primarily discussed the overall impact of mandates on the ambulance service. She indicated that 35-40 ambulances were taken out of service due to staffing losses. Staff were absent due to termination, stress leave, and illness.

She had sepsis and tried to obtain an exemption from getting the COVID-19 injection but was denied.

She observed a great deal of bullying between colleagues and between medical staff and patients.

She reported that the greatest increase in ambulance calls occurred following the vaccination program.

Vonnie Allen

Emotional Testimony from Veteran Nurse Once a Hero, Now Shamed and Muzzled

After 34 years working as a nurse on the maternity unit, Vonnie Allen was terminated after refusing to comply with the vaccine mandates.

Ms. Allen was denied service, restricted from speaking, and was not allowed to attend when her daughter was hospitalized.

Cathy Careen

Teacher Terminated from her Job

At the time when the pandemic was announced, she was working full-time as a teaching and learning assistant (TLA).

In 2006, she was diagnosed with Guillain-Barré syndrome. As a result, she did not want to take the COVID-19 genetic vaccine, as it had not been tested on patients suffering with her condition.

When the vaccine mandates were announced, she refused to take the vaccine due to her pre-existing condition. Her neurologist wrote a letter saying she should not take the vaccine.

Her request for exemption was denied. She appealed to the union, but they did not support her.

She was denied employment insurance benefits.

International Human Rights Law

Gail Davidson

Canada's Obligations Under International Human Rights Law

Ms. Davidson was a retired lawyer who had worked 20 years as an expert in international human rights law.

Canada had obligations under international human rights law. Many of these laws were violated by the mandates imposed in Canada during the declaration of the COVID-19 pandemic.

Right to Informed Consent was violated.

Certain international laws to which Canada was a signatory cannot be suspended, but they were suspended.

Her opinion was that the restrictions of rights of employees were in violation of international human rights laws.

Conclusions

A variety of COVID-19 mandates were unilaterally imposed on workers in all levels of government and in a variety of private industries across Canada.

Generally speaking, most non-pharmaceutical measures imposed at the workplace were complied with by employees; however, the imposition of compulsory vaccine mandates was resisted by many workers.

Resistance to mandatory vaccines resulted in a significant loss of qualified workers in all industry sectors. The loss of workers was due to suspensions, dismissals, forced retirements, voluntary early retirements, or worker resignations.

Many workers who were suspended, terminated, or dismissed were deprived of any assistance from the employment insurance plan due to the way their dismissals were coded.

Testimony received, indicated that the imposition of a mandatory vaccine was in direct contradiction to the principle of Informed Consent, which is a cornerstone of modern medicine.

Very few exemptions were provided to employees who had medical conditions, religious objections, or were concerned with taking an experimental gene therapy.

Despite the viable option of working from home, many employees were denied this option.

Shortages of staff resulted in reduced patient care due to the mandates implemented in the medical field.

Unions did not support the objections of their members to mandatory vaccines, and due to the union agreements, these workers were denied the right to appeal their layoff decisions.

The imposition of mandatory vaccines, in addition to the breach of medical privacy, resulted in toxic work environments which extended not only to staff working in facilities but also to the public accessing these services.

The mandates violated international human rights laws, to which Canada was a signatory. Rights to health include:

- Informed Consent,
- Freedom from Coercion, and
- Freedom from Experimentation.

The mandates that were imposed on Canadians violated many of the existing protected rights that are granted and recognized by both Canadian law and international laws and agreements, to which Canada has obligations.

In addition, Canada has certain obligations under international law, and there are certain rights that can be limited, under certain conditions, and there are other right that are absolute, which cannot be restricted.

Testimony of the witnesses provided examples of government actions which violated certain rights which were absolute rights, and therefore, the actions of the government were not in accordance with Canada's obligations under international law.

The Commissioners heard evidence that under international law, absolute rights cannot be violated, even under emergency situations.

Examples of absolute rights include:

International Treaty Rights

These include the right to: life; freedom of belief, conscience and religion; freedom from coercion to adopt a belief other than by choice; freedom from torture and ill treatment, the right to freedom from experimentation; freedom from ex post facto laws; and effective remedies for violations.

Jurisprudence Rights

These include the right to education, work, health, Informed Consent, and freedom from coercion.

The actions taken by the government were not in accordance with international laws and treaties to which Canada was a signatory.

Generally speaking, the laws that set out the legal limitation of the government's actions in Canada were well established and should have been sufficient to prevent the imposition of mandates on unwilling people through threats or coercion.

The violation of essential human rights came about from the wilful violation of those laws by both state and private actors.

A further issue in Canada is the financial reality of enforcing citizens' rights against government entities or large corporate entities. Governments or large corporate entities have virtually unlimited financial resources and can simply exhaust the financial resources of most private citizens.

Add to this the doctrines of "judicial notice" or "mootness." These doctrines effectively eliminate the right of citizens to their day in court. Canada is required to uphold the principle of the rule of law, which is necessary to protect the rights of citizens.

The rule of law requires that laws be properly purposed, properly passed, equally applied to all, and that there be measures in place to ensure equality, accountability, and access to all citizens. This is sadly not the case in Canada.

Recommendations

We recommend the following:

- A. **Immediate development of a judicial panel**, overseen by citizens, with the responsibility to investigate the human rights violations that were committed by both governments and private corporations during the pandemic.

- B. **Develop and implement** a constitutional and international law education course for all judiciary positions across Canada. The intent is to educate judges and Crown attorneys as to their responsibilities under the constitution and international treaties to which Canada is a signatory nation.
- C. **Carry out immediate judicial reviews** of all pandemic-related court cases that were denied on the basis of mootness or judicial notice.

7.1.10. Policing During COVID-19 Pandemic: Balancing Authority and Citizens' Rights

Introduction

The role of law enforcement agencies in Canada is firmly rooted in the principles of maintaining public safety, upholding the rule of law, and safeguarding the fundamental rights and freedoms of its citizens.

Policing at various levels of government, from federal to provincial to municipal, forms a critical part of Canada's social fabric. Yet, as the nation grappled with the unprecedented challenges posed by the COVID-19 pandemic, the actions of law enforcement agencies came under heightened scrutiny.

It is critical to understand the role and intent of the police in Canada, emphasizing what they are meant to do and what falls outside the scope of their duties. While the police are entrusted with maintaining order, their authority is carefully controlled by the principles of democracy and respect for individual rights.

Many witnesses described actions of the police to enforce government mandates during the COVID-19 pandemic that may have encroached upon the basic and fundamental rights of Canadian citizens. These actions included forced closures of businesses, arrests of citizens, the forceful breakup of peaceful protests, and the arrest and imprisonment of members of the clergy.

Canadians must assess whether law enforcement agencies in Canada have struck the right balance between protecting public health and respecting the constitutional rights and civil liberties of Canadian people during these extraordinary times.

Witnesses described specific cases and events that have garnered attention, weighing the considerations of public safety, individual freedoms, and the rule of law.

In a country that takes pride in its commitment to democracy and human rights, it is essential to critically evaluate the actions of the police in the context of the COVID-19 pandemic and reflect upon the broader implications for Canadian society. By engaging in this dialogue, we seek to promote a deeper understanding of the challenges faced by law enforcement and the rights of citizens, ultimately contributing to a more informed and just society.

Testimony of Witnesses

Witnesses who testified concerning the actions of the police include the following:

Chief John Greg Burke

Chief Burke described how he was assaulted by store employees for not wearing a face mask, despite his having a medical exemption from wearing a mask. When the police were called, they allegedly assaulted Chief Burke and arrested him. Chief Burke had interactions with both Bedford Police and RCMP.

Tom Marazzo

Mr. Marazzo described his interactions with the police while attending the truckers' protest in Ottawa, which included the alleged assault of a disabled war veteran.

Natasha Petite

Ms. Petite testified that due to a disability, she was not able to wear a mask. She testified how when she and her mother were shopping, police were called and she was pushed to the ground by police and arrested.

Vincent Gircys

Mr. Gircys was a retired 32-year veteran of the Ontario Provincial Police. He attended the Ottawa truckers' protest, where he acted as a liaison between the protestors and the police. Mr. Gircys testified that the police had committed alleged crimes against various churches. Mr. Gircys also testified that the police services refused to investigate alleged crimes related to the vaccines.

Tobias Tissen

Mr. Tissen ministered a church in southern Manitoba during the COVID-19 lockdowns. His church was closed down by the RCMP and he was arrested for keeping his church open during the pandemic.

Richard Abbot

Mr. Abbot was an Edmonton police officer for 25 years. He discussed his experiences and observations of the police actions during the protest in Coutts, Alberta.

David Leis

Mr. Leis testified regarding the failure of Canadian institutions to protect the civil rights of Canadians.

Danny Bulford

Mr. Bulford retired after a 15-year career with the RCMP. He spoke about the actions of the RCMP during the protests. He further spoke about a police detective who was disciplined for launching an investigation into suspicious infant deaths potentially related to the vaccines.

Pastor James Coates

Pastor Coates testified how his church services were disrupted by the police and he was arrested and jailed for keeping his church open during the lockdowns.

[Discussion of Police Actions](#)

Testimony of the witnesses suggested that the police took actions to enforce mandates and rulings that were contrary to section 52.1 of the Canadian Constitution, which included the *Canadian Charter of Rights and Freedoms*.

Section 52(1) of the Constitution states:

52.(1) The Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect.

Lockdowns, forced vaccinations, restrictions of travel, interruption of church services, and assaults on peaceful protestors are all actions which appear to be inconsistent with the *Canadian Charter of Rights and Freedoms* and/or the *Criminal Code* of Canada.

Citizens' fundamental rights were violated under the guise of a public health emergency, despite the government not having to prove the validity of that public health emergency within an objective and independent inquiry, or through open and honest debate.

Only one narrative was permitted and any dissenting options were censored and vilified by the media and public officials.

Testimony was provided on how significantly people's lives were affected, which included death due to the mandates, allegedly through increases in suicides or credible allegations concerning an unsafe medical procedure being forced upon citizens.

Testimony showed that information provided to the public by the government and the media misled the people and, in so doing, may have contributed to deaths.

Witnesses testified that they were allegedly forced to take medical procedures under threat of loss of employment. It may be reasonable to believe that the actions taken to have people take injections against their will could be considered a *Criminal Code* violation.

Forcibly subjecting a person to unwanted medical treatment in Canada can potentially violate several provisions of the *Criminal Code* of Canada, depending on the circumstances and the severity of the actions involved. Here are some relevant sections of the *Criminal Code* that may apply:

- Assault (section 265): Forcing someone to undergo medical treatment against their will may constitute assault under the *Criminal Code*. Assault includes not only causing bodily harm but also the intentional application of force without consent.
- Aggravated Assault (section 268): If the forced medical treatment results in severe bodily harm or endangers the life of the victim, it may be charged as aggravated assault, which carries more severe penalties.
- Kidnapping (section 279): If the victim is forcibly taken to a medical facility or detained against their will for medical treatment, it could be considered kidnapping under certain circumstances.

- Uttering Threats (section 264.1): Threatening someone with harm or injury if they refuse medical treatment may lead to charges of uttering threats.
- Unlawful Confinement (section 279): If a person is forcibly confined to a medical facility or prevented from leaving against their will for medical treatment, this may be treated as unlawful confinement.
- Mischief (section 430): Interfering with or damaging medical equipment or property related to medical treatment may fall under the offence of mischief.

Consent is a crucial factor in medical treatment in Canada, and any medical procedure performed without Informed and Voluntary Consent can lead to criminal charges.

However, specific charges and penalties will depend on the circumstances and the evidence available. Legal authorities will thoroughly investigate and assess each case to determine the appropriate charges.

The police failed to take action and investigate credible allegations of criminal wrongdoings, despite being presented with evidence of such alleged wrongdoings by multiple sources throughout Canada.

Witness testimony indicated that frontline police officers could initiate a criminal investigation on their own and that an investigation of any alleged criminal actions related to the pandemic measures and police actions must have been authorized by senior administrative staff.

Testimony confirmed that in a number of instances when police officers took action to investigate allegations of misconduct, these officers were disciplined.

The actions of the police services at the various peaceful protests sites, but most notably the Ottawa protest, indicated that the police were being given erroneous information concerning the nature and threat posed by the protestors. Witness testimony described how the protestors were exercising their rights to peaceful protest and that the character and the nature of the protestors was readily evident. Despite this, the police frontline members were replaced by members who had not been in direct contact with the protestors. These replacement members allegedly acted in a completely inappropriate manner using excessive force and violence on an unarmed and peaceful crowd of Canadian citizens.

The area where the Ottawa protests took place, in front of Canada's Parliament, was monitored by numerous video cameras, so there are likely a great number of recorded videos available which recorded both the actions of protestors and the police. This video record is critical to any investigation into the alleged misconduct of the police. As yet, this video record has not been presented to the public, and we do not know if it is being used in any criminal investigations of the police conduct.

Police officers are not robots; they are human beings entrusted with a crucial role in upholding the law and ensuring public safety. In performing their duties, officers are not merely expected to blindly follow orders but, rather, to employ their judgment and analytical skills. They must assess the legality and appropriateness of the orders they receive, all while considering the specific circumstances unfolding before them. Importantly, officers have a solemn duty not to enforce any orders that are illegal or in violation of fundamental rights. This obligation to act appropriately, guided by the reality of the situation on the ground, underscores the importance of independent decision-making within the framework of the law and serves as a cornerstone of democratic policing in free and just societies.

It is unknown whether any internal investigations of police actions have been undertaken, despite the level of alleged violence perpetrated by the police on the civilian population.

The Commission heard testimony that the police services were experiencing internal struggles with the implementation of the mandates on their own members and that unions representing members were not defending the member's rights. This allegedly resulted in low morale and a removal of many experienced officers from the ranks at a time when the services were already experiencing staff shortages and morale issues.

Conclusions

In conclusion, the role of law enforcement agencies in Canada is deeply rooted in the principles of safeguarding public safety, upholding the rule of law, and protecting the rights and freedoms of Canadian citizens. The imposition of the various COVID-19 pandemic mandates posed unprecedented challenges, which brought the actions of these agencies into focus. It is essential to comprehend the intended role of the police in Canada, emphasizing their duty to maintain order within the boundaries of democracy and individual rights.

During the pandemic, police actions came under scrutiny, particularly in cases where they may have infringed upon the fundamental rights of citizens. This scrutiny encompassed instances such as forced business closures, citizen arrests, the dispersion of peaceful protests, and even the arrest and incarceration of clergy members. Canadians must carefully evaluate whether law enforcement agencies effectively balanced public health concerns with constitutional rights.

The witnesses' testimonies shed light on specific incidents where actions taken by the police seemed inconsistent with section 52(1) of the Canadian Constitution, which incorporates the *Canadian Charter of Rights and Freedoms*. The fundamental rights of citizens appeared to be violated under the pretext of a public health emergency, raising questions about the validity of these measures without objective inquiry or open debate.

The impacts on people's lives, including alleged harm and death, underscore the gravity of these issues. The testimonies also pointed to potential misinformation contributing to public perceptions and deaths. Additionally, there were allegations of coercive measures, potentially constituting criminal offences.

Frontline police officers faced challenges in investigating these allegations due to the need for authorization from senior administrative staff, and instances of officers facing discipline for initiating such investigations were reported. The response to peaceful protests, particularly in Ottawa, raised concerns about police actions and the accuracy of information provided to officers.

In assessing the actions of law enforcement during the pandemic, it is crucial to remember that police officers are human beings entrusted with the duty to uphold the law and protect the public. They are not automatons but individuals who must analyze orders critically and consider the prevailing circumstances. They bear the responsibility of refusing to enforce illegal or rights-violating orders. Independent decision-making within the framework of the law is foundational to democratic policing.

The situation also raised concerns about internal struggles within police services that affected morale and staffing levels. These issues are complex and multifaceted, warranting ongoing dialogue, investigation, and reflection to ensure that the actions of law enforcement agencies align with the values of democracy and justice in Canadian society. By engaging in this discourse, we strive for a deeper understanding of these challenges, ultimately contributing to a more informed and equitable society.

Recommendations

- A. **Independent Judicial Investigations:** Conduct independent and transparent judicial investigations into allegations of illegal activities by law enforcement officers during the pandemic, ensuring accountability and adherence to the rule of law. This investigation must have the power to enforce subpoenas to obtain witness testimony and critical documents.
- B. **Review and Revise Policing Protocols:** Collaborate with law enforcement agencies to review and revise their protocols and guidelines for enforcing government mandates, with a focus on respecting individual rights and freedoms while safeguarding public health.
- C. **Enhance Training and Education:** Provide comprehensive training on handling public health crises to law enforcement officers, emphasizing respect for human rights, de-escalation techniques, and community engagement.
- D. **Public Awareness Campaigns:** Launch public awareness campaigns to educate citizens about their rights and responsibilities during health emergencies, promoting dialogue and cooperation between the police and the community.
- E. **Community Policing Initiatives:** Promote community policing initiatives that foster positive relationships between law enforcement agencies and the communities they serve, enhancing trust and cooperation.
- F. **Clear Accountability Mechanisms:** Establish clear mechanisms for holding law enforcement agencies accountable for their actions during the pandemic, ensuring transparency and fairness in the disciplinary process.

G. **Civilian Oversight:** Strengthen civilian oversight bodies to independently monitor police conduct during public health crises, ensuring adherence to legal and ethical standards.

H. **Regular Reporting and Transparency:** Mandate law enforcement agencies to regularly report on their activities during health emergencies, providing transparency and accountability to the public, while respecting privacy and security concerns.

By implementing these recommendations, authorities can strike a balance between maintaining public safety during health crises and upholding the fundamental rights and freedoms of citizens, ensuring a more just and equitable response to future pandemics.

7.2. Social Impacts

7.2.1. Neglect and Isolation of Seniors in Canada Amidst COVID-19 Interventions

Introduction

The interventions put in place by the various levels of government and by various “independent” service providers in Canada during the COVID-19 pandemic have destroyed and ended lives across every segment of Canadian society, profoundly impacting every age group. However, one of the most vulnerable populations affected by the mandates in Canada has been seniors.

As Canada implemented both pharmaceutical and non-pharmaceutical based measures such as “vaccines,” social distancing, and lockdowns, significant consequences as a result of these interventions quickly emerged. Among these consequences, the neglect and isolation of seniors have become prominent issues. This section explores the devastating effects of COVID-19 measures on Canadian seniors.

Testimony of Witnesses Detailing Neglect and Isolation of Seniors

Based on the testimony of witnesses, it was obvious that the various government agencies, private corporations, and citizens in general knew very early on in 2020 exactly who was most at risk from the virus and what focused steps should have been taken to reduce these risks.

Based on decades of experience in the treatment of and care for seniors, these caregivers and regulators must have known what devastating impacts would result from the implementation of the interventions; however, many of these agencies, institutions, and individuals continued to devastate our seniors in an inhuman, profound, and intentional way.

Many stories of unconscionable neglect and cruelty were brought to the Commission hearings.

Testimonies were received from the following witnesses:

Dr. Patrick Phillips (Truro, NS)

Dr. Phillips testified that the hospitals were empty during COVID-19 and that many persons were neglecting their health or were afraid to go to the hospitals for care.

Shelly Hipson (Truro, NS)

Ms. Hipson testified that, based on her freedom-of-information requests she was able to confirm that the hospitals and specifically ICU facilities, were not overwhelmed due to COVID-19.

Dr. Peter McCullough (Truro, NS; Virtual Testimony)

Dr. McCullough testified that there were a number of alternative treatments available, as opposed to a COVID-19 experimental vaccine, very early in the pandemic. He further indicated that alternative methods were less risky in seniors than an untested vaccine. Dr. McCullough stated that there was no evidence that a person who had no symptoms of COVID-19 could transmit the illness to anyone else; therefore, the lockdown of healthy people was unnecessary.

Paula Doiron (Truro, NS)

Ms. Doiron worked in a nursing home and testified that they were short-staffed and that the situation was chaotic. She further testified that she was not aware of any on-site monitoring carried out by government regulators.

Janessa Blauvelt (Truro, NS)

Ms. Blauvelt was a licensed practical nurse (LPN) at the hospital. She left her position because she refused to get the injection. She reported much dissension in the workplace due to injection status.

Marc Auger (Toronto, ON)

Mr. Auger's father was in a long-term-care facility and was locked down in his room for long periods of time. As a result, his father's dementia got substantially worse.

Oliver Kennedy (Toronto, ON)

Mr. Kennedy, a recreational therapist for seniors, was terminated for his refusal to take an injection.

Richard Lizotte (Toronto, ON)

Mr. Lizotte's elderly brother, who was in care, reacted to the injection and was taken to the hospital, where he was isolated and not allowed any visitors. His brother was sent to palliative care and died alone.

Victoria McGuire (Toronto, ON)

Ms. McGuire was a registered nurse who stated that during 2020 and 2021, there were very few people in the hospital and that there was a toxic environment in the hospitals due to animosity against the uninjected.

Leanne Duke (Toronto, ON)

Ms. Duke's father had Parkinson's and dementia, and at the time of the pandemic, her father was in a primary-care home. Prior to the pandemic, she was spending two to three hours a day caring for her father in the facility, as the staff refused to provide the proper care required for his stoma. After the lockdowns, she was barred from entering the facility to care for her father. During the lockdowns, her father could not go to medical appointments. She said that most days during the lockdowns, her father was left in his own waste.

Lynn Kofler (Toronto, ON)

Ms. Kofler was a registered nurse in a long-term-care facility. She witnessed serious injuries in her unit and stated that there were 34 deaths out of a total of 55 residents. She said the facility was in COVID-19 lockdown, despite there being no cases of COVID-19.

Cindy Campbell (Toronto, ON)

Ms. Campbell had worked 28 years as a nurse. She testified that due to departmental closures at hospitals, there was an excess of staff. She said that prior to the pandemic, the emergency room resembled a war zone and that during the pandemic, the emergency room was very slow.

Scarlett Martyn (Toronto, ON)

Ms. Martyn was an advanced-care paramedic who lost her job for refusing to get injected. She reported a toxic atmosphere in the hospitals. She said that at the beginning of 2020, hospitals were empty. Once injections rolled out, there was a wave of “sudden death” calls.

Maureen Somers (Toronto, ON)

Ms. Somer’s husband was taken to the emergency with abdominal pains. The doctor was only interested in his injection status and would not provide treatment, because he wasn’t vaccinated. A second doctor came in on the next shift and did an emergency appendectomy.

Martha Voth (Winnipeg, MB)

Ms. Voth’s elderly husband was admitted to hospital with difficulty breathing and shortness of breath. The hospital refused to provide him with O₂ therapy and put him on respirator. He died shortly thereafter.

Sara Martens (Winnipeg, MB)

Ms. Martens’ elderly husband was in a traffic accident, taken to the hospital, tested for COVID-19, and tested positive. Her husband was in emergency on O₂ but was coherent. Once he tested positive for COVID-19, a nurse said they would not be providing him with treatment. The hospital would not let her speak to the doctor. The hospital intubated him and then placed him on a ventilator. He died shortly thereafter.

Michelle Kucher (Winnipeg, MB)

At the beginning of 2020, Ms. Kucher was working in Selkirk, Manitoba, in the healthcare field. In 2020, Michelle moved in with her mother to take care of her, following a surgery that her mother had in January 2020. Due to lockdowns and loneliness, she died in 2021.

Angela Taylor (Saskatoon, SK)

Ms. Taylor was an LPN in a seniors home. She talked about the isolation and loneliness of the residents and how so many of the seniors had simply given up on life and died due to the treatment they received during the lockdowns.

Marjaleena Repo (Saskatoon, SK)

Ms. Repo was an elderly lady who was diagnosed with stage-4 cancer and could not wear a mask. She obtained an exemption but was targeted and victimized by many in the community due to her inability to wear a mask. She was allegedly terribly abused and doxxed by the local radio station.

Jody McPhee (Saskatoon, SK)

In May 2021, Ms. McPhee's elderly father got an injection. Within 45 minutes, they knew he was dying. He drove himself to the hospital; she was not allowed to see him because she was not on a "list." Staff said her father died of a reaction to injection.

Dr. Christopher Flowers (Saskatoon, SK)

The takeaway from Dr. Flowers' testimony was: "Pfizer clinical trials did not include any seniors or people with comorbidities."

Heather Burgess (Saskatoon, SK)

Heather was a retired nurse with a mother in long-term care due to Alzheimer's disease. Her mother was locked down for very long periods of time with no activities, and even meals were taken in her room, alone. Her mother was not allowed any visitors and thought that she had been abducted. Her mother was in a constant state of terror and tried to run away three times. Eventually, Ms. Burgess' mother was injured and died.

Judy Soroka (Red Deer, AB)

Ms. Soroka was a retired nurse with a back injury. Due to lockdowns, she could not get therapy treatment, and her condition deteriorated.

Caroline Hennig (Vancouver, BC)

Ms. Hennig was living in Costa Rica at the time of the pandemic and came to Canada to care for her father, who was in poor condition in a long-term-care facility. Over several months, she nursed him back to health and then returned home. Several months after her departure, he stopped communicating and began to fail; he requested to die under the MAID (medical assistance in dying) program. She believed his decision was due to the neglect and lack of care in the facility.

Zoran Boskovich (Vancouver, BC)

Mr. Boskovich and his wife were forced to take early retirement due to injection mandates. As a result, they will have serious financial shortfalls for the rest of their lives due to reduced pension payouts.

Lynette Tremblay (Québec City, QC)

In 2020, Ms. Tremblay's father was in a long-term-care home. There were no cases of COVID-19 in the home, but the residents were locked down and isolated anyway. No one could visit, and the residents were locked in isolation. In a phone call with her father, he told her that he had tested positive for COVID-19 but had no symptoms. Police were in attendance at the home to prevent anyone from coming in or out of the facility. According to the testimony, when a patient tested positive for COVID-19, all medications and treatments of the patient were withheld. Her father allegedly died due to neglect and isolation.

Shawn Buckley (Québec City, QC)

Mr. Buckley testified that under the interim order which authorized the use of the COVID-19 injections in Canada, the COVID-19 injections were exempted from providing the safety and efficacy proof that is normally required of any other new drug approved in Canada.

Dr. Denis Rancourt (Québec City, QC; Ottawa, ON; Virtual Testimony)

Dr. Rancourt and his team reviewed the all-cause mortality statistics for Canada, and he stated that there was no increase in all-cause morbidity due to a virus. The increase in deaths coincided with the lockdowns and the rollout of the injections.

Stephanie Foster (Saskatoon, SK)

Ms. Foster's elderly mother died immediately after being administered the injection at a local pharmacy. Her mother did not want to get the injection but was convinced she had to do it to keep everyone else safe. She said that her mother died immediately after getting the injection, while still in the pharmacy. She further described how no one who was in line for the injection reacted or even left the lineup, they remained in the line, despite what they had seen. No autopsy was performed.

Neglect and Reduced Access to Healthcare

One of the primary concerns for seniors during the pandemic was the neglect they experienced due to a healthcare system which no longer addressed their needs.

The focus on "protecting the healthcare system," rather than "protecting the public from the disease," resulted in limited resources for other healthcare needs.

Steps were taken to dismiss healthcare staff who had refused to undertake an experimental medical procedure. Many healthcare professionals simply quit or took early retirement; many were terminated from their positions. No one was spared these actions—from senior first responders to emergency room doctors to nurses and all level of support staff.

Patients in the healthcare system were sent home.

Both patients and healthcare professionals were terrorized by the government and media reports concerning the morbidity and infectious nature of the virus which causes COVID-19. As a result, a cruel and toxic environment developed throughout the healthcare system.

Many members of the public were so terrified that they would not visit the hospital, even in dire situations, and when they did go to the hospital, they were often given very little care. The situation was even worse if these people had not been injected.

The situation was even worse for our seniors.

Routine check-ups, elective surgeries, and non-urgent appointments were postponed or cancelled, leaving seniors grappling with delayed medical care. Consequently, many seniors have had to endure prolonged pain, worsening conditions, and deteriorating mental health, leading to an overall decline in their quality of life.

Moreover, the fear of contracting the virus has deterred seniors from seeking necessary medical attention, resulting in undiagnosed conditions and unaddressed health issues. This fear-induced hesitation had severe consequences, as conditions that could have been easily managed if detected early, progressed to advanced stages. As a result, the neglect of seniors' healthcare needs exacerbated their overall vulnerability during the pandemic.

When the injections were developed in late 2020, there was no evidence that they were safe to use in the seniors population, given the fragility and multitude of pre-existing conditions in that population. None of the vaccine testing carried out prior to the interim order included specific tests on populations of seniors.

The testing carried out prior to releasing these experimental injections was only on "healthy" persons.

Testing injections on seniors is of paramount importance for several reasons:

- Older adults have a higher risk of severe illness and death due to COVID-19, making them a priority population for injection. Understanding the safety and efficacy of injections in seniors, is essential to protect this vulnerable group from the adverse effects of the virus and adverse effects of any new type of injection.
- Aging is associated with changes in the immune system, which can affect the response to injections. Older adults may have a reduced immune response, making it crucial to determine the effectiveness of injections in this population. Additionally, seniors often have underlying health conditions and may take multiple medications, necessitating thorough testing to ensure injection compatibility and safety.

Despite the lack of testing and the lack of any safety or effectiveness data related to seniors, this population was threatened, coerced, and terrified into taking the injections. Many witnesses indicated that their loved ones died immediately following the injections.

Ensuring the safety and efficacy of COVID-19 genetic vaccines in seniors is crucial for protecting this vulnerable population from severe illness and mortality. Rigorous testing protocols, including clinical trials that specifically included seniors, were never implemented to assess injection safety and effectiveness in this highly vulnerable age group.

Isolation and Loneliness

Another critical consequence of COVID-19 non-pharmaceutical measures has been the enforced isolation of seniors.

The unnecessary restrictions on social gatherings, visitation policies in long-term-care homes, and physical distancing guidelines have significantly limited seniors' interactions with their families, friends, and support systems.

Many seniors who resided alone or in care facilities experienced an overwhelming sense of loneliness and isolation, which had devastating effects on their mental and emotional wellbeing.

Isolation not only leads to increased feelings of loneliness and depression but also contributes to cognitive decline and a higher risk of developing dementia. The absence of regular social interactions and engagement can accelerate the decline of seniors' cognitive abilities.

Additionally, the total lack of emotional support and companionship left many seniors feeling disconnected from their loved ones and the community, which further exacerbated their sense of isolation.

The detrimental effects of isolation and loneliness on seniors had devastating impacts on the physical, mental, and emotional health including the following:

Physical Health

- Isolation and loneliness can have a profound impact on the physical wellbeing of seniors. The Commissioners heard testimony that social isolation increases the risk of various health problems. Seniors who lack social connections are more likely to develop chronic conditions such as cardiovascular diseases, hypertension, and weakened immune systems. Additionally, the lack of social engagement may lead to sedentary lifestyles, contributing to a decline in physical fitness and mobility.

Mental and Cognitive Decline

- Loneliness and isolation can have detrimental effects on seniors' mental and cognitive health. The absence of regular social interaction can increase the risk of depression, anxiety, and cognitive decline. Studies have linked prolonged loneliness to an increased likelihood of developing conditions such as Alzheimer's disease and other forms of dementia. The absence of stimulating conversations and mental challenges may contribute to a decline in cognitive abilities over time.

Emotional Wellbeing

- Seniors who experience isolation and loneliness often grapple with significant emotional distress. Feelings of sadness, worthlessness, and a lack of purpose can become pervasive. The absence of social connections and meaningful relationships can lead to a diminished sense of self-worth and overall life satisfaction. Emotional wellbeing is closely tied to social interactions, and the lack thereof can have severe consequences for seniors' mental health.

Quality of Life

- Isolation and loneliness directly impact the overall quality of life for seniors. The absence of social support networks can result in decreased life satisfaction and reduced enjoyment of daily activities. Seniors may feel disconnected from society and deprived of opportunities for engagement and personal growth. As a result, their sense of purpose and fulfilment may diminish, leading to an overall diminished quality of life.

The detrimental effects of isolation and loneliness on seniors cannot be underestimated. Witnesses testified that these effects were recognized and were well known throughout the healthcare community. However, despite this knowledge, healthcare providers wilfully followed the COVID-19 propaganda and engaged in the very activities that they knew would seriously harm or even cause the painful and lonely deaths of the very people they were supposed to be caring for. They knew what they were doing was wrong, but they followed their orders anyway.

How these caregivers were able to so easily dehumanize this vulnerable population is outside of the scope of this report. The Commissioners recommend that investigations be undertaken into the treatment of residents of long-term-care homes and about whether owners, staff, or employees should face liability or consequences where residents were mistreated.

Testimony was received concerning many seniors who simply gave up living as a result of being isolated, not only from their loved ones but by "healthcare" staff and caregivers.

One witness testified that upon returning home from overseas, she found her father, who was in a care facility, near death due to the isolation and neglect. The witness was able to intervene and nurse her father back to life. Once her father was well and once again in good health (due to her care), she had to return to her home overseas. Shortly after, she was informed that her father had requested and been granted a supervised death under the government MAID program.

In her opinion, her father chose to die rather than to face the isolation and neglect that he had previously experienced without the intervention of his daughter.

Testimony was received that many seniors with dementia were simply left alone, locked in their rooms for days and weeks or even months at a time. These patients were simply left to rot and eventually die.

Many of the witnesses, including staff and family were asked if they ever saw any government inspectors on the premises of these facilities, to ensure that the residents were receiving care. All witnesses stated that they were aware of no such in-person inspections by independent outside agencies. The regulators simply turned their backs on what was going on.

It must be noted that a significant part of the problem was the systematic dismissal of any existing care staff who refused to submit to the injections that were mandated by their employers. Some staff were terminated and others simply resigned or retired.

These actions left already understaffed facilities with a critical shortage of trained and experienced care staff. The result further eroded the quality and quantity of care that was being provided.

Oftentimes family and friends were not aware of the dire situation that had developed within the care facilities, because they were also locked out and were not allowed to visit their loved ones.

Phone calls or digital calls were no substitute to seeing what exactly was going on in these facilities, especially considering many seniors were unable to communicate their predicaments.

Financial Struggles and Digital Divide

Outside of care facilities, independent seniors also faced significant financial challenges during the pandemic. Many seniors rely on part-time work or small businesses to supplement their income, and the economic downturn caused by COVID-19 mandates severely impacted their financial stability. Job losses, reduced hours, and closures of businesses left many seniors struggling to make ends meet, leading to heightened stress and anxiety.

Furthermore, the rapid shift to digital communication and online services has highlighted the digital divide among seniors. With limited access to technology and digital literacy, many seniors have struggled to connect with their loved ones, access essential services, and participate in virtual social activities. This exclusion from the digital realm has further deepened their sense of isolation and made it more challenging for them to adapt to the changing landscape brought about by the pandemic mandates.

Conclusion

The neglect and isolation of seniors in Canada due to COVID-19 measures had significant adverse effects on their physical health, mental wellbeing, and overall quality of life.

Addressing the needs of seniors during these challenging times is not only a matter of compassion but also a responsibility society must uphold.

By prioritizing seniors' healthcare, promoting social connections, addressing financial struggles, and bridging the digital divide, we can ensure that seniors are not forgotten, neglected, or isolated but rather, supported, cared for, and included in the collective response to the pandemic.

Given the profound and inhuman treatment that many seniors in care facilities received, it is imperative that a nonpolitical investigation be carried out to determine if criminal charges should be laid and, if so, against whom.

Speed is of the essence in undertaking this investigation, since, given the fragile nature of the victims, there may not be many of them left to give evidence.

Recommendations

- A. **To alleviate the neglect and isolation** faced by seniors, it is crucial for the federal, provincial and territorial governments, communities, and individuals to take proactive steps. First and foremost, healthcare systems should prioritize healthcare needs of seniors, ensuring that seniors have access to essential medical care and support services.
- B. **Moreover, efforts should be made to enhance** the social connections of seniors. This can include facilitating safe visitation policies in long-term-care homes, promoting intergenerational programs, and encouraging community organizations to provide support and companionship to isolated seniors. Volunteering initiatives, teleconferencing platforms, and community outreach programs can help bridge the gap between seniors and their support networks.
- C. **Financial assistance programs should be expanded** to specifically address the needs of seniors who have been adversely affected by the pandemic mandates. Providing targeted financial support, job training, and re-employment opportunities can help seniors regain their financial stability and alleviate some of the stress they face.
- D. **Bridging the digital divide among seniors** should be a priority. Initiatives aimed at enhancing digital literacy and providing seniors with the necessary tools and resources to access online services can empower them to connect with their loved ones, access information, and engage in virtual social activities.
- E. **It is imperative that a judicial investigation** be carried out immediately to determine if any criminal wrongdoing was perpetrated on our senior populations during the pandemic. Witness statements from staff, seniors, and family must be immediately obtained and archived, to be used as evidence in any future prosecutions.
- F. **An investigation should be conducted** into how the various regulatory agencies abandoned their roles of protectors of seniors and never appeared to visit facilities to check on the operation and level of care being given out.
- G. **Those caregivers who simply followed** the orders given to them to isolate and dehumanize our seniors in their care must be re-educated or removed from the system and not allowed to continue to provide “care” to seniors.

- H. **Like other professions**, caregivers and administrators working with seniors should be mandated to participate in annual professional development and training programs.

7.2.2. The Effects of Sustained Propaganda and Terror

Introduction

Propaganda can have a profound impact on the masses, shaping public opinion, influencing beliefs, and driving collective behaviours. The pandemic was a textbook case of the collaboration of government and industry to subvert the democratic institutions and convince the citizens of the validity and truthfulness of a narrative that was objectively false from the start.

This propaganda was initially used to terrorize Canadians and then to convince Canadians that an unprecedented government intervention into their lives and the suspension of what Canadians thought to be their fundamental human rights was justified.

Many Canadians not only believed this propaganda but embraced and supported the measures being dictated by the government, despite their obvious shortcomings.

Testimony Concerning the Effect of Propaganda and Terror

Persuasive techniques and manipulation of information were used to promote a specific agenda or ideology, with the intent of gaining support, maintaining power, adopting tectonic shifts in public policy, and inciting fear. Here are some key effects of propaganda that were employed during the pandemic:

- The government distorted or selectively presented information to shape public perception. By framing issues in a particular way, using emotionally charged language, or exploiting existing biases, they were able to influence how people perceived events, individuals, or groups. This manipulation resulted in altered perspectives and skewed understandings of reality. Testimony was heard from a number of witnesses—including Rodney Palmer, who detailed how this was perpetrated on the public via the media.
- The government propaganda sought to mold public opinion by reinforcing certain beliefs or ideologies, while discrediting opposing views. It exploited cognitive biases, such as confirmation bias and selective exposure, to reinforce pre-existing beliefs and create an echo chamber effect. This led to the entrenchment of polarized and biased perspectives, hindering critical thinking and open dialogue. Testimony from Dr. Peter McCullough demonstrated some of the focused techniques that were used to accomplish this.

- The government appealed to emotions to elicit specific reactions from the citizens. By evoking fear, anger, or a sense of social responsibility, they were able to mobilize individuals and create a desired emotional response. This emotional manipulation led to impulsive or irrational decision-making, blurring the lines between fact and emotion. Testimony was presented from a number of witnesses detailing how name-calling and shaming was used to develop hatred toward other groups. The Prime Minister of Canada referred to a large and identifiable segment of the Canadian population as “racists” and “misogynists” and threatened them by stating that the government would have to decide how to deal with them. This, in the NCI’s opinion, dehumanized dissenters and promoted hatred and, potentially, violence against this group. Testimony was heard how seniors and disabled persons were violently attacked in public as a result of this type of rhetoric.
- The government targeted specific groups or communities, fostering a sense of collective identity and cohesion. By emphasizing common interests and highlighting perceived threats, it created an us-versus-them mentality that further polarized society and exacerbated divisions. This led to social fragmentation and hindered collaboration and understanding among different groups. The government propaganda emphasized how groups of citizens who disagreed with their mandates were placing others in danger, despite the government knowing that the Information they were providing was not true.
- Propaganda was used to stifle dissenting voices and alternative perspectives by marginalizing or discrediting them. This can create an environment where individuals fear expressing dissenting opinions or questioning the prevailing narrative, leading to a chilling effect on free speech and the exchange of ideas. Both media and government personalities demonized dissenting opinions. Their labels of “anti-vaxxer” or “science deniers” were intended to associate people who did not consent to the experimental injections with “Holocaust deniers.” Many people fell prey to the fear of being labelled and remained silent.
- Propaganda was used to influence behaviours and actions by manipulating public opinion. It shaped public attitudes towards specific policies, products, or social norms, thus directing individual and collective behaviour. This has had far-reaching consequences and impacted voting patterns, consumer choices, and social dynamics. Testimony included commentary on how certain businesses were allowed to remain open while others were closed and how certain community groups were deemed as socially unacceptable.

It is important to be aware of the potential effects of propaganda on the masses and to critically evaluate information and sources.

It appears that in this instance, the propaganda was so pervasive and so persistent that even the various government agencies either believed the propaganda themselves or were so influenced by the toxic and vindictive environment that they acquiesced to it, despite knowing it was wrong. Lieutenant Colonel David Redman testified that he was aware of senior people within the emergency measures organizations who knew the narrative was false and who further knew that the public health officials were neither trained to, nor capable of, managing and directing an emergency response; however, they kept silent over fears of reprisals.

Promoting media literacy, critical thinking, and an open-minded approach can help individuals guard against manipulation and make informed decisions based on accurate and reliable information. Society benefits from diverse perspectives, open dialogue, and a commitment to truth, which can counteract the negative effects of propaganda.

The second element of the government's campaign of control included the introduction and promotion of terror towards a purposely unknown and ill-defined menace (pandemic).

According to a variety of testimonies, it was evident that the pandemic had been in the planning stages for years and affected almost every area of our institutions.

The very definition of various fundamental words had been changed shortly prior to the 2020 announcement of the pandemic.

The meaning of fundamental terms such as pandemic, vaccine, and biologic

These fundamental terms have very specific meanings to the population, based on a long history; however, their meaning needed to be changed in order to evoke terror and eventually control masses of people.

Terror is a powerful tool that is used to influence a population through fear and intimidation. Here are some ways this tool was weaponized to influence the population:

Terror was used to create a climate of fear and anxiety within the population. Acts of violence, threats, or intimidation tactics were designed to generate a pervasive sense of insecurity and vulnerability. This fear paralyzed individuals, suppressed dissent, and deterred resistance to the measures. People blindly accepted the narrative and welcomed the absolute violation of their fundamental civil rights, and many were all too willing to actively assist in the suppression of these rights on their fellow citizens.

Demonstrations of extreme violence by authorities were broadcasted daily on legacy media, reinforcing the fear of reprisals for dissent. These included the police actions against the protestors in Ottawa, as testified to by Tom Marazzo.

The government and media organizations utilized acts of terror strategically in order to shape public opinion. They sought and gained sympathy or support for their cause by portraying themselves as victims or by framing their actions as justified responses to perceived injustices. By manipulating narratives and propaganda, they aimed to sway public perception in their favour. This was clearly evident in the Freedom Convoy, which peacefully protested the pandemic mandates in Ottawa. The government used mainstream media to portray these people as violent, racists, and anarchists, who were threatening the very lives of the people of Ottawa. This portrayal terrorized the average Canadian citizen, and combined with a virtual blackout of dissenting options, they were able to mobilize resentment toward this group.

Police were used as a instrument of terror and were employed as a means of exerting control over a population. Through threats of violence or actual acts of brutality, those controlling the police sought to maintain power and ensure compliance with their demands. This created a climate of silence and obedience, stifling dissent and resistance.

Mr. Tom Marrazo testified how he observed the enforcement of terror on innocent and peaceful protestors in Ottawa. He also testified that despite the hundreds or even thousands of security cameras that were deployed in the area surrounding the protests, the government had not released any of the probably thousands of hours of video recordings detailing what exactly happened in the Ottawa protests.

Terror was used to undermine societal stability and erode trust in institutions. By targeting infrastructure, public spaces, or key figures, acts of terror can create a sense of chaos, destabilize communities, and undermine faith in the ability of authorities to protect citizens. This can disrupt social order and create an environment conducive to further manipulation and control. The government targeted dissidents and even church leaders, arresting and jailing several of them across Canada.

Government leaders, including the Prime Minister of Canada, and several Premiers of provinces, openly promoted divisions between groups and used this support to exacerbate existing divisions within society and fuel intergroup conflicts. By targeting specific communities or perpetrating acts of violence that incite retaliatory actions (such as the police actions at the various protest sites), the government sought to deepen social divisions and promote further animosity. A cycle of violence and mistrust ensued, which hindered efforts towards peace and reconciliation.

Terror was used as a tool to suppress dissent and curtail individual freedoms. By creating an atmosphere of fear, some individuals self-censored their views, refrained from expressing dissent, or limited their participation in public life. This enabled the government to maintain control and prevent opposition from emerging.

It is essential to recognize and condemn the use of terror as a means of influencing populations because it undermines human rights, democratic values, and social cohesion. Countering terror requires a multifaceted approach, including addressing root causes of violence, promoting inclusive societies, strengthening institutions, and fostering resilience within communities.

Conclusion

In conclusion, the Commissioners are of the view that the Government of Canada, in concert with provincial governments and the mainstream media, embarked on an information campaign designed to instil fear in the hearts of citizens and ensure that they did not resist any and all draconian measures that were announced. Whether the media were state-controlled or simply agreed with the government's approach and began repeating their messaging without question was not discovered through testimony at the Inquiry. Further investigation into the relationship between the government and the media during the pandemic time needs to be done. Regardless, the cooperation of the media with the government during this time created a campaign of propaganda and terrorism that represents a grave violation of human rights, democratic values, and the principles of international law. Governments that engage in or support acts of terror against their own people undermine the fundamental rights and freedoms of their citizens, erode trust in institutions, and perpetuate cycles of violence and fear.

The prevention of state-controlled propaganda and terrorism requires a comprehensive approach that includes promoting accountability, upholding human rights, fostering democratic governance, and strengthening international cooperation.

It is crucial to establish robust legal frameworks, independent oversight mechanisms, and a free and independent media to expose and challenge abuses.

Civil society empowerment, education, and awareness play a vital role in advocating for human rights and holding governments accountable for their actions.

International pressure and cooperation are essential in addressing state-controlled terrorism. The global community must stand united in condemning such actions and must utilize diplomatic, economic, and legal measures to hold accountable those responsible for perpetrating or supporting acts of terror.

Ultimately, the prevention of state-controlled terrorism is an ongoing commitment that requires the collective efforts of governments, civil society organizations, and individuals who uphold the values of human dignity, justice, and respect for human rights.

In the instance of the propaganda and terrorism that was perpetrated by the Canadian government on its citizens, we acknowledge that this campaign could not have been successful except for the collusion and cooperation of the traditional media in Canada.

There was almost a complete and utter lack of criticism or questioning of any of the media narrative. To this day, despite the mountain of evidence that the severity of the pandemic was seriously overblown and that the measures, both pharmaceutical and non-pharmaceutical, did unimaginable harm to our country, no traditional media outlet has launched any kind of unbiased investigation.

Recommendations

Preventing governments from using propaganda and terror against their people requires a multifaceted approach that involves promoting accountability, safeguarding human rights, and fostering democratic institutions. Here are some key strategies:

- A. **Establish and uphold a robust human rights framework** that protects the fundamental rights and freedoms of individuals. This includes enshrining indelible human rights in constitutions, implementing international human rights conventions, and ensuring an independent judiciary to safeguard citizens' rights.
- B. **Foster a strong rule of law** by ensuring that government officials and security forces are held accountable for their actions. This includes establishing independent oversight bodies, conducting transparent investigations into allegations of human rights abuses, and prosecuting those responsible for violations.
- C. **Promote freedom of expression** and an independent media that can serve as a watchdog to hold governments accountable. Protect journalists, bloggers, and activists from harassment, censorship, financial repercussions, and violence, and ensure their ability to report on government actions without fear of reprisal.
- D. **Support and empower civil society organizations**, including human rights groups, advocacy organizations, and community-based initiatives. These organizations play a crucial role in monitoring government actions, advocating for human rights, and providing support to victims of abuse.
- E. **Promote and strengthen democratic governance** by ensuring free and fair elections, transparent electoral processes, and respect for the will of the people. This includes promoting political participation, guaranteeing the independence of electoral bodies, and providing opportunities for citizens to engage in decision-making processes.
- F. **Leverage international cooperation** and pressure to address human rights violations. Encourage diplomatic efforts, international organizations, and regional mechanisms to hold governments accountable for their actions, and impose targeted sanctions or other measures against those responsible for terrorizing their own populations.
- G. **Support international human rights mechanisms**, and provide them with the necessary resources and authority to investigate and address human rights violations perpetrated by governments. Collaborate with these mechanisms to bring attention to abuses and advocate for meaningful action.

H. **Promote human rights education** and awareness among citizens, government officials, and security forces. Encourage a culture of respect for human rights, tolerance, and non-violence through educational programs, public campaigns, and training initiatives.

Preventing governments from using terror against their people requires ongoing commitment and vigilance. It is a collective effort that involves the active participation of citizens, civil society, international actors, and the government itself. By upholding human rights, promoting accountability, and fostering democratic values, societies can strive towards preventing and addressing government-led terror.

7.2.3. Social Effects of Mandates on Canadian Institutions

Introduction

Historically, Canadians have had a high level of trust in their public institutions. Trust in public institutions is often measured through public opinion surveys which assess public confidence in various institutions, including government, parliament, the judiciary, the police, and public health agencies.

While trust levels can fluctuate over time, especially in response to specific events or policies, Canada has consistently ranked relatively high, compared to many other countries, in terms of public trust in institutions. Factors contributing to this trust include Canada's reputation for political stability, democratic governance, and robust public services.

The long-term effects of government actions during the COVID-19 pandemic has significantly reduced Canadians' confidence and trust in their government institutions. This erosion of trust in the fundamental institutions of Canada is prevalent not just in Canada but around the World.

According to the testimony of Gail Davidson, Canada no longer enjoys the trust of its citizens or that of the citizens of much of the world.

The perception of tyranny is subjective and can be influenced by a range of factors, including political biases, international relations, media narratives, and individual experiences.

While opinions may differ, it is worth noting that Canada no longer enjoys a universally positive reputation for democratic governance and respect for human rights, globally.

Canada's long standing tradition of fairness and transparency has been severely eroded, and this negative perception will affect Canadian society for generations to come.

The intent of this section is to provide an overall or general commentary on the subject of institutional trust: detailed discussion and analysis of certain institutions included here are contained in other sections of this report.

Testimony of Witnesses' Social Effects of Mandates on Canadian Institutions

Many witnesses testified as to the performance of the fundamental institutions of Canadian society during the COVID-19 pandemic.

Canadian institutions that were discussed included the following:

- Parliament, legislatures, executive branch,
- Judiciary,
- Legal profession,
- Police,
- Healthcare,
- Regulatory agencies,

- Media,
- Financial institutions,
- Human rights organizations,
- Universities/public schools,
- Churches, and
- National/multinational corporations.

Witness David Leis spoke at length about the absolute erosion and wanton destruction of traditional Canadians' confidence in their democratic institutions and how the existential survival of traditional Canadian democracy was in peril.

Regina Goman spoke about her experience in communist Poland and her participation in the Solidarity movement. She told how, based on her experience in Poland, the actions of the Canadian government in restricting and cancelling basic human rights was a stark warning to Canadians that the country was slipping toward tyranny.

Lt. Col. David Redman, who is an expert on emergency planning, testified that despite his expertise, he found the different levels of government would not listen to his counsel concerning the emergency response to the pandemic, and he further stated that the professionals in the emergency planning agencies were sidelined. In his opinion, the emergency response was a complete failure from the outset, and the government was hostile to any suggestions that may have improved the results.

Gail Davidson, an expert in international human rights law, spoke about how, in her opinion, Canada violated the International Human Rights treaties to which Canada is a signatory and is legally obligated to uphold.

Retired Judge Brian Giesbrecht testified that he felt the courts and judiciary had failed Canadians. He testified that, in his opinion, the courts were no longer accessible to Canadians and that the judiciary was avoiding their responsibility to deal with difficult issues that have arisen during the pandemic. Judges often succumbed to political pressure to follow the pandemic narrative, and Canadian citizens no longer received fair and unbiased hearings.

Legal tools such as rulings of "mootness" and "judicial notice" were used to avoid hearing and ruling on government actions. Judges simply deferred to government regulations, robbing citizens of equal standing under the law.

Lawyer Bruce Pardy spoke about how the courts have demonstrated a bias toward the government position, as opposed to testing the narrative. He also spoke about the weakness of the *Charter of Rights and Freedoms*.

Lawyers James Kitchen, Jeffrey Rath, and Leighton Grey spoke at length about the failure of the Canadian judiciary.

Several doctors—including Dr. Chris Milburn, Dr. Phillips, and others—stated that the Colleges of Physicians and Surgeons failed at protecting the public. In the opinion of the witnesses, the Colleges of Physicians and Surgeons simply enforced the government narrative and did not base their actions on an understanding of science. In addition, these regulators inserted themselves between physicians and patients as well as striking down long held principles and practices in medicine.

Health Canada promoted racial division in Canada by offering early eligibility of the vaccine based on race, as opposed to identifying vulnerable people of all races, based on age and comorbidity. This practice built up a feeling of resentment within Canada.

Many witnesses testified about how they were treated by the police. Tom Marazzo, Vincent Gircys , Richard Abbot, Danny Bulford, and others testified concerning the assault of citizens by police organizations during the demonstrations. In their opinion, the police were no longer acting as protectors of the public but were acting as enforcers of the government edicts. Inappropriate conduct included various breaches of many aspects of the *Charter of Rights and Freedoms* as well as police using excessive force when dealing with peaceful protest.

Several pastors testified that the police were used to forcibly invade their churches to shut down religious services and arrest pastors.

Rodney Palmer and Marianne Klowak spoke about the complete absence of any traditional journalistic standards in Canadian media. Mr. Palmer detailed bias, misleading news stories, and significant omissions of opinions that were counter to the government narrative.

Several witnesses spoke about the actions of Canadian financial institutions in the freezing of bank accounts of citizens who had not been convicted of any crime. The financial institutions simply undertook to freeze bank accounts, without any push-back on the regulator, nor was there any evidence that these institutions consulted their legal counsel in any kind of an effort of protecting the rights of their depositors.

Testimony was received from witnesses who refused to be coerced to take an experimental injection and, as a result, were dismissed from their jobs. Employers took unilateral actions which allegedly violated human rights. Many of these dismissed employees took their complaints to their unions and the human rights commission, where their complaints were dismissed. Neither the unions or the human rights commissions actually took any action to challenge the employers on these violations.

Universities and public schools followed the government mandates without any regard for the detrimental effects that students were experiencing. The Commissioners heard testimony from retired professors, teachers, and students. In many instances, the institutions adopted policies that were more restrictive than those enacted by the government, and often they prolonged the implementation of these restrictions.

According to the witnesses, students were impacted in a variety of ways that included lost educational opportunities, physical distress, and social and mental developmental damages. Further administration of many schools allowed a toxic atmosphere of hate and bullying to develop against anyone who did not comply with the narrative.

Many churches failed their congregations and were in lockstep with government directives restricting their operation. This was despite the obvious contradictions in the regulations that allowed big box stores, liquor stores, and cannabis stores to remain open as essential services. After the initial pronouncement of the pandemic and lockdowns, most pastors complied and closed their churches to protect the congregations. As the mandates continued and deepened, and it became obvious that the mandates and lockdowns were wrong, many pastors reopened their churches, understanding that the church plays a vital role in the mental, social, and spiritual health of their congregations. Wesley Mack, Hon. PhD, testified on the importance of church attendance to communities of faith.

Testimony was received from pastors who were fined, arrested, jailed, or forced out of their churches, including Pastor Steven Flippin, Pastor James Coates, Pastor Jason McVicar, and Tobias Tissen.

Witnesses testified that national and multinational corporations, including pharmaceutical companies, allegedly took advantage of the environment of terror and panic that gripped the government and the country. Employees were terminated due to non-compliance with unilateral injection mandates.

Pharmaceutical corporations took advantage of panicked and inexperienced government regulators to negotiate incredible concessions on the approval, manufacture, and distribution of an experimental gene therapy while protecting themselves from liability.

Large corporations also turned over confidential client records and monitored clients on request of the government. In some instances, this was done without a court warrant and without the conscious knowledge of the clients. One example discussed was the monitoring of over 30 million Canadians, through their cell phones, by Health Canada.

Conclusions

Here are a few reasons why Canadians' trust in their institutions has been shaken:

Democratic Values and Political Stability

Canada was traditionally widely regarded as a stable and well-functioning democracy. It has had a long-standing tradition of upholding democratic values, including free and fair elections, the rule of law, freedom of speech, and respect for human rights. These factors contributed to Canada's reputation as a country with strong democratic institutions.

Over the course of the pandemic, many of these democratic rights were attacked, diminished, or eliminated. The Government of Canada, along with the provincial governments, effectively suspended many of the fundamental human rights as set out in the *Charter of Rights and Freedoms*. They suppressed peaceful dissenting opinions; they arrested peaceful protestors; and they silenced dissent through the use of the judiciary, police, and even financial institutions..

Canadians were so accustomed to their rights that they could not bring themselves to believe what was happening before their very eyes.

Many Canadians found themselves in a position where they could not obtain legal counsel, as many lawyers in Canada would not represent persons who were challenging the government lockdowns and mandates.

Multiculturalism and Inclusivity

Canadians are known for their commitment to multiculturalism and diversity. The Canadian government, however, had established policies and programs to promote the vilification of certain groups of Canadians by using a propagandized narrative of institutional racism. In order to “protect” these threatened minority rights, they enacted extremely obtuse laws and regulations which are being used to stifle legitimate dissent and to force citizens to accept their extreme policies or face legal consequences. Those consequences include arrest, fines, and incarceration. This change in approach has not gone unnoticed in the international community.

Strong Human Rights Record

Canada has previously been recognized for its commitment to human rights, both domestically and internationally. Canada is a signatory to numerous international human rights treaties and has actively participated in global efforts to promote and protect human rights. During the pandemic, Canada enacted policies and enforced new laws which suspended human rights in the country, and many of the measures were in direct violation of the international human rights treaties to which Canada is a signatory. Gail Davidson, an expert in international law, set out the details of these gross violations, in her testimony.

Canada’s legal framework, including the *Canadian Charter of Rights and Freedoms*, failed to protect the individual rights and freedoms of its citizens. Many of the most basic and fundamental rights “guaranteed” by the Charter were simply brushed aside, under section 1 of the Charter, titled “Guarantee of Rights and Freedoms.” By invoking this clause, and without providing clear and transparent justification of the reasons, the government was able to suspend Charter freedoms, and the judiciary did nothing to stop them.

Perception of Government Response

The lack of effectiveness, transparency, and communication of government responses to the pandemic influenced significant mistrust in institutions. Governments demonstrated a lack of

efficient and transparent decision-making, they did not communicate clearly, and they did not implement evidence-based measures.

Objectively false statements, missteps, inconsistent messaging, and delays in decision-making eroded trust.

Political Polarization

The pandemic became politicized in most contexts, leading to polarization and divisions along political lines. Trust in government institutions was influenced by pre-existing political beliefs, with individuals more likely to trust or distrust institutions based on their alignment with their political ideologies.

Communication and Information Dissemination

The ability of governments to effectively communicate accurate and timely information is crucial in building trust. The governments in Canada did not engage in open and transparent communication. Although they provided regular updates, many in the population knew that the updates were skewed and biased. In addition, the government relied on “trusted” experts who, in many instances, were known to have received significant government funding and thus had a conflict of interest, which eroded trust in government institutions.

Handling of Crisis Management

The perception of how well government institutions handled the crisis—including the ability to control the spread of the virus, implement effective public health measures, and protect vulnerable populations—influenced trust.

The public health officials in charge of the emergency response displayed no expertise in emergency management, and the existing emergency planning apparatus was sidelined.

Elected officials who are supposed to remain in control of any crisis situation abrogated these responsibilities to non-elected, and all too often incompetent, bureaucrats with no experience in crisis management.

Trust in Science and Expertise

Trust in government institutions was influenced by the public’s perception of the government’s reliance on skewed, false, incomplete, and biased scientific evidence and expertise.

Governments did not follow evidence-based decision-making and sought guidance from inept and inexperienced public health officials and even disregarding crisis plans previously developed by the same public health officials.

Decisions were perceived as politically motivated or contradicting scientific consensus, further eroding the trust of Canadians.

Social and Economic Impacts

The social and economic impacts of COVID-19 mandates—such as business closures, job losses, and financial hardships—have influenced trust in government institutions. Individuals and communities experiencing negative consequences rightly attributed these difficulties to government decisions, which led to decreased trust.

Trust in Public Health Institutions

The response of public health institutions, such as the Public Health Agency of Canada and local health authorities, influenced trust in the broader government system.

Trust in these institutions was crucial, as they provided guidance, expertise, and recommendations during the crisis. The directives being issued by public health were often erratic and were given in a state of panic; and many of the regulations and edicts contradicted long-held medical practice, and all too often they made no sense in a medical or scientific way.

The public was never presented with an overall plan but was simply exposed to a long list of rules and regulations, without any consideration for the quickly developing situation. A dizzying array of different rules from province to province further contributed to a perception that the measures were political and not informed by good health policy.

It is important to recognize the pandemic and its impact on trust in government institutions as complex and multifaceted. Trust can be influenced by a combination of factors, and individual experiences and perspectives play a role. Governments that actively address concerns, engage in transparent communication, prioritize public health, and demonstrate accountability have a better chance of rebuilding and maintaining trust in the long term.

Recommendations

The process of restoring trust in Canadian institutions is a very difficult and complex one. What was destroyed in a very short period of time will take a generation to restore, and only if these institutions make a concerted effort to restore that trust through their day-to-day actions.

Momentary publicity campaigns and propaganda blitzes will not serve either the institutions or the people of Canada's best interests.

If these concerns are not addressed in a forthright manner, the very existence of Canada as a free and democratic nation is at risk.

We recommend the following:

- A. **It is not an option** to take a “business as usual” posture and simply carry on as if nothing happened. Institutions must recognize and publicly admit their culpability in what was perpetrated on Canadians and, if appropriate, must face criminal and civil penalties for their actions.

- B. **Transparency and Accountability:** Information related to the institutions' actions during the COVID-19 pandemic must be made publicly available, creating a culture of transparency and accountability within public institutions.
- C. **Ensure that decision-making processes** are open and accessible to the public, and that the actions and performance of public officials are subject to scrutiny.
- D. **Establish mechanisms for oversight**, such as independent audits or ombudsman offices, to hold institutions accountable for their actions.
- E. **Ethical Conduct:** Promote and enforce high ethical standards within public institutions. Implement robust codes of conduct that govern the behaviour and decisions of public officials and employees. Provide ethics training to ensure that individuals understand their responsibilities and the expectations placed upon them.
- F. **Effective Governance:** Strengthen governance structures and mechanisms to ensure efficient and effective functioning of public institutions.
- G. **Enhance the professionalism** and expertise of public servants through training and development programs. Foster a merit-based culture that rewards competence and performance.
- H. **Public Engagement:** Actively engage with the public and involve stakeholders in decision-making processes. Seek public input through consultations, town hall meetings, surveys, and other participatory mechanisms. Demonstrate that public institutions are responsive to the needs and concerns of the people they serve.
- I. **Communication and Information Dissemination:** Establish clear and consistent communication channels to keep the public informed about the work and activities of public institutions. Provide timely and accurate information, particularly in times of crisis or controversy. Use plain language and accessible formats to ensure that information is easily understandable by all segments of society.
- J. **Collaboration and Partnerships:** Foster collaboration and partnerships with civil society organizations, academia, and other stakeholders. Engage in meaningful dialogue and involve external expertise in policy development and implementation. Collaborative approaches can help build trust and ensure that institutions benefit from diverse perspectives.
- K. **Learn from Mistakes:** Acknowledge and learn from past mistakes or failures. Publicly address any instances of wrongdoing or misconduct, and take corrective actions. Demonstrate a commitment to learning, improvement, and the prevention of similar issues in the future.

- L. **Long-Term Vision and Consistency:** Develop and communicate a clear long-term vision for the institution's role and purpose. Demonstrate consistency in actions and decision-making, avoiding unnecessary reversals or abrupt changes. Consistency helps build trust by showing that institutions are reliable, accountable, and predictable.
- M. **Independent Oversight and Checks and Balances:** Strengthen the role of independent oversight bodies, such as auditors general, ombudsman offices, or anti-corruption commissions. These bodies can provide an additional layer of accountability and help prevent abuses of power or corruption.

Rebuilding trust in public institutions is a long-term endeavour that requires sustained commitment and effort. By implementing these strategies, institutions can work towards restoring faith in their integrity, competence, and ability to serve the public interest.

7.2.4. The Impact of COVID-19 Measures on the Military

Introduction

The Commission heard from current and former members of the Canadian military, as well as a lawyer who represented hundreds of current members and veterans who were disciplined or dismissed as a result of the COVID-19 mandates.

Based on the testimony, the Canadian military placed the uptake of vaccines ahead of the safety of members of the Armed Forces, which served to destroy morale and has the carryover effect of weakening Canada and the defence of our nation.

Dr. Matthew Tucker (Truro, NS)

Devon Sexstone (Winnipeg, MB)

Michel Gagnon (Winnipeg, MB)

Catherine Christensen (Red Deer, AB)

Josée Belleville (Québec City, QC)

Terry LaChappelle (Truro, NS)

Impact of Pandemic Measures on the Canadian Armed Forces

Members of the Canadian forces are required to receive a large number of vaccines during their service. The Commission heard from several former members who had consented to receiving multiple vaccines in the past, often stating, with pride, that they had received more vaccines than anybody else in the room. Despite this history, the requirement to receive the COVID-19 vaccine was not acceptable to many.

The Commission heard testimony that many members were coerced into taking the vaccine in order to keep their jobs. Additionally, many former members testified personally about their experience in being discharged due a refusal to receive the vaccine. These included: Devon Sexstone, Michel Gagnon, and Josée Belleville. Additionally, Terry LaChappelle, a veteran and civilian contractor on the CFB Trenton base, lost his job.

Michel Gagnon testified that there were very few members of the services who were capable and trained to fly military planes like he was. He estimated that the total cost to train him was approximately \$2 million. The removal of him as a pilot is a costly loss to the Canadian Armed Forces.

Dr. Matthew Tucker, who worked as a family doctor for members of the Canadian Armed Forces, testified that during the pandemic, he experienced an increase in patient visits for mental health issues, which he attributed to the pandemic restrictions. During this time, he also worked as an emergency doctor at a civilian hospital. He did not treat a single patient for COVID-19 until January 2022.

Dr. Tucker testified that there is a crisis in the military in terms of morale and that many are leaving the service. As a result, he is concerned about the security of our country. Mr. LaChappelle estimated that 800-900 military personnel were dishonourably discharged as a result of refusing the vaccine. Some were called back, but many refused to return.

Ms. Christensen testified that the Canadian Armed Forces lost an estimated 3000 to 5000 personnel due to the mandatory vaccination policy, out of a regular force of 68,000. She estimated that this included personnel who were discharged as well as those who experienced vaccine injuries. This is the highest loss of personnel since World War II. Ms. Christensen stated that the cost to the Canadian Armed Forces exceeds \$3 billion in loss of training, experience, and expertise. This does not include costs to the members. She further discussed the toxic environment that was promoted and created within the Canadian Armed Forces against the unvaccinated, which she claimed was ongoing.

Implementation of the Vaccine Mandates

At first, the Canadian Armed Forces did not implement a mandate; they simply applied pressure to members to “do the right thing.” However, in the fall of 2021, the military announced that it would “show leadership” and “set an example” by having a 100 per cent vaccine rate within its ranks.

Implementing a mandate in order to set an example does not support the position that the mandate had anything to do with the health of the members of the Canadian forces. The job of the Canadian military is not to set an example to the rest of Canada about their personal health choices. Moreover, the members of the military are an unusually healthy subset of the population, who were at very low risk of negative outcomes from COVID-19.

The Armed Forces can order soldiers into life-threatening situations. Ms. Christensen’s testimony was that this power was abused when implementing the mandate. Soldiers are expected to rely on their superiors to look out for them, and only order them to make sacrifices on good principle. This covenant was broken by the vaccine mandates.

Because the COVID-19 vaccines were new, experimental products with no long-term safety data, the military mandate had the effect of causing Canada’s military personnel to be treated as guinea pigs. The vaccines carried the risk of injury and death (albeit small), meaning that the mandate put soldiers in danger—but not for the purpose of defending the nation. Notably, the Commission heard that there had been zero deaths in the Canadian Armed Forces from COVID-19.

Avenues of Recourse for Members of the Canadian Armed Forces

Interestingly, the vaccine mandate was implemented by way of a directive, instead of an order. Ms. Christensen described the difference between an order and a directive.

An order could be: Take control of a particular hill. Directives would then follow that determined how to take the hill. There is no appeal for a soldier who fails to follow a directive. The Commission heard testimony that if the mandate had been made by way of an order, then the military would have had to accommodate requests for exemptions, such as religious exemptions. Ms. Christensen believes that the mandates were implemented by way of directive in order to avoid this process, and ensure that no exemptions were given—as part of meeting the stated goal of 100 per cent vaccinated.

Members of the Canadian Armed Forces who have grievances about their employment are not entitled to apply to a court. Thousands of members filed complaints about the mandates. The problem is that complaints went to the Chief of Defence Staff for review. The Chief of Defence Staff, however, is the one who implemented the mandate in the first place. Thus, members were left with no avenue or recourse within the services.

Trust among the ranks has been seriously eroded.

Members were gagged from speaking out against the mandates.

Members of the Canadian forces are prohibited from speaking out against the military, or their chain of command. Any members who do speak out publicly are disciplined.

It is for this reason that Canadians have not heard about the crisis in the Canadian Armed Forces that has resulted from the vaccine mandates. The Commission also heard testimony that members who were injured or disagreed with the mandates (whether vaccinated or not) were afraid to speak up. The Commission watched a video of members who were involved in fighting the mandates, and many of the faces were obscured or blurred to protect their identities.

Testimony Concerning Vaccine Injuries in the Armed Forces

Ms. Christensen testified that service members who became vaccine injured were told that their injuries were not service-related. This meant that injured members were not entitled to either a medical release from the services or compensation for their injury.

Recommendations

The fact that a citizen has put on a uniform and vowed to serve and protect Canada should not strip them of all rights and leave them with no legal avenues. The Commission makes the following recommendations:

- A. **Grievances by service members** should be outside of their chain of command and to an independent reviewer, such as the Office of Inspector General.

- B. **Whistleblower legislation should be strengthened** to allow soldiers to report on abuses within their chain of command without fear of discipline or retaliation.
- C. **Comprehensive healthcare should be provided** to all injured service members, for as long as necessary.
- D. **An apology** should be issued for implementing the vaccine mandate.
- E. **Where a medical product is provided** to members of the Armed Forces, mandatory monitoring and reporting of injuries and sickness should be performed.

7.2.5. Impact of COVID-19 Measures on the Education System

Introduction

The Government response to the COVID-19 pandemic has significantly disrupted nearly every facet of life, including education. This is a global phenomenon, but the focus in this report is specifically on Canada, where the education system, from primary school to university, has been deeply affected by the pandemic and the ensuing government-imposed measures.

When we speak about the education system, we must remember that we're not simply discussing infrastructure, textbooks, and school buses. Rather, at the heart of this system are precious young individuals—children and adolescents whose dreams, aspirations, and futures have been entrusted to it. It is their right to have an environment that promotes learning and creativity, while also offering them safety, stability, and the means to grow holistically. They are not mere numbers on an enrolment sheet but unique individuals with their own potential and vulnerabilities.

In the context of the COVID-19 pandemic, it's crucial to acknowledge that the education system completely failed due to the restrictions placed upon it by the government and the teachers unions. The purpose of this system extends beyond the imparting of academic knowledge, such as reading, writing, and arithmetic. It is equally tasked with safeguarding the mental, emotional, and social wellbeing of its students, protecting them from harm both inside and outside the classroom.

Unfortunately, due to the unprecedented actions taken by the government during the pandemic, the system was strained beyond its capacity. While a half-hearted attempt to continue providing education through online platforms was initiated, it fell short in shielding its students from the mental, emotional, and developmental impacts of this global crisis. Hence, it is vital to recognize these shortcomings and work tirelessly towards addressing them, keeping in mind that the lives and futures of our young ones hinge on these actions.

The actions taken by the government were unnecessary, based the testimony of witnesses who stated that the information concerning which populations were actually at risk was available and known to public health as early as March of 2020, when the declaration of a pandemic was made. Further, the actions taken to contain the spread of the virus were ineffective and created a cascade of changes and challenges for both educators and students.

Canadian education had to shift gears rapidly, moving from in-person teaching and learning to online modalities. Teachers had to quickly adapt to new ways of delivering lessons, while students had to adjust to learning from home, often with varying degrees of success. Not only has this transformation impacted the quality and access to education, but it has created significant mental health implications for children and young adults, and created a new group of "unschooled" children who are at risk of never acquiring even a basic education.

The following sections will examine the impact of the government's response to COVID-19 on various levels of education in Canada. This will include a review of how the sudden transition to online learning has deepened the digital divide, affected academic progress and access to school-provided nutrition, and disrupted tertiary education.

The profound impact of these measures on children's mental health, brought on by social isolation, increased anxiety and depression.

Based on the testimony and analysis, a series of recommendations are made to mitigate some of the damage done and help Canadian education emerge stronger and more resilient from this unprecedented crisis.

Witness Testimony

The following witness testimony was utilized in the analysis:

Cathy Careen, a teacher, tried to get an exemption from the mandatory vaccines. She was eventually terminated for not taking the vaccine.

Bliss Behar was a high school student when the vaccine mandates were imposed on his school. After doing his own research into the vaccines, he decided he should not take a vaccine. As a result, he dropped out of school. He spoke out and was subject to attacks on social media.

Dr. Irvin Studin testified that he began seeing children out of school in 2020, and it took him several months to understand what he was seeing. On further investigation, he was better able to appreciate the extent of what was happening. He stated the degree to which our childhood education system had collapsed in Canada. It was an experience completely foreign to such a developed country.

Kim Hunter, a teacher for 25 years, talked about the effects of masking on children.

Kassandra Murray, a school teacher, testified to the effects of masking on children and how a toxic environment developed within the classroom due to the mandates and the fear of other staff.

Kathy Howland, an education assistant, spoke about being forced to take the vaccine and her alleged adverse effects from the vaccine.

Katrina Burns, a teacher for seven years, spoke about the effects of masking on children in the classroom.

Elizabeth Galvin had a daughter who committed suicide after she found herself isolated and scared when the university closed the campus.

Jay McCurdy was a teacher of grades 7 and 8. He testified to the effects of the lockdowns on students.

Pierre Attallah had two children in school and testified to the effects of the mandates on his children.

Leigh Vossen was a student in university at the time of the lockdowns, and testified concerning her experiences.

Kyra Pituley was a 15-year-old student in Grade 9, and she spoke about how the lockdowns and remote learning impacted her.

Stephanie Foster was a teacher assistant; she had to get the vaccine to keep her job; she has had an alleged vaccine injury.

Charlotte Garrett was a teacher for disabled adults; she described her alleged vaccine injury and also discussed the effect of the mandates and lockdowns on her students.

Kelcy Travis, the mother of six children, described the effects the mandates had on her family and children.

Chantel Kona Barreda was teaching on a reserve when the mandates were put in place; she lost her job for refusal to take the vaccine.

Dianne Molstad was a teacher and a councillor for 30 years. She described her experiences with applying for a vaccine exemption.

Angela Tabak spoke about her son. He was forced to take online courses and could not access his psychiatric care; he committed suicide.

Dr. Patrick Provost, a university professor, was suspended for six months without pay for speaking out against the vaccines for children and questioning the narrative of the COVID-19 pandemic. He was facing the prospect of losing his tenure.

Madison Peake was a student in university when the mandates were put in place. She spoke about the effect of the mandates on her education and on her family.

Dr. Keren Epstein-Gilboa, an expert on childhood traumas, spoke about the effects of the mandates and masking on children.

Aidan Coulter was enrolled as a student at university. He was not allowed back to classes due to vaccine mandates.

[Discussion of Impacts on Education](#)

Primary and Secondary Education: In response to the COVID-19 pandemic, Canadian provinces and territories transitioned primary and secondary schools to remote learning. This change was unnecessary and had numerous unrecognized or ill-considered consequences.

One significant impact was the widening of the digital divide. Not all students had access to reliable Internet or technology, which led to disparities in educational attainment.

Not every student had access to a safe and suitable space in which they could attempt to be home-schooled; for some, school is the only safe space available.

There were also challenges in teaching certain subjects, like science and arts, which often required hands-on learning.

Further, schools provide more than just education; they are a source of nutrition for many children. The government-imposed COVID-19 response brought considerable developmental challenges for primary grade children, encompassing social, mental, speech development, and disturbing increases in mental illnesses and antisocial behaviour.

Social Development: Social interactions at school are pivotal in children's social development, teaching them to communicate, share, negotiate, and develop empathy. With school closures and social distancing measures, children have lost out on these valuable interactions. Playdates, an essential aspect of social learning and emotional understanding, have also been severely limited. This lack of social interaction can hinder children's ability to build social skills, establish strong relationships, and understand social norms and cues.

Mental Development: The mental wellbeing of children has been significantly impacted by the pandemic. As routines and structures have been upended, children have experienced heightened stress and anxiety. The uncertainty surrounding the pandemic, fear of the virus, and reduced contact with supportive networks (friends, teachers, extended family) has exacerbated this situation.

Speech Development: Speech and language skills often develop rapidly in primary grade children, supported by interactions with teachers and peers. Reduced interaction time with teachers, who play a crucial role in correcting and improving a child's speech, can slow speech development. Moreover, children learn language not only from explicit teaching but also from overhearing and participating in conversations. The shift to online learning limits these opportunities.

Increase in Mental Illnesses and Antisocial Behaviour: The mental strain of the pandemic, along with social isolation, can lead to a range of mental health issues, such as depression and anxiety. Children may not fully understand why their routine has been disrupted, leading to feelings of confusion and stress. The pandemic also resulted in increased screen time, which can contribute to sleep issues, physical inactivity, and reduced social skills, further impacting mental health. Regarding antisocial behaviour, long-term isolation and lack of peer interactions may lead to difficulties in social situations and reduce the development of empathy and sharing habits.

To mitigate these effects, it's important to create structures that can support children during these challenging times. This could include virtual social activities, increased access to mental health supports, structured home routines, limited and purposeful screen time, and involving children in family conversations to stimulate speech development. It's also crucial for adults to openly discuss the pandemic with children in age-appropriate ways to reduce fear and anxiety.

Tertiary Education

Colleges and universities also shifted to online learning. The abrupt transition negatively impacted the quality of education due to reduced student engagement, lack of practical learning opportunities (especially in STEM (Science, Technology, Engineering, and Medicine), medical, and technical disciplines), and networking opportunities.

The government actions during the COVID-19 pandemic caused numerous disruptions to the lives of university and college students. The lockdowns and school closures have led to lost opportunities and delays that can have long-lasting implications on these students' educational and career trajectories.

Delayed Academic Progress: With the abrupt closure of universities and colleges, many students faced delays in their academic progress. While some courses transitioned online, others, particularly lab-based or practical courses, were more challenging to adapt. This led to incomplete courses, postponements, or even cancellations, forcing students to defer their graduation dates.

Lost Opportunities for Research and Internships: For many students, especially those pursuing graduate degrees, participating in research projects is a crucial part of their education. The pandemic led to the suspension of many such projects, robbing students of valuable research opportunities. Additionally, internships, a vital stepping stone to the job market, were cancelled or shifted to a virtual format, often providing a less enriching experience.

Reduced Networking Opportunities: Universities and colleges provide students with various opportunities to network with professors, alumni, visiting scholars, and industry professionals. This networking often leads to job opportunities, internships, or collaborations. The transition to virtual learning has significantly reduced these opportunities.

Limited Access to Campus Facilities: Access to facilities like libraries, labs, study rooms, and sports complexes significantly enrich the learning experience. The closure of these facilities due to lockdowns not only disrupted students' academic progress but also negatively impacted their overall university experience.

Challenges in Transitioning to the Job Market: The economic downturn brought about by the pandemic has led to a challenging job market for new graduates. The lack of internships and networking opportunities due to lockdowns further compounds this problem.

Loss of Campus Experience: Beyond academics, the college or university experience is often about personal growth and the creation of lifelong memories. The shift to remote learning has resulted in a loss of campus life experience, including participation in clubs, sports, cultural events, and social interactions, all of which contribute significantly to a student's personal development.

The pandemic's impact on higher education was profound and led to significant delays and lost opportunities. It is crucial for institutions to find innovative ways to support students during these challenging times, such as virtual internships, online networking events, and flexible academic plans.

Impacts on Mental Health

Schools and universities are not just places of learning; they are also hubs of social interaction and play a significant role in mental health. The changes wrought by the pandemic have had substantial mental health impacts.

Social Isolation

Social isolation, a significant consequence of lockdown measures, involves reduced social interaction and physical contact with others. This abrupt shift in daily life is deeply disconcerting, especially for elementary, high school, and university students who are used to a routine packed with social interaction. This transition affected students' mental and emotional health, educational progress, and overall wellbeing in a variety of ways.

Emotional Impact: The sudden loss of everyday contact with friends, classmates, and teachers can lead to feelings of loneliness, sadness, and frustration. For many students, school is not just a place of learning but also a vital social environment. Without these regular interactions, students may feel cut off from their social networks, leading to a sense of isolation.

Mental Health Effects: Prolonged social isolation can exacerbate feelings of anxiety and depression. Human beings are innately social creatures, and isolation can create a heightened sense of stress and worry. It can also lead to a decrease in motivation and concentration, impacting students' academic performance.

Educational Disruption: Collaborative learning opportunities have been proven to enhance understanding and problem-solving abilities. The absence of face-to-face group work can affect students' learning experience and engagement levels, possibly leading to a decline in academic performance.

Development of Social Skills: Particularly for younger children, school is a critical setting for developing social skills, forming friendships, and understanding social norms. Social isolation can hinder the development of these critical skills.

Lack of Routine: For many students, the structure and routine provided by attending school or university provide a sense of normalcy and control. The loss of this routine can create feelings of disorientation, restlessness, and anxiety.

Physical Health: Reduced opportunities for physical activity (gym classes, sports teams) can lead to a more sedentary lifestyle, potentially impacting students' physical health and increasing feelings of lethargy or sluggishness.

Loss of Support Systems: For some students, school is a safe haven, providing support systems like counselling services, mentors, and free meals. The loss of these services can exacerbate feelings of isolation and insecurity.

The impacts of social isolation due to school and university closures are profound and varied, underlining the critical role that these institutions play beyond academic instruction. They're essential for social interaction, mental health support, and a stable routine—all of which are crucial for a student's holistic development.

The Commission heard testimony from witnesses who stated that their children had simply dropped out of school, or had succumbed to depression and despair, with some resorting to suicide.

Anxiety and Depression

Several key factors have contributed to an increase in anxiety and depression among school-age students during the COVID-19 pandemic:

Social Isolation and Loneliness: School closures and social distancing measures led to prolonged periods of isolation from peers, which play a crucial role in a child's social and emotional development. Missing out on these interactions could lead to feelings of loneliness and alienation, which could trigger or exacerbate anxiety and depressive symptoms.

Disrupted Routines: School provides a structured routine that offers predictability and a sense of control to students. The sudden loss of this routine due to the pandemic could lead to feelings of uncertainty, which is a common trigger for anxiety.

Online Learning Challenges: The transition to online learning presented its own set of challenges. Some students may have struggled with the lack of in-person instruction, technological issues, or lack of a conducive learning environment at home. The stress and frustration from these challenges could contribute to feelings of anxiety and depression.

Fear and Uncertainty about the Pandemic: The continuous flow of news about the pandemic, coupled with fear about contracting the virus or it affecting loved ones, could lead to elevated anxiety levels. Uncertainty about the future, concerns about academic progress, and changes in exams and grading could also increase stress and anxiety.

Limited Access to Mental Health Services: Many students rely on school-based services for mental health support. With schools closed, students may have found it more difficult to access these services, causing existing mental health conditions to worsen.

Grief and Trauma: Some students may have lost loved ones to the virus, causing profound grief and potentially leading to depressive symptoms. Others might have had parents or caregivers working on the frontlines, causing additional worry.

Increased Family Stress: With the pandemic causing economic instability and job loss, family stress levels have increased. Higher levels of family stress can lead to increased anxiety and depressive symptoms in children and adolescents.

Understanding these factors is crucial for creating strategies to address the mental health crisis among students during the COVID-19 pandemic.

Conclusions

The COVID-19 pandemic and the subsequent government-imposed lockdowns and closures have had a profound detrimental impact on education at all levels in Canada. Although the government and public health stated that these measures were implemented to protect public health, they did not appear to have properly considered what would most surely result from the significant disruption in the educational system. Students of all ages, from primary grade children to university students, have faced unparalleled challenges, including but not limited to social isolation, mental health issues, disrupted routines, and delays in academic progression.

Government actions did not fully account for the wide-ranging impacts these measures would have on the education system and the students it serves. The sudden transition to remote learning highlighted and exacerbated existing inequalities, strained resources, and put enormous pressure on both students and educators. It is essential to recognize that the impacts extend far beyond academic achievement and have deeply affected students' mental health and overall wellbeing.

Similarly, universities and colleges imposed their own lockdowns and restrictions, which caused them to shift to virtual learning environments and dismiss students who refused or were unable to comply. The loss of in-person interaction, networking opportunities, access to campus facilities, and delays in academic progression all contribute to a vastly altered and often diminished university experience.

Moreover, teachers' unions—facing a perceived change in working conditions, mounting pressures regarding teachers' safety, and the challenges of remote instruction—played a role in reinforcing the need to implement the unnecessary lockdowns and closures during the pandemic. The unions' actions and advocacy for teachers' "rights and resources," seemed ill-considered and appear not to have taken into account the actual data that was available as early as March of 2020.

Recommendations

- A. **Avoid Prolonged School Closures:** Recognize that extended school closures should not be imposed in the future, as they have profound and far-reaching negative impacts on the socialization and education of children.
- B. **Prioritize In-Person Learning:** Ensure that in-person learning remains the primary mode of education, even during public health crises. Remote learning should only be used as a last resort and for a limited duration, and in conjunction with parental consultation.
- C. **Data-Informed Decision-Making:** Base any decisions related to school closures on comprehensive and up-to-date data, considering the specific needs and circumstances of each region or community.
- D. **Support Vulnerable Populations:** Develop targeted support systems for vulnerable students, including those with disabilities and students from low-income backgrounds. Recognize that these populations may be at higher risk than the general student population and provide specific measures to protect them. Do not impose these measures on the entire student population.
- E. **Enhance Mental Health Services:** Invest in mental health support services within schools to help students cope with the emotional toll of the pandemic and the challenges of social isolation.
- F. **Prioritize Social and Emotional Learning:** Incorporate social and emotional learning into the curriculum to help students build resilience and emotional intelligence, especially in the aftermath of the COVID-19 pandemic.
- G. **Maintain Transparent Communication:** Keep parents, students, and the community informed with clear and transparent communication regarding the reasons behind any decisions related to school closures or restrictions.
- H. **Plan for Crisis Scenarios:** Develop contingency plans that prioritize education and socialization, while maintaining health and safety during future crises.
- I. **Learn from Past Mistakes:** Conduct a comprehensive review of the government's response to the COVID-19 pandemic in education, and use the lessons learned to shape future policies that prioritize the wellbeing and education of our children.

By implementing these recommendations, we can work towards a future where our education system remains resilient in the face of emergencies, ensuring that our children's socialization and development are protected and nurtured.

7.2.6. The Restructuring of Traditional Educational Institutions due to COVID-19 Measures

Introduction

Historically, most stakeholders in education were motivated to fulfil their teaching responsibilities within the pedagogical framework and curriculum outcomes required to meet societal needs. More recently, the focus of student learning moved toward global interconnections and the need to ensure citizens from all walks of life acquired sufficient knowledge to meaningfully participate in globally aligned industry. For the most part, being introduced to integrated and interconnected global communities was not a hindrance. Student needs were primarily met, and learning opportunities that empower and educate students were fulfilled. In essence, student achievement and critical thinking accompanied by related buzz words was the goal. That is, until COVID-19.

When COVID-19 came along, global aspirations were shut down. Barriers to the world as we knew it were imposed. A new set of boundaries were erected, with COVID mandates leading to new societal norms. This included learning institutions as well. Depending on where one lived and the type of school one attended, the governing mandates for education became vastly different. In-person class learning was abruptly stopped and replaced almost as quickly with online or distance learning, or some form of hybrid instruction.

In the beginning, mandates were temporary, such as the two weeks to flatten the curve. Over time, more permanent lockdowns and restrictions were legislated by authorities. Consequently, students in the K-12 system had their social circles curtailed. Recreational parks were closed. Family gatherings were restricted, and students of all ages (as a demographic within a broader societal construct) were seriously disadvantaged.

At the post-secondary level, students faced similar consequences. Higher education took a sudden U-turn from scholarly inquiry, research, and investigation (under the umbrella of academic freedom) into a mandated environment of conformity, intolerance, and discrimination.

Accordingly, universities abandoned the foundation of learning for the betterment of society—in favour of institutional compliance, whereby senior management, boards of governors, and university presidents responded favourably and with vigour to government dictates. Ivory towers (widely accepted as the think tanks within society) mimicked layers of government bureaucracy, submitting to ever-changing whims of health authorities. To say the least, the results were destructive. Instead of the arts, humanities, and social sciences playing a formative role in shaping public policy, society as we knew it was under siege.

Certainly, the damage to education—and, by extension, the social fabric—was massive. Serious gaps in student development, academic rigour, relationship-building, and curriculum outcomes were sidestepped, eclipsing the prevailing COVID narrative into every aspect of instruction, administration, and student interactions. Teachers, staff, and students alike felt the burden of repeated COVID messaging—hand sanitizers, social distancing, curtailed speech—all the while, the continued introduction of even more nonsensical protocols.

In the aftermath, the Canadian public has seemingly ventured into territory for which we are ill prepared to understand. Some suggest the playbook is George Orwell's *1984*. Others claim the attack on Western democratic ideals is much worse. Regardless of where one stands on COVID itself, there are outstanding questions requiring meaningful answers. For example, how did an educated free and democratic nation get here and where is society going?

Herein, you will hear witnesses testify of the real harms caused in the education sector over the last three years: the disparity, the derogatory and very public shaming, the humiliating treatment by colleagues, the increasing polarization at every juncture, job losses, the human casualties, and the outright rejection of constitutionally protected rights and freedoms. You will hear from parents whose lives have been tragically changed forever. And teachers forbidden to do what they loved to do—instilling knowledge and confidence in our youth. And one strong lady, who in spite of her personal circumstances, tried to educate others on the harms to children.

Each testimony is a real-life story representative of thousands—perhaps hundreds of thousands—of citizens who witnessed firsthand the moral turpitude by culpable people with no authority or jurisdiction to govern but who did so anyway. Clearly, boundaries were broken. The question is whether society is worse off now than we were pre-COVID.

Analysis of Witness Testimony

What was the intention of the COVID-19 measures undertaken by the governments? In many ways, the Milgram experiment⁴⁰ could be rightly considered a microcosm of COVID measures, except that COVID was unveiled on a global scale. Nevertheless, the mandates appear to have little to do with COVID. In fact, as many witnesses allude, an era of uncertainty was ushered in, and the very institutions established to protect citizens failed miserably. In this context, Orwell's repressive doublespeak comes to mind, where truth and facts are replaced with negationism.

As witnesses attested, valuing one another as human beings was no longer the embraced societal underpinning. And the consequence that evolved was that power for the sake of power became the overarching and multi-layered system where contrary voices were shut down. Citizens' consciences and convictions were systematically manipulated or rejected, by the stroke of a pen, not only by governments and health authorities responsible for COVID dictates but also non-rational intolerance for our neighbours became equally entrenched in academic workspaces.

At first the events seemed isolated. But over time, a bullying mindset accelerated within communities. Authoritarian and judgmental attitudes became prevalent. Ironically, in hindsight, we perceive it to have been a very odd conception of power that emerged. People with even limited power to control others felt self-justified approval to abuse and harass our colleagues and peers.

⁴⁰ Eldridge, Stephen. "Milgram experiment." *Encyclopedia Britannica*, August 31, 2023, <https://www.britannica.com/science/Milgram-experiment>. (accessed September 1, 2023)

In a logical world, where unjustified fear and threats against citizens would never be tolerated, the idea of individuals seeking power over others would be suspect. But it happened. Thus, has society become transactional? Is every interaction with others no longer privy to compassion?

The trickle-down effect meant individuals seeking empowerment and control over others in their own small corner of the world could rationalize their aggressive behaviours because of the even higher state hierarchical powers ordering blind compliance imposed upon them.

Rule-making authority then, as Prof. Bruce Pardy testified, is not emanating from legislatures passing statutes whose purposes are for the good of society but, rather, delegating rule-making authority to administrators, regulators, boards of governors, and corporate entities. The consequential ramifications, as witnessed throughout COVID, is that “individual autonomy must yield to the expertise and authority of officials acting in the name of public welfare.” As also stated, when officials are given the authority to override individual autonomy, bad things inevitably happen.

From an education perspective, values of kindness and empathy should have determined the treatment of all stakeholders within congregant settings, and most particularly those environments where relational bonds are forged. Why? Because when education is successful, both teachers and students learn because their spirit and willingness to serve others is prioritized.

Instead, these scholarly, well-learned individuals operating in various capacities within educational institutions caved to the whims of bureaucrats acting outside the democratic models exemplified in public policy literature. By virtue of their academic achievements alone, these officeholders should have recognized that governments have always been poor proxies when it comes to acting in the best interests of the populace. Further, as testified to as well, when governments try to achieve more complex goals with detailed data, it tends to choke on its own ineptitude. In other words, the idea that governments could handle any pandemic should have raised red flags throughout academia. The very basic understanding that infighting among bureaucracies increases immensely as the totalitarian goals of making all that is private a part of the public realm should have caused concerns.

Still, there is yet another boundary that has been damaged. That is, our moral God-given rights and freedoms were not just stretched, to determine at what point citizens would object to further demands, but broken. Not just entangled for a short period of time but ripped apart, leaving the social fabric worse off than before. The sheer number of perplexing issues that emerged, including how quickly universities and colleges took hold of discretionary powers and implemented institutional mandates and lockdowns on campus—even while health authorities were still only recommending cautionary practices—should have shocked the populace. The fact that some refused to lift mandates after health authorities did should be equally concerning.

And then there was censorship. The experiences of Mr. Marazzo are a prime example. Mr. Marazzo worked as a combat engineer for 25 years. He holds a bachelor's degree in software and a master's degree in business administration. He was teaching a College when the pandemic hit. Just prior to the start of the school year in 2021, the dean of the college sent out an email threatening termination if the faculty were not vaccinated. Mr. Marazzo responded by sending legal information to approximately 200 employees. Almost immediately his colleagues proceeded to publicly shame him by flooding his inbox, while ignoring the contents of his email. Shortly after, he received a termination letter. At the time of his testimony, he was living off his savings.

Those witnesses who had chosen not to comply were ostracized. Ms. Repo, for example, experienced this personally when she attempted to go about her day-to-day life after receiving a devastating terminal medical diagnosis. Her legitimate mask exemption was never honoured. At times, she was told by hospital staff that her mask, which caused breathing problems, needed to be repositioned. The only glimmer of hope was an oncologist who, for a brief moment, behaved compassionately by giving her a hug. At every other juncture—whether the orders to comply with masking came from a transit driver, restaurant server, or radio host—she was a target of hostile verbal abuse, to the point where she constantly worried whether her attackers would come to her home.

Although Ms. Repo was not an educator by profession, she was concerned about those with breathing or hearing issues and, similarly, the long-term effects of masking on children—so much so that she made a presentation on these harms to the City of Saskatoon, which was essentially ignored.

Yet Ms. Hunter, an early childhood teacher with over 20 years of experience, confirmed Ms. Repo's masking concerns. Ms. Hunter stated the impacts of masking included difficulty breathing, hypoxia, high levels of carbon dioxide, increased heart rate, and high systolic blood pressure. Clinical symptoms of mask wearing include headaches, fatigue, shortness of breath, skin conditions, psychological effects, cognitive difficulties, and dizziness. High levels of CO₂ reduce blood pH, which may lead to long-term complications such as cancer, diabetes, dental issues, and neurological disorders. A person wearing a mask is not supposed to touch it, or the mask is considered contaminated and must be thrown away.

Other concerns include bonding and attachment, particularly if the adults nursing or bottle-feeding an infant are masked. Eye contact and voice recognition (especially a mother's or father's voice, or that of other family members) are foundational for socioemotional growth, including passive and active communication. Young children, such as those in preschool settings and daycares, learn communication through imitation and therefore need to see people's facial expressions to understand the nuances of human communication.

Ms. Garrett's focus was teaching English as a second language to refugees and newcomers. Earlier in her life, she had suffered a vaccination injury, so when COVID vaccinations came along, she decided against taking any more. When in-person classes resumed, the school administrators forced her to get an antigen test to enter the building, even when there was no one else there. She said students who were not double-vaccinated were no longer allowed to attend. Also, as an aside, she mentioned bimonthly staff meetings were all about promoting the COVID agenda. She pointed to the Nuremberg trials and the lessons we all should have learned from history. She was not the only educator to experience these behaviours.

Ms. Barreda, a grade 7 teacher at an Aboriginal reserve, similarly chose not to get the vaccine. Her employment contract was terminated, and her daughter was forced to leave the school. She filed a human rights complaint, but it was denied. Online learning led her daughter to feel isolated and depressed. When Ms. Barreda reached out to the band council for answers, her questions were ignored. She said she tried to follow the science, but it only led to money—not science.

Medical reasons were also a concern for Ms. Careen. A teaching assistant in Newfoundland, she described what it was like to be diagnosed with Guillain-Barré syndrome, and not be vaccinated. As a result of her decision, she was placed on an unpaid leave of absence. She was further denied employment insurance benefits. The lack of her income in the family caused severe financial stress. She said all of her attempts to be heard were ignored.

Another teacher, Ms. Murray, was teaching a grade 1-2 class at a private school when COVID mandates were announced. She had received a legitimate mask exemption from her family doctor, which she said was initially honoured by school administrators. At some point, the work environment changed, becoming more hostile. School faculty meetings became more focused on how to police COVID protocols rather than education standards. She indicated teaching had become much more fear-based.

Ms. Murray observed how the rules had affected children. Students experienced developmental delays, including loss of tone of speech, smell, and taste. To compensate for the delayed development, she had to continually seek innovative ways to introduce the rules without the threat of fear.

Because she was not vaccinated, Ms. Murray's lesson plans had to be given to a substitute teacher. As time went on, she was eventually informed that the only way she could return to the classroom was if she wore a microclimate helmet. She eventually had to leave. The emotional stress in the work environment led to Ms. Murray seeking a psychotherapist for support.

Ms. Geml also testified as to the hardships she and her family experienced when she was unable to wear a mask. Beyond the fearmongering in the community, the family was also restricted from attending funerals or hospitals. Her daughter experienced additional harassment. She was subject to teachers calling the unvaccinated “murderers.” She was banned from school activities and friends’ homes. The school principal told her she was lucky kids like her were able to attend school. Ms. Geml said her daughter often came home from school in tears.

She questioned how society had reached the point where we have become so cold and cruel to people. Ms. Geml was not alone.

Ms. Travis, a mother of six, could not watch her son play sports. Her children missed dental appointments. The father of her newborn could not be part of the new-baby experience because of his vaccination status. She lost her employment between pregnancies, resulting in severe financial hardship. Ms. Travis said she would like to see more accountability and transparency at all levels of government because it is we, the people, who pay the bills.

Students with special needs did not fare any better. As teacher Ms. Burns testified, she found it difficult to watch children with behavioural needs and severe learning disabilities respond to COVID protocols. Masks, in particular, led to students’ difficulty in breathing. She saw the children become emotionless because they were not able to express themselves. As well, some children worried about contracting and spreading COVID. There were arguments among teachers and students when the students’ parents were not in favour of masking.

Ms. Burns had a medical accommodation declined by her employer. She offered to submit to daily testing to maintain her teaching position but was denied. She was placed on unpaid leave. As a result, she is no longer a rule follower. The family has had to move from the community. She has lost friends. The mental health of her family has been impacted. She is troubled to have been categorized as a misogynist and racist due to her personal medical choices.

Ms. Howland’s testimony corroborates Ms. Burns’ experiences. Ms. Howland is an educational assistant, working with special education students with Down’s syndrome, ADHD, and other learning disabilities. She could not speak freely about her adverse reaction to the vaccine. Her professional life has been negatively impacted, as she now struggles with background noise. She currently works primarily on literacy with students, but her hearing loss has greatly affected her ability to perform her job.

Mr. McDougall was passionate about children. He had worked for 13 years in childcare settings. His son was born the very day the pandemic was announced. In April 2020, the daycare was closed to the children. He spent time helping with groundskeeping and facility maintenance projects within the community. He said everything changed sharply in October, when cohorts were formed. At this time, the children were separated into groups. Mask mandates followed. Mr. McDougall took great exception to masking, not just for himself but for the children too.

He had been working with an autistic child for years. Before COVID, the staff were very excited about the child's progress with his peers; he had reached a relatively normal level of functioning. Once the masks came in, he regressed. In fact, he became very aggressive and violent toward staff. Mr. McDougall said facial recognition difficulties were an issue. He said he could not stand seeing what was happening to special needs children. Eventually, he left his position.

Families with special needs children experienced difficulties as well. Ms. Smith had a 28-year-old son with minor special needs and a 24-year-old daughter with Down's syndrome. Pre-COVID, her daughter attended a full-day program for disabled adults. The routine of the program was very important to her daughter. Because her daughter underwent heart surgery at 10-weeks-old, her mental and emotional states were impacted more than the average child's. When the program was closed due to lockdowns, Ms. Smith observed signs of depression in her daughter. Although the day program has since resumed, her daughter was still affected, fearing the program could be cancelled again.

Ms. Tabak shared the story of her son Kyle. He had an accident that left him with a brain injury. By 2020, Kyle was living on his own and working. He decided to return to school, but his cognitive issues remained a challenge. He was required to complete a lengthy and very personal questionnaire with a psychiatrist to continue with online learning.

When Ms. Tabak and Kyle went to his appointment, the psychiatrist was not there. This did not help her son's wellbeing. Kyle was told to go through telehealth. Throughout COVID, he bought into the narrative. He became fearful, and he reduced his work hours. One day Kyle called to say he had no groceries. Even so, Ms. Tabak said the last conversation with Kyle went well.

However, Kyle called 911. Sadly, when the emergency responders arrived, he was already deceased. Kyle had written apology letters to both the RCMP and EMS. He had also written an apology to each of his family members, explaining his anxiety and depression. Ms. Tabak said the family was able to donate Kyle's organs so that potential transplant patients waiting for organs could be helped.

Kyle was not the only young person who did not know where to turn. The day before her 20th birthday, Danielle Galvin also took her own life. She was a second-year student at a Canadian University. Earlier that same week, two other students also died by suicide. They all would have been in grade 12 when the lockdown measures were first put in place.

Danielle's mother, Ms. Galvin, recalled the deadline for Ontario students to accept offers to attend university. Once an offer was accepted, all other offers on the table were rescinded. The University of Guelph said it would keep its residence open. This was a major factor in Danielle choosing Guelph over Western. Two days later, the University of Guelph reneged on its promise, throwing thousands of students' plans into chaos.

Ms. Galvin, along with other parents, contacted school administrators. They were informed that the Wellington-Dufferin-Guelph health unit had conducted an inspection and, therefore, would only allow a few students into residence. The university did eventually allow foreign students into residence. Ms. Galvin was informed by the Minister of Colleges and Universities that the ministry does not interfere in the operations of colleges or universities.

Further, the University of Guelph administration did not mandate professors to deliver virtual lectures. In Danielle's case, this meant four out of five professors in her first-year class did not deliver a single lecture. In November 2020, Danielle attempted suicide but was found by a friend. Ms. Galvin and Danielle's sister rushed to the hospital, but neither was permitted entry. The doctor said this was because Danielle was 18-years-old and was considered an adult.

By Christmas 2020, the provincial government advised people to isolate in bubbles, so Ms. Galvin and her two daughters spent Christmas together, without extended family. During the winter of 2021, Danielle had moved into a townhouse. Ms. Galvin observed the Ontario government was still allowing regional health units to dictate mandates, so the rules differed across the province. At the university, the campus police patrolled the grounds constantly looking for students who were violating the rules. Danielle and four of her friends were issued \$880 fines.

To attend school in September, students were required to be vaccinated. Ms. Galvin and her two daughters were vaccinated. In-person classes were resuming, but as Ms. Galvin pointed out, Danielle's mental health had greatly deteriorated. In January 2022, the province was locked down again for two weeks, despite all the students being vaccinated. Ms. Galvin implored the University administration, the MPP, and the Ministry of Colleges and Universities to allow the students back into schools.

She cited research from the Canadian Paediatric Society warning that the risks to students were far greater if they were not allowed back into school. On January 17, 2022, the University of Guelph called a snow day, even though students were learning virtually. It was this same week that Grace died by suicide. A few days later, and still waiting to start post-secondary school, Sayuri died by suicide. A few days after that, Danielle died by suicide. None of these young women knew each other, but they were all so despondent after almost two years of punishing lockdowns and restrictions that greatly disrupted their lives. Ms. Galvin believes that these academic and social disruptions were a major contributing factor in the breakdown of their mental health and eventual suicides.

Other concerns came to light. Witness Gary Bredeson, an Alberta resident, had three adult children attending post-secondary schools when COVID hit. He said the boys had become quite sick following Christmas break. By March 2020, post-secondary schools in British Columbia had moved to online. He became concerned over the difficulties of the boys completing online courses in the basement. Mr. Bredeson said the increased costs for a lower level of instruction, plus the cumulative social effects of being shut out of the social fabric, weighed heavily on the family.

In another example, Mr. Paquette studied medicine at Sherbrooke University prior to obtaining a bachelor's degree in elementary and preschool teaching. He communicated regularly with pediatricians, public health physicians, and others. In his opinion, the pediatricians had either been silenced or had chosen to remain silent. He said the notice from the Association des Pédiatres du Québec (APQ) at the start of the 2021 school year was ignored by public health and the government, which collectively chose not to publicly defend the precautionary principle for children. Mr. Paquette concluded the COVID measures were disproportionate and detrimental to children's development. In Québec, he said the data was misused, creating instead an unwarranted fear that led to the populace accepting the measures.

Post-secondary students did not have a voice either, as evidenced by Ms. Vossen. An in-house graphic designer, she had one course remaining to graduate. In August 2021, she was notified that all students attending classes in person required a COVID vaccination. She did not believe it affected her because her course was online. Later, the course was dropped.

She expressed concern to the president of the College, stating, "On behalf of a group of concerned students, I would like to see the data." The College retracted the mandate, and she requested an in-person meeting, which was denied. Soon after, she opened an Instagram account called Students Against Mandates, using her graphic design background. She received thousands of messages from students across Canada. Many contained stories of their own personal experiences with employers, administrators, and school authorities.

Ms. Vossen said the response from the freedom community was very positive. However, she had a hit article written against her. She was called an "alt-right extremist" and a "Nazi." The article brought her family into it. She observed threats and rude comments on Reddit, Twitter, Facebook, and Instagram. All of her previous friends cancelled her.

With her educational status in limbo, Ms. Vossen had no intention of returning to an institution that discriminated against her. The positive was the strong support system she received from so many others facing similar predicaments. She said, "Throughout history, we have seen that 'doing it for the greater good' leads to nowhere good."

Mr. McCurdy, an elementary school teacher in Ontario for more than two decades, brought a broader perspective. He said schools were in lockdown for 28 weeks. He discussed the challenges of remote learning within the context of students who did not have access. He pointed to attendance in his own grade 7-8 classes, which dropped to 50-60 per cent of pre-COVID numbers.

He indicated the expectations for students to pass was very low. For those students who did attend and participate, the quality of learning he was able to deliver was drastically diminished. Students lost all their extracurricular activities and opportunities to socialize, which are critical aspects of school and childhood development. In terms of the learning environment, Mr. McCurdy recalled seeing fellow teachers yelling at children to put on their masks. During mandates, children were not allowed to talk to each other while eating. He also noted that since the pandemic, it was very common to have multiple staff off on any given day.

The consequences of COVID policies and measures were already evident in the system. There were immense deficits in children's learning skills, resiliency, coping skills, problem solving, and confidence levels. He admitted many more children were further behind academically, with some lacking basic reading and writing skills. There was also a much higher prevalence of conflict and violence in schools.

He said he spent more time giving extra help to students than ever before. School attendance had not returned to normal. His other concern stemmed from the move to replace staff with individuals who were not equipped to cope with the increase in aggression and mental health issues. He said replacing educational assistants with paid volunteers to help with children created safety issues.

He was also disappointed that no one at the school board or provincial level acknowledged the negative effects from lockdowns. He believed a cost-benefit analysis of these policies should have been done. He further believed the analysis must include public input and consultations, because we as a society should be working to protect our children. He called the potential damage we have done, "mind-blowing."

Mr. Studin, the chair of the Worldwide Commission to Educate All Kids (Post-Pandemic) and president of the Institute for 21st Century Questions, raised similar concerns. He coined the term "third-bucket kids" for the students who are neither in physical nor virtual school and are now receiving no schooling whatsoever. Mr. Studin believed most Canadians assumed that all children who were not in physical school had transitioned to virtual learning. This was not the case.

He also said many children did not have the physical or financial resources, such as Internet access, to complete virtual learning. Others did not have in-home support that could have alleviated language barriers, learning disabilities, and unsafe or abusive situations.

Mr. Studin admitted the initial school closures in early 2020 could be called a policy mistake and possibly even be forgiven. However, school closures after this time were policy crimes. He said any intelligent society should have understood there would be massive—indeed, catastrophic—consequences to closing schools for so long, leading to great destabilization when these same children become adults.

His international colleagues do not understand how Canada failed so badly. He continued by saying, "We now understand that it is central to always keep schools open, not just for the wellbeing of children but for the proper functioning of the society."

Mr. Allen concurred. He said lost educational opportunities will have long-term consequences. As a professor, he could speak to the lost opportunities at the university level. Low education equals lower wages, poorer health outcomes, and decreased life expectancies. If one calculates the value of lost lives, it swamps any benefits from the lockdowns. Factor in the increased family breakdowns, suicides, and supply-chain interruptions and, simply put, it was going to take a generation to find out the actual costs of COVID.

From a public policy perspective, Mr. Leis had stated that Canada is guided by the principles of classical liberalism, which have an extraordinary history related to the assumption that we are born free. Within this framework, we have governments to serve us, but these same governments are not above the law. Therefore, to lock down a society because of COVID is outrageous: the economic, social, educational, and health consequences of this are astronomical. He said we underestimated the reason we have a limited state. Mr. Leis reiterated that classical liberalism is foundational to Western society.

He said freedom of speech allows us to debate and get to the truth. It is also the cornerstone for our standard of living and technological advancement. If we have censorship and the imposition of the state telling us that facts are not facts or that the end justifies the means or that we must follow the science but not in the name of science, we do not have a future. He pointed to lessons that we need to learn.

First, debate is essential (like intellectual friction). It is amazing what we can learn from those who disagree with us. Second, as our society moves closer to authoritarianism, the logical fallacy of never attacking one's opponent personally has become more prevalent. Third, in a healthy society, the state undertakes the judicial function to ensure the rightful implementation of law. There are no arbitrary arrests. Therefore, for all these reasons and more, COVID was a policy disaster. But not only a policy disaster; rather, also one where civil society was utterly assaulted.

Indeed, tyranny is simply unfettered discretion, Mr. Leis said, and it is happening in public health and, by extension, our politicians. For the direction of this great nation to change, it will require more than the voices of a few. It is time to stand and proclaim, "No more." Or as Jordan B. Peterson put it, "We hurt the educational opportunities of children and failed to see that the reaction to a crisis can be worse than the crisis itself."

Conversely, there was a very tiny win. At the University of Calgary, where there is a large Christian presence, lawyer James Kitchen successfully appealed the denial for religious accommodation for approximately 200 students. Initially, the accommodation requests were denied, with only a few students able to get one. He said the denials appeared to be completely arbitrary and that no one seemed to care about the law. After the appeal, all the requests were granted. He supposed, before COVID, there was some respect for the law. But Mr. Kitchen could only conclude that this was moral depravity, and perhaps fear, to the point of not being rational anymore.

As a whole, the personal and professional testimonies within, as excruciating as each might be, offer a glimmer of hope. That going forward, we will all come to recognize that the only real opposition to illegitimate institutional powers, bullying and coercion by unelected puppet masters, and fear-incited dictates and penalties, lockdowns, public shaming, and censorship is when Canadian citizens come together collectively and demand that the public service, mandated to serve the citizenry, actually does.

Recommendations

- A. **As publicly funded institutions**, both universities and colleges must adhere to the law of neutrality before demanding compliance for policies that potentially may not be legally enforceable.
- B. **In all publicly funded institutions**, whereby the mission includes scholarly inquiry and academic freedom as institutional tenets, there must be room for dissenting voices, debate, dialogue, and, most particularly, policy revisions when the evidence points to a change in the data and statistics that led to restrictive policies initially.
- C. **There must be a cost-benefit analysis** of any policy that leads to school closures, and discussions must include the public and education stakeholders.
- D. **In the interest of academic freedom and integrity**, post-secondary institutions and faculty should be able to ask pointed questions free from any fear of repercussions.
- E. **Investigate scientific findings** that contradict the narrative, and provide internal grant funding to ensure the evidence relied upon by governments and health authorities is accurate.
- F. **Post-secondary institutions** should not be allowed to impose additional mandates or extend mandates beyond that imposed by the government regulators. During the COVID-19 pandemic, once the initial two-week to flatten the curve period had concluded, post-secondary institutions should have lifted all policy restrictions. Similarly, when the emergency orders were lifted, post-secondary COVID policies should also have been terminated.
- G. **Offer an array of learning platforms** and alternative arrangements for academic study, including in-person classes, and online, distance, and hybrid options.
- H. **Ensure all students have an opportunity** to reach their potential without discrimination or bias due to vaccination status.
- I. **Any faculty or staff member who suffered a job loss**, was terminated, or was placed on unpaid leave and subsequently barred from campus should be immediately restored to good standing. Additionally, any negative or potentially stigmatizing comments regarding the employee's COVID stance should be removed forthwith from that employee's files. Pensions should be fully restored to pre-COVID status.

- J. **Post-secondary institutions should focus** on student achievement and not the removal of students from programs for not being compliant with newly established vaccination policies. No student should lose academic standing or lose successfully completed academic credits for non-compliance to a policy.
- K. **Students in residence should have opportunities** to socialize with other residents under the auspices of cohorts. Students should never be restricted to their rooms.
- L. **Reimburse students who paid for residence** in good faith but because of a change in COVID policies combined with an individual's unvaccinated status, were forced to vacate the premises.
- M. **Accommodation in accordance with the *Charter of Rights and Freedoms*** must be made. It is a constitutionally protected right for all persons. Therefore, faculty, staff, and students requesting accommodation should not only have their concerns heard but taken seriously when blanket COVID policies are initiated. This includes accepting medical, religious, and personal exemptions. It also means consideration for other circumstances, including personal choice, convictions, conscience, deeply held beliefs, or health risks (for example, previous adverse reaction to a vaccine).
- N. **Health policies should provide allowances** for bodily autonomy and personal choices. Employees and contractors—including faculty members, staff, and students—should not be required to disclose their medical information to obtain an allowance.
- O. **Policies that lead to the segregation** of a specific group of students is discriminatory. Therefore, any policy promoting segregation must be immediately removed.
- P. **Post-secondary institutions** should have to provide justification in writing for responding to government mandates with inflexible approaches.
- Q. **Any policy must be subject to revision** when it becomes apparent that restrictions are not necessary. For example, there should be a mandatory review process every 30 days.
- R. **Meet with stakeholder groups—including faculty**, staff, and students—who made different choices regarding vaccines and COVID policies.
- S. **Eliminate all policies and procedures** that directly violate human rights legislation, including denial of a service or services.
- T. **Employment loss and/or disciplinary action** (including unpaid leave) must follow the same human rights procedures for all faculty and staff. Vaccination status should not be a sufficient excuse or justification for applying union procedures differently.
- U. **A union's mission is to protect and defend the rights** of staff and faculty across campus. The union does not have the right to arbitrarily deny unvaccinated staff and faculty the right to file a grievance and to have the grievance heard.

- V. **Employees with long-standing service** should not suffer a loss of pension and other benefits because of personal health choices.
- W. **Third-bucket youth** who were not educated during the pandemic need to be found and their circumstances addressed so they can be educated and subsequently prepared for the future.
- X. **Schools should not be closed** for periods of time exceeding one week in duration.
- Y. **Virtual schooling is not advantageous** to youth experiencing learning disabilities, having language barriers, or living in an unsafe or abusive situation. These additional barriers to learning need to be taken into consideration.
- Z. **Young, healthy people should not be shut out** of schools for as long as they were. Studies as early as May 2020 showed that suicides, eating disorders, opioid deaths, and substance abuse were skyrocketing among young people. Students should have been allowed to go back to in-person learning with no more interruptions.
- AA. **Special needs children and adults** require additional guidance and direction. Therefore, one-size-fits-all blanket policies need to be reconsidered.
- BB. **Public shaming and labelling of citizens** by government officials contributes to lawlessness. Government officials and those in positions of authority need to be held to a higher standard. At the same time, governments should not be permitted to blatantly work against their populations.
- CC. **Educators need to publicly defend** the precautionary principle for all children and youth.

7.2.7.COVID Impact on the Social Fabric

When describing COVID's impact on Canada, the question really comes down to this: Where to begin? Certainly, the tiny cracks in the social fabric may have surfaced pre-COVID, but in the aftermath, these splinters have become deep crevices. Regardless of where one turned, the threat of even further damage was frightening.

At the beginning of COVID, the prevailing narrative was "two weeks to flatten the curve." Most of the citizenry at the time understood that a pandemic could pose a very real threat. Thus, for the most part, the majority of Canadians were willing to concede to a temporary shutdown for the sake of society as a whole. But what happened when two weeks became two months? And two months, two years?

Some argue COVID is multifaceted and complex. Decisions were made with the goal of protecting public health and safety. Any criticism, even constructive commentary, was quickly dismissed, and dissenters outside the one-sided, prevailing narrative were silenced. Nevertheless, pointed questions needed to be asked. Perhaps the most pressing question: Were the governments and the public service honest with the Canadian people?

Traditionally, when a nation comes under siege from outside forces, its citizens unite to defend the country's interest. However, the response to COVID and the federal government's invoking of the *Emergencies Act* appeared to garner the opposite response. Instead of rallying together in one accord, with a determination to save Canadian ideals, citizens willingly complied with ever-changing health mandates, even when these bordered on the nonsensical. Indeed, mask-wearing, social distancing, and experimental gene therapy tended to be accepted as the price for participating in society.

In actuality, it could be said that Canada's COVID policies brought out the worst in people. The sense of defeat was palpable in the hearts of men and women on the streets. Hope and optimism for the future was not generally observed within the populace. For many Canadians, there were simply too many hurdles to overcome, so they compromised both principles and conscience just to survive.

Subsequent research points to the negative developments that have permeated nearly every aspect of Canadian society. While, admittedly, a multitude of factors influenced the advance of the pandemic, it would be remiss to think, after hearing the witness testimony, that ulterior motives were not at play.

The witnesses alluded to a variety of societal breakdowns, and the irreparable damage that followed in the aftermath of COVID dictates. It is important to recognize the burdens placed on people from all walks of life, journeying within multiple layers of society, because the long-term effects of COVID mandates are intergenerational. In fact, as stated, it could be generations before the harms committed over the years 2020–2023 can be undone, or perhaps they can never be undone. Noticeably, lawlessness increased, but not from the citizenry. Rather, the wrongs that were being committed stemmed from all levels of government officials—the few that believed they knew much better than the populace.

For example, the rule of law, wherein the same application of the law applies to the homeless on the street as the judges dressed in robes in the Supreme Court, has been violated. The supremacy of God was sidestepped. Constitutional rights and freedoms were discarded as if these protections never existed. In many situations, ordinary people who stood for this country, have fallen. Normal day-to-day lives have been damaged. Education and learning opportunities for young people were disrupted.

Medically, suicides, addictions, and domestic abuse increased at phenomenal rates. Adverse medical effects from COVID injections were not accepted by health agencies, even though medically qualified, professional physicians attested to the vaccine injuries to patients. Scientists who contested the prevailing narrative became outcasts. Family businesses were destroyed because these were not considered essential. Neighbours forgot how to trust one another. In its wake, a host of economic, social, health, legal, and public policy tragedies have yet to be acknowledged by the authorities responsible.

One outcome is definite. We are not the same society we were before COVID. Many questions remain. These should include whether the populace is satisfied with the emergence of a new political model that, in essence, replaced all the tenets of parliamentary democracy and justice in Canada. Certainly, the idea that legislators (in consultation with the electorate) no longer decided our destiny during COVID—where Canadians shop, whom citizens befriend, the beliefs and opinions people subscribe to—should have been concerning enough. But appointed (non-elected) health authorities and public service employees, who with the stroke of a pen can further impose predetermined restrictions on one's conscience and arbitrarily decide where one's inherent rights to live as free men and women should start and stop, should raise serious alarms. Is this the society Canadians want?

How Did We Get Here?

The reality is the elected officials vacated their posts and instead, abdicated or gave over their respective political and public administration responsibilities to chief medical officers employed as bureaucrats within public health. Equally notable, these individuals were also allotted extraordinary powers that clearly went beyond the scope of good governance and accepted democratic

principles. Therefore, in this specific context, did the actions of chief medical officers and corresponding health bureaucrats border on the political doctrine and practices recognized in political science circles as absolutism.⁴¹

After all, this didn't just happen in one province, or even within Canada. The one-mind that emerged occurred in most jurisdictions around the world. The Western ideals that Canadians had come to cherish were extinguished by the stroke of a pen. But whose pen? Who decided that the rights and freedoms of citizens no longer mattered in Western democracies? And why, in such a blessed democratic nation as Canada, did so many blindly follow?

As the numerous witnesses alluded to while sharing their personal testimonies, ordinary citizens were arrested and detained in prisons for standing firmly on the rights and freedoms established in the *Constitution Act, 1867*; the Charter; and the *Bill of Rights*. Where was the presumption of innocence? What happened that negated the administration of justice?

The questions do not end here. For the three COVID years, the ever-changing mandates differed, depending in which part of Canada one lived. Language changed. The legacy media suddenly became experts in public health, without ever attaining a medical degree. The content these journalists did not substantively understand translated into a word-for-word repeat of press releases disseminated by public health officials. The more bizarre the content contained in health alerts, the easier it became for media to report—for example, 8 p.m. curfews, wherein no citizens were allowed on the streets in Québec, or how travellers were required to obtain travel papers prior to entry into New Brunswick or Nova Scotia. The Atlantic bubble zone was yet another example—wherein residents in the Atlantic region could travel freely throughout the eastern provinces without question, but Canadians living elsewhere were subject to additional scrutiny and COVID preauthorizations.

⁴¹ Absolutism: “the political doctrine and practice of unlimited centralized authority and absolute sovereignty. The essence of an absolutist system is that the ruling power is not subject to regularized challenge or check by any other agency, be it judicial, legislative, religious, economic, or electoral.” britannica.com. [https://www.britannica.com/summary/absolutism-political-system#:~:text=absolutism, Political doctrine and practice, economic, or electoral agency.](https://www.britannica.com/summary/absolutism-political-system#:~:text=absolutism,Political doctrine and practice, economic, or electoral agency.) (accessed 2023)

This same legacy media also gained an expertise in public shaming. Anyone who opposed the prevailing narrative and, most particularly, those with medical and scientific expertise were labelled as “conspiracy theorists,” delivering a message of “disinformation”⁴² and “misinformation.”⁴³ For their servitude, the legacy media was paid handsomely by their political masters in Ottawa. Truth, investigative journalism, and professional ethics were no longer priorities of mainstream news agencies. As quickly as the government could print news releases, the media adopted them as their own.

There could not be a timelier era for the biblical prophecy forecasting when “right is wrong and wrong is right”⁴⁴ to come to fruition. For example, the term *freedom fighter*, according to artificial intelligence,⁴⁵ is subjective—meaning what one group views as freedom, another might consider an act of terrorism or insurgency. Therefore, artificial intelligence does not acknowledge freedom as an inherent, God-given right in Canada. Any responsible educational inference that willingly omits absolute truth (truth that cannot be manipulated) when constitutional tenets are already defined should scare Canadians.

Further, it appears the media, alongside federal and provincial government institutions, only resorted to historical context for villainy⁴⁶ so they could then mangle it beyond recognition to prove a desired outcome consistent with COVID mandates. Are there even recommendations capable of countering this increasing trend toward propaganda-type reporting?

⁴² Disinformation is false information deliberately spread to deceive people. Disinformation is an orchestrated adversarial activity in which actors insert strategic deceptions and media manipulation tactics to advance political, military, or commercial goals. Disinformation is implemented through attacks that weaponize multiple rhetorical strategies and forms of knowing—including not only falsehoods but also truths, half-truths, and value judgements—to exploit and amplify culture wars and other identity-driven controversies. <https://en.wikipedia.org/wiki/Disinformation> (accessed 2023)

⁴³ Misinformation: Misinformation is incorrect or misleading information. It differs from disinformation, which is deliberately deceptive and propagated information. Early definitions of misinformation focused on statements that were patently false, incorrect, or not factual. <https://en.wikipedia.org/wiki/Misinformation> (accessed 2023)

⁴⁴ “Woe unto them that call evil good, and good evil; that put darkness for light, and light for darkness; that put bitter for sweet, and sweet for bitter.” Isaiah 5:20: King James Version, 1611.

⁴⁵ Chat.openai.com, (accessed August 31, 2023)

⁴⁶ Villainy: befitting a villain (as in evil or depraved character) <https://www.merriam-webster.com/dictionary/villainous> (accessed 2023)

But legacy media were not the only perpetrators. Social media quickly joined ranks, becoming judge and jury of all commentary that allegedly contravened community standards. Facebook, YouTube, and other social media giants censored content, disciplining or suspending privileges of any user who posted content concerning COVID. At no point did governing authorities, the judiciary, or Crown prosecutors challenge these actions by social media conglomerates, even though freedom of thought, belief, opinion, and expression clearly includes freedom of the press and other media of communication⁴⁷ in the Charter.

There is also another emerging concern regarding dialogue and actions that are contrary to the Charter. Increasingly, it appears Canadians' rights and freedoms are only concrete and tangible "when reasonable." For clarity, there is no "when reasonable" attached to Charter rights and freedoms. These rights are inherent and God-given. These are not within a government's purview to take away. The framers of this nation recognized and founded Canada on these pillars—the supremacy of God and rule of law. These same citizen protections were then reaffirmed and entrenched in 1982.

Further, these citizen rights are guaranteed to be free from any interference or intrusion from government agents of the state. All government institutions are expected to remain neutral, which by extension, prohibits government from selectively cherry-picking which legal activities are deemed reasonable and which are not. These same limitations on government apply to Charter-protected accommodation.

It is herein that the intersection of citizens and governing authorities requires further investigation: the COVID messaging, the forceful actions of authorities, and the question of whether Canadians are once again willing to sacrifice their individual and collective rights and freedoms whenever governments or bureaucrats impose mandates in the future.

Before garnering a response, it may be insightful to review some of the COVID measures imposed over the last three years, and how COVID mandates and government dictates negatively affected the social fabric.

- A. Children were told if they visited their grandparents, grandma would die. If these same young people visited their friends, their peers could become infected. Families had to make an appointment to visit loved ones, and far too often, this included bringing the negative results of a rapid COVID test.
- B. Children could not play in parks or playgrounds. Social time was not allowed.

⁴⁷ Section 2(b) of Canadian Charter of Rights and Freedoms states: "Freedom of thought, belief, opinion and expression, including freedom of the press and other media of communication."

- C. Libraries, museums, and youth activity centres were closed. So, too, were hiking and skiing trails. Education was moved to remote or online. Student-learning expectations and curriculum outcomes were minimized. Structured schedules, so essential to those who plan their lives around them, were disrupted. This, in particular, had a significant impact on people with special needs, as the program services necessary for their health and wellbeing were shut down.
- D. The gaps in access to education were even more pronounced when marginalized communities are factored in (for example, financial stress, increased worry, increased conflicts).
- E. Public policies contradicted each other. For example, soup kitchens in Ontario were permitted to feed up to 50 persons in a facility at the same time, but religious services held in the very same building were limited to five or ten in-person gatherings, depending on the COVID mandate in place at the time. There was the witness who shared her story. While her mother was alive, she was not permitted in the hospital. But when her mom died, she could sit by her mother's bedside and hold her hand. Spiritual care for a palliative patient was conducted through a window. The five children of a man who was assaulted by a disgruntled customer could not see their father before he died. There was also the heartbreaking story of one young teen who ventured down a path from where he could not return.
- F. Health authorities were adamant that COVID vaccines were effective and safe, and yet after administering the vaccine to seniors living in long-term-care facilities, there were more COVID outbreaks, more COVID deaths, and presumably more adverse injury events. In Ontario and Québec, specifically, there were reports of the elderly being found in deplorable conditions. When employees walked out at one facility, the resulting circumstances were so shocking that the Canadian Armed Forces were called in to help.
- G. Individuals with special needs, including learning disabilities, or mental health issues were put on hold. Countless Canadians waiting for surgeries continued their medical struggle without healthcare intervention. The elderly became even more isolated from friends and families. Many died. The short- and long-term impacts on vulnerable populations are still to be tallied.
- H. The homeless, who generally find shelter on city streets and in wooded areas, were forced to find alternative ways to comply with 8 p.m. curfews because COVID measures and lockdowns already prevented them from finding a temporary warming space, bathrooms, or showers in government buildings and not-for-profit facilities.
- I. Charitable organizations, including churches, were prevented from offering in-person support programs within the community. For example, Alcoholics Anonymous moved all meetings online. Temporarily, this might have been considered an acceptable compromise. However, if the persons needing AA relied on free computer usage from the library, they no longer could receive support because the libraries were closed. Ironically, the very addiction these recovering addicts were running from was still open and ready to serve.

- J. Funeral restrictions were maximized, adding to the grief of family members and friends attempting to say goodbye to a loved one. Proper burials and funeral services looked very different from pre-COVID. As a consequence of the pandemic, the grief and mourning processes were disrupted, negatively affecting people's emotional wellbeing. One witness reported that the COVID practice was contrary to the bereavement recommendations for grieving families listed on the Canada.ca website.
- K. For the first time in known history, middle-aged women, typically with children still at home, were dying by suicide. The mean age of these women was 47 years old. This demographic was never identified as a risk group. Witnesses spoke of other deaths by suicide as well—of beloved ones who could no longer see the light of this day that would guide them safely into the next.
- L. Mobility restrictions were linked directly to the COVID mandates in each province and territory. In larger provinces like Ontario, different rules applied depending on the health district one resided in. Internationally, borders were closed by governments. Hotels were secured as quarantine facilities for travellers arriving in Canada. The whereabouts and activities of Canadian citizens were tracked by public health agencies. Those who travelled outside of Canada were subjected to specific protocols. Inside Canada, where travel from province to province is a guaranteed mobility right in the Charter, several provincial governments imposed additional obstacles and border checkpoints. Citizens were often quarantined. Within the quarantine procedures, travellers were questioned every day by health officials. In several provinces, documentation required by health officials included a mandatory travel itinerary complete with details of overnight locations (including the names and addresses of all residents in the home) if spending time at a family member's or friend's home. Two examples show the length to which governing authorities would go to control the populace.
 - 1. In September 2021, Prince Edward Island, for example: ordered anyone travelling to the province be tested, regardless of their vaccination status; recommended travellers 12 and older be tested again between the fourth and eighth day after they entered the province; required that school-aged children under 12 who returned to PEI from travelling, test negative for COVID-19 before attending school; ordered unvaccinated or partially vaccinated travellers to isolate for eight days upon entry and then test once again. The province's PEI pass, which permitted entry onto the Island, would only be issued to people who showed they were at least two weeks removed from their second COVID-19 vaccine dose.⁴⁸

⁴⁸ Keith Doucette. "Travellers to P.E.I. to be tested for COVID-19 at its borders starting Thursday." September 28, 2021. <https://globalnews.ca/news/8227858/pei-covid-19-border-testing-delta/> (accessed November 2023)

2. In northern Ontario, travellers were required to sign in at eating establishments with verifiable personal contact information. Washrooms in most restaurants, tourist information centres, gas stations, and rest stops were closed to the public.⁴⁹ The changing rules became so complicated that Restaurants Canada created a chart informing food and drink establishments of public health requirements, which coordinated with colour codes.⁵⁰ For example, green was to “prevent,” yellow was to “protect,” orange was to “restrict,” red was to “control,” and grey was to “lock down.” Accommodations added further layers of restrictions. Hotel swimming pools and gyms were closed.
- M. Newborns were taken from their mothers at birth under the pretence that the infant or mother may have COVID. Depending on the specific hospital, the mother could not see the child for up to 24 hours.
- N. Families were denied access to loved ones in hospitals and long-term-care facilities. Scheduled surgeries were put on hold. Many patients on long waiting lists died in the interim.
- O. Access to information requests were ignored by the majority of federal and provincial governments and agencies.
- P. Bank officials who forced patrons to line up outside in the winter months based their orders on social-distancing and customer-limit protocols. During the day, when staff were at the bank, an added emphasis was placed on sterilizing ATM machines; but in the evening, there were no employees ensuring compliance with COVID measures.

⁴⁹ CBC News. “Here’s what you can and can’t do starting Sunday as Ontario reintroduces COVID-12 capacity limits.” CBC.ca, <https://www.cbc.ca/news/canada/toronto/ontario-new-restrictions-omicron-what-you-can-and-cant-do-1.6290506>. accessed December 17, 2021. (accessed November 2023); Ryan Rocca, et al. “A look at the current COVID-19 restrictions in Ontario.” Globalnews.ca, <https://globalnews.ca/news/7767497/list-covid-restrictions-ontario/>, April 18, 2021. (accessed November 2023)

⁵⁰ Restaurantscanada.org. <https://info.restaurantscanada.org/hubfs/GR/Ontario%20Public%20Health%20Measures.pdf> (accessed November 2023)

Q. Unions are supposed to protect the rights and interests of paying members. The purpose of unions is to negotiate with employers on collective bargaining issues and workplace concerns. During COVID, however, witness testimony repeatedly pointed to the failure of unions to represent their members. Unions did not ensure vaccine-related policies were fair or transparent, and that workers' rights and/or personal medical concerns were taken into account before employment status decisions were made. There was rarely accommodation made for employees with medical and religious exemptions. The unions did not negotiate for alternative work arrangements. Safety measures such as ventilation and sanitation, and additional safety precautions designed to protect both vaccinated and unvaccinated employees were not raised with the employer. Unions did not argue for members' vaccination choices that emphasized personal autonomy and medical privacy. When employees who were unvaccinated were escorted from the workplace, unions did not defend the employees' rights. Witnesses said their filed grievances were not heard. Legal and ethical issues were not considered when the COVID vaccinations were introduced. The balancing of collective and individual interests, normally advocated for by unions, was not strived for. Unions did not advocate for employer policies that protect public health and respect workers' rights.

R. As alluded to in witness testimony, regulatory bodies⁵¹ were determined to control members who questioned COVID mandates. This was particularly true in healthcare, but other witnesses told of similar actions in their own regulatory professions as well. It was observed from the testimony that many of the actions taken by the respective regulatory bodies may have gone beyond the scope of their authority. This was not a first-time occurrence for the College of Physicians and Surgeons in Ontario. In a similar context, it should be noted that the Alberta courts in the Shelia Lewis organ transplant case went to great lengths to protect the coveted doctor-client privilege.⁵² The Honourable Judge R. Paul Belzil opined that in the view of the court, it is not necessary for treating officials to reconcile differences in expert opinions, but rather physicians must be free to decide which expert opinions they accept in exercising their clinical judgment which informs the standard of care.⁵³

⁵¹ There are three types of regulatory agencies in Canada: self-governing bodies, which regulate the conduct of their own professionally qualified members; independent government agencies and boards; and regular line departments headed directly by Ministers, which regulate specified industries and activities. The governing body is empowered by provincial legislatures to determine their own requirements for admission and similarly, to discipline members who do not adhere to prescribed standards of professional conduct.

⁵² [30] It is not sufficient to establish that physicians are acting within a legislated, publicly funded framework. Were that determinative, it would follow that all decisions made by physicians would be subject to Charter scrutiny, a proposition which is contrary to existing jurisprudence, where courts have explicitly held that physicians acting in the regular course of providing medical care are not government agents: see *R v. Dersch*, 1993 CanLII 32 (SCC), [1993] 3 SCR 768 at 777, 85 CCC (3d) 1; McKitty at para 48; *Rasouli (Litigation Guardian of) v. Sunnybrook Health Sciences Centre*, 2011 ONSC 1500 at paras 84-93, 105 OR (3d) 761, aff'd in *Cuthbertson v Rasouli*, 2013 SCC 53 on other grounds.

⁵³ From paragraph (42) The Honourable Judge R. Paul Belzil (J.C.Q.B.A.) concluded in Paragraph 89, "the Charter has no application to clinical treatment decisions made by the Treating Physicians, and in particular has no application to the Treating Physicians establishing preconditions for XX transplantation. The Originating Application is dismissed in its entirety." The case was heard on June 29-30, 2022. The decision was made on July 12, 2022. *Lewis v. Alberta Health Services*, 2022 ABQB 479.

And yet many highly educated and qualified professionals, among them physicians and surgeons, who spoke publicly against government-imposed mandates—including COVID vaccines and/or governments' responses to COVID—were subject to disciplinary actions initiated by their own professional regulatory bodies. Dissenting viewpoints were suppressed; physicians were made examples of in order to prevent other doctors from raising concerns too. Moreover, one physician testified to his willingness to lose his livelihood and professional credentials to warn the populace of the potential dangers of COVID-19 vaccinations. The fact that an increasing number of medical physicians are being systematically suspended, disciplined, or professionally removed from their positions cannot be ignored.

As the testimony revealed, the respective colleges appeared to have turned investigations into fishing expeditions. In one example, the college went so far as to seize patient files from the doctor's office. Still, not one of these accused healthcare professionals harmed or caused the untimely death of a patient.

- S. Ethics⁵⁴ in the medical context includes Informed Consent. This did not happen. Governing authorities passed legislation that absolved pharmaceutical companies from wrongdoing. This meant pharmaceuticals were no longer accountable to the Canadian public for adverse medical reactions, undue harm, or death. Moreover, the clinical trials for COVID-19 vaccines are ongoing, so ethically, how could health authorities and governments condone the vaccines as safe and effective?
- T. Both economically and socially, COVID presented significant challenges. So-called quiet quitting was an emerging trend that appeared to gain momentum as the mandates increased. It was almost as if Canadians were entering their homes and closing the door to the outside world once and for all.

Business operations were defined by bureaucrats as either essential or non-essential. Many people lost their jobs. Households faced reduced income. Family businesses that had weathered previous economic downturns were forced to close while big-box stores and government-sponsored businesses remained open. Building-size regulations or fire code occupancy authorizations were not used as a standard for determining gathering numbers. From witness testimony, Costco was allowed 818 customers in the store at the same time, while businesses and churches with similar size facilities were restricted to ten. The reduction in businesses led to decreased choices in consumer purchasing. For businesses forced to close, there was financial distress and economic hardship.

⁵⁴ Government of Canada. Tri-Council Research Ethics, https://ethics.gc.ca/eng/policy-politique_tcps2-eptc2_2018.html. (accessed November 2023)

- U. The goal of science is the pursuit of knowledge--not necessarily the pursuit of truth. There is a distinction. When the public follows the science, there is a shifting alliance from the supremacy of God to the supremacy of science. But science changes over time. It is not constant, which is part of the attraction to the discipline of science. Consider the Milgram experiments, the rationale of conscientious objectors,⁵⁵ and the various scenarios like electroshock treatments⁵⁶ that led to the establishment of professional ethical standards, such as the Tri-Council.⁵⁷
- V. Religious and medical exemptions have long been accepted as forms of accommodation in Western democracies. This apparently changed during COVID, when the decision-makers for employment insurance (EI), for example, universally disallowed EI benefits to unvaccinated claimants. Given that the EI program is sustained through payroll deductions of employers and employees, the federal government does not have the legal, moral, or ethical authority to suggest the decision to reject exemptions are about balancing individual rights with the public interests. These civil employees are not qualified to determine the legitimacy of exemptions either. Why not? Because EI is not funded by the federal government. The other point worth noting here is that these same employees are not hired to challenge the legitimacy of medical or religious exemptions. Public service employees are hired to perform their duties according to the legislation that governs their responsibilities. There is no discretion in the legislation. EI as public policy is intended to provide Canadians with income when their employment circumstances change.

It should also be noted that limiting exemptions, is not a legal, moral, or ethical way for increasing vaccination rates within the broader community. It borders on coercion, which in and of itself is illegal in the public square, and this becomes more egregious when demanded as a program requirement from government employees.

⁵⁵ *Britannica*, The Editors of Encyclopaedia. "Conscientious objector." *Encyclopedia Britannica*, 28 Jul. 2023, <https://www.britannica.com/topic/conscientious-objector>. (accessed September 1, 2023)

⁵⁶ ECT electroshock therapy also known as electroconvulsive therapy Electroshock therapy: History, effectiveness, side effects, and more (medicalnewstoday.com). (accessed June 30, 2021)

⁵⁷ Government of Canada. https://ethics.gc.ca/eng/policy-politique_tcps2-eptc2_2018.html. (accessed November 2023)

W. This brings the conversation directly to the Canada Emergency Response Benefit (CERB), the Canada Recovery Benefit (CRB), the Canada Recovery Sickness Benefit (CRSB), the Canada Recovery Caregiving Benefit (CRCB), and the other forms of government compensation handouts during COVID. CERB was considered a key financial support program introduced by the federal government to provide financial assistance to individuals who were directly affected by the pandemic and lost income as a result of job loss, quarantine, caregiving responsibilities, or reduced working hours. This begs an obvious question: How can employees who contribute their hard-earned income to payroll deductions (which includes EI premiums) be denied insurance benefits for choosing not to be vaccinated, and yet, the federal government can dole out public funds with no questions asked? It is no wonder the Lord says the right hand of government does not know what the left hand is doing.⁵⁸

This could explain why civil liberties groups criticize the discriminatory acts of governments or why the truckers at the Freedom Convoy stood their ground in Ottawa and Windsor, Ontario, and Coutts, Alberta. Because all levels of government and health authorities, including elected and non-elected officials, arbitrarily put onerous restrictions on the movement or peaceful assembly of citizens within the public square. Indeed, the governing authorities went too far when they infringed on individual freedoms. As the testimony revealed, these same governing authorities condoned bending a knee for Black Lives Matter and other groups during COVID mandates, but then threatened the truckers and attendees at churches and funerals with hefty fines and jail time. Besides heavy-handed bullying, the police services in Canada did not follow their own emergency plans or established protocols. There was no pursuit of justice for the greater good, either. Section 7 of the Charter—which guarantees life, liberty, and security—was discarded, as were many other constitutional provisions.

As Canadians witnessed, governments at all levels continued pursuing their objectives throughout the pandemic. Political legislation was still being put forward. The public service was still employed. Bureaucrats remained nameless. Justice was behind a screen, wherein only the privileged could obtain access. In the process, governments continued to award contracts to businesses that health authorities deemed essential. It would be difficult to deny the obvious patronage and nepotism. In the example of drug stores, witness testimony alluded to contracts awarded to administer COVID vaccinations outside of a fair and open tendering process that provided every entity, business, or organization with the same opportunities. The administrative state continued playing games with citizens' lives—because at no point were these employees held accountable for wrongdoing.

Nevertheless, when someone points the finger at citizens, there are three fingers pointing back at them. Governments, like the people, are bound by the law. Governments cannot just decide which laws are to be obeyed and which are to be disregarded.

⁵⁸ Jonah 4:11.

Throughout COVID, there were winners and losers—each declared by the same governing officials who were elected to represent the public's best interests but did not. There was excessive power imposed by authority figures against hardworking Canadians: police versus citizen, teacher versus student, employer versus employee, judge versus accused, elected official versus constituent, vaccinated versus unvaccinated. Is this the trickle-down effect of passive-aggression?⁵⁹ Or is it simply the governments' method for crumbling a democracy from the inside out?

Regardless, the same application of the law for citizens did not apply equally to those in privileged positions of power. And there was no accountability or transparency. As numerous witnesses shared, ordinary citizens were arrested and detained in jail cells for standing firmly on the rights and freedoms established in the *Constitution Act of 1867*, the Charter, and the *Bill of Rights*. Churches were seized. The RCMP sent canine units to hunt for peaceful churchgoers. Truckers participating in the Freedom Convoy had assets seized. And so did a retired Ontario Provincial Police officer for facilitating dialogue between the truckers and governing administrators.

Did anyone ask: Where was the presumption of innocence? Or what happened in Canada that negated the administration of justice? Who is responsible for adhering to the Precautionary Principle⁶⁰ in public policy making, which should have legitimized the adoption of preventive measures to address potential risks to the public? Who is the ultimate judge when egregious actions should lead to liability, but there is no public recourse? Who lied?

Perhaps the country can take a lesson from witness Steve Kirsch, who said, "The state has manipulated your mind; once you are willing to question your beliefs, everything else makes sense."

⁵⁹ Passive-aggression behaviour is when you express negative feelings indirectly instead of openly talking about them, for example, During World War II, when soldiers wouldn't follow officers' orders, experts described them as "passive-aggressive." A new term back then, but one that is still relevant today. Someone who uses passive-aggression may feel angry, resentful, or frustrated, but they act neutral, pleasant, or even cheerful. They then find indirect ways to show how they really feel. Passive-aggression isn't a mental illness. But people with mental health conditions may act that way. Passive-aggression could damage your personal and professional relationships.

⁶⁰ The Precautionary Principle was explicitly framed in 1992 via the Rio Declaration by representatives of 178 nations as: "Where there are threats of serious or irreversible damage, lack of full scientific certainty shall not be used as a reason for postponing cost-effective measures to prevent environmental degradation." Rio Declaration on Environment and Development, Principle 15, U.N. Doc. A/CONF. 151/26 (Aug. 12, 1992).

This is not to suggest there are not some glimmers of hope. The *Ingram* legal case in Alberta is most certainly a step forward for democracy and justice. Citizens are awakening to the repeated propaganda and messaging that consumed the airwaves over the three COVID years. Critical questions are being asked. And over 300 brave souls, Canadian citizens who believe in standing up for what is right and just and true, shared their personal testimony so that this nation, from shining sea to sea to sea, could be restored from the clutches of schoolyard bullies in adult bodies who need to understand, first, the meaning of *good governance* before sitting in positions of privilege.

American writer, novelist, and Pulitzer Prize winner Pearl Buck⁶¹ (1892–1973) described the true essence of society in this way: “Our society must make it right and possible for old people not to fear the young or to be deserted by them, for the test of a civilization is the way that it cares for its helpless members.” United States Vice-President Hubert Humphrey⁶² carried Ms. Buck’s thought one step further when he said, “The moral test of government is how government treats those who are in the dawn of life, the children; those who are in the twilight of life, the elderly; those who are in the shadows of life: the sick, the needy, and the disabled.”

Or, as Jesus so aptly said in the synagogue in Nazareth, “The Spirit of the Lord is upon Me, because He hath anointed Me to proclaim good news to the poor. He has sent Me to proclaim liberty to the captives and recovering of sight to the blind, to set at liberty those who are oppressed, to proclaim the year of the Lord’s favour.”⁶³

This is the ultimate mission field for all Canadians to pursue, and in so doing, let the brave NCI witnesses and the truckers in the Freedom Convoy join the many other Canadian voices that understand real answers are not found in rationalizing logic (because as we have observed over the COVID Years, logic too often turns into evil), but rather in shining brightly in one accord, so we too, as proud Canadians, can adamantly declare, “Never again.”

Recommendations

The discussion raises important concerns about the negative impacts of the federal government’s pandemic response on the fabric of Canadian society. These impacts encompass a wide range of areas, from personal freedoms and trust in institutions to economic, social, and health consequences. To prevent such issues from happening in the future, we put forth the following 12 recommendations.

- A. **National Crisis Oversight Council:** Commission a study to determine the validity of setting up a National Crisis Oversight Council (NCOC), with a rationale and expected format as follows:

⁶¹ <https://www.britannica.com/biography/Pearl-S-Buck>. “What makes a novel ‘American’? Pearl S. Buck challenged the status quo”—The Pulitzer Prizes.

⁶² https://www.goodreads.com/author/quotes/149820.Hubert_H_Humphrey.

⁶³ Luke 4:16–21.

Rationale

Establishing the NCOC is essential to safeguarding democratic principles, protecting individual rights, and maintaining public trust during future emergencies, such as pandemics. The NCOC will serve as an independent, multidisciplinary body tasked with monitoring, policing, and investigating government actions during crises.

Basic Characteristics and Principles

Representation: The NCOC will comprise representatives from diverse sectors of society, including law, medicine, science, faith, business, media, arts, and culture. Each member will undergo a public appointment process, with credentials and potential conflicts of interest transparently disclosed.

Subpoena powers: The council will possess subpoena powers, allowing it to compel testimony and evidence from all sectors, including government officials, the judiciary, and other relevant stakeholders.

Public access: To ensure transparency and accountability, the NCOC will offer the public direct and unfiltered access. A user-friendly platform will enable citizens to express concerns, provide observations, and access council proceedings.

Legislative clarity: The powers and responsibilities of the NCOC will be clearly outlined in legislation, eliminating the need for regulatory details to be determined separately. This legal foundation will establish the council's authority and scope.

Empowerment for change: The NCOC will have mechanisms to influence government actions during emergencies. It will be empowered to make recommendations, demand corrective actions, and trigger public awareness campaigns when necessary. Its primary goal will be to uphold democratic values and individual rights and freedoms, and help ensure the wellbeing of citizens.

Media access: The council will be expected to have unrestricted access to all forms of media to maintain public trust and transparency. Regular briefings, reports, and public statements will keep citizens informed of its activities and findings.

Purpose and Benefits

The NCOC would be founded on the principle that a robust system of checks and balances is vital in times of crisis. Its purpose would be to:

Safeguard democracy: Ensure that democratic principles are upheld during emergencies, preventing overreach and abuse of power.

Protect individual rights: Safeguard citizens' fundamental rights and liberties, even when extraordinary measures are deemed necessary.

Maintain public trust: Enhance transparency and accountability in government actions, fostering public confidence in crisis management.

Promote evidence-based decisions: Encourage government responses to be grounded in science, data, and expert advice.

Support effective governance: Assist in identifying gaps and weaknesses in government responses—leading to more effective crisis management.

Advance public discourse: Facilitate open dialogue between government, experts, and the public to promote informed decision-making.

In summary, the establishment of the NCOC would be a proactive response to ensure that during future emergencies, the rights and values of Canadian society are upheld. It strengthens democracy, promotes transparency, and empowers the public to actively participate in safeguarding their wellbeing and fundamental rights.

- B. **Transparency and honest communication:** Governments should prioritize transparent and honest communication with the public during crises. Information about the nature of the crisis, measures being taken, and the expected duration of those measures should be clearly and consistently conveyed.
- C. **Accountability mechanisms:** Establish mechanisms for holding public officials accountable for their decisions during crises. This includes oversight bodies that can review actions taken by governments and ensure they align with constitutional rights and freedoms.
- D. **Respect for constitutional rights:** Safeguard constitutional rights and freedoms, even during emergencies. Governments should not infringe on these rights without clear and justifiable reasons, and any restrictions should be proportional and time-limited.
- E. **Balanced approach:** Develop and implement a balanced approach to crisis management that considers public health alongside economic, social, and mental wellbeing. Decisions should be evidence-based and consider the broad spectrum of societal impacts.
- F. **Community engagement:** Engage with communities, civil society organizations, and a wide range of experts in decision-making processes. Encourage open dialogue and ensure that policies and measures are sensitive to the unique needs and circumstances of different groups within society.
- G. **Education and awareness:** Promote public education and awareness about public health measures, their rationale, and the expected outcomes. Informed citizens are more likely to be able to make informed decisions and hold officials accountable for their actions.

- H. **Support for vulnerable populations:** Develop strategies to support vulnerable populations during crises—such as the homeless, those struggling with addiction, and victims of domestic abuse. Ensure that access to essential services is maintained.
- I. **Healthcare infrastructure:** Invest in and strengthen healthcare infrastructure to ensure capacity and readiness for future public health emergencies. This includes resources for mental health services, addiction treatment, and domestic violence support.
- J. **Mandatory ethics training for health care workers:** To enhance the ethical standards and ensure the protection of fundamental patient rights and access to care, we strongly recommend the implementation of annual mandatory ethics training for all healthcare workers. This training should apply to frontline, administrative, and managerial staff across the healthcare system, resulting in the following benefits:
- **Ethical awareness:** Annual ethics training will promote awareness of ethical principles, ensuring that all healthcare workers have a comprehensive understanding of their ethical responsibilities toward patients, colleagues, family members, and the healthcare system as a whole.
 - **Patient-centred care:** Ethical training will underscore the importance of prioritizing patients' wellbeing, rights, and dignity in all healthcare decisions and actions. It will reinforce the commitment to patient-centred care.
 - **Legal and regulatory compliance:** Ethical training will help healthcare workers understand and comply with legal and regulatory requirements related to patient rights and access to care, reducing the likelihood of breaches and legal issues.
 - **Improved communication:** Ethical training can enhance communication skills, fostering open and honest dialogue with patients and their families. This will contribute to better-informed decision-making and greater patient satisfaction.
 - **Crisis preparedness:** In times of crises like the COVID-19 pandemic, healthcare workers will be better prepared to make difficult ethical decisions under pressure, ensuring that patient rights and access to care are upheld even in challenging circumstances.
 - **Accountability:** Mandatory training establishes clear expectations and accountability for ethical behaviour. It provides a basis for addressing breaches and taking corrective actions promptly.
 - **Continual improvement:** Annual training allows healthcare workers to stay updated on evolving ethical guidelines and best practices, facilitating a culture of continual improvement in patient care.
 - **Organizational culture:** Ethical training can contribute to building a culture of respect, compassion, and integrity within healthcare institutions, benefiting both patients and staff.

- K. **Scientific integrity:** Protect the integrity of scientific research and expert opinions. Encourage open debate and diverse perspectives within the scientific community to ensure that policy decisions are well informed.
- L. **Legislative safeguards:** Review and update emergency powers legislation to strike a balance between swift response and protection of individual rights. Ensure that such powers are subject to regular parliamentary review and oversight.

In essence, the goal is to develop a comprehensive strategy that prioritizes the health and wellbeing of citizens while respecting democratic values, individual rights, and the resilience of Canadian society as a whole. These recommendations aim to foster a society where crises are managed with care, accountability, and a commitment to the long-term welfare of all citizens.

7.2.8. The Effects of Government Pandemic Measures on Faith Communities

Introduction

When governments decided to close gathering places during COVID, it wasn't by chance or because the safety of citizens was at risk. It was according to the playbook of totalitarian regimes that authoritarian governments resort to when attempting to control the citizenry. By design, the first to close were gathering places where people could freely converse. From a bigger-picture perspective, it appeared to be all part of the plan to prevent people from discussing the motivations behind the launching of a strange flu-like pandemic—and possibly, too, in meeting, from finding ways to resist the oppressive actions of governments that followed the playbook.

Curiously, the first ordered closed were restaurants, in-person bereavement, addictions support, small businesses, schools, meeting places, and places of worship—each deemed non-essential by health authorities. Although this section primarily deals with churches and how governments used force to shut down congregant assemblies that had remained open or that decided to reopen during the pandemic, it is also a message of hope and education: that going forward, every citizen initiative, every support group, every business regardless of size or purpose, every school, and every church will always be deemed essential. Readers will also have an opportunity to understand why governments and their agencies acted beyond the scope of the law.

More important, this section on faith and churches provides a glimpse into the lives of the real heroes in Canada—the many NCI witnesses who boldly and very publicly proclaimed their very personal life experiences. These strong men's and women's actions represented a higher calling, including standing up for democratic ideals, the Constitution, an ordered society, and functioning social fabric—where men and women are free to serve others without barriers from the state. It is these individuals (and the many more voices NCI could not accommodate) that will be recorded in the history books. For it was these honest hardworking Canadians who stood boldly against persecutors and prosecutors alike.

Perhaps the next time the federal and provincial governments, the media, the judiciary, professional regulatory bodies, police forces, the public service, school boards, ministers of health, and solicitor generals act beyond their respective scope of authority, and not under the supremacy of God and rule of law, the people of Canada will stand together in unity against any and all authorities that choose not to respect the people of Canada, from which ultimately comes their power.

Why is this important? Because this democratic experiment called Canada—founded firmly under the supremacy of God and rule of law—is still worth fighting for. To this end, public policy makers need to become educated with Canada's constitutional roots—and those governing, reacquainted with representing the populace, rather than appointing non-elected bureaucrats to dictate by rule. Therefore, if the intent is to represent well, governing authorities ought to respect that every citizen, including the privileged, are not only equal and free, but on a lifelong spiritual journey.

While people's beliefs in God or a higher power may differ, what is universally true for all citizens who are not philosophical materialists is that Canadians are united in our understanding of life as being a spiritual journey. That citizens are living souls, unique beings created for a purpose, and for this reason alone, citizens require the freedom to embark upon their respective faith mission, in accordance with their personal conscience and convictions.

These same ideals and moral values inspired Canada's first Constitution. Not just religious-based traditions, as today's secular-minded might imagine, but moral values that reflected the conscience and faith of people throughout the country. It is in this spirit the framers and founders laid down a God-inspired foundation that resulted in Canada becoming a beacon of hope. The founders were determined to prevent legislative or administrative decision-makers from fettering the exercise of discretionary powers in the future. Carefully crafted checks and balances were critical in establishing the institutional pillars and framework that would prevent citizens from potentially enduring abusive authoritative governments. Legal precepts were based on the moral laws of God. Freedom and, most particularly, keeping religious freedoms safe from tyranny and dictators, was paramount. This led to Canada's founding on the supremacy of God and rule of law.

"Insofar as the dialectic between God as supreme and law as human rule is observed, maintained, nurtured, developed, and practised, Canadians will be blessed with rights and freedoms truly worthy of men and women."⁶⁴

In other words, neither the supremacy of God or the rule of law could be true unless both were equally true. A more comprehensive explanation of the significance of this point follows. But for now, any theological or political analysis intended to shape this nation should begin with God and church.

So, what is a church? Metaphorically, a church can be likened to a lighthouse. It orients ships away from coastal dangers. It also directs ships safely into harbour. In carrying out these dual responsibilities, the lighthouse illuminates a light so powerful it resonates with neighbours near and far. Nonetheless, a lighthouse is much more than an historic landmark. Ships sailing in the height of a raging storm would be lost without it. For the lighthouse keeper, never letting the light go out is much more than a job. Indeed, it can be legitimately equated with a life calling.

It is from this perspective that the figurative aspects of the lighthouse can be compared to religious and faith-based organizations. Like lighthouses, churches, too, are analogously situated as beacons of light in communities, instrumental in warning people of life's imminent dangers—both spiritual and physical. This may explain why churches strive to provide stability for congregations. Similarly, churches carry the torch of inviting people into abundant life, wherein, like the lighthouse, the light of life shines brightly.⁶⁵

⁶⁴ Polka, Brayton. *Dialectic of Biblical Critique*, 1986.

⁶⁵ John 4:14; John 5:24; John 8:12.

Further, people recognize the need for an anchor that holds during times of societal upheaval. Historically, churches have stepped into this role. Recognized as places of belonging and solace, church communities are charged with spreading the good news gospel message of the Lord Jesus Christ. Often this includes displaying faith and the love of others through charitable works. These include loving one's neighbours, taking care of the elderly and orphans, and giving so that no one within society is without.⁶⁶

But today, like many societal constructs, there are exceptions. Not every church provides spiritual direction and moral guidance. Not every religious organization believed it was wrong to acquiesce to a government-imposed moratorium on civil liberties and freedoms. For the churches consequently caught in the quagmire of COVID restrictions, several immediate concerns emerged. Specifically, the spiritual leaders and attendees of these congregations believed blind obedience to worldly governments contravened the Lord's command to assemble.⁶⁷ The authorities in Canada ignored this nation's founding principles.

Many of the congregants within churches that remained open or reopened during the pandemic cited the scriptural example of apostles Peter and John, who authorities commanded not to preach in that name. The apostles responding said, "Whether it be right in the sight of God to hearken unto you more than unto God, judge ye. For we cannot but speak the things which we have seen and heard."⁶⁸ Thereafter, the apostles continued preaching in the name of Jesus.

Other churches pointed to Romans 13. Here, apostle Paul offers a reasoned rationale for submitting to higher authorities. To paraphrase, rulers, by virtue of their office are responsible for promoting the good within society, while similarly protecting the public's interest. When churchgoers submit to governing authorities, it is because these same authorities understand the important contributions religion and churches make within communities and, by extension, the social fabric. Reverend Jonathan Mayhew offered an in-depth commentary of Romans 13 in the year 1750. He states:

Some suppose the apostle in this passage enforces the duty of submission, with two arguments quite distinct from each other; one taken from this consideration, that rulers are the ordinance, and the ministers of God (Romans 13:1-2, 4) and the other, from the benefits that accrue to society, from civil government (Romans 13:3-4, 6). And indeed, there may be distinct motives and arguments for submission, as they may be separately viewed and contemplated.

⁶⁶ Acts 2:36-41; Acts 6:1-5.

⁶⁷ Hebrews 10:25.

⁶⁸ Acts 4:19.

But when we consider that rulers are not the ordinance and the ministers of God, but only so far forth as they perform God's will, by acting up to their office and character, and so by being benefactors to society, this makes these arguments coincide, and run up into one at last. At least so far, that the former of them cannot hold good for submission, where the latter fails.⁶⁹

As alluded, the persons who are vested with authority are those who are democratically authorized to carry out their legislative duties and responsibilities on behalf of the citizenry. Who those are, the apostle notably leaves Christians to determine for themselves; but whoever they are should be obeyed. Why? Because it is not without God's permission that these are clothed with authority to cultivate good within society. This is not to suggest that rulers have their commission immediately from God, the supreme Lord of the universe, because according to Reverend Mayhew, this would border on blasphemy.

Only mind to do your duty as members of society; and this will gain you the applause and favour of all good rulers. For while you do thus, they are, by their office, as ministers of God, obliged to encourage and protect you; it is for this very purpose that they are clothed with power.⁷⁰

But what happens when these same state authorities choose to do evil, subsequently becoming a terror to good works? Historically, the Romans 13 interpretation wherein believers are taught to submit to oppressive leaders without question (also recognized historically as the divine right of kings' doctrine) is not a new impasse. For centuries, this long-misunderstood analysis has surfaced in the public square, primarily whenever a plan is underway for some governing authority to overstep its constitutional and legal authority.

Some surmise the intent of these constant resurgences of Romans 13 is to confuse and divide the church. Nevertheless, to suggest Paul's counsel to believers, translates into blindly submitting to lawless rulers acting in contradiction to their own laws, is reprehensible to many who believe there is only one King. That is, Jesus Christ, the one and only blessed Potentate, as King of kings and Lord of lords.⁷¹

⁶⁹ Mayhew, Jonathan. *A Discourse Concerning Unlimited Submission and Non-resistance to the Higher Powers*, 1750

⁷⁰ Ibid.

⁷¹ I Timothy 6:15; Revelation 19:11-16; Revelation 17:14; Deuteronomy 10:17; Psalm 136:3.

For rulers are not a terror to good works, but to the evil. It cannot be supposed that the apostle designs here, or in any way of the succeeding verses, to give the true character of Nero, or any other civil powers then in being, as if they were in fact persons as he describes, a terror to evil works only, and not to the good. For such a character did not belong to them; and the apostle was no sycophant, or parasite of power, whatever some of his pretended successors have been. He only tells what rulers would be, provided they acted up to their character and office.⁷²

Therefore, it should be obvious that when apostle Paul spoke concerning the office of civic rulers, his purpose was to encourage that which was good. It was not to dictate beliefs and practices in religious circles, or to make laws for governing men's consciences; or even to inflict civil penalties for religious crimes. Apostle Paul (formerly Saul) understood the value of an ordered society wherein God's authority is fully recognized. As a Pharisee of Pharisees, Paul was very well educated. But Paul also understood the Lord's grace: "For by grace are ye saved through faith, and that not of yourself. It is the gift of God."⁷³

Still, as the inversion of Romans 13 suggests, most scribes and pharisees were non-believers, recognized as heathen when it comes to faith, and therefore, relentless enemies of the Lord Jesus and the beliefs of faith-based Christianity. After Paul's conversion, the apostle himself suffered reproach. He was repeatedly imprisoned, beaten with rods, stoned, shipwrecked, in perils of waters, in perils of robbers, in perils of the heathen, and even in perils of his own countrymen. Wherever Paul travelled, he was at significant risk—in the city, in the wilderness, and in the sea.⁷⁴ While Paul repeatedly suffered at the hands of tyrannical-type rulers, he was not about to give these same rulers the authority to exterminate the Christian faith. Didn't Paul repeatedly preach against the idolatries and superstitions of paganism which resulted in the promotion of evil?⁷⁵ Reverend Mayhew asks the same question.

⁷² Mayhew, Jonathan. *A Discourse Concerning Unlimited Submission and Non-resistance to the Higher Powers*, 1750.

⁷³ Ephesians 2:8-9.

⁷⁴ Mayhew, Jonathan *A Discourse Concerning Unlimited Submission and Non-Resistance to the Higher Powers; With Some Reflection on the Resistance Made to King Charles 1. And on the Anniversary of his Death: In Which the Mysterious Doctrine of that Prince's Saintship and Martyrdom is Unriddled*. 1750.

⁷⁵ II Corinthians 11:21-27.

Can anyone reasonably suppose that the apostle had any intention to extend the authority of rulers, beyond concerns merely civil and political, to the overthrowing of that religion which he himself was so zealous in propagating. But it is natural for those whose religion cannot be supported upon the footing of reason and argument, to have recourse to power and force, which will serve a bad cause as well as a good one; and indeed, much better.

There are additional reasons why certain churches challenged health orders. First, the scriptures dating back to the beginning of civilization are full of examples of good governance. Canada's parliamentary practices and laws are firmly grounded in biblical text. The election of leaders through a democratic process also emanates from the Bible. Some prime examples include the selection of seven table servants to look after the widows and orphans;⁷⁶ the replacement of the disciple who betrayed Jesus in the Garden of Gethsemane⁷⁷; the Israelites desiring an earthly king to rule over them;⁷⁸ and when God instructed Adam and Eve to be good stewards over the land.⁷⁹

The Old Testament offers a further example whereby the Lord God raises seven of twelve judges for the explicit purpose of saving His people out of the hands of raiders.⁸⁰ One of these judges was a woman named Deborah. Therefore, the right of resistance, and by extension, the right of believers to resist the usurpation of power by tyrannical authorities has its origin in scriptures as well.

The point being the right of people to depose a ruler whom they find oppressive was established very early in the scriptures. There were also acts of peaceful civil disobedience. In Moses' time, for example, the midwives were ordered to kill all Hebrew male newborns. When called to give an account before Pharaoh, these midwives pointed to the Hebrew women giving birth before the midwives could arrive.⁸¹ There is more:

⁷⁶ Acts 6:1-15.

⁷⁷ Acts 1:12-26.

⁷⁸ I Samuel 8:4-22.

⁷⁹ Genesis 1:28; I Peter 4:10.

⁸⁰ Exodus 18:13-17; Judges 4:4-5:15; Judges 2:16-17; Deuteronomy 16:18-22; Judges 11:27; II Chronicles 36:15; Amos 3:7; Judges 7.

⁸¹ Exodus 1:15-21.

If those who bear the title of civil rulers, do not perform the duty of civil rulers, but act directly counter to the sole end and design of their office; if they injure and oppress their subjects, instead of defending their rights and doing them good; they have not the least pretence to be honoured, obeyed, and rewarded, according to the apostle's argument. For his reasoning, in order to show the duty of subjection to the hither powers, as was before observed, built wholly upon the supposition that they do, in fact, perform the duty of rulers ... exalted to bear rule; and as magistracy duly exercised, and authority rightly applied, in the enacting and executing good laws.⁸²

In this context, laws have two purposes. The first is to ensure the common welfare and best interests of the people comes to fruition. Second, the laws must be agreeable to the will of the beneficent author and supreme Lord of the universe; whose King of kings⁸³ rules over all: and whose tender mercies are all over His works.

To suggest tyrants are God's ministers would be particularly corrupting when these same rulers oppress the citizens they are called to represent. The Scriptures again point to the example of the Israelites in Egypt. The Israelites had asked for time off from their brick-making responsibilities to worship their God. Pharaoh decided that if all the Israelites could think of is worshipping God, then perhaps, they needed to fetch the straw, too, for making bricks. Up until this point, the Egyptians would bring the straw.⁸⁴ In today's world, it could be likened to the constant increases in taxes. Whatever way the example is discerned, it is important to observe these authorities had stopped submitting to the ordinance of God. This meant, in turn, failing to rule for the good of all people.

Over time, philosophers and scholars shifted their focus. Rather than question whether Christians have a right to oppose unjust laws, the reasoning moved to the justice or injustice of the laws on their own merit. Ironically, the conclusion, "A law which is not just does not seem to me to be a law."⁸⁵ This same premise is confirmed again in section 52(1) of the *Canadian Charter of Rights and Freedoms*, which states, "The Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect."⁸⁶

⁸² Mayhew, Jonathan. *A Discourse Concerning Unlimited Submission and Non-resistance to the Higher Powers*, 1750.

⁸³ Revelation 19:6.

⁸⁴ Exodus 5:6–20.

⁸⁵ Augustine of Hippo. *The City of God*; Cicero, Marcus Tullius. *De Republica*; Aquinas, Thomas. *Summa Theologica* [De civitate Dei]. January 1, 426.

⁸⁶ Charterpedia—Section 52(1) of the Constitution Act, 1982—The supremacy clause (justice.gc.ca).

As stated previously, the preamble to the Constitution formally recognizes Canada is founded upon principles that recognize both the supremacy of God and rule of law. This means every right and freedom guaranteed within the Charter are formally declared to be founded upon these two principles. Together, these prefatory words are the grounding point which inevitably holds this nation together. It is equally important to note the founding fathers relied on the same tenets in establishing Canada's original Constitution, the *British North America Act* (BNA).

In the interest of clarity, it is important to understand that the supremacy of God and rule of law must concurrently hold true. If neither aligns perfectly—or there is a movement of either the supremacy of God or rule of law taking precedence over the other—the result is a broken democracy. Why? Because the rule of law is no longer subject to the supremacy of God (spiritual) and vice-versa: the supremacy of God is no longer beholden to lawful interpretation (political/judicial).

Without both being subject to the other, the elevation of the rule of law leads to tyrannical authoritarian governments which then insist any new law created, even those laws which are absolutely immoral, must be obeyed. Conversely, without the supremacy of God, there lacks an understanding of a much higher law, a spiritual law, that emanates from knowing there is a hereafter.

When Benedictus Spinoza wrote *Theologico-Political Tractatus*, he argued the Bible, as the sovereign cause of itself, must be interpreted separately on its own terms. Therefore, the Bible cannot be subordinated to a conception of reason, which in this case, would be viewed as a political authority, which is neither superior or inferior to it, either its master or its slave.

For religion, and Christian assemblies in particular, the moral laws of God are not written on tablets of stone or established through legal precedent but penned in individual hearts. Thus, the separation of governance and religious powers is, by virtue of their respective roles, completely independent from one another. This distinct separation is fully understood, since both pillars must, by design, remain fully accountable to both God as supreme and the rule of law. Further, as the framers of Canada's founding Constitution, the *British North America Act*, reveal, church responsibilities to the state are not described. Only the state's obligatory duties to the public are specifically defined. Interestingly—but not surprising, given the original founder debates—the BNA remained silent on the status, authority, and responsibilities of religious institutions within the union. At its root, the duty of the state is neutrality.

For clarity, the law of neutrality refers to the legal principles and regulations that govern the behaviour of states during times of conflict.⁸⁷ Neutrality is the state of not taking sides but, instead, maintaining an impartial stance, and that essentially means not favouring one party or perspective over another. In Canadian constitutional jurisprudence, this means the state has an obligation and responsibility to ensure its laws or policies do not unduly burden the practice of religious freedoms. Taken one step further, the state is prevented from enacting laws that result in favouring, or conversely, heavy-handedly burdening one religious belief system over another.

While the rights and freedom provisions in both the historical documents and the Charter apply equally to both religious and non-religious, secular and non-secular persons alike, it quickly became evident during the COVID pandemic that the safeguards, protections and fundamental principles afforded to every citizen equally were increasingly denied to the only congregants the state viewed as a threat to its current and evolving state ideologies.

Perhaps, here, it should be stated that while representatives of every religion and faith group were invited to testify at NCI, it was primarily those of the Christian faith who chose to do so. This was not a premeditated design or some one-sided agenda to stack the deck. It is just what happened. Further to this point, it should be acknowledged that newcomers and immigrants to Canada might have been afraid to publicly speak because in the countries from whence they came, airing one's views publicly could inevitably result in danger or death.

Regardless of religious (or non-religious) affiliations, all Canadians should recognize that any limitation imposed by the state on even one single Charter freedom can be no greater than necessary or, by extension, must be demonstrably justified by those that govern. As background, the *Canadian Charter of Rights and Freedoms*, enacted in 1982, forced all governments to revise laws that were contrary to the Charter by 1985. The citizenry presumed, going forward, that any law enacted after 1985 would remain consistent with Charter provisions, and therefore, for the most part, was not concerned that their constitutionally protected rights and freedoms would ever be jeopardized.

The Charter guarantees citizens more than one freedom. Every citizen, for example, has the right to hold and practice their deeply held beliefs without interference or disruption by state authorities. Other protections include freedom of thought, opinion, belief, conscience, and expression. Accommodation and equality rights correspondingly prohibit discrimination.

⁸⁷ Scott, F.R. *A Policy of Neutrality for Canada*, January 1939.

However, the terms of citizens' rights and freedoms were arbitrarily changed with the introduction of emergencies legislation in Canada. Formerly known as the *War Measures Act*, the *Emergencies Act* granted the federal government expanded powers that go beyond the scope of acceptable laws and regulations within Western democracy. While the *Emergencies Act* covers a wide range of emergencies—including war, invasion, and insurrection—this Act was written to suggest emergency powers can be invoked when government(s) believe the situation cannot be adequately managed through existing laws and resources.

The procedure for declaring an emergency in Canada is this: the Act requires the Governor-in-Council (cabinet) to declare that a state of emergency exists. This declaration must outline the nature of the emergency and specify to the public the powers that governments plan to exercise. Depending upon the severity of the emergency, the authorization presented to the public by governments may restrict the ability of citizens to carry on their day-to-day activities. To prevent abuse, the emergency declaration must be reviewed on a strict cyclical timeline. Likewise, any restrictions on the populace are subject to judicial oversight and must be consistent with Canada's constitutional rights and freedoms.

As we heard from NCI witness testimony, the concerns cited by all levels of government in the beginning of the COVID pandemic may have warranted some societal restrictions, but it didn't take long before the truth began to surface. Was COVID a national emergency such as war, insurrection, or an invasion? Did COVID threaten the populace? Or was it a hoax? As one witness asked, "What is the point of strict distancing in the airport, only to crowd everyone into a plane like sardines in a can?" Another witness asked why COVID restrictions for air travel were lifted in the United States months ahead of Canadians. Yet another witness simply asked, "Is this Canada?" Certainly, the contradictory rules raised numerous questions.

Around this time, pockets of citizen resistance across Canada began to emerge. A number of churches decided to open their doors and stand in the gap for all Canadians. Like the founders of this nation, the churches wanted to ensure the inherent, God-given rights and freedoms of all citizens remained intact. This included the right of all Canadians to attend religious services, to worship God, and to be fully accommodated when state policy priorities transcend personal convictions and conscience. The overarching rationale? That within the spirit of the law, any attempt by the state to impose another authority over the church (including governments) translates into undermining the authority of Jesus Christ as the head of the body of Christ Church, which cannot be tolerated.⁸⁸

⁸⁸ Ephesians 1:22-23; Psalm 118:22; Ephesians 4:8, 12; Ephesians 5:23; I Corinthians 11:3; Colossians 1:18; Psalm 68:18; Colossians 2:10.

As alluded to previously, this inalienable right to worship the Lord not only predates the founding of Canada but has, from the beginning, been instrumental in nations receiving the Lord's blessings. As the framers of this nation ultimately decided—when they intentionally chose a unique, one-of-a-kind correlation for church and state within the Canadian political landscape—only He determines the standing of His Church.⁸⁹

Not to be outdone, federal and provincial authorities have more recently relied on a self-serving interpretation of section 1 of the Charter, which ironically, gives deference on all judicial matters to the ruling government. It is at this juncture that the witness testimony becomes even more meaningful in shaping the relevance and necessity of the modern-day church to stand in opposition to a lawless state.

Equally significant are the innumerable negative consequences that emerged within the social fabric when churches became noticeably absent from the societal constructs. Like the ships seeking guidance from a lighthouse keeper amid a rampant, late-night storm, multitudes of people needed an anchor to secure themselves and family members in the societal turbulence caused by COVID measures. Sadly, the spiritual guidance and support the populace sought could rarely be found. Were government authorities successful in their quest to extinguish the light displayed via faithful assemblies? Or was the Constitution simply rules that have been papered over? It is from these perspectives and many more that long-lasting and satisfactory remedies must be found.

Canada's Historic Beginning

Canadians understand intuitively that a Constitution is a corpus of fundamental law that must, by definition, be subject to the control of those whose lives it regulates. And, similarly, that constituents in Canada are not subservient to the arbitrary whims of dictators, whose motivations include oppressing the populace. Even before Canada was founded as a nation, churches responsible for spiritual matters operated separately from legislated government institutions. Or, as the Scottish used to sing, "Never the twain shall meet."⁹⁰

This ideal was a priority for the initial framers of this nation. These practical men, (who were often claimed to be pragmatists), understood democratic principles well and, as such, envisioned a future remarkably unique from what they had known from the past. This was evident from the lengthy debates and deliberations which followed: on self-government, representative institutions, security of property, the rule of law, the framework of democratic ideals in a new land that to them must include freedom of conscience, individual rights, and responsible governments that guarantee at its very core political liberty and equality.

⁸⁹ John 18:28; Acts 5:29; I Peter 2:13-17; II Chronicles 7:14.

⁹⁰ Lang, Andrew. "The Bonnie Banks of Loch Lomond." 1746-1876.

Undoubtedly, the founding fathers firmly believed themselves to be free men. This is evident from the dialogues regarding conscience and liberty within the constitutional framework of a responsible parliamentary government. Although the status of the church within governments and society had yet to be established, its institutional importance was integral to the discussions that took place.

As Reverend Mayhew preached, "Let us all learn to be free, and to be loyal. Let us not profess ourselves vassals to the lawless pleasure of any man on earth ... [instead] be loyal to the Supreme Ruler of the universe, by whom kings reign, and princes decree justice. To which King eternally immortal, invisible, even to the only wise God, be all honour and praise, dominion, and thanksgiving through Jesus Christ our Lord. Amen."⁹¹

He further claimed that any citizen advocating for unlimited submission or passive obedience to a king or monarchical government wherein those in authority have a divine right to do whatever they please whenever they want, to the point where no one can resist, is misled. But the reverend does not stop at the divine right of kings doctrine,⁹² as being only applicable to the king. He also includes all subordinate officers acting beyond their commission and the authority. Today, the equivalent of subordinates would be the public service.

Equally key to the prevailing mindset at the time (and very different to our post postmodernism era) was the understanding that hardly anyone would have argued against imposing consensual standards within a community, even when they extended to the private conduct of consenting adults.

⁹¹ Mayhew, Jonathan. *A Discourse Concerning Unlimited Submission and Non-resistance to the Higher Powers*, 1750.

⁹² Divine right of kings is a political doctrine in defence of monarchical absolutism, which asserted that kings derive their authority from God and could not therefore be held accountable for their actions by any earthly authority such as parliament or the legislature. The bishop Jacques-Benigne Bossuet (1627-1704) was one of the principal French theorists of divine right, asserting that his power was modelled on that of a father's and was absolute, deriving from God; and that he was governed by reason. Anti-absolutist philosopher John Locke (1632-1704) wrote his *First Treatise of Civil Government* (1689) in order to refute such arguments.

While the obvious imminent concern was the very real possibility and threat of dictatorial rulers and writing a Constitution that would prevent tyrannical government from coming to power, the founding debates represented a much broader intersection—which included the preservation and practice of liberty and religion. For example, T.L. Wood described *liberty* as inalienable rights.⁹³ An inalienable right is usually characterized as one that may never be waived or transferred by its possessor.⁹⁴ For example, the right to life, liberty, and security. These differ from forfeitable or absolute rights.

“The natural liberty of man is to be free from any superior power on earth and not to be under the will or legislative authority of men but to have only the law of nature for his rule.”⁹⁵

Interestingly, William D. Lawrence was opposed to Confederation, calling the proponents of a unified country traitors and enemies. Further to the point, he said in 1884, “All great results have been the result of years of thought and care . . . there is nothing like a stiff opposition for a man to succeed . . . Kites rise against, not with the wind.”⁹⁶ Nevertheless, he proclaimed the spirit of liberty as forever being heard wherever it exists, and that limiting a person’s freedom would never satisfy a free people.⁹⁷

Charles Tupper, for the most part, agreed with both colleagues, firmly believing both civil and religious liberty is needed to be enjoyed by all. He added that he himself would be happy knowing there existed no hostility between different religions.⁹⁸ And Frederick Brecken ventured even further, pointing to self-government as the greatest blessing of all because he could now worship God as he pleased. But after some reflection, he also later queried if becoming part of the dominion would at some point in the future, jeopardize this inherent religious freedom.⁹⁹

⁹³ March 10, 1870.

⁹⁴ Liberty is the exemption from extraneous control; freedom: the power or liberty to order one’s own actions; the power of the will in its moral freedom to follow the dictates of its unrestricted choice and to direct the external acts of the individual without restrain, coercion, or control from other persons.

⁹⁵ Locke, John. *Second Treatise of Government*, 1689.

⁹⁶ Moore, Marven. *The Nova Scotian*, January 12, 1884.

⁹⁷ Lawrence, William D. *The Nova Scotian* (Halifax) January 12, 1884.
Written by Marven Moore. 1883.

⁹⁸ March 28, 1864.

⁹⁹ March 8, 1870.

A similar sentiment was reiterated by John McMillan when confronted with anti-Christian and unphilosophical excess. Here he pointed directly to Scripture, asking his opposers, who said this line: "And hath made of one blood all nations of men for to dwell on the face of the earth, and hath determined the times before appointed, and the bounds of their habitation, that they should seek the Lord, if haply [sic] they might feel after Him, and find Him, though He be not far from every one of us."¹⁰⁰ For those who may not understand the question to Mr. McMillan, this scripture refers to the God of the Bible who desires that we seek after Him.¹⁰¹

Others, like W.H. Pope, would be happy to see the province he represented, Prince Edward Island, unite with neighbouring provinces if it would result in the Protestant population having less cause to dread popish supremacy, that religious animosities would weaken, and ultimately great good would become the consequence.¹⁰²

Still another, Robert Pinsent, advocated enjoying the privileges of Britain's unwritten constitution [the British constitutional conventions] in its full perfection, without blot or blemish. But Pinsent also wanted an education system that offended none, the fullest measure of civil liberty, and perfect freedom and equality in religion, where the exercise of constitutional government can be better and more effectively applied.¹⁰³

What does all this mean? Taking together, the original framers wanted the Constitution to be legitimate in the public's eyes. The priorities were twofold. The first was how to prevent tyrannical persons from gaining governing authority; and the second, the intertwined connection between churches and state, and civil liberties. This should not be surprising. After all, these men (based upon their own personal convictions), wanted the particular religious institutions they cherished to continue. However, they also understood the underlying necessity that within broader society, this also included respecting the religious traditions of others as well.

¹⁰⁰ Acts 17:26.

¹⁰¹ June 5, 1865.

¹⁰² April 18, 1864.

¹⁰³ February 3, 1869.

To this end, religious liberty was repeatedly discussed in the context of responsible government. Notably, at length. Many sided with John Locke's arguments¹⁰⁴ that all legitimate government rests upon the consent of the governed, and therefore, the government is beholden to the people. Locke is famous for suggesting church and state should be separate. Perhaps, to a greater extent, that religion and religious distinctions should be banned altogether from operating side-by-side with governments within the political sphere. In essence, this meant politics and the leaders within political systems should be concerned with the people's legal rights and material welfare. Period. But the leaders had no authority over the hopes and fears associated with spiritual matters, and the life hereafter.

Others joined in the discourse. For Richard J. Cartwright, there were two issues that could lead to the loss of liberty. The first situation occurs when hereditary rulers from aristocratic and oligarchic backgrounds manage to attain positions of power within the governing body. The second is when rulers professed to represent the people so they could obtain power but, then, later exploited them, essentially making rules in defiance of the people's wishes. More to the point, he opposed governments taking actions that fail to protect minorities and individuals from authoritative overreach.

Mr. Cartwright went on to say: "I think that every true reformer, every real friend of liberty will agree with me in saying that if we must erect safeguards, they should be rather for the security of the individual than of the mass and that our chiefest care must be to train the majority to respect the rights of the minority, to prevent the claims of the few from being trampled underfoot by the caprice or passion of the many."¹⁰⁵

From these multifaceted commentaries, it was evident that any direction taken toward the establishment of a Constitution for a Dominion from sea to sea to sea must involve steering away from the possibility of tyrannical dictators. From this stance, the following question is asked: Should there be some basic rights ascribed that no amount of majority can trample? Isn't this the gist of the Constitution?

George-Étienne Cartier considered the underlying motivation that had made England great, comparing it to the vision he wanted to see Canada embrace. He asked, "Had the diversity of race impeded the glory, the progress, and the wealth of England? Had they not rather each contributed their share to the greatness of the Empire? ... In our own federation, we should have Catholic and Protestant, English and French, Irish and Scotch, and each by his efforts and success would increase the prosperity and glory of the new Confederacy."¹⁰⁶

¹⁰⁴ Locke, John. Second Treatise of Government. 1689.

¹⁰⁵ March 8, 1865.

¹⁰⁶ Cartier, George-Étienne. February 9, 1865.

Looking into the future, T.L. Wood asked, "What would happen if Ottawa were ever so amiable and ever so pure that the moment citizens felt the yoke tightening, would the people repent?"¹⁰⁷ For those not as familiar with the Scriptures, the term *revolt* may seem like a better fit than the word *repent*. By way of explanation, the people of Israel in the Old Testament often turned to the worship of small gods and idols. Whenever the Israelites did this, their nation would stop prospering. Many times, this led to the Israelites becoming slaves. When they finally repented and asked the Lord God's forgiveness, Israel would become a blessed nation again. Mr. Wood's reference then suggests that when Ottawa tightens the yoke, it's because the people have turned away from the Lord God, and the only way to return to becoming a blessed nation is by recognizing, once again, God as supreme.

John Sanborn concluded that to render a constitutional obligation secure, it must first be in the hearts of the people. He, too, asked the question: "Why was it that the English had always resisted attempts upon their Constitution?" His response? "Because every link of the great chain had been conquered by resistance to oppression, and by sacrifices of blood, by resistance to royal exactions and assumptions, and these achievements were preserved, held dear, understood, valued, and clung to with all the tenacity of that great people's nature. This was the reason why it rested upon such a solid foundation, why it had endured so long and was likely to endure forever."

All this to say that within the founding debates, there was considerable latitude to discuss the status of religion within the context of responsible government. Unlike the U.S., where the separation of church and state are clearly defined constitutionally, Canada created a distinctive Constitution, the *British North America Act*, which remained completely silent on the standing of churches. Translated, this meant the founders, as ardent defenders of religious liberty, had no intention of churches becoming subject to temporal governments and popish-type supremacy.

Certainly, the founders had choices. It wasn't like the topic of religion, faith, and Christian conscience was not on the table. It most certainly was. Yet, when the founding constitutional documents were signed, any reference to church status was nil. In effect, the BNA was wholly about governance in the physical realm, yet nothing was defined in the spiritual.

This non-acknowledgment of the church was further confirmed in the 1982 *Charter of Rights and Freedoms*. Think of the rule of law, and God, and the federal and provincial powers as separate pillars. Each can be likened to a pillar, but in Canada these pillars do not intersect. If they did, they would not be pillars. When federal and provincial powers overlap, the federal power has supremacy. Similarly, the Constitution, under the supremacy of God, has supremacy over federal powers. This is why the Constitution defines federal power. Therefore, the status of the church, from the viewpoint of citizens, has not changed since the founding of the nation in 1867. The Charter simply reaffirmed the position of the authors who initially created the *British North America Act*.

¹⁰⁷ March 10, 1870.

Again, the Canada Constitution inclusive of the Charter does not define church and state as interrelational. What the Charter does do is rightly reaffirm the constitutional guarantees and protections of churchgoers. As Canadian citizens, these congregants have the same rights as other citizens to freely assemble and associate. By extension, congregants from all faiths (or non-faiths) can freely worship without opposition or disruption from governing authorities.

The underlying premise, then, is simple: state authority starts and stops with the administration of justice and fair laws. Government responsibilities extend solely to ensuring orderly social structures are maintained, as it pertains to the life, liberty, and security of the populace it is installed to represent. As evidenced, the BNA clearly defines the powers allotted to federal and provincial jurisdictions. Section 91 of the BNA defines the federal and provincial powers.¹⁰⁸

Conversely, the body of Christ Church is solely responsible for overseeing spiritual matters under God. These are not intertwined responsibilities wherein the church shares these obligations with governments. Neither are these overlapping responsibilities where the prevailing government could assume a fine line between government's obligatory duties and the churches' spiritual authority. In actuality, the silence between these two pillars concludes the state has no authority to bind men's consciences because all authority, including the power to forgive sins was already wholly given to Jesus. As the Scriptures state, "And ye shall call His name JESUS, for He shall save His people from their sins."¹⁰⁹ Even more obvious, the founders of this great nation had no desire to make churches subject to government.

Therefore, neither government, the judiciary, or state actors can demand Christian churches in Canada—or for that matter, any church or religious institution—comply with government dictates through arbitrary or heavy-handed actions. Alternatively, as witnessed during the COVID pandemic, this could involve civic authorities and law enforcement selectively focusing on religious organizations and outdoor religious gatherings whose beliefs they personally oppose.

Why not? Because the separation of governance and religious powers is, by virtue of their respective roles to the populace, completely independent from one another. There is a distinct separation, even though both pillars are fully accountable to God and rule of law—institutionally distinct because church responsibilities to the state are not defined. Only the state's obligatory duties to the populace are strictly defined.

¹⁰⁸ Section 91 of the *British North America Act, 1867*, now the *Constitution Act, 1867*, grants broad powers to the federal government. Its legislative goal is to ensure the peace, order, and good government of Canada. In relation to all matters not coming within the classes of subjects by this Act assigned exclusively to the Legislatures and the Provinces, Parliament would have power over matters of national interest. Issues of regional interest would be given to the province.

¹⁰⁹ Matthew 1:21–23; Matthew 28:18.

So again, what is the church? For Bible-believing churches, there is a strong emphasis on faith and salvation. There isn't one specific religious denomination universally associated with Bible believers. Instead, it's a broad term that incorporates various evangelical, charismatic, and independent faith-based assemblies.¹¹⁰ Traditionally, these churches emphasize the Lord Jesus as King of kings and Lord of lords, and the Bible as the supreme authority for its beliefs and worship.

Moreover, faith is considered a central tenet.¹¹¹ As well, the emphasis is that salvation can only be obtained through Jesus Christ as Lord and Saviour.¹¹² In alignment with Jesus' teachings, these highlight the power of a believing faith in Him, which in turn, leads to miraculous healings, both physically and spiritually. For example, the Scriptures point to apostle Peter's shadow healing the sick lying on the roadside as he passed by. Apostle Paul regularly cast out demons from people considered to be insane or mad by society. It is within this context that Bible-believing churches tend to be stronger and more united, both internally as a church and within the community at large. Jesus' commandment to love one another is a strong component of Christian faith, which often leads to varying forms of evangelism and sharing the Lord Jesus with others.

It should also be stated that not every NCI witness who testified held a Bible-believing worldview or faith to the same degree. This aspect alone signifies the magnitude and breadth of the religious community identified as Christian. This too should prompt an understanding that God did not create cardboard cut-outs. Neither does being created as equals negate everyone possessing a singular uniqueness and purpose. This may explain why painting all Christians with the same brush does not work.

Still, it is remarkable that the testimony collectively led to the same questions, primarily: How were governing authorities able to justify the lockdowns? Where were the churches? And what can believers now do to pick up the pieces of a fragmented social fabric?

Perhaps, understanding how the witnesses viewed church may help. For Wesley Mack, Hon. PhD, church was a fellowship of believers who come together for a common cause—where people who desire teaching and learning can receive spiritual nourishment and, without the threat of external deterrents, can enjoy social interaction with co-worshippers and the pastoral community. Equally significant within the church are the numerous outreach initiatives that support the broader community and demographics at large and, most particularly, cater to the most vulnerable.

¹¹⁰ Colossians 2:19; Ephesians 2:29-31; I Corinthians 12:13; Colossians 1:18; Ephesians 1:22.

¹¹¹ Acts 4:12; John 14:6; I Corinthians 15:14; Hebrews 11:6.

¹¹² Ephesians 2:8-9; Hebrews 12:22; II Corinthians 5:7.

Gospel minister Tobias Tissen added to this definition. He maintained that a church provided a much-needed avenue for socializing and getting together, which includes the exchange of both social and spiritual dialogue. From the church perspective, both he and the congregants who attended felt an obligation to continue gathering. To this end, the church had a duty and responsibility to fulfil scripture and, similarly, not forsake the assembling of the saints, in accordance with the Scripture Hebrews 10:25.¹¹³

Other ministers, including Rev. Randy Banks, highlighted the importance of offering spiritual nourishment to patients in hospitals and long-term-care facilities. He reiterated the value and importance of God at the bedside, particularly when, traditionally, this would be a time when people would be at their lowest. But as Mr. Banks also pointed out, spiritual sustenance and healing is not only for palliative patients facing imminent death but also offers much-needed spiritual support for family members and close friends as well.

On this point, Mike Vogiatzakis had an epiphany. Amid a funeral for a six-year-old boy, the police threatened fines if he exceeded gathering limits. An uncle of the boy confronted the director, asking, “What kind of a man are you to keep me from seeing my nephew?” It was here that Mr. Vogiatzakis’ compassion led to inviting both this man and all those waiting in the parking lot to attend the boy’s funeral. He believed that if all the churches had stayed open throughout the pandemic, there would have been fewer deaths. His conclusion? “If we get prosecuted [sic] [persecuted] on earth for doing the right thing, we have another life to live afterwards.”

Jérémie Miller raised concerns that the COVID measures implemented by government were causing division in the community. Early on, he began to question conflicting government messaging, particularly the mantra that suggested it was the citizen’s fault Canada is still coping with a pandemic. He was not an anti-vaxxer. He received the first COVID vaccination. When he returned to get his second vaccination, nurses told him he should consult a doctor. This was because he had experienced side effects after the first vaccination. Big picture, he said church obligations include standing against oppressive policies. He referred to his religious practice and his belief in the right to be protected to live his faith without barriers.

The personal convictions of pharmacist Camille Mitchell led to submitting a notice of liability and a declaration of faith to her employer, the president of Island Health, and the president of the Health Sciences Association. She had been a pharmacist for 26 years. She applied for a vaccine exemption. She was hoping her religious exemption would be approved. However, Ms. Mitchell’s employer never acknowledged her religious exemption. Similar to many other NCI witnesses, religious [and medical] exemptions were either very difficult to get or these were not being honoured.

¹¹³ Hebrews 10:25.

One of these witnesses was nurse Grace Neustaedter, who testified of her strong personal faith. She held a master of science in nursing. In the beginning of COVID mandates, Ms. Neustaedter thought the vaccination was a reasonable precaution. Because of her research and knowledge, she also knew a vaccination would take five to ten years to be properly tested. She soon realized the required clinical trials and Informed Consent could not happen within the COVID time frame. She also heard health professionals denigrating the unvaccinated, even when these same patients could hear them. She eventually walked away from the career she loved. The irony was, on the same day she was prohibited from setting foot on Alberta Health Services property, she received her 40-year employee recognition plaque.

Ms. Neustaedter's religious exemption was denied. She never even heard back from her employer after the exemption was received. She did hear that only one exemption was accepted, and this was for a non-Christian. Ms. Neustaedter continued to attend the same church her family had participated in for more than 40 years. She was surprised people didn't question the COVID restrictions. Some said it was all part of God's plan. Others swore at her husband, who physically couldn't wear a mask. She observed that people were more concerned about their own health and welfare than what Jesus would want them to do. They began attending a new church that had intentionally remained open.

Brandon Pringle also felt a firm commitment to religious freedom. In his case, he was persuaded that like-minded believers should not be prohibited from gathering. As he testified, he spoke to the societal breakdown that occurs when churchgoers are prohibited from meeting. Prior to COVID mandates, Mr. Pringle's family was very close. Family and church events were a regular component of family interactions. They all attended the same church. When the mandates went beyond the two weeks to flatten the curve, Mr. Pringle spoke with his adult children. From a faith-based perspective, he outlined his concerns about emerging tyrannical mandates. They agreed to disagree. He didn't realize how bad it was going to get. At one point, his son-in-law claimed the reason COVID continued was because the unvaccinated would not comply. Using propaganda, the media had launched a campaign intended to target the unvaccinated. Mr. Pringle was saddened that his once close-knit family was becoming divided.

Patrick Allard was a member of the Manitoba Group of Five. He organized his first protest on May 9, 2020, in front of the Legislature. He called the rallies "mental health rallies" because it brought people together so they were not alone. He missed church so he attended an outdoor drive-in church. He was arrested for shaking hands and hugging people. He said he was treated like a criminal by the police. His bail conditions stated he could not communicate with certain people. He compared the rallies to the government-approved Manitoba Hydro Union and Black Lives Matter demonstrations. He said these were scheduled during COVID mandates too. The difference? There were no arrests in the latter government-approved demonstrations.

Mr. Allard thought Canada might go down this path again in the future and thus, in his opinion, there's nothing Canadians can do but continue to stand. It doesn't help, as witness Mr. Pardy pointed out, that the courts were dismissing the evidence of those challenging the rules, or that the constitutional rights and freedoms of citizens were not being honoured by the courts. The question for Mr. Allard then was simple. If the courts were not willing to sort out COVID rules because it would be similar to serving a political function, perhaps it was time for God to intervene.

Dr. Gerald Bohemier said red lights began flashing when everything he had learned in science and in his profession as a chiropractor was contrary to the government messaging on COVID. When attending rallies, he observed a constant police presence. The police recorded the attendees. He was arrested and, from his testimony, not treated very well. The legal protections put in place to protect citizens from unnecessary detainment were not available. He spent the night in jail.

Dr. Bohemier also attended a drive-in church. He knew church services were purposeful and the rights of citizens constitutionally protected. Therefore, religious services could not be interrupted by government authorities. Ironically, Dr. Bohemier was led to remind the police of *Criminal Code* 176, which prohibits any person from obstructing officiating clergyman, disturbing worship or meetings wherein an assemblage of persons meets for a moral, social, or benevolent purpose. He alluded to the police officers committing a crime. Section 176 specifically states:

Obstructing or violence to or arrest of officiating clergyman

- **176 (1)** Every person is guilty of an indictable offence and liable to imprisonment for a term of not more than two years or is guilty of an offence punishable on summary conviction who **(a)** by threats or force, unlawfully obstructs or prevents or endeavours to obstruct or prevent an officiant from celebrating a religious or spiritual service or performing any other function in connection with their calling, or **(b)** knowing that an officiant is about to perform, is on their way to perform or is returning from the performance of any of the duties or functions mentioned in paragraph (a) **(i)** assaults or offers any violence to them, or **(ii)** arrests them on a civil process, or under the pretence of executing a civil process.
- **Marginal note: Disturbing religious worship or certain meetings (2)** Everyone who wilfully disturbs or interrupts an assemblage of persons met for religious worship or for a moral, social, or benevolent purpose is guilty of an offence punishable on summary conviction.
- **Marginal note: Idem (3)** Everyone who, at or near a meeting referred to in subsection (2), wilfully does anything that disturbs the order or solemnity of the meeting is guilty of an offence punishable on summary conviction.

Pastor Steven Flippin described how *Criminal Code* 176 was breached when the church he was involved with reopened. Two factors contributed to the decision. First, if the legislature was willing to delegate their rule-making authority to unelected officials and, likewise, the church fell outside of the government and judicial jurisdictions, it only made sense for the church to restore its servitude status of helping others. Relying upon the Scripture in Hebrews 10:25, Mr. Flippin said Christ commands us not to be subservient to government. Indeed, he reaffirmed Christ's desire that we all come to Him.

It should be said, however, the decision to open was not made in isolation. Both the elders and church members consulted together. In time, both the police and health authorities were knocking at the door. Fines were issued. He was told that no court would accept *Criminal Code* section 176 in the same way the church interpreted it. Even though statutes are in place to protect the church from those who would obstruct services, this did not stop the authorities from spying on the church. Eventually, the church was prosecuted and Pastor Flippin forced to take the fines personally. Nevertheless, he said there were wins: attendance doubled; those who attend include young families, new immigrants, and everyday Canadians.

But not everyone was a winner. Mildred Kucher, a woman in her 90s, regularly attended church. Pre-COVID, she was constantly socializing with family and friends. In this regard, the church was more than just a place to go but essential. It might be important to note here that Ms. Kucher was a social butterfly. In fact, as her daughter suggested, it was difficult to get an appointment to see her. Of course, when the churches closed, everything changed for Ms. Kucher. She had always said she didn't want to die of loneliness, but in the end, it was loneliness that led to her passing. For so many reasons, David Leis' testimony hit the nail on the head. Never before in the history of Canada has there been such a policy disaster. "Canadians relied on institutions on the assumption that they would serve them, but instead they were let down."¹¹⁴ Through no fault of her own, Ms. Kucher had become a casualty.

Witness Don Woodstock ventured down a different road. He was so adamant that churches were essential and, therefore, should be open that he started a petition that would pave the way for church congregants to hold services in big box stores. As a business operator in the security business, he understood firsthand the COVID fear instilled in clients. For Mr. Woodstock, the paranoia that pit neighbour against neighbour, dividing communities, had gone too far. It was time to rise above the damage caused by COVID policies.

¹¹⁴ Leis, David. Frontier Centre for Public Policy. 2023.

Another witness, Steven Setka, shared Mr. Woodstock's motivation to challenge the prevailing COVID mindset. He raised concerns with his church leadership regarding vaccination passes. The church had reserved a section for undeclared individuals. Within a church of a thousand people, Mr. Setka was the only churchgoer in the unvaccinated seating section. He had since changed churches, which included adjusting to a new social circle. Being deemed an outcast by both his extended family and his church led to a lot of anxiety, depression, and loneliness. In part, he blamed not having a strong, supportive community around him for his struggles. But it wasn't just churchgoers who were at odds with how churches dealt with COVID measures. Pastors witnessing the negative impacts of COVID lockdowns on the social fabric were not always welcome either.

Pastor Jason McVicar's experience specifically shows that not every church is the same. Just like so many entities within society, there will always be some that more effectively meet the physical and spiritual needs of the people they serve, and some that will not. In Pastor McVicar's case, the Board of Directors within the church did not align with his stance on vaccines. Even though the government offered bribes in the form of opening to full capacity if the congregants were vaccinated, Pastor McVicar did not concede his principles. Instead, he parted ways. In so doing, he was able to find a welcoming congregation that did not take issue with his unvaccinated status.

Like varying denominations, leadership roles within the church can differ too. For example, Mr. Tissen did not consider himself to be a pastor. Rather, he considered ministry to be a higher calling. In part, this could be because the role of pastor is often linked to professional employment, whereas ministry is when one willingly chooses to serve others.

Mr. Mack considered himself to be an elder. He said he missed in-person church services. Having spent most of his life working in the church community, COVID measures leading to the closure of assemblies represented a significant change. Although he was still able to watch church services online, he said it was not the same as physically going to church. Christians are called to fellowship, serve, and support one another. COVID restrictions prevented Mr. Mack from giving back to the community. To him, this was a significant loss. He also lost friends because of church closures. Social interaction with like-minded co-worshippers had ended. He said the lack of interactions with the pastoral team left a gap. In terms of the broader community, outreach initiatives were suddenly put on hold. He found the spiritual nourishment that he was used to receiving in his day to day lacking. He was further deprived of visiting family due to border closures.

Mr. Tissen also confirmed the far-reaching impact of COVID measures and lockdowns. First, the church with 160 congregants had been shaken by the actions of police and health authorities during the pandemic. The broader community was divided. At home, his family, too, had suffered from actions taken by government. His children were traumatized by the very police they had been raised to respect. He further alluded to a family get-together in the park. After being widowed, his mother had made plans to return to Europe. It was kind of like the last supper. But instead of a family memory, she watched her adult son arrested and pulled out of reach by state authorities, as if Mr. Tissen was some sort of hardened criminal. His crime? Ministering the good news gospel of the Lord Jesus Christ to those seeking the purpose of life. And, as he indicates, showing others, by his own example, how to love their neighbours.

At 28-years-old, this family man had a much deeper understanding of right and wrong than the RCMP officers who chose to arrest him: These same officers who watched Mr. Tissen bury his father. The same detachment of officers who believed it was within their authority to block the church entrance from congregants who desired to worship the Lord. As another NCI witness observed, the police were on the wrong side of the law.

As an aside, the church of God in Steinbach, Manitoba, had zero COVID outbreaks, no deaths, and everyone to the day of testimony, were still in good form. Mr. Tissen confirmed that in the beginning, the restrictions were novel, and like everyone else, the church family stayed home for a bit. But when they realized people should be there for one other and there was a calling within the Scriptures to do so, the church moved to drive-in services. The scriptural reference refers to believers not forsaking the assembling together, as the manner of some, but instead, exhorting one another, and so much the more, "as ye see the day approaching."¹¹⁵

Mr. Tissen said there was no division regarding the decision to reopen the church. He said the congregation remained in one accord, like a family should be. He observed drive-in church is not the same as physical and social interactions with other believers. Still, when the church acted on their constitutionally protected right to serve God in a manner that historically in Canada could never lawfully be restricted, the church became a target.

Witness Dr. Francis Christian likened many of the actions of governments during the COVID pandemic to the tyranny found in the Soviet Union. He pointed to how the data disseminated through media and health authorities was meant to deceive the public. He also commented on how data was used to frighten and manipulate the population. Although most of Dr. Christian's testimony focused on vaccines, he spoke about the persecution against anyone who speaks outside of the prevailing narrative. This was an outcome for churches that reopened in Canada had become all too familiar with over the last three years.

¹¹⁵ Hebrews 10:25 King James.

Again, not everyone was going to stand by and watch Canada destroyed. Rick Wall identifies himself as a God-fearing man and praying father. During the pandemic, he missed attending church. As the business owner of a trucking firm, he became suspicious of COVID measures early on. Mr. Wall participated in an outdoor drive-in church because he felt violated that his right to worship the Lord freely was taken away. This was about the same time outdoor gathering sizes were decreased to five persons. Almost one hundred people attended the first outdoor church service. Consequently, everyone who attended received fines for non-compliance to health orders. When the truckers decided to travel to Ottawa as part of the Freedom Convoy, Mr. Wall and his wife prayed about it. They were willing to lose everything to stand for what was right. The couple were both at peace over the decision. On January 17, 2022, truckers went from zero to hero. The truckers had captured global media attention.

Mr. Wall said the non-compliance order was consistent with an outdoor sermon he heard. At the outdoor services he attended, there was always a police presence. Mr. Wall did not ask why the gathering numbers for both indoor and outdoor church services were the same. Nevertheless, it might be insightful to understand what the Lord Himself said: "Who hath measured the waters in the hollow of His hand, and meted out heaven with the span, and comprehended the dust of the earth in a measure, and weighed the mountains in scales, and the hills in a balance?"¹¹⁶

It is important to note that in these examples, as witness David Leis alluded, it would appear Canadian society is moving closer to authoritarianism. He said it was so sad that people have forgotten their role in serving people. Others might suggest the landscape witnessed by the public was the contrast between good and evil.

Retired OPP officer Vincent Gircys agreed. He admitted tremendous mistakes had been made because of COVID, and that police forces had violated the oath each officer had taken to uphold the law and serve the community. These deliberate blunders by authorities were like a festering sore within the profession he had been so very proud of, not that many years prior. It should be noted that upon retirement, Mr. Gircys had received an exemplary service medal for his years of service. Yet, as Mr. Gircys testified, he was also concerned with police behaviour.

Watching the deployment of 200 police officers on horses shutting down one single restaurant led him to question how police actions were being taken against citizens. Further, on multiple occasions, he witnessed the tyrannical behaviour of the Aylmer police department toward the Church of God assembly. As a former police officer, he referred to the police actions and the continued violations of Canadian's constitutional rights and freedoms as deplorable.

¹¹⁶ Isaiah 40:11-12.

Beyond the criticism, Mr. Gircys commended officers who voluntarily left the Aylmer police force, for these officers did the right thing. He began publicly raising concerns. He referenced the *Canadian Charter of Rights and Freedoms* as the most supreme law of the land. Most particularly, he pointed to the preamble in the Charter which states, “Wherein Canada is founded upon the supremacy of God and rule of law.” He remembers his early days in policing when he was issued a King James Bible—a Bible he still carries to this day. He was also instrumental in facilitating communications between the Freedom Convoy truckers and governing authorities. For his efforts, he received two arrest warrants, a \$10,000 fine, and his bank accounts were frozen.

Witness Richard Abbot, a member of the tactical unit and SWAT team, confirmed these incidents were not just in the public eye but within the police ranks as well. Officers who refused to disclose their vaccination status were subject to segregation and the “Shame Room.” The latter was the workspace designated for the unvaccinated. Even though officers worked side-by-side in shared vehicles and physical spaces, management continued to mandate irrational policies. It was acceptable for officers to work together side-by-side throughout their shifts but not to break bread at the same table.

As a lawyer, Leighton Grey had the pleasure of representing Grace Life Church, and their struggle with Alberta Health Services (AHS) investigators to understand the law. He said the same AHS employees were given extraordinary powers but had no understanding of how to wield them. Further, Mr. Grey testified the health services investigator had the authority to summon police and make arrests, which eventually led to the imprisonment of Pastor James Coates.

Mr. Grey further explained that section 176 of the *Criminal Code* essentially prevents the disruption of worship services. And, as Mr. Gircys explained, the protocols and procedures that should have been followed for forensic investigations, were not. It is imperative for police investigators to collect physical, documentary, and testimonial evidence before reaching conclusions. This did not happen in the churches cited here. Therefore, the RCMP who accompanied AHS to Grace Life Church failed in a similar manner as the Ottawa police. The police officers did not understand their oath and Constitution, for if these officers had, they would also have known their actions violated both the Constitution and their oath, plus section 176 of the *Criminal Code*.

Nevertheless, as Mr. Grey admitted, the entire Grace Life Church incident was an international embarrassment. Bruce Parry, professor of law at Queen’s University, seconded Mr. Leighton’s testimony concerning the law. He reiterated that Canada’s legal system is based upon the separation of the state into three different branches: the legislature; the executive, or administration; and the judiciary, or courts.¹¹⁷ The rationale for these branches being separate is to prevent too much power from being concentrated in any one branch or person.

¹¹⁷ The federal government is separated into three branches. Faith assemblies, or churches, are not listed in how government is structured.

Everything other than the elected legislature and the courts falls under administration. This means the administration is not authorized to act without the legislature passing a statute authorizing the action. Under this umbrella, it's then the job of the courts to enforce the legislation. The emerging issue, as Mr. Pardy stated, is that the legislatures are no longer passing statutes that contain rules for the administration to follow (as the framers of the country did with the *British North America Act*). Instead, the legislatures are passing statutes which delegate rule-making authority to the administration. Lawyer John Carpay, in his testimony, concurred. He presented a long list of substantive issues and recommendations for the legislative branch level to address.

But what has happened over time is that the administration and not the courts or elected officials have become the experts. To change this direction, the people of Canada must challenge the premise that our government officials have the expertise and authority to tell us what to do in the name of the public good.

The Honourable Brian Giesbrecht is a retired judge. He weighed into the discussion, reaffirming the mediatory nature of the courts to stand between the government and citizens. He was disappointed with the response of the courts to health mandates. He observed tremendous hardship for people. It did not help that the judges accepted the prevailing narrative of governments and health authorities. He pointed to some of the health mandates which, he said, were particularly unreasonable. Moreover, if the courts were simply going to accept any government order as truth, then what was the purpose of the courts?

When the pandemic was first announced, Mr. Giesbrecht began comparing traditional pandemic policies to COVID responses in Sweden. He teamed up with another NCI witness (retired Lieutenant Colonel David Redman) who was experienced in emergency planning. He said it was like Canada was doing practically the opposite of what the planned emergency response called for. When the two compared Sweden's COVID response to Canada's, Sweden's hands-off measures appeared to be doing much better.

He had hoped that by investigating public policy in Sweden, some form of reasonable, objective discussion would emerge. Mr. Giesbrecht was surprised at the hostile reaction he received from mainstream media. He said the media, including the *New York Times*, wrote a scathing account about Sweden and how people were dropping like flies. This was not true. He questioned the idea that anyone taking a different view to lockdown mandates (beyond conformity and compliance) was discouraged. He noticed people were increasingly becoming divided.

He gave his opinion on how the courts handled COVID, concerning common law and the Charter. At first, he was surprised and disappointed with how the courts responded to the challenges of citizens and lockdowns. The public expect judges to stand between them and government overreach. Generally, this did not happen. The judicial response seemed to predominantly side with the government narrative. That is, if governments and public health make some sort of proclamation, then who are the judges to question them? He believed what the judges did by deferring decision-making and authoritative powers to health authorities in COVID cases was wrong.

He compared some of the decisions coming out of the United States, where there was a vigorous and lively testing of the rules. He believed this was very helpful from a societal perspective. He raised the example of air travel and masking mandates. The difference between Americans travelling on planes without masks versus Canadians still having to wear them was illogical. For months, Canadians were still required to mask, long after masking rules had been removed in the United States.

Courts south of the border had also struck down several of the most egregious vaccine mandates months before these same mandates were put to rest in Canada. Vaccine mandates caused tremendous hardship for people in terms of adverse reactions, employment, and social interactions. If people thought they could go to court and get the most egregious mandates removed, and obtain a reasonable response to their challenge, this might have helped. It seemed people generally did not think the courts were an option.

The primary issue is that deference is given to health authorities without testing the facts or properly looking into the case. The courts are being too quick to accept whatever decisions are made by governments or health officials, taking what the governments present at face value. The dispute is this: If the court is simply going to accept every decision made by governments, then what role do judges play? Why are courts even needed?

Mr. Giesbrecht cited several examples in Manitoba: the outdoor, drive-in church services where congregants remained under surveillance by a huge police presence, the inability of families to hold funerals and say goodbye to loved ones, going for a hike in a park only to discover the trails were closed, and other rules that were particularly unreasonable. Citizens had a rightful expectation that when they attend court, the judiciary would rightly consider all sides of the story and rule accordingly. Not simply to parrot health authorities. In other words, the public didn't expect the judiciary to privilege the government decision. In this context, this would be considered unreasonable.

Still, people rely on the courts to protect their individual liberties from the dictates of governments. He said it appears Canada is not the same country now as it was before the pandemic. He had spent considerable time thinking about these matters. Citizens need to ask themselves if civil liberties are important anymore or if they are happy with government making all the decisions. Conversely, judges must ask whether they played a role and whether, after three years, the courts protected the peoples' rights. He expects media and politicians should also ask the same questions.

In a similar context, Mr. Leis said there is a reason Canada has a limited state. It is important because there needs to be room for the working people, which extends beyond Ottawa. He said the government has tentacles everywhere, creating conflicts of interests. He referred to classical liberalism as a cornerstone of Western democracies. Freedom of speech allows Canadians to debate. If censorship is imposed by the state telling the populace what the facts are, even when they are not facts, Canada will not have a future.

This raises yet another question. Will Canada have a future when the courts are closed to the public? As the testimony alluded, the courts were closed. Consequently, there was no avenue for church organizations to file criminal charges against the state for egregious violations of *Criminal Code* 176. Church congregants were similarly denied an opportunity to address the oppressive actions taken against them by enforcers who swore an oath to uphold the law. There was more than sufficient evidence of wrongdoing. In addition to police reports, health inspector's notes, private videos and surveillance records, the documentation proving both health authorities and police officers violated this *Criminal Code* section was overwhelming. Videos of state authorities entering churches during worship services were also prevalent on social media and in the public square.

This unprovoked attack on Christian churches and citizens should have sounded the alarms within the judiciary. At the very least, there should have been a judicial reconsideration of how these acts of lawlessness against citizens could negatively impact the social fabric, and the judicial responsibility to prevent this from happening. Instead, the judiciary and prosecution teams, for the most part, remained silent. Even when congregants informed enforcement officials that their respective actions violated section 176 of the *Criminal Code* and that, therefore, the operations were illegal, the perpetrators did not stop. Time after time, police and health inspectors were at the church doors, determined to make an example of churchgoers, as if these people were hardened criminals and not hardworking taxpayers. Outdoor churches were not off the hook either. There, citizens were observed and under state surveillance as well. Those who attended outdoor worship services were identified through police video and vehicle licence plates, and subsequently burdened with outrageous fines.

In one example, the police chief attended an outdoor church service in his private vehicle, and he proceeded to video churchgoers in attendance. No warrant was obtained in advance for violating individual privacy. There was no presumption of innocence. There was no randomness. The police actions were deliberate. The rights and freedoms of every citizen were suddenly diminished. Any long-standing principle or tradition that had served Canada well for almost two centuries was suddenly eradicated.

In comparison, there was no police surveillance or enforcement measures at Costco or Walmart. There were no arrests at the Black Lives Matter rallies, even though people gathered at these, too, during COVID lockdowns. Ultimately, the reverberated state message was clear. Any citizen who did not remain in subjection to the prevailing narratives of the state were in complete violation of these new laws—which were not laws, because these were not based on legal precepts or moral tenets, the supremacy of God or rule of law.

As testified, dictated mandates by appointed health bureaucrats superseded the Charter, the *Bill of Rights*, and now the *Criminal Code*, too. Most noticeable, as well, the mandates imposed on citizens were not equally applied to those in authority. There emerged instead a two-tier system between the authorities that govern and the citizens being governed. So much for the rule of law. But this leads to further questions in relation to democracy. Is this what lawlessness looks like? When state officials sworn to uphold the law can choose to violate it without legal consequences? That because the courts were closed to the public, the laws that have ordered Canadian society since its democratic foundation no longer matter?¹¹⁸

Again, when the respective pillars in Canada were initially established, it was understood that an individual's faith and convictions, and their respective religious institutions, are not under man's laws. Why? Because the Lord has written His spiritual laws in people's hearts. Every individual knows what is right and wrong. Further, from the New Testament, Jesus summarized all the Old Testament commandments into two. That is, love the Lord with all your heart, all your soul, all your mind, and all your strength, and love one another.¹¹⁹ Therefore, worshipping God is not contrary to the law, for it is embedded in the hearts and minds of the people.¹²⁰

¹¹⁸ These same questions apply to *Criminal Code* Section 245.

¹¹⁹ For Gentiles, there are four additional laws found in Acts 15 and Acts 21.

¹²⁰ Acts 18:13-15.

Further, the greatest love story ever told is even more profound because even though men and women transgressed the laws (because we can't possibly keep them), the Lord Jesus changed the ordinance completely in order to establish a brand-new law: the law of love. This isn't a competition. From the very beginning, the Lord God wanted to walk in the cool of the afternoon with His people. When His people just didn't get it, He made a way where there was no way. He stepped down from glory so that each and every one of His beloved creation could have abundant life in Him. The rebellious will not hear the Word of the Lord. But for those who hear His call, we need to understand that God dealt with humanity before the law was given—in the time of Abraham—wherein we were saved by faith. His plan, even before the foundation of the earth was established, was to fulfil the law once and for all.¹²¹ This Jesus did through the shedding of His own blood.

In this context then, where there is no law, there is no transgression. The law was simply to point us to the Lord Jesus, and when we meet Him face to face, heart to heart, the sins that He paid for are taken away.¹²² The bottom line, then, is this. Believers in the Lord Jesus no longer need a grocery list of do's and don'ts telling them how to live. Because the hearts of believers are in Christ. His righteousness dwelling within, showing and enabling believers how to live. Apostle Paul summarized this best when he said, "The only thing that counts is faith expressing itself through love."¹²³

Therefore, on its own standing, the Bible supersedes the laws of men. As law-abiding citizens, Christians are responsible to a higher authority—this same Master that this entire nation is founded upon—the supremacy of God. As Apostle Paul reminds, the letter of the law kills but the Spirit gives life.¹²⁴ In this new era, the Lord did something that hasn't been done before. He called us into a different life wherein there is liberty and freedom for one and all. Not just so people simply cope or chore away day to day in the mundane but that each and every man and woman has a higher calling that is glorious.

¹²¹ Matthew 5:17-18; Romans 10:4.

¹²² Hebrews 7:27; Hebrews 8:12; Hebrews 9:12-14, 26-28; Hebrews 10:10-22; 1 Peter 3:18; Romans 4:15; Romans 2:13-23; I Corinthians 6:1; Jeremiah 32:23; Ezekiel 18:5; Isaiah 8:20; Psalm 19:7; Psalm 1:2; Psalm 37:31.

¹²³ Galatians 5:6. New International Version.

¹²⁴ II Corinthians 3:3-18.

Pastor James Coates from Grace Life Church understood the difference between man's law and God's and, as such, was willing to stand on his convictions and faith to ensure God-given rights continued to be honoured by the state. As a Bible-believing church, the congregants also believed in their scriptural obligation to continue meeting in person. This led to the decision to open in spite of health restrictions. Pastor Coates was ticketed and arrested in February 2021. He was given strict bail conditions. If he were to accept the conditions imposed, he would be breaking his promise to God. If he did not, he would be in contempt of court for holding church services. For the latter, he could face criminal charges. Mr. Coates refused to bow to the dictates of government bodies. The question for him was: who is God--the state or Jesus Christ? For his response, he remained in jail for 35 days. Even though he was not a flight risk, he was placed in shackles on both his feet and hands. Eventually, there was a satisfactory resolution reached on the bail conditions. The Crown released him and Grace Life Church continued to meet.

In March 2021, the church building was seized. A triple-fence with 24-hour surveillance was installed by the state. It was shocking and unprecedented for this to happen in Canada. The Grace Life congregation went underground. Legal counsel James Kitchen met with the church every week to determine how a church of 500 to 800 people could continue meeting while evading the authorities.

Mr. Kitchen was a member of the Law Society of Alberta. He practiced constitutional, administrative, and criminal law. He fundamentally believed the law was unjust and it was his moral and ethical duty to help the church end the unjust law. The church found locations in the middle of nowhere to meet. He recalled how the church was being sought out by authorities. When they had met twice in a row in the same location, a van with a canine unit showed up at that same location the third Sunday. The church had already switched locations, so they were not there.

Another example was Pastor Tim Stephens from Fairview Baptist Church in Calgary. The congregation met in a mountain provincial park beside the city of Calgary. The pastor preached from a tent. There were reports a helicopter was circling around, watching the congregation. Mr. Kitchen reminded the audience that as a nation we cannot forget the persecution of these churches. The measures taken were unjust and motivated by a public health or health crisis. The constitutional structure, Canada designed to protect citizens and their freedoms, was failing.

Mr. Kitchen was in attendance both times Mr. Stephens was arrested. Both arrests were in front of his children. An hour before Pastor Stephens' second arrest, the police called Mr. Kitchen to let him know their intent. There was no obligation to call him. Mr. Kitchen immediately called Sheila Gunn Reid from Rebel News, who had a cameraman in Calgary. Rebel was able to deploy them just in time to film the arrest. He said there are other churches facing similar consequences.

Pastors Tracy and Rodney from the church of the Vine in Edmonton prevented a public health inspector from coming into the sanctuary during worship service. As a more charismatic church, they believe church services are a sacred and divine time where the Spirit of the Lord is present. Having someone attend strictly to gather information and observe, with the intent of shutting the church was seen to be disruptive. Ideologically and spiritually, such a government official was an enemy. The church was right. Subsequently, the church was ticketed for obstruction.

During the trial, Mr. Kitchen argued it was a breach of section 2(a) of the *Charter of Rights and Freedoms*. This section guarantees religious freedoms. The prosecutor applied to the court to not allow Mr. Kitchen to argue that religious rights were violated, declaring that this would amount to wasting the court's time. Mr. Kitchen did not expect the court to agree with the Crown. Mr. Kitchen was going to be in court the week following the NCI testimony. He was appealing this court's decision. He said it should have shown how hollow and meaningless section 2(a) of the Canadian Charter had become that freedom of religion could not be argued in a court of law anymore.

Mr. Kitchen explained the importance in caring deeply about what happened in these cases. Freedom of speech goes hand in hand with freedom of religion. If the nation does not keep freedom of religion, it will not respect a citizen's right to protest either. He further explained, these transgressions of the law don't just apply to Christians. Atheists would not be permitted to speak either if Christians can't retain their freedom of religion. He reaffirmed these democratic rights are interwoven fundamental freedoms so we cannot keep one and discard the other. It is for this reason all Canadians must care about what is happening to Christians during COVID lockdowns.

There were similar considerations in other provincial jurisdictions. For example, when the province of Ontario moved to a five-tier coloured system, the COVID measures varied, depending on which region one lived. Toronto, for example, was a red zone, which meant total lockdown for residents. Mr. Mack pointed to the hypocrisy that existed between COVID measures for churches and big box stores. By the beginning of 2021, pockets of resistance were beginning to emerge. A couple of pastors were arrested and fined for speaking out publicly. Most churches at this time remained closed.

It was almost a year later before he saw the church fight back. An archbishop appealed to the Premier of Ontario to allow churches to open for Easter. The archbishop's request was turned down. He was not sure if the three churches he was involved in (including a mega church with 5,000 congregants) had corresponded with governments. But he did say that as a consequence of government mandates, the gathering numbers for churches had decreased across the country. Many within society had given up on the church community entirely because of everything that happened. He noted that independent churches seemed to do better. Nevertheless, some churches were forced to close and sell their buildings and assets.

When the churches were finally permitted to open again, congregants were required to wear masks, social distance, and be vaccinated. The unvaccinated had to sit in more secluded seating areas, away from congregants. It's also important to observe that even after all COVID mandates were lifted, some religious institutions continued to enforce masking and social distancing measures within the church buildings. Who made the decision within the churches? Mr. Mack said that in the three churches he was involved in, there was a church committee that decided how the mandates applied to the church. These committees would also correspond with the congregants, ensuring that all three churches followed COVID measures.

In terms of impact, many believers said there was a loss. Many congregants lost touch with friends. Contributing to the church community failed to happen. Whereas pre-COVID, maintaining regular worship and devotions was integral to family connections and/or social interactions, now there was a loss. The Freedom Convoy provided some optimism. When Mr. Gircys attended the Freedom Convoy in Ottawa, he saw more hugs than at an Italian wedding. The crowds were peaceful, positive, and joyful. He did not see violence or concerns. He said CBC lied about the Convoy. Mainstream media reports contributed to the emergence of a police state. The Ontario Provincial Police (OPP) admitted the intel was inconsistent with what the media and government were proclaiming.

Instead, the police accepted a single side of the narrative, even when counter information was available. In the end, police departments caved to political pressure and interference. This, he said, is why police agencies should always remain at arm's length and separate from politicians. He further explained that police officers are just ordinary people who are capable of great violence if they are lied to or led to believe they personally could be in grave danger. There was political pressure and interference.

Mr. Grey's testimony alluded to a report commissioned by the Alberta Government. It was intended to determine from a psychological perspective what language and methods could coerce Albertans to comply with the vaccination mandates and lockdown restrictions. He said the number of unknown deaths has increased seven times since the vaccines rolled out. Witness Jody McPhee's father could certainly have been considered one of the seven-fold statistics.

The determination of religious exemptions of religious exemptions coupled with employment termination has led Ms. McPhee to navigate through the court system, along with several thousand others. Mr. Grey said employers, governments, and unions conspired together to force favourable outcomes. Although Ms. McPhee did not specifically address her faith beyond experiencing a lack of compassion from authorities, it can be said her personal convictions and beliefs contributed to her job loss, particularly given the reference to Christ in her termination letter.

Mr. Tissen offered additional insight into possible government motivations. He received considerable support from friends, but he and his family also experienced a lot of hate too. It was all part of the government's tactic to divide humanity. He said if the government had the resources to send that many officers to a church, or by extension, to his home, why couldn't these same funds be used to check in on people and ask how they are coping, and, as well, to allow citizens to use their own judgment and common sense when it came to the potential risks associated with COVID.

He spoke of how his three children were traumatized from witnessing their father's arrest and the multiple times police officers came to the house to hand out tickets: not just one officer. Sometimes, there were as many as five officers at the door. He saw one of his children peering into the police station to see if they could see their father. He said the entire incident was heart-wrenching. Beyond the church, the private school associated with the church was also greatly affected. There were no end-of-year ceremonies for students or family picnics.

He too saw the hypocrisy of government policies that allowed big-box store parking lots to be full, while church parking lots were arbitrarily closed by RCMP. He noted the congregation is made up of peaceful, law-abiding Christians who were prevented from peaceful assembly and worship. Mr. Tissen cited the car rally event for the farmers in India as an example. Unlike the church gathering, no one in attendance was fined or in trouble for organizing these events. There was also the group of solidarity protesters raising aboriginal political concerns who were not targeted by RCMP either.

Mr. Tissen did not point to these groups to raise contention but rather as a point of comparison, showing the inequalities in how consequences for contravening COVID dictates were applied. He reaffirmed that neither he nor the congregation were being rebellious for the sake of being rebellious. He believed churches are instrumental in supporting individual's faith journey in addition to spiritual support.

Conclusions

When asked his opinion on church closures, Mr. Mack suggested more resistance from the church as a collective might have changed the societal outcome. Sadly, many have given up on attending church because of everything that happened. While some churches attempted to resist and hold services, they were fined. He recalled seeing videos of police physically removing and arresting pastors from the few churches that stayed open. These actions by governments against their own citizens in Canada caught international attention.

What was the reasoning? Canada is now contravening freedom of religion because it no longer adheres to or has a desire to understand Christian principles. How far is this going to go? Retired OPP officer Mr. Gircys probed a little deeper. He asked, how are we going to be treated if the lies continue, knowing that police officers are ordinary men and women? There is nothing in the police training that would inform officers differently. He concluded by saying what happened with COVID needs to be exposed. The idea that the pandemic was so dangerous that it justified all these public policy decisions is what he names the "Great Lie."

Mr. Gircys believes the lies are endless. But to keep the regime going, there must be more lies. When this happens, it is an indication of a totalitarian regime. If you control healthcare and can censor people, if you control education that indoctrinates, if you restrict movement as in fifteen-minute cities, and many more examples too numerous to cite, this is the ideal foundation for totalitarianism. Add a fear-based pandemic into the mix, and the result is a police state. Besides, when media works in collusion with government, it is collusion at its best and yet another indicator that all is not well within Canada's parliamentary democracy.

But there is a way out. Mr. Gircys offered a number of recommendations. First, he believes Canada needs to establish a nationwide COVID-19 forensic task force, vetted by the judiciary and one that is completely independent of government. He said it must also have the authority to issue arrest warrants.

Mr. Gircys provided a rationale for a task force. He said a task force could investigate the failings of the police community during the pandemic. For example, the police failed to adhere to the plan. He said that in policing, there is a plan for everything. Police don't decide to wing it because the circumstance this time is a pandemic, and they are scared.

He said the police failed to understand the information. Instead, they accepted a single narrative from government and the media and would not accept any counter information. He knew firsthand that concise detailed reports were submitted to the various authorities and agencies, but no one listened. In addition, the police failed to understand their Oath even though section 52.1 of the Charter states: "The Constitution of Canada is the Supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect."

It was difficult for Mr. Gircys to witness situations where the police were heavy-handed. In his opinion, the officers were not only ill informed but were provided with false and misleading information. He watched the behaviour of the officers. The police had to have believed there was a serious threat against them or there was a very real possibility they could be harmed. Mr. Gircys repeated that all his observations were consistently inconsistent with what media was saying, which is why he believes the officers had to be given false and misleading information—in order to do what the police officers did.

Still, even if the officers perceived there would be violence, professional and personal opinion should have changed when they saw there was no threat. Continuously, the same peaceful response should have caused the officers to question, particularly when the circumstances the officers witnessed were church women singing, children playing, and men ministering to the congregants. Yet, another question: At what point does one's conscience kick in? At what point did the officers realize the information they were given wasn't true?

Is there a valid explanation? Mr. Gircys heard one officer say during a debrief that the information came from something he watched on CBC. However, Mr. Gircys walked the perimeter of the Trucker Convoy in Ottawa for three weeks and the joy-filled atmosphere never changed. Clearly, the violence came from the police officers. It appears a new contingent of officers were brought in, and it's very likely these new police officers were primed with various forms of intel, including that they might be dealing with crazy people.

There were other concerns. Lawyers reported the courts were making decisions that found Charter rights and freedoms were not violated, so the Charter could not be used as a legal defence. As such, there was no opportunity to question the discrepancies between restricted gathering numbers for churches and the number of customers permitted in big box stores, even when the square footage in both the church and the stores were equivalent in size. It is for this reason witness Mr. Woodstock started a petition. He thought if churches met in the big box stores, that would solve the issue.

Certainly, the restrictions placed on religion, and more specifically, the Christian faith during COVID, was a concern for members of the public. Many who did not consider themselves to be religiously inclined before COVID started attending. Mr. Tissen said many came to the church who would not normally have ventured in. There seems to be an awakening around why churches were being targeted by governments. Many of these new attendees equated COVID health mandates with gross government overreach.

However, the persecution of Grace Life Church led to heightened awareness of these types of actions across Canada. Legally, Grace Life Church is part of the Ingram case, which is still before the court. Once a judicial decision is made other court actions will follow. A fine of \$1200 is the worst-case scenario facing Pastor Coates personally, but the church could end up owing hundreds of thousands of dollars to the state. This is the same state or nation which was established under the Supremacy of God and rule of law. This is the same state in which the framers of Canada's Constitution decided, by making churches a pillar, that governments had no authority over religious organizations.

In terms of legal recourse, Pastor Coates is contesting the violation of his right to believe under the *Canadian Charter of Rights and Freedoms*. Other lawyers testified. Mr. Kitchen reaffirmed Mr. Pardy's testimony. That is, the Canadian government is set up intentionally to divide power so that the legislative, executive, and judicial systems are separate. The courts are the third branch of government. Each branch polices the others so that no one branch can become too powerful. For a long time, this constitutional structure functioned well. However, in March of 2020, the legislative and the judicial branches were shut down. All power coalesced into the executive branch. Now unelected Public Health Officers ruled. He went on to say that power corrupts. Thus, it would have been the job of the judicial branch to exert controls over the executive branch. However, as the public and church congregants are well aware, the doors to the courts were closed.

When reinstated, the courts now saw their role as enabling government, which allowed governments to act in an arbitrary and oppressive manner for the greater good. Mr. Kitchen observed judges who were afraid for their personal safety throughout the COVID years. He had hoped that judges would recognize that there must be some personal sacrifice attached to their high-level positions. And that attached to the duty and obligation to serve their country, there is an understanding it may involve some personal risk.

Mr. Kitchen knew for himself that he would never wear a mask but watched judges act fearfully. He suspects that judges too are consumers of mainstream media. Judges are appointed by politicians who share their political views. He pointed out that the legal profession over the last 25 years has mostly shifted to the left. Mr. Kitchen observed that judges with a lot of experience dealing with complex Charter issues were not ruling on COVID cases.

The questions then are this: Why are there so few judges ruling against government restrictions? What happened to judicial independence, and the duty to ensure people's constitutional rights and freedoms are protected? Specifically, the public wanted answers regarding human rights, the harms caused by masking, vaccine mandates and exemptions, general COVID restrictions, and the enormity of fines for worshipping God. Perhaps, the judges who may have formerly ruled in favour of personal freedoms are being prevented from presiding over these cases now. It also appears that chief justices were taking many of the restriction-related COVID cases. This, in and of itself, led to many of the rulings being pro-government and pro-health restrictions.

Another dilemma that emerged is the regulatory capture of professional colleges. Examples of these include the Colleges of Physicians and Surgeons, as well as the regulatory bodies for accountants and lawyers. Similar to the three arms of government, it is imperative that regulatory bodies have independence from the government as well. Indeed, the purpose of these colleges is to resist and criticize government policies while also protecting the public interest. When regulatory bodies choose to wholly support government and criticize and/or remove licensing from their professional members, the message being sent to the public is not only pro-government, but the move is towards tyranny.

Mootness in the legal arena is similarly a concern. Courts don't want to waste their time on academic debates. Rather, courts want to act on real issues. This leads to the appearance of judges using mootness to help governments promote their actions. In this context, if governments enact a law, it takes lawyers time to launch a challenge, file the court documents, and schedule a hearing date. Then, just before the hearing, government removes the law. Everyone affected by the newly imposed law (yet now removed) is now left with substantial legal costs. The case has not been heard, so therefore, no time was spent in court arguing the merits of the case. Beyond the lack of discourse and constructive debate, there is no recourse either because the respective government has removed the law in question. This happened many times during COVID. In essence, the government could impose tyrannical laws, pull the law before a hearing, and then call any action against government as moot. This means no one could hold the government accountable.

But governments could then reinstate that law or something equally as unconstitutional later. Mr. Kitchen recommended that some judges could be elected to overcome the problems associated with political appointments. He suggested that judges who rule provincially should be appointed provincially. Through the election process, it is more likely that judges will reflect the views and values of the province. Mr. Kitchen estimated that conservative judges are now outnumbered eight to one in Canada. He also pointed out that often, judges with left-leaning opinions are not always tolerant of their colleagues' conservative voices.

Mr. Kitchen said it has taken a quarter of a century to arrive where the judicial system is now. It will likely take just as long for the system to recalibrate back to adherence to the rule of law and the Charter. He believes the *Charter of Rights and Freedoms* has been rendered useless. To change this, the Charter may require amending or maybe even be discarded. Before the Charter, very strong decisions had been made by conservative judges in favour of human rights.

Now, with the Charter, those rulings are rare. At the very least, section 1 (which allows the judiciary to limit an individual's Charter rights) must be discarded. Mr. Kitchen believes that a moral society can engage in self-government and subsequently live more freely with more equality. Interestingly, the founders of Canada discussed self-government in their deliberations as well, so this might be a discussion worth pursuing in the days ahead. Regarding judicial appointments, it's a well-established fact that political and bureaucratic favouritism can occur, and this becomes especially problematic when it's seen as nepotism within the context of good governance. Indeed, laws are only as good as the people who enforce them and live by them.

The ethical challenges weave a deeper thread. Imagine how morally bankrupt one has to be to insist that someone submit to an experimental injection or be fired from their job. To prevent these types of actions by the state from taking place in the future, Mr. Kitchen recommended that Canadians stop consuming corrupt mainstream media and seek more truthful alternate news and information sources.

Mr. Pardy suggested new legislation around delegation of parliamentary and legislative responsibility would be a good beginning. He added the Charter likely needs to be revised, since it has been shown to be inadequate. He also called for more transparency in the public service. Mr. Leis went further, saying it is atrocious what has happened and that it was by design that so much information was withheld from the public. He was equally disturbed by a law profession that did not ensure the rightful application of the law. Jordan B. Peterson considered how public opinion was manipulated to justify the imposition of restrictions on citizens' basic human and constitutionally protected rights.

To counter the conflicting protocols, Mr. Allard cited the insightful example he used to persuade a school principal not to impose mask-wearing protocols on his daughter. He said if his daughter was to be segregated from classmates in the school, then students from every other minority group should also be segregated. Rightly, the principal understood the analogy and the human rights consequences of such a move. Canada's forefathers had similarly referred to society taking care of its minorities as well, and in so doing, humanity would be all the better for it.

Francois Amalega took a different approach. A resident of Québec, he immigrated to Canada in 2012. When COVID began, he understood the stakes were high. In Canada, the government was trying to take the place of God, but any government posing as a small "g" god would be void of all hope. He believed withdrawing religion from the public square is not the answer.

A mathematician by profession, Mr. Amalega observed the contradictory rules and how the uncertainty was creating anxiety. He said things did not fit. He taught his college students to think critically, and yet the pandemic narrative did not align with the COVID data and statistics. The analogy he used was the government is building the plane, while Canada is flying it. The only conclusion he could reach was governments were lying to Canadians. Instead of protecting citizens, he said they were trying to destroy the social fabric. Not willing to concede, Mr. Amalega began publishing on social media. His Facebook account was constrained. Nevertheless, he kept on going –refusing to wear a mask at the College or in public places. He said by pursuing peaceful civil disobedience, he was fighting the good fight of faith for all Canadians. For not complying to mask mandates at work, he was suspended for three days and later two weeks. The College offered a compromise. They did not want to see him leave. Mr. Amalega resigned, saying he made the choice.

He used the extra time he had on his hands to protest. There was no violence. Every protest he attended was peaceful. The time came for Mr. Amalega to protest inside the police station. He told the police he was looking for freedom again, which was locked up in the police station. By now, he had received numerous tickets and was jailed four times for refusing to wear a mask. He was unsure how many nights in total he spent in jail. One of the mask fines was for showing up in court to fight his fine for not wearing a mask. Another time, Mr. Amalega was held in prison for over three months for being within 300 feet of Premier Legault, who showed up unexpectedly at the protest. Premier Legault allegedly regularly violated 8 p.m. curfews.

When interviewed, he told the media he had won. He referred to the various ways prisoners were treated. He wants to know which judge signed his arrest warrant because to him, that judge is the biggest criminal of all time. Mr. Amalega drew the comparison that if he is condemned, then the judge too is condemned. We are all accountable for our actions and this includes judges.

He understood COVID-19 as a medical story whereby people would say anything as if it were the truth even when there was no proof. Everything is opaque. He said when citizens don't respond to intimidation and fight for justice, becoming more vocal about the wrongs governments are committing, the people win. And by extension, this nation and all the citizens within Canada will win.

The question was asked: Where does Mr. Amalega get his inner strength? He said it is his belief in God that keeps him motivated to keep standing for what is right. He explained human authority is a gift of God, but like Canada's founders, he maintained human authority is also beholden to God. Why is this testimony so critical? Because one man believed in standing firmly for his personal convictions, for truth, and for those who cannot stand. In total, he received \$98,000 in fines. He had hoped to reach \$100,000 before testifying at the NCI. Nevertheless, the point was made. Being a person grounded in faith, standing boldly against unlawful mandates, may come with a personal cost, but the tangible benefits for the good of society going forward are long-lasting.

Is there a spiritual climate change needed in Canada? He responded by saying that when he first arrived in Québec, the topics of politics and religion were forbidden topics, but these are the most important topics within a society. Even non-believers are an important subject. He said it is not good for only one religion to dominate, but to withdraw religion altogether from society is not good either. Why? Because religion offers hope. Government does not offer hope.

Regardless of how one perceives Mr. Amalega's actions, his sincere, deeply heartfelt testimony is confirmation that COVID is all about a spiritual struggle. The upside, and Mr. Amalega's message is, when people band together and stand solid on their convictions, the truth shall prevail.

At the end of the day, Mr. Amalega's insights might prompt churches to require that Canada restore the democratic pillars which have blessed this nation over time. There can be no disorder within a democracy. This means federal and provincial governments cannot abdicate their electoral responsibilities to the public by appointing bureaucrats from health agencies to rule in their stead. When the law of the land is broken, because rulers have decided to act outside the citizens who promote good works, society breaks down. Jesus calls those responsible for social upheaval workers of iniquity¹²⁵ because they have rejected the Lord's overriding law of love in the New Testament.

With regard to citizens' lack of access to courts during COVID, there was no standing for ordinary citizens to bring criminal charges against police and state authorities. In earlier times, Jesus stepped up, becoming a mediator¹²⁶ between God and man. But who stepped in for hardworking Canadian citizens during COVID? This question requires a response. Because at the end of the day, closed courts essentially gave employees of the state a licence to do whatever they wanted to do. And what happened? state officials chose to disrupt the peaceful order of society and the worship of the Lord in church services by actions that were unlawful.¹²⁷

¹²⁵ Psalms 59:2-12; Matthew 7:21-23; Ezekiel 18:30; Psalm 119:133; Proverbs 10:29; Micah 7:8; Titus 2:14; I Corinthians 13:5-7.

¹²⁶ I Timothy 2:5-6.

¹²⁷ <https://laws-lois.justice.gc.ca/eng/acts/C-46/section-176.html>.

The final point: churches are pillars that are not answerable to man-made governments. This foundation was established historically by the founders of this great nation and in Canada's Constitution. The questions the founders reckoned with will need to be asked once again. In other words, can we enact laws that can infuse life into our nation? Because if the most knowledgeable and wise individuals could discover a law that could bestow life, then Jesus' sacrifice would have been meaningless.¹²⁸ However, on the cross, Jesus exhibited the highest form of love in the universe, and this love represents the Life and Light for our great nation.

May every church understand what it took for each of these witnesses to come forward and boldly stand. The overarching message is that we all, churches included, continue to shine His light brightly.

Recommendations

- A. **Recognition of all religions**, including the Body of Christ Church, by all levels of government is paramount in a free and democratic society and must be afforded all protections and shields guaranteed under the *Criminal Code*, the *Constitution Act, 1867*, the *Bill of Rights*, and the *Canadian Charter of Rights and Freedoms*.
- B. **Churches do not require the permission of governments** to open or close. However, when churches decided to respond favourably to the governments' call—two weeks to flatten the curve—these same churches must also have had the decision-making authority to reopen when projected COVID death and illness numbers don't come to fruition.
- C. **Revisions of the *Emergencies Act***. In May 2020, the launching of the *Emergencies Act* granted Cabinet powers to evacuate people and remove personal property from any specific area, acquire property, direct any person or any class of persons to render essential services, regulate distribution and availability of essential goods, services, and resources, authorize emergency payments, establish shelters and hospitals, and impose criminal sanctions. Moreover, the Act allows the federal government to essentially nationalize parts of the economy wherever it thinks it's necessary, including Cabinet assuming the control, restoration, and maintenance of public utilities and services to ensure the wellbeing of Canadians.

Later, citizens witnessed governments creating travel passes to curtail movement under the *Emergencies Act*. There needs to be parliamentary and legislative revisions to the *Emergencies Act* in an effort to reduce the unprecedented sweeping powers of the federal government over provincial jurisdictions and the citizenry and the unbridled discretion of authorities and powers administering new criminal laws without established opportunities for redress.

¹²⁸ Galatians 2:21; II Corinthians 5:14-15; I Thessalonians 4:14; Romans 5:7-8; Hebrews 9:15.

- D. **All governments should be required** to provide full disclosure of all the relevant data that led to the declaration of emergency measures, the degree of parliamentary oversight, the dialogue regarding the risks and legitimacy of the lockdowns, and how temporariness was factored into the invoking of the Act.
- E. **Governments and public sector employees** by virtue of public funding must remain neutral. Freedom of religion is a protected right that supersedes the authority and actions of governments. Public policy can neither be discriminatory in how the law is applied. For example, all churches regardless of the number of congregants, the square footage of the building, or the ability for each individual church to accommodate citizens within the boundaries of ever-changing COVID restrictions were painted with the same brush. On its face, the essential and non-essential list of organizations afforded carte blanche government approval appears discriminatory, and therefore, should be challenged under human rights legislation.
- F. **Remedy discriminatory conduct** through mandatory education programs. For example, the duty to accommodate is a legal concept that aims to ensure every citizen has equal access to benefits, services, and opportunities. In the context of the Canadian Charter of Rights and Freedoms, the duty to accommodate refers to the principle that individuals and groups should not be treated unfairly or denied opportunities because of their personal characteristics or religious beliefs. In fact, the duty to accommodate places a duty on all employers and service providers, including governments and institutions, to make reasonable adjustments to the policies and practices without unnecessarily imposing hardship on the legitimate interests of a workplace.
- Throughout COVID, legitimate questions were ignored. Yet, discretionary discriminatory actions were evident, imposing undue hardship on those who requested religious accommodation. Therefore, mandatory religious education courses for all public sector employees to ensure citizens are not discriminated against for religious practices and beliefs would send a much-needed message to public sector employees who discriminately targeted men and women of faith.
- G. **Going forward, there must be a clear**, evidence-based rationale for locking down citizens and society. And subsequently, when the *Emergencies Act* is revoked, there must be ample opportunities for redress, public conversations, and debate in the public square that will counter future restrictions on the citizenry.
- H. **Criminal Code section 176** must be retained.
- I. **Every individual has an inherent right** to end-of-life, spiritual and/or pastoral care or God at bedside services that align with their specific faith. Therefore, all publicly funded institutions, including hospitals, and long-term care facilities must comply.

- J. **Courts must accept deeply held beliefs** for religious convictions and respect that not every citizen, when writing an affidavit to support their views, is familiar with conveying the breadth and depth of their convictions in a manner that would overwhelmingly influence the Court.
- K. **The presumption of innocence** must be adhered to in all judicial proceedings occurring in every province and territory but Québec, where the latter operates under civil law. From the evidence, it appears prosecutors have too much influence on how the court uses its time. For example, the statement that constitutional arguments are a waste of court time and, therefore, should not be heard is not acceptable. Again, if a citizen's constitutional rights have been violated by virtue of their personal beliefs, thoughts, opinions, or expression, the actions of governments must be called into account, or else the law is being brought into disrepute.
- L. **Bail conditions must be reasonable and fair** and cannot prevent an individual from performing their employment duties and responsibilities. This includes pastoral service within a religious context.
- M. **Separation of courts,** the separation of courts from the public service.
- N. **Regarding procedural fairness and natural justice,** it's time for a comprehensive national dialogue to take place involving the church and Canadians who firmly believe the church is foundational and necessary for the social and economic wellbeing within communities. The church is uniquely qualified and capable of making decisions that impact the social fabric.
- O. **The prevailing belief** that there is a higher spiritual accountability in this life which determines our individual standing for eternal life cannot and should not be negated by government or judiciary.
- P. **Churches and citizens are encouraged** to create a public policy watch for any legislation that potentially negates the rights and freedoms of faith groups. The attempt to silence religious speech over the last three years should not go unnoticed.

7.3. Economic Impacts

7.3.1. Impacts of Mandates on Small-/Medium-Sized Business

Introduction

The mandatory lockdowns of businesses had a devastating effect on small- and medium-sized privately owned businesses across Canada.

According to Statistics Canada, in 2020 there were 1.22 million employer businesses in Canada, and of these, 1.2 million or 97.9 per cent were small businesses (1 to 99 employees), and 22,725 were medium-sized businesses (100 to 499 employees).

<https://ised-isde.canada.ca/site/sme-research-statistics/en/key-small-business-statistics/key-small-business-statistics-2021>

In 2020, small businesses employed 7.7 million persons or 67.7 per cent of the private workforce in Canada, and medium businesses employed another 2.3 million persons or 20.6 per cent of the private workforce. So, together these two types of business employed 88.3 per cent of the entire private workforce in Canada.

Small- and medium-size businesses in Canada account for approximately 51.9 per cent of Canada's Gross Domestic Product that is generated by the private sector.

At the time of writing this report, Statistics Canada had included on their website "Key Small Business Statistics 2022"; however, many of the comparison graphs included in this "2022" report had not been updated beyond 2019 statistics, and information updates were to December 2021. Updating these graphs to reflect the period of time during the pandemic is crucial to understanding what happened due to the mandates.

These figures from Statistics Canada highlight the critical nature of small- and medium-sized businesses in Canada.

Although the pandemic mandates had an effect on all businesses in Canada, the impact was particularly acute when it came to privately held small- to medium-sized business.

These small- and medium-sized businesses did not have access to the level of resources that were available to support the larger national and international businesses operating in Canada.

As privately funded entities, the majority of small- and medium-sized businesses lacked access to alternative sources of funding for their operations.

Shortages of supplies and materials were most keenly felt by these small- and medium-sized businesses as they did not have exclusive access to suppliers in the same manner that national or multinational businesses did. So many of them simply ran out of supplies.

Labour shortages were also keenly felt by the small- and medium-sized businesses as employees either stayed home or left the labour market due to early retirements or forced mandatory vaccinations.

Many workers who qualified for government assistance stayed home for the full duration of their benefits.

Businesses experienced additional costs due to new requirements for spacial separation, hygiene, and the restriction of facility occupancy.

The terror generated by the government reporting and the media created a toxic and fear-filled environment that caused many employees to fear coming to the workplace.

Small businesses, the backbone of the Canadian economy, were particularly vulnerable during the pandemic. Many were forced to close temporarily or permanently due to lockdown measures and reduced consumer spending. The impact of these closures on business owners, employees, and local communities has been profound.

Even businesses that managed to survive faced ongoing financial struggles, including rent payments, utility bills, and limited access to credit. The government implemented relief programs such as the Canada Emergency Business Account (CEBA) and the Canada Emergency Rent Subsidy (CERS) to provide financial assistance. However, the long-term viability of many small businesses remains uncertain, particularly in industries heavily impacted by ongoing restrictions and changing consumer behaviours.

Catherine Swift testified that many owners of the businesses that she represents reported significant negative impacts due to the various government “support” programs. These effects included the fact that many employees stayed away from the workplace until such time that their CERB benefits ran out.

Tamara Ugolini testified how her small start-up business was destroyed due to COVID-19 mandates imposed by the government, resulting in discontinuation of operations and financial loss.

Testimony Concerning Impacts of Mandates on Small-/Medium-Size Business

Catherine Swift

President of the Coalition of Concerned Manufacturer's and Businesses of Canada; she reviewed the mandate effects on small- and medium-sized businesses.

(Toronto: March 30, 2023)

Douglas Allen

Economist; he provided an economic analysis of lockdown measures.

(Vancouver: May 4, 2023)

Chris Scott

Owner of a café; he described the effects of mandates on his business and community.

(Red Deer: April 28, 2023)

Joseph Bourgault

Owner of medium-sized manufacturing facility; he described the impact of mandates.

(Saskatoon: April 20, 2023)

Don Woodstock

Small security firm owner; he made interesting observations of mandates.

(Winnipeg: April 14, 2023)

Darrell Shelley

Business owner; he described the effects of COVID-19 mandates on his audio visual business.

(Truro: March 17, 2023)

Terry Lachapelle

Equipment operator; he lost retirement income due to lockdowns.

(Truro: March 17, 2023)

Peter Van Caulert

Small business owner; he reported on the effects of mandates on his training business.

(Truro: March 17, 2023)

Jamie Paquin

Owner of wine business; he related the effects of mandates and a comparison to Japan's mandates.

(Toronto: March 30, 2023)

Tamara Ugolini

Family hydrovac business; she described how they were bankrupted by COVID mandates.

(Toronto: March 31, 2023)

Catarina Burguete

Owner of family brewery and bar; she reported their bar closed due to mandates.
(Toronto: April 1, 2023)

Shea Richie

Restaurant owner; he described the impact of public health measures on his business.
(Winnipeg: Thursday, April 13)

Rick Wall

Owner of trucking company; he described the effects of lockdowns on trucking.
(Winnipeg: April 14, 2023)

Bryan Baraniski

Owner of hotel and restaurant; he recounted the impact of public health measures on business.
(Saskatoon: April 20, 2023)

Zoey Jebb

New business owner with loan from Business Development Bank of Canada in 2019; she ended her business in bankruptcy due to mandates.
(Saskatoon: April 22, 2023)

Louise Wilson

Owner of Dollar Store; she related the impact of mask mandates.
(Saskatoon: April 22, 2023)

Michele Tournier

Owner of chuck wagon racing business; he described the impact of COVID measures on business.
(Saskatoon: April 22, 2023)

Sunje Petersen

Family-owned tourism business in Yukon Territory; she recounted the impact of lockdown measures on her business.
(Red Deer: April 26, 2023)

Tracy Walker

Hairstylist from home; she described the public health surveillance of her business due to COVID measures.
(Red Deer: April 26, 2023)

Colin Murphy

Music and sporting events planner; his business closed for long periods due to mandates.
(Red Deer: April 26, 2023)

Sherry Strong

Author; she had to close her public speaking business due to mandates.
(Red Deer: April 26, 2023)

Drue Taylor

Massage therapy clinic owner; she no longer works due to an alleged COVID vaccine injury.
(Red Deer: April 27, 2023)

Conclusions

COVID-19 lockdowns have dealt a severe blow to small businesses in Canada. Many were forced to temporarily close their doors or operate with limited capacity, resulting in significant revenue losses.

The sudden decline in consumer spending and reduced foot traffic had a direct impact on sales, leading to financial hardships, layoffs, and, in some cases, permanent closures. Small businesses often lack the financial reserves or access to credit to weather extended periods of reduced or halted operations.

Small businesses are a significant source of employment in Canada, contributing to local economies and providing livelihoods for numerous individuals. The lockdown measures have led to widespread job losses, with many small businesses unable to sustain their workforce during prolonged closures. Unemployment rates have risen, exacerbating financial insecurity for individuals and families, while reducing overall consumer spending power.

Lockdowns and restrictions have disrupted supply chains, affecting small businesses' ability to source necessary goods and materials. Import delays, transportation disruptions, and shortages have further strained small businesses already grappling with reduced revenues. These challenges have hindered their ability to maintain consistent inventory levels, meet customer demands, and operate efficiently.

The impact of COVID-19 lockdowns extends beyond economic repercussions. Small business owners and employees often experience heightened levels of stress, anxiety, and uncertainty. The constant fear of financial instability, the burden of making difficult decisions, and the social isolation associated with lockdown measures can have detrimental effects on mental health and overall wellbeing.

While the Canadian government has implemented various support programs for businesses, including financial aid and wage subsidies, small businesses have faced challenges accessing these resources. Eligibility criteria, application processes, and delays in disbursement have created barriers for many small businesses, leaving them without the necessary financial lifeline to navigate the crisis effectively.

Certain sectors, such as hospitality, tourism, and retail, have been particularly hard hit by COVID-19 lockdowns. These industries heavily rely on in-person interactions and foot traffic, making it difficult to adapt to the restrictions and generate revenue through alternative means. Small businesses within these sectors face unique challenges and require tailored support to survive the economic downturn.

The detrimental effects of COVID-19 lockdowns on small businesses in Canada are significant and multi-faceted. The economic consequences, including revenue losses, job cuts, and supply chain disruptions, have left many small businesses on the brink of closure.

The toll on mental health and wellbeing further compounds the challenges faced by business owners and employees.

As the nation begins to understand the underlying motivation and failure of governments' actions during the pandemic, it is crucial to recognize the importance of small businesses and the devastating impact governments' actions had on them. Targeted support to mitigate the losses caused by governments' draconian and misguided measures is required.

By prioritizing the needs of small businesses and fostering an environment of resilience and recovery, Canada can work towards rebuilding its economy and ensuring the long-term viability of its small business sector.

Recommendations

A. Financial Support:

- a) Simplify and expedite access to financial assistance programs, ensuring that small businesses can easily navigate the application processes.
- b) Provide targeted financial aid to sectors that have been disproportionately affected.
- c) Extend and expand wage subsidies to encourage businesses to retain employees and minimize layoffs.

B. Flexible Regulations:

- a) Implement flexible regulations and licensing requirements to support businesses in adapting to changing circumstances and exploring new revenue streams.

- b) Streamline bureaucratic processes to reduce administrative burdens on small businesses and expedite approvals.
- c) In cases where governing authorities decided businesses were non-essential, there needs to be accommodation made to allow these businesses to reestablish themselves or in cases where the business has closed, gone bankrupt, et cetera, an understanding within the public service that this is not a consequence of the business owner not wanting to work but a direct result of decisions made by governing authorities.

C. Access to Capital and Credit:

- a) Enhance access to affordable capital and credit for small businesses through low-interest loans, loan guarantees, or grant programs.
- b) Collaborate with financial institutions to develop tailored financial products specifically designed to address the needs of small businesses during recovery.

D. Promote Local Online Shopping:

- a) Encourage consumers to support local businesses by promoting the importance of shopping locally.
- b) Develop and implement marketing campaigns to raise awareness of online platforms and e-commerce solutions that facilitate purchases from local businesses.

E. Training and Skill Development:

- a) Offer training programs and workshops to small business owners and employees to enhance their skills in areas such as digital marketing, e-commerce, and remote work.
- b) Collaborate with educational institutions and industry associations to develop training initiatives specifically tailored to the needs of small businesses.

F. Collaboration and Networking:

- a) Facilitate networking opportunities among small business owners, allowing them to share experiences, insights, and best practices.
- b) Foster collaboration between small businesses and larger corporations through partnerships, supplier diversity initiatives, or mentorship programs.

7.3.2. Impacts of Mandates on Canadian Citizens

Introduction

The COVID-19 mandates were the greatest and most widespread intrusion into the lives of Canadian citizens that has ever occurred.

COVID-19 mandates were imposed by almost every level of government and were further supported by many institutions and private corporations, including the traditional media.

The tools employed to get citizens to submit included

- arrests
- public shaming
- financial penalties and fines
- denial of services or the threat thereof
- propaganda
- censorship
- secrecy and extensive use of “Orders in Council”
- financial incentives
- isolation
- suppression of the truth

Every aspect of Canadian life was affected.

COVID-19 mandates included the following

- forced loss of employment and denial of employment benefits
- suspension of the *Charter Rights and Freedoms*
- coerced medical procedures
- breaches in medical privacy
- elimination of Informed Consent
- restriction of travel
- lock-up of, and isolation of, the most vulnerable Canadians, including the elderly
- mandatory lock-ups and quarantines
- tracking and monitoring of citizens’ private communications and cell phone data without a warrant
- suspension of religious services
- suspension of educational institutions
- shutting down of private enterprise
- restrictions of family gatherings
- terrorizing large sections of the population
- institutionalizing/normalizing of hate speech; and hate of identifiable groups

Laws and mandates that were imposed on the population were enforced unevenly and in the cases of some politicians were not enforced at all.

The impacts to the citizens of Canada and our entire society are devastating and will last for generations to come.

Testimony Concerning Impacts of Mandates on Canadian Citizens

A wide range of testimony was heard from many witnesses located across Canada.

In all instances the witnesses described how the fundamental aspects of their lives and the lives of their families were destroyed.

The terror and propaganda campaign that was unleashed on Canadians caused family divisions and in some instances family breakups. Parent was pit against parent, husband against wife, children against parents; grandparents were denied access to beloved grandchildren, and the most elderly of our citizens were locked away and isolated, left to rot and die in abject loneliness, fear, and depression.

The rate of suicides, drug overdoses, domestic violence, societal violence, family breakups, divorce, and general health problems increased dramatically.

Fundamental institutions of our society were under attack; some responded to protect their rights and traditions, while other institutions completely failed, adopting every measure without question, and enforcing these edicts on their members.

Many churches abandoned their fundamental belief in separation of church and state; they closed their doors and the congregations were left on their own without support, in what was the most trying time since World War II.

The medical profession and the entire medical infrastructure started to shut down and concentrate on an imagined tsunami of COVID-19 illness which never came, meanwhile citizens' normal healthcare needs were neglected and postponed.

Excess Mortality During the Pandemic Period

The testimony of Dr. Denis Rancourt spoke about the rise in societal damage due to the COVID-19 measures, and he claims that based on an analysis of "all cause mortality," there is indisputable evidence that there were no detectable excess deaths due to a viral pandemic. Dr. Rancourt did testify that there was a rise in excess mortality which was entirely attributable to

- COVID-19 mandates (non-pharmaceutical interventions)
- COVID-19 genetic vaccines toxicity

Dr. Denis Rancourt

Dr. Rancourt presented a detailed analysis of all cause mortality data for Canada which provides no evidence of virus mortalities.

(Virtual testimony: June 28, 2023)

Dr. Rancourt examined the cause of excess deaths during the COVID-19 pandemic worldwide.

(Québec City: May 11, 2023)

Dr. Denis Rancourt provided a critical analysis of all-cause mortality during the pandemic and COVID-19 vaccine rollout.

(Ottawa: May 17, 2023)

According to the research of Dr. Rancourt and his team, all of the excess deaths that occurred during the pandemic were caused by the measures undertaken by the government.

Employment Disruption/Terminations

Many witnesses testified as to how they lost their jobs due to the mandates, related to forced vaccination with the COVID-19 injections.

Employees who were engaged in public service jobs, private corporations, military, or even volunteer organizations were faced with the unilateral imposition of a mandatory medical procedure, and failure to comply meant losing one's employment.

In addition, some people were terminated from their employment for exercising their rights to freedom of expression and belief.

Loss of employment struck almost every level of our society from healthcare providers to lawyers, to construction workers, ministers, small business people, teachers, and researchers—just about every area of our society was affected.

To make this situation worse, many of these employees were denied any social assistance through the Employment Insurance plan, and many were held in a kind of legal limbo as the employers called their terminations "leave without pay."

In addition, unionized workers found that they were not being supported by their unions and were left with no other means of pursuing their rights due to the collective agreements in place.

Testimony was received from the following witnesses:

Dr. Chris Milburn

Dr. Milburn was terminated from his position as an emergency room physician due to his expression of his free speech rights.

Dr. Patrick Phillips

Dr. Philips lost his medical licence due to his expression of his free speech rights.

Cathy Careen

She was a teacher who lost her job for not getting a second injection, due to a reaction to the first injection.

Chet Chisholm

He was a paramedic who was banned from returning to work since he only had one injection, due to a reaction to the first injection.

Artur Anslem

He worked for a Canadian railway and was forced to get the first injection. In November of 2021, he had a severe reaction—pericarditis—and was not able to return to work until December 2022.

Terry LaChapelle

He retired from the military and worked on a military base as a civilian contractor. He lost his job due to the vaccine mandate.

Amie Johnson

She was a dental hygienist and lost her job of 22 years due to a vaccine mandate imposed by employer.

Sabrina McGrath

She lost her job at the Nova Scotia Liquor Commission due to a refusal to get the COVID vaccine.

Pastor Jason McVicar

He lost his job as a pastor of a church for his refusal to take the COVID vaccine.

Joe Behar

A New Brunswick civil servant, he lost his job of 20 years as he refused to take the COVID vaccine.

Janessa Blauvelt

A licensed practical nurse, she lost her job due to her refusal to take the COVID vaccine.

Linda Adshade

She was working on COVID-19 data for the Nova Scotia government; when mandates came in, she refused to get the injection and was terminated.

Katrina Burns

She was a substitute teacher who refused to take the injection and was dismissed from her job.

Oliver Kennedy

He was a recreational therapist who was terminated for refusing to get an injection.

Victoria McGuire

She was a registered nurse of 21 years who was terminated from her job for refusal to take an injection.

Rick Nicholls

He was a member of the Ontario legislative assembly who was removed from government caucus for refusing to take the injection.

Lynn Kofler

She was a registered nurse who lost her job due to her refusal to get the COVID vaccine.

Sean Mitchell

He was an advanced care paramedic terminated from his job due to a refusal to get an injection.

Cindy Campbell

An emergency room nurse and educator for 28 years, she was forced into early retirement due to the vaccine mandate.

Kimberley Snow

She lost her job in retail management due to her refusal to get the COVID vaccine.

Ksenia Usenko

A nurse for 15 years, she lost her job in a Rehab Unit as she refused to take a COVID injection.

Jason Kurz

A nuclear technician with working for an electrical power, he lost his job due to his refusal to take the injection and is banned for life from working with a subcontractor of the power company. Essentially, he is barred from working in the industry.

Scarlett Martyn

A paramedic for 24 years, she was terminated from her job due to her refusal to get a COVID injection.

Sean Howe

A locomotive engineer, he was put on unpaid leave for eight months for refusing to get the COVID injection.

Shelly Overwater

A lawyer, she was dismissed from her group practice for supporting other staff who refused to take a COVID vaccine.

Devon Sexstone

He lost his job with a courier company for refusing to take the COVID injection.

Rick Abbot

A police officer for 25 years with the Edmonton Police, he lost his job due to speaking out against the mandates and the actions of the RCMP at Coutts, Alberta.

Jessica Kraft

She lost her job for refusing the COVID injection. She refused due to an existing heart murmur, but she could not get a doctor to give her an exemption.

Michelle Malkoske

A nurse for eight years, all of her shifts were cancelled due to her refusal to get the COVID injection. Her husband was also laid off from his job due to his refusal. They had no income for three months.

Todd McDougall

He worked for thirteen years as a childcare worker and was terminated for refusing to comply with COVID measures of masking and social distancing at weekend protests.

Michel Gagnon

He was forced into early retirement from the military as he did not want to get the COVID injection.

Dr. Francis Christian

A surgeon of 25 years, he was fired from his job due to speaking out against mandates.

Anne McCormick

A former pharmacist working as a pharmacy assistant, she was fired for refusing to wear a mask, despite her medical exemption from wearing a mask.

Cindy Stevenson

She was put on unpaid leave from CN Rail for refusing to get the COVID injection, and while she eventually returned to work, she decided to leave given her concerns about health and safety.

Elodie Cossette

The director for services at a group home, she was terminated for refusing to get injected.

Chantel Barreda

She was a teacher and was terminated from her position for refusing to get the COVID injection.

Danny Bulford

He left the RCMP due to COVID vaccine mandates.

Jacques Robert

He lost his property manager job of 15 years for refusing to take the COVID injection.

Scott Crawford

A paramedic for 30 years, he was suspended from his job for refusing to get the injection. He was not allowed to visit his dying mother in the hospital.

Michelle Ellert

She is on disability leave with adverse COVID vaccine reactions after she was forced to get a vaccine or lose her job. Her mother and daughter each had reactions to the injections.

Babita Rana

She was placed on unpaid leave from her 28-year computer programming position at the University of Alberta for refusing to get the COVID injection.

Grace Neustaedter

A registered nurse for 41 years, she was forced into early retirement due to her refusal to take the COVID injection.

Suzanne Brauti

She worked for the federal government and was terminated due to her refusal to get injected. She was denied a religious exemption and denied Employment Insurance coverage.

Darcy Harsch

He worked with adults with disabilities and was put on unpaid leave due to his refusal to get the COVID injection.

Philip Davidson

He worked for 14 years in the public service in the area of policy development and lost his job due to his refusal to declare his injection status.

Dr. Chris Shaw

A research professor with a PhD in Neuroscience, he lost his position at the university as he refused to take the COVID injection.

Sean Taylor

A military veteran working as a civilian nurse at the time of the pandemic, he was terminated for speaking out on the COVID mandates.

Dr. Ben Sutherland

A researcher for Fisheries and Oceans Canada, he was terminated from his position due to his refusal to take the COVID injection.

Zoran Boskovic

A forester who worked for the provincial government, he lost his position due to his refusal to take the COVID injection.

Camille Mitchell

A pharmacist, she was fired from her hospital job when she refused to take the COVID injection.

Josée Belleville

She was 13 years with the Canadian Armed Forces Special Operations. She was bullied, harassed, and humiliated until they terminated her for not getting the COVID injection.

Gary Lalancette

He was a computer programmer for 30 years and was terminated from his job for refusing to get injected.

Dr. Patrick Provost

He was suspended and is currently facing termination from his job as a professor of Biology and Immunology for speaking out against the mandates and the injections.

Sheila Lewis

She was removed from the transplant waiting list for not taking the COVID injection; she could not live without the transplant. In August of 2023, Sheila passed away as a result of her terminal illness.

Kristen Nagle

She is a nurse who lost her job for not complying with the mandated injection. She testified that she was investigated by the College of Nurses and placed on an indefinite suspension.

Jean-Philippe Chabot

Married and father of five children, he was fired from his job at CBC for refusing to get the injection. He could not collect Employment Insurance as CBC coded his termination as misconduct.

Anita Krishna

She worked for 25 years for Global News but was terminated for speaking against the government narrative and mandates.

William Bigger

He has autism and was terminated from his job. He was unable to participate in any of the programs he needed for social support and development.

Laurier Mantil

She was a letter carrier for 7 years and lost her job over refusal to take the COVID injection.

The preceding witnesses described being unilaterally required by their employers to take the COVID-19 injections. The threat against them was that if they did not comply with this unilateral order, they would lose their employment, so they were threatened under loss of employment.

In addition, many of them were denied any assistance from their labour unions and, as a result, were deemed ineligible to take their cases to any further tribunals due to the collective agreements with their unions.

Many of them reported that, at first, they were not immediately fired but were placed on leave without pay or they were suspended indefinitely without pay. This appeared to be a technique used by many employers. When they were finally terminated, their Records of Employment (ROE) were generally coded in a way that they would not be eligible to receive Employment Insurance.

At least one witness testified that his employer, who was a very large power generation company, banned him for life from not only working for that company but also banned any and all contractors who worked for the company from hiring him for life. This effectively ended his career as a nuclear technician.

The environment in many workplaces had become poisoned, and a hateful and bullying atmosphere was allowed to develop, with hate focused on the group of people who refused to comply with the mandates.

Individuals' private medical status were identified and made known in the workplace, further subjecting those persons to ridicule and hatred.

The political class and the media class were responsible for creating these conditions through their relentless campaign of propaganda and terror.

The damage that these actions inflicted on Canadian society cannot be underestimated. The damage to institutions, families, communities, and the damage to various institutions is profound.

Critical workers who were desperately needed were unceremoniously demonized, ostracized, and then terminated.

The following witnesses described a variety of situations which they experienced or observed during the mandates.

The scope of these testimonials touch every aspect of society in Canada.

Chief John Grey Burke

He was a victim of violence (due to his mask exemption because of cancer) at a Canadian Tire store, as a result of terror induced from propaganda.

Natasha Petite

She had a medical exemption from wearing a mask and was attacked in a Walmart store. Police arrested her due to terror related to propaganda.

Marylaine Bélair

Her husband was run over by an angry customer in the parking lot of a Walmart store. The customer was enraged by mandates. Her husband was rushed to hospital, but she was denied entry to be with him. He was in the hospital for four and a half months until passing away from his injuries. Her children were only allowed to see him once in the four and a half months, and he got very little care.

Tobias Tissen

Mr. Tissen was arrested, fined, and jailed for opening a church.

Pastor James Coates

He refused to close his church. He was arrested, fined, and jailed.

Steven Setka

His refusal to get a COVID injection caused a split within his family, and when his church brought in vaccine passports, he was refused entry.

Elizabeth Galvin

Her daughter committed suicide after her university was locked down, and she was quarantined away from any friends and support groups.

Brandon Pringle

He experienced bullying at work, and his family was split over his refusal to get injected. He was not allowed to visit grandchildren for six months due to terror induced in his family.

Marjaleena Repo

Wearing a mask presented a serious health risk to her, and so she got a mask exemption. She was diagnosed with terminal cancer, and she wrote a post on Facebook concerning how she was being treated. She got many threatening responses, and a radio station allegedly also attacked her and revealed her personal information. She experienced inhumanity and terror caused by COVID mandates.

Pastor Steven Flippin

He watched his congregation deteriorate due to church closings and isolation. He kept his church open to support members, and he was fined.

Mandy Geml

She was pregnant through 2020, so she did not get a COVID injection. The schools were shut down due to mandates, and the kids had no activities. Her daughter was bullied by a teacher for not getting the injection. Her mother was in a nursing home and was isolated, and they could not visit her. She commented on how quickly people turned on each other due to terror.

Heather Burgess

Her father passed away leaving her mother with dementia in a long-term care home. Her mother was locked down and isolated and was not allowed any visitors. Her mother thought she had been kidnapped; she could not understand the isolation. When her mother was dying, the geriatric nurse kicked them out and would not let them see her. She got vocal when they started injecting kids, and she has been isolated and ridiculed.

Judy Soroka

She was a retired nurse with back injuries and needed therapy and treatment, which she could not get because of the lockdowns. Her condition got worse due to the lack of treatment during the mandates.

Dianne Molstad

She had high blood pressure and she refused to get the injection. Her family doctor of 30 years fired her as a patient as she had not been injected. It took her three days of calling to get a new doctor.

Angela Tabak

Her son had special needs, but prior to the mandates, he was living on his own and working. Due to mandates he lost his job and was isolated at home. He could not get any treatment for his physiological condition and continued to deteriorate, and he spent hours watching news reports. He was found dead from suicide.

Kim Hunter

She has been an early childhood teacher for 20 years. She witnessed the effects that masks were having on the children and did research into the effectiveness of masking. Her workmates isolated her and attacked her for not wearing mask.

Caroline Hennig

Her father's health deteriorated quickly in a long-term care facility due to isolation and neglect. She removed her father from the home and nursed him back to health. She had to readmit him to care as she left the country; he deteriorated and died under the government's assisted suicide program (MAID).

Lynette Tremblay

Her mother was in long-term care during the pandemic; the facility was in lockdown despite having no cases of COVID-19. She was denied entry to see her mother, and the police were at the facility blocking people from entering. Patients were allegedly not receiving care during the lockdowns. She took photos as proof of neglect and was barred from the facility.

Marc-André Paquette

He is a kindergarten teacher. He reported significant issues that he was observing with the development of children while subject to mask mandates. He said the politicians had created a campaign of terror to coerce children to comply with mandates and take injections.

Dr. Keren Epstein-Gilboa

She has a PhD in developmental psychology. She stated how children were traumatized due to the propaganda and by the various mask mandates and school shutdowns.

Aidan Coulter

He was a student at Canadian University. He received a letter from the university demanding that he take the injection or he would not be allowed to attend university, so he dropped out.

The testimony of these witnesses describe a society in free fall, where blind violence is used in place of reason and how citizens were attacked or arrested or even killed due to the blind terror that was induced in the population.

People suffering from visible disabilities were attacked and subjected to violence, even an elderly woman with a terminal condition. In the depth of her shock and grief, she was allegedly subjected to mob violence, which was assisted and abetted by a local radio station. These types of attacks are unheard of in Canada.

Witnesses described how their elderly loved ones were subjected to horrific conditions of neglect, isolation, and hate, simply due to the terror induced by propaganda.

People were prevented from seeing or being with their loved ones at the most personal moments of their lives.

Families broke apart and young people took their lives, due to loneliness and isolation.

Expert witnesses testified to the lifelong developmental problems that have been created for our children and that no concrete remedial steps are being taken at present to address these developmental and behavioural effects.

Churches, the traditional centres of our communities, were closed, pastors were vilified, and entire congregations were isolated and prevented from gathering. There was no separation of church and state during the pandemic.

Conclusion

The mandates that were imposed on the citizens of Canada represent the most profound invasion into the private lives of Canadians. No one was spared this assault.

While citizens were subjected to the never-ending narrative that COVID-19 lockdowns were implemented to mitigate the spread of the virus and protect public health, that narrative has now proven to be objectively false.

Many witnesses to this Commission testified that there was no especially deadly or virulent virus that needed to be contended with. The government, at the very least, simply panicked, and they implemented extremely draconian measures which had significant detrimental effects on Canadian citizens.

Some of the damaging effects experienced by individuals during the mandates included

- **Job losses and reduced income:** Lockdown measures resulted in business closures and layoffs, leading to job losses and reduced income for many individuals. This caused financial hardships and increased financial insecurity for households.
- **Small business closures:** The restrictions and closures disproportionately affected small businesses, resulting in permanent closures and the loss of livelihoods for business owners and employees.
- **Financial stress:** Reduced income, uncertainty, and the strain of managing expenses during lockdowns caused financial stress for many individuals and families.
- **Increased stress and anxiety:** The uncertainty and disruption caused by the pandemic measures led to heightened levels of stress and anxiety for individuals. The fear of contracting the virus, financial concerns, social isolation, and other factors have taken a toll on mental wellbeing.
- **Social isolation and loneliness:** Physical distancing measures and restrictions on social gatherings led to increased social isolation and loneliness, which can contribute to mental health issues such as depression and anxiety.
- **Impact on vulnerable populations:** Vulnerable groups, including those with preexisting mental health conditions, seniors, and individuals experiencing domestic violence were particularly affected by the isolation and limited access to support services during lockdowns.
- **Disrupted learning:** School closures and the shift to remote learning disrupted the education of students at all levels. This created challenges in terms of access to resources, effective learning environments, and social interaction, impacting academic progress and wellbeing.
- **Increased educational disparities:** The transition to remote learning exacerbated existing educational disparities, with students from low-income households, those without access to reliable internet or technology, and marginalized communities facing additional challenges in accessing quality education.
- **Delayed medical treatments:** Non-urgent medical procedures and routine check-ups were postponed or delayed due to the strain on healthcare systems during the pandemic. This resulted in delayed diagnoses, potential health complications, and increased healthcare needs in the future.
- **Mental and preventive health impact:** Access to mental health services, preventive screenings, and regular healthcare services were limited during lockdowns. This has impacted the overall health and wellbeing of individuals and could lead to long-term consequences.
- **Disruption of social connections:** Physical distancing measures and restrictions on gatherings disrupted social connections and the ability to engage in community activities, resulting in a loss of support networks and reduced community cohesion.

- **Impact on cultural and recreational activities:** Closure of cultural venues, cancellation of events, and restrictions on recreational activities limited opportunities for entertainment, cultural participation, and personal fulfillment.

People lost their jobs, and families struggled to survive; some people even lost their lives due to alleged vaccine injuries, suicide, or other violence. There was even testimony alleging that a senior was driven into the government's own assisted suicide scheme and lost their life due to isolation and depression.

The effects of these mandates will be with us for generations.

There are no concerted efforts being undertaken to try to repair the damage done.

Governments are misrepresenting what happened and along with their accomplices in the media, they are reframing the narrative and convincing people that it is over and they should simply move on.

The censorship continues. The lies and the false narrative continue and are further diversifying into other areas without pause.

Recommendations

- An independent judicial investigation** must be undertaken to determine responsibility and criminality. Any and all institutions, individuals, or organizations that were responsible for breaking of the law need to be brought to justice.
- Laws need to be strengthened** to specifically prohibit the mandating of medical procedures and the exposure of private health information. There are current laws in place, but somehow these laws did not protect Canadians.
- Canada must affirm its adherence** to international law and human rights and invite an investigation of the actions of the government according to these treaties.
- An intensive program** aimed at addressing the developmental damage done to our children must be undertaken and implemented immediately. It is not acceptable to simply move on with business as usual. Children have been emotionally, developmentally, and educationally damaged, and remedial actions are required.
- An investigation into the actions of the CBC** and privately held media companies in Canada must be undertaken to determine criminality under the current hate speech and terrorism laws in Canada. It was the relentless stream of hate, propaganda, and terror which was responsible for much of the damage done.
- All employees who were terminated** due to refusal to take a medical procedure must be rehired and paid compensation. All costs of these actions need to be paid for by the parties who mandated and implemented the terminations.

- G. **The regulations concerning the operation of elderly persons' care homes** need to be reformed. Never again should these institutions be allowed to lockdown, isolate, and ignore the needs of the residents and their relatives. Compensation needs to be paid and criminal charges laid as appropriate.
- H. **A mandatory course on the *Canadian Charter of Rights and Freedoms*** is to be developed and become mandatory for all public service employees, as part of the effort to assure that these actions are never supported again.
- I. **A high-school level course must be developed** to teach the *Canadian Charter of Rights and Freedoms* and civics to all high school students in Canada. This course must be mandatory nationwide.
- J. **The history of what happened** during the pandemic, including an accounting of who was responsible, must be developed and included as a module in all high school history courses. This history is to be mandatory.
- K. **Government officials**, the judiciary, and regulatory boards did not adequately safeguard the interests of Canadians. It is imperative to implement measures that establish civilian oversight for many of these institutions, ensuring their independence from political influence and interference.
- L. **Financial Support:**
- Ensure efficient and accessible delivery of financial assistance programs to individuals impacted by the mandates, including those who have lost their jobs or experienced reduced income.
 - Expand income support programs and consider targeted initiatives for vulnerable populations, such as low-income individuals, single parents, and seasonal economy workers.
 - Provide rent and mortgage relief programs to ease the financial burden on individuals facing housing insecurity.
- M. **Mental Health Support:**
- Increase access to mental health services, including telehealth options, to support individuals experiencing heightened stress, anxiety, and other mental health challenges.
 - Implement public awareness campaigns to reduce stigma associated with seeking mental health support and promote available resources.
 - Invest in community-based mental health programs and initiatives that address the specific needs of diverse populations.

N. Educational Resources and Support:

- Ensure access to remote learning resources and technologies for students to minimize educational disruptions.
- Provide additional support and resources for students from disadvantaged backgrounds to address students experiencing educational disparities and issues related to technology.
- Invest in educational and vocational training programs to support individuals in re-skilling or up-skilling to adapt to changing job market demands.

O. Healthcare Access and Outreach:

- Prioritize and expedite non-urgent medical procedures and screenings that were delayed or cancelled during the mandates to address healthcare needs and prevent further complications.
- Increase outreach efforts to promote preventive healthcare measures such as regular check-ups.
- Enhance access to telehealth services and digital health platforms to facilitate remote consultations and healthcare support.

P. Community Support and Engagement:

- Facilitate virtual community engagement initiatives to foster social connections, combat social isolation, and promote community resilience.
- Provide funding and resources to community organizations and non-profit groups that offer support services, food banks, and other essential resources for those in need.
- Encourage employers to prioritize employee wellbeing by implementing flexible work arrangements, promoting work-life balance, and supporting mental health initiatives.

Q. Communication and Information Dissemination:

- Ensure clear, consistent, and timely communication about public health guidelines, mandates, and available resources to keep citizens informed and reduce confusion.
- Utilize diverse communication channels to reach different segments of the population, including multilingual communication and accessibility measures for individuals with disabilities.
- Combat misinformation and promote evidence-based information through public health campaigns and collaborations with trusted sources.

R. Long-Term Preparedness and Resilience:

- Invest in healthcare infrastructure, including increased hospital capacity and resources, to improve pandemic preparedness and response capabilities.

- Establish contingency plans and strategies to manage future crises effectively, balancing public health priorities with minimizing social and economic disruptions.
- Foster collaboration between government, businesses, and community stakeholders to develop comprehensive and coordinated approaches for future emergencies.

By implementing these recommendations, the Canadian government and relevant stakeholders can provide support and assistance to citizens impacted by the COVID-19 interventions, helping individuals navigate the challenges, promote wellbeing, and build resilience during and beyond the pandemic.

7.3.3. Financial Impact of the COVID-19 Pandemic Response on Canada

Introduction

The actions of the various levels of government, private organizations, and individuals during the COVID-19 pandemic caused unprecedented disruption to the economy of Canada.

The announcement of the pandemic and subsequent implementation of pharmaceutical and non-pharmaceutical measures resulted in significant economic damage, ranging from widespread job losses to business closures and government debt accumulation.

This section explores the financial impact of the pandemic on Canada, delving into its effects on various sectors of the economy and the measures taken.

According to testimony from Dr. Jordan Peterson, a new disease was detected, which was not well understood, and the authorities panicked and used that panic to impose tyranny. In order to avoid responsibility for their actions, they abdicated their political responsibility to hypothetical experts in public health.

Both political leaders and citizens allowed these non-elected officials to use terror to justify implementation of restrictions. These same officials then unleashed unbridled spending on measures that were actually caused by the restrictions imposed by them. The actions of the government caused “untold economic damage” to all sectors of our economy.

The best way to try to evaluate the damage discussed by Dr. Peterson is to review the data provided by the Treasury Board of Canada to understand the magnitude of spending that was carried out.

Witness David Leis stated that the costs of the mandates were profoundly damaging in all aspects of our society including economics. He further stated that governments did not follow their emergency plans to mitigate these effects.

Evaluation of the totality of the economic effects are well beyond the scope of this report; however, the testimony received did point to a number of specific areas of economic impact and further suggested other significant sources of economic impact which are not yet understood.

Economic Contraction and Unemployment

The pandemic measures led to a sharp contraction of the Canadian economy as restrictions on movement and business operations severely disrupted various sectors. Industries such as hospitality, tourism, retail, and entertainment were hit hardest, resulting in widespread layoffs and business closures.

According to Statistics Canada, the country experienced its steepest economic decline on record in the second quarter of 2020, with a contraction of 11.5 per cent.

The increase in unemployment rates was one of the most significant financial consequences of the pandemic. Many individuals lost their jobs or faced reduced hours, causing financial instability and impacting their ability to meet basic needs. The unemployment rate surged from 5.6 per cent in February 2020 to a peak of 13.7 per cent in May 2020, representing millions of Canadians affected by the economic fallout.

As noted previously, significant taxpayer funds were expended to provide economic support to workers who were forced into an unemployed situation due to the government-imposed mandates.

At the same time, many workers who lost their employment for refusing the mandated injection were refused employment benefits.

Government Spending and Debt Accumulation

As a response to the government's own actions in implementing the mandates and various other unnecessary and ineffective measures, the Canadian government implemented significant fiscal measures.

These measures included direct support to individuals and businesses, wage subsidies, and increased healthcare spending. The Canada Emergency Response Benefit (CERB) provided temporary income support to those who lost their jobs or income due to the pandemic. The Canada Emergency Wage Subsidy (CEWS) aimed to help businesses retain employees.

According to the [Treasury Board of Canada](#), the federal government's expenditures related to COVID-19 included the following:

2020-2021:	\$134.9 billion
2021-2022:	\$ 40.1 billion
2022-2023:	\$ 6.0 billion (to February 2023 only)
Total:	\$181.0 billion

To illustrate where this money was spent, a breakdown of the COVID-19 expenditures for **2020-2021** are provided by the Treasury Board as follows:

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Canada Emergency Response Benefit (CERB)	\$65.23 B
Safe Restart Agreement	\$15.88 B
Canada Recovery Benefits	\$14.47 B
Further Support for Medical Research and Vaccine Developments	\$ 3.18 B
Canada Emergency Student Benefit (CESB)	\$ 2.95 B
Essential Workers Wage Top-up	\$ 2.88 B
One-Time Payment for Seniors Eligible for Old Age Security (OAS) and the Guaranteed Income Supplement (GIS)	\$ 2.46 B
Canada Emergency Commercial Rent Assistance (CECRA) for Small Businesses	\$ 2.15 B
Safe Return to Class	\$ 2.00 B
Canada Recovery Caregiving Benefit	\$ 1.97 B
Regional Relief and Recovery Fund	\$ 1.87 B
Funding for Personal Protective Equipment and Supplies	\$ 1.80 B
Cleaning Up Former Oil and Gas Wells	\$ 1.72 B
Supporting Provincial and Territorial Job Training Efforts as Part of COVID-19 Economic Recovery	\$ 1.50 B
Enhancing Student Financial Assistance for Fall 2020	\$ 1.35 B
Supporting Indigenous Communities in the Fight Against COVID-19	\$ 1.03 B
Expanding Existing Federal Employment, Skills Development, Student and Youth Programming	\$ 879.99 M
Rapid Housing Initiative	\$ 870.44 M
Support for Persons with Disabilities	\$ 810.30 M
Support for International Partners	\$ 698.77 M
Safe Restart Agreement Federal Investments in Testing, Contact Tracing, and Data Management	\$ 533.26 M
Support for Cultural, Heritage, and Sport Organizations	\$ 497.87 M
Support for Canada's Academic Research Community	\$ 434.46 M

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COVID-19 Response Fund	\$ 430.46 M
Canada Recovery Sickness Benefit	\$ 419.84 M
Support for the Homeless (through Reaching Home)	\$ 394.08 M
Indigenous Public Health Investments	\$ 387.43 M
Emergency Community Support Fund	\$ 349.70 M
Support for Workers in the Newfoundland and Labrador Offshore Energy Sector	\$ 320.00 M
Supporting a Safe Restart in Indigenous Communities	\$ 314.77 M
Canada Emergency Response Benefit Administration Costs	\$ 309.38 M
Canadian Armed Forces Support for the COVID-19 Response	\$ 292.37 M
Enhancing Public Health Measures in Indigenous Communities	\$ 278.98 M
Support for the On-Reserve Income Assistance Program	\$ 262.18 M
PPE and Related Equipment Support for Essential Workers	\$ 254.22 M
Canada Revenue Agency Funding for COVID-19 Economic Measures	\$ 242.90 M
Support for COVID-19 Medical Research and Vaccine Developments	\$ 239.29 M
Support for Indigenous Businesses and Aboriginal Financial Institutions	\$ 228.80 M
Quarantine Facilities and COVID-19 Border Measures	\$ 228.50 M
Health and Social Support for Northern Communities	\$ 179.60 M
Support for Food Banks and Local Food Organizations	\$ 170.94 M
Supporting Canada's Farmers, Food Businesses, and Food Supply	\$ 157.52 M
Supporting Public Health Measures in Correctional Institutions	\$ 155.79 M
Support for Fish Harvesters	\$ 144.82 M
Virtual Care and Mental Health Support	\$ 137.32 M
Support for Local Indigenous Businesses and Economies	\$ 133.00 M

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Supporting and Sustaining the Public Health Agency of Canada and Health Canada's Pandemic Operations	\$ 132.53 M
Targeted Extension of the Innovation Assistance Program	\$ 127.29 M
Ensuring Access to Canada Revenue Agency Call Centres	\$ 127.24 M
Support for the Canadian Red Cross	\$ 99.34 M
Funding for VIA Rail Canada Inc.	\$ 90.43 M
Support for Health Canada and the Public Health Agency of Canada	\$ 83.74 M
Indigenous Mental Wellness Support	\$ 82.43 M
Support for Food System Firms that Hire Temporary Foreign Workers	\$ 74.04 M
Support Essential Air Access to Remote Communities	\$ 68.58 M
Parks Canada Revenue Replacement and Rent Relief	\$ 57.29 M
Consular Assistance for Canadians Abroad	\$ 56.50 M
Addressing the Outbreak of COVID-19 among Temporary Foreign Workers on Farms	\$ 50.61 M
Support for Women's Shelters and Sexual Assault Centres, including in Indigenous Communities	\$ 49.96 M
Addressing Gender-Based Violence during COVID-19	\$ 48.86 M
Support for Fish and Seafood Processors	\$ 45.19 M
Bio-Manufacturing Capacity Expansion—National Research Council Royalmount Facility	\$ 43.47 M
COVID-19 Communications and Marketing	\$ 43.07 M
Supporting Distress Centres, the Wellness Together Canada Portal	\$ 41.72 M
Emissions Reduction Fund for the Oil and Gas Sector	\$ 31.71 M
Support for the Broadcasting Industry	\$ 31.59 M
Support for Safe Operation in the Forest Sector	\$ 30.08 M
Support for Canada's National Museums	\$ 25.70 M
Support for Veterans' Organizations	\$ 20.00 M

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New Horizons for Seniors Program Expansion	\$ 19.97 M
Support for Food Inspection Services	\$ 19.40 M
Support for Canada's National Arts Centre	\$ 18.20 M
Supporting the Ongoing Delivery of Key Benefits	\$ 17.80 M
Canada Emergency Student Benefit—Administration Costs	\$ 17.62 M
Financial Relief for First Nations through the First Nations Finance Authority	\$ 17.10 M
Women Entrepreneurship Strategy—Ecosystem Top-up	\$ 15.03 M
Personal Support Worker Training and Other Measures to Address Labour Shortages in Long-Term and Home Care	\$ 12.73 M
Immediate Public Health Response	\$ 12.50 M
Granville Island Emergency Relief Fund	\$ 10.44 M
Advertising Campaign: Government of Canada's COVID-19 Economic Response Plan	\$ 10.00 M
Support for Main Street Businesses	\$ 7.82 M
Support for the Federal Bridge Corporation Limited	\$ 5.76 M
Support for the National Film Board	\$ 4.74 M
Investments in Long-Term Care and other Supportive Care Facilities	\$ 4.65 M
Support for Children and Youth	\$ 4.20 M
Canadian Digital Service	\$ 3.59 M
Labour Market Impact Assessment Refund	\$ 2.78 M
Canada Student Loan Moratorium	\$ 2.49 M
Support for the National Capital Commission	\$ 1.94 M
Innovative Research and Support for New Testing Approaches and Technologies for COVID-19	\$ 1.41 M
Regional Air Transportation Initiative	\$ 1.10 M
Support for the Audiovisual Industry	\$ 795.07 K

Supporting Court Operations and Access to Justice	\$ 70.16 K
Total	\$134.85 B

Detailed breakdowns of the expenditures for years 2022 through 2023 are available from the Treasury Board of Canada.

These controversial initiatives led to a substantial increase in government spending and a surge in the national debt. The federal budget deficit for the 2020–2021 fiscal year reached a historic high of over \$354 billion. As a result, Canada’s total federal debt surpassed the \$1 trillion mark, which will have long-term implications for the country’s fiscal health and future economic policies.

Canada’s Department of Finance reported the following values for the National Debt of Canada:¹²⁹

March 31, 2019: Canada reported a federal national debt of \$685.5 billion dollars.

March 31, 2020: Canada reported a federal national debt of \$721.4 billion dollars.

March 31, 2021: Canada reported a federal national debt of \$1.0487 trillion dollars.

March 31, 2022: Canada reported a federal national debt of \$1.1345 trillion dollars.

It must be clearly understood that it is Canadian citizens who are responsible for this debt and that the size of this new debt will have significant impacts on Canadians for generations to come.

Witness Edward Dowd testified concerning the costs related to excess deaths in the United States, and although these deaths are not directly related to the Canadian experience, certain indications can be gleaned from the statistical cost estimates related to excess deaths reported in the 2021 to 2022 period. According to Mr. Dowd, in the United States over the period of 2021 to 2022, there were an estimated 300,000 excess deaths that he attributed to vaccine deaths and deaths due to mandates imposed. The estimated economic cost of these deaths is estimated to be on the order of \$150 billion.

Witness Dr. Denis Rancourt’s estimate of these costs for Canada is approximately 10 per cent of these figures, which would equate to around \$15 billion in loss.

These estimates do not include the additional losses due to lost productivity.

¹²⁹ Data on National Debt taken from Government of Canada “Debt Management Reports” <https://www.canada.ca/en/department-finance/services/publications/debt-management-report.html>

Dr. Douglas Allen testified that the modelling of deaths utilized by the government to justify their actions was based on false assumptions, and the estimated number of deaths was grossly incorrect. The estimated number of deaths predicted by the government model was approximately 15 times what actually happened.

Additional costs that were not taken into account include

- lost education opportunities,
- increased deaths and reduced life expectancy due to increased unemployment,
- increased deaths due to despair,
- increased domestic violence and family breakdown,
- supply chain disruption costs and consequences, and
- direct deaths caused by lockdowns and vaccines.

Dr. Allen stated:

Lockdowns are not just an inefficient policy, they must rank as one of the greatest peacetime policy disasters of all time.

Stock Market Volatility and Investment Implications

The stock market experienced significant volatility during the pandemic, with widespread fluctuations in values across various sectors. While some companies thrived due to increased demand for certain products and services (for example, technology and e-commerce), others faced steep declines. Investors faced heightened uncertainty and risk, impacting retirement savings, investment portfolios, and overall financial stability.

The pandemic's financial impact also highlighted the need for diversification and resilience in investment strategies. It underscored the importance of considering factors such as industry resilience, sustainability, and adaptability when making investment decisions. The volatile market conditions prompted many individuals to reassess their financial goals and seek professional advice to navigate the uncertainty.

Some investors removed their capital from the market altogether fearing account lockouts or wholesale market devaluation.

Dr. Douglas Allen testified that there was an \$80 billion drop in the stock market in Canada between March and April 2020 as a result of the government's actions.

Conclusion

The government response to the COVID-19 pandemic had far-reaching financial consequences for Canada, impacting various sectors of the economy and affecting the lives of individuals and

businesses across the country. The economic contraction, increased unemployment, government spending, and growing debt levels created significant challenges. Small businesses have struggled to survive, and investors have faced heightened volatility and uncertainty in the financial markets.

Addressing these financial impacts requires a multifaceted approach that involves continued government support, fiscal prudence, and a focus on economic recovery and resilience.

Balancing public health measures with targeted support for affected industries and individuals is crucial for mitigating the long-term effects of the pandemic on Canada's financial wellbeing. By learning from this crisis and implementing strategic policies, Canada can emerge stronger and more resilient in the post-pandemic era.

Recommendations

- A. **Restraints must be placed on public health officers.** They must be required to immediately justify their recommendations with legitimate cost-benefit analyses, and their decisions must be subject to the authority of publicly elected officials and the transparent scrutiny of the public.
- B. **All scientific studies on either side** of a crisis must be made available to the public so that the effect of propaganda can be minimized.
- C. **Public health officials should never be placed in charge** of an Emergency Response. Emergency Response must remain the purview of professionals trained in medical and emergency procedures who understand how to set goals and achieve them.
- D. **Lockdowns and mandates** must require direct legislative authority. These steps cannot be allowed to be carried out under regulations.
- E. **The media must be held to account** for their collusion in the propaganda that caused the panic among citizens and authorities.
- F. **A detailed financial audit must be undertaken** on each and every dollar that was spent on the pandemic. It must be determined whether any mishandling of these funds occurred.
- G. **Identify and prioritize essential expenditures** directly related to public health and safety, such as healthcare infrastructure and support for vulnerable populations.
- H. **Evaluate the effectiveness and efficiency** of existing programs and initiatives to ensure resources are allocated wisely, redirecting funds from less effective areas to more impactful measures.
- I. **Focus financial support** on the most affected sectors and individuals, such as small businesses, low-income households, and those facing unemployment or reduced income due to the mandates.

- J. **Streamline administrative processes** to reduce red tape, bureaucratic delays, and associated costs, ensuring funds are disbursed promptly to those in need.
- K. **Enhance transparency and accountability** in spending by providing regular public reporting on the allocation and utilization of funds, enabling citizens to monitor government expenditures.
- L. **Invest in long-term emergency planning** and preparedness measures to mitigate the impact of future pandemics or health emergencies. This may include strengthening public health infrastructure, establishing emergency funds, and enhancing the capacity for rapid response and data collection.
- M. **Ensure that future public health emergencies** are operated by the existing Emergency Management Apparatus and that the public health authorities provide input into that apparatus but are not able to lead or control it.
- N. **Response to future public emergencies** must be driven by and directed by local emergency planning personnel on the ground and not driven by federal government political processes.
- O. **Consider the potential cost-saving benefits** of investing in preventive healthcare measures, public health education, and research and development in the healthcare sector.
- P. **Continuously monitor the effectiveness and impact** of government spending on COVID-19 mandates and measures, adjusting allocations as needed based on evolving circumstances, scientific evidence, and changing priorities.
- Q. **Engage in rigorous and public evaluation** and assessment of programs and policies to identify areas of inefficiency or ineffectiveness, making data-driven decisions to optimize resource utilization.
- R. **Focus on measures that stimulate economic recovery** and job creation, such as infrastructure investments, targeted incentives for business growth and innovation, and initiatives to promote consumer spending and tourism.
- S. **Balance short-term relief measures** with long-term economic strategies to foster sustainable growth and resilience in the post-pandemic era.
- T. **Canada must adopt a Canada First policy** where our national interest drives overall policy agendas. This applies to all aspects of our nation, including fiscal, financial, social and environmental policy. Global planning and response with a lack of Canadian input created the situation that we now find ourselves in.
- U. **Canada is a country** whose economy is dependant on natural resource extraction and production. Canada must implement policies to upgrade and expand these core economic drivers so that export income can be quickly injected into the Canadian economy, addressing these historic debts caused by the government's actions during the pandemic.

- V. **Some of the damage and hardships** experienced by Canadians was caused by an acute lack of independence and diversity of critical aspects of our economy. Canada must rigorously review and apply the anti-combines laws (*Competition Act*) to limit Canadians exposure to undue influence from the many monopolies that currently exist across critical sectors of our economy.

By implementing these recommendations, governments can exercise restraint in spending while ensuring that essential needs are addressed, support is provided to those most affected, and long-term preparedness measures are in place. It is crucial to strike a balance between fiscal responsibility and the necessary investments to protect public health, support the economy, and promote the overall wellbeing of citizens.

7.4. Media Actions During the Pandemic

Introduction

A free and robust democratic society is uniquely and inextricably dependant on the free exchange of accurate and reliable information that is without bias and without government or corporate influence.

It is absolutely imperative that a media source declare any known or perceived biases which it may have to the public so that the public can clearly make a distinction between facts and opinion.

The Canadian public depended on the media providing fair and accurate information to allow them to properly assess the situation as it unfolded and to allow the public to make critical decisions both for themselves and their families.

This report utilizes the following definitions:

Media is defined as:

The main means of mass communication (broadcasting, publishing, and the Internet) referred to collectively as the media. Examples include cable and over-air television and radio, internet services, as well as print media such as magazines and newspapers.

Traditional media is defined as:

Print media and broadcast media comprised of state and corporate media companies, encompassing television, radio, magazines, newspapers, and internet content as produced solely by those state and corporate entities..

Internet service provider is defined as:

Internet services which include simple access provision to the supply of media companies which provide a “public discussion” platform.

Freedom of Expression and Freedom of the Press

The concepts of freedom of expression and freedom of the press are so important to the development of and maintenance of a democratic society that these freedoms are clearly set out in the foundational documents of Canada. For example, Section 2 of the *Canadian Charter of Rights and Freedoms* as expressed and codified in the Constitution Act, 1982.

<https://laws-lois.justice.gc.ca/eng/Const/page-12.html#docCont>

Within the *Constitution Act, 1982* under Fundamental Freedoms, item 2 states the following:

2. Everyone has the following fundamental freedoms:

(a) freedom of conscience and religion;

- (b) freedom of thought, belief, opinion and expression, including freedom of the press and other media of communication;
- (c) freedom of peaceful assembly; and
- (d) freedom of association.

Item (b) specifically indicates that there is to be “freedom of the press and other media of communication.”

Freedom does not simply refer to the censorship of various forms of media or communication, it also encompasses the absence of interference or influence from the state. A free press is in direct opposition to a paid press which is expressly concerned with and exists to espouse the opinions and positions of those entities that are paying it.

The freedom of the press and media extends to all areas of communication (written or spoken) and in the instance of this investigation must include the freedom of scientific research and publication.

Consumers in Canada are generally protected from unscrupulous or misleading advertising and information. There are generally provisions to protect consumers from “Conduct Against Consumers,” which is to protect the public from misleading and deceptive conduct and unconscionable conduct, et cetera.

So the question becomes exactly what type of media coverage did Canadians receive from their traditional media outlets over the course of the pandemic?

Did the traditional media examine with a critical eye everything that the government was telling Canadians, or did they simply echo what was being provided to them from government sources?

Did the traditional media support freedom within their own newsrooms? Did they permit investigative reporters to examine the claims being made by the government and prepare news stories that were presented to the public?

Did the traditional media carefully interview all sides of the issues, and did they take extra care to protect people who presented alternative views to that government narrative?

Has the traditional media done anything in the current situation to address any of their real or perceived shortcomings during the pandemic?

Testimony Concerning Media Actions During Pandemic

Significant testimony was provided to the Commission which clearly demonstrated that freedom of the press and other media no longer exists in Canada, on all levels involving the traditional media sources in Canada.

Based on the testimonies received, the traditional and online corporate media did not act independent of government and corporate influence.

The dissemination of critical and accurate information concerning the facts related to the pandemic itself, effective measures to treat COVID-19, government-imposed mitigative measures, and the safety and effectiveness of vaccines were almost entirely based on government and industry or government- and industry-influenced or sponsored sources.

Active measures were taken by traditional and online media sources to suppress, censor, and ridicule opposing opinions related to the pandemic.

The recommendations and mandates were in a constant state of change, and the investigative press took no steps to actively investigate or evaluate the validity of those measures and made no attempts to inform the Canadian people of the realities of the measure being mandated.

Without accurate and complete information, the Canadian people could not make critical decisions on medical matters that deeply affected every aspect of Canadian Society. Furthermore, without clear and accurate information, the public were never put into a situation where they could provide "Informed Consent" prior to accepting any proposed medical treatment that was being foisted on them by the government, medical community, and even their employers and religious leaders.

Many Canadians were left at the mercy of what turned out to be an unrelenting cascade of false, misleading, and incomplete information as provided by various government agencies.

Many Canadians were not aware, due to exclusionary reporting and outright censorship, of the experimental and untested nature of the COVID-19 vaccines.

Many Canadians were not aware of the significant planning that had taken place prior to the pandemic and how the mandates and directives of the government during the pandemic were in conflict with the recommendations of the official emergency pandemic plans.

Critical definitions of terms were revised and facts were blurred in order to coerce Canadians into accepting the government/industry narrative.

Long understood and trusted terms were used to provide a false sense of confidence for Canadians. Examples include:

- pandemic,
- vaccine,
- biologic,
- Spike Protein Disease,
- ambassador,
- safe and effective,
- relative efficacy, and
- absolute efficacy.

Traditional media providers and their news broadcasts in Canada are no longer independent of the government and special industry interests as they are either directly funded by government and large industry groups or receive very significant funding through advertising from these organizations.

Due to the Canadian government's lack of enforcement of the *Competition Act*, traditional media companies in Canada have been allowed to conglomerate to the extent that little or no independent companies now exist. Most news and media outlets are owned and controlled by a very small cadre of large corporations. This reduces Canadians' choice of independent media outlets to near zero.

According to testimony received, the CBC alone receives more than one billion dollars in direct government funding; it is not known how much additional funding they receive from government advertising or pharmaceutical industry advertisements.

Other traditional media sources in Canada received hundreds of millions of dollars of direct government funding over the course of the pandemic period. It is interesting to note that this funding was not provided to all media firms, only specific media firms, especially traditional media sources.

In addition, the days of an independent media in Canada and in most of the Western world are long gone. The days of the independent newsroom or the news outlet that are not owned and controlled by huge multinational interests have passed.

Most traditional news sources in Canada are no longer independent, and they no longer permit independent and unbiased journalism to take place within their organizations. Reporters are often specifically directed as to what stories they can and cannot cover, based on a corporate directive.

As demonstrated from the Twitter Files release in the United States, government agencies were working hand in hand with large media firms such as Twitter, Youtube, and Facebook to directly censor and/or limit the exposure of opinions and facts that did not support the approved government narrative.

The NCI heard very specific testimonies from the following witnesses:

Rodney Palmer

A veteran journalist, Rodney Palmer presented on the difference between news gathering and propaganda, exposing how CBC shifted away from news gathering to promoting propaganda and fomenting hate.

(Toronto: March 30, 2023)

In his second testimony with the NCI, Rodney Palmer reported on the bias at CBC in terms of their funding and manipulation of the news.

(Ottawa: May 18, 2023)

In a taped announcement for the NCI, Rodney Palmer described CBC's new Twitter label.
(April 18, 2023)

Anita Krishna

She described her behind-the-scenes journey as a former Global TV director.
(Ottawa: May 18, 2023)

Jean-Philippe Chabot

A former CBC employee, he described how he navigated his vaccine status disclosure.
(Ottawa: May 18, 2023)

Marianne Klowak

A former veteran CBC journalist, she testified on the decline of journalism at the CBC during the pandemic.
(Ottawa: May 18, 2023)

Jeff Sandes

He reported on the changing landscape of journalism.
(Vancouver: May 3, 2023)

Jeffery Tucker

He described the loss of trust in mainstream media during COVID-19.
(Winnipeg: April 14, 2023)

Dr. Robert Malone

He testified on COVID-19 injections and 5th-generation warfare against humanity.
(Toronto: March 30, 2023)

Cathy Jones

She described how the media was complicit in the pandemic narrative.
(Ottawa: May 17, 2023)

James Corbett

An independent journalist, he discussed the international health emergency treaties.
(Ottawa: May 18, 2023)

The testimony of witnesses allege that the media sources in Canada, which should in a democratic society inform Canadians, did not perform their duties in a non-biased and fair manner.

Witness statements describe a corrupt and biased system of reporting that only presented the government and corporate narrative while omitting any reasonable and balanced dissenting information regardless of the source and the credentials of those sources.

Many witnesses described being targeted by media for ridicule and, in some instances, with violence.

Widely cited is the August 26, 2021, front page of Canada's largest newspaper the *Toronto Star*.

In addition, media carried an interview from September 8, 2021, with Mr. Justin Trudeau who stated the following:

Yes, there is a small, fringe element in this country that is angry, that doesn't believe in science, that is lashing out with racist, misogynistic attacks, but Canadians, the vast majority of Canadians, are not represented by them, Trudeau said.

These are simply a few of hundreds of statements and headlines that targeted Canadians with hate and made them potential targets for violence.

Few if any dissenting articles were provided in the traditional media to rebut these statements or offer an unbiased review of these statements.

In fact, many statements were carried in the traditional media that were factually incorrect and to this date, many of these media outlets have not retracted or condemned the comments made.

People who had legitimate opinions that were contrary to the government narratives were savagely vilified in the traditional media. People were called "anti-vaxxers," "haters," "misogynists," "racists," and "extremists."

Witnesses testified that the news was being directed from central corporate headquarters and that reporting or investigation of any opinions which were contrary to the government narrative were not to be pursued.

According to the testimony of Mr. Rodney Palmer, the news organizations contained within the traditional media morphed into propaganda organizations rather than news-gathering organizations.

Mr. Palmer included the following Oxford definition of news gathering:

Canadians get the podium party started
Cyclist Keely Shaw captures country's first medal of the Paralympics with a bronze in pursuit race and swimmer Aurélie Baard follows with another in 50-metre freestyle, A20

TORONTO STAR
WEATHER: HIGH 33 C | CHANCE OF THUNDERSTORMS | MAP A22 | THURSDAY, AUGUST 26, 2021

If an unvaccinated person catches it from someone who is vaccinated, boohoo, too bad. I have no empathy left for the wilfully unvaccinated. Let them die. I honestly don't care if they die from COVID. Not even a little bit. Unvaccinated patients do not deserve ICU beds. At this point, who cares. Stick the unvaccinated in a tent outside and tend to them when the staff has time.

No job could mean no job for Air Canada employees
Workers without valid reason for an exemption have until Oct. 30 to be vaccinated

KARONELLE AND SHANAN TROTH
Air Canada announced Wednesday that it is mandating COVID-19 vaccines for all of its employees following other airlines that have imposed vaccine policies for their workers. The airline also announced that those who fail to comply or qualify for valid medical reasons may be terminated.

It's a polarizing debate, but patience and understanding for those not getting shots is in short supply as we all look to heal from pandemic
Story, A2

SECTION ON 31 RECENT POSTS ON TWITTER

- Should the vaccine be mandatory for Ontario cops? Police chiefs and officer unions take sides, A14
- Vaccination requirement to see live sports or shows will survive any court challenge, expect says, B1

AIR CANADA: continued on A7

... the process of doing research on news items, especially ones that will be broadcast on television or printed in a newspaper.

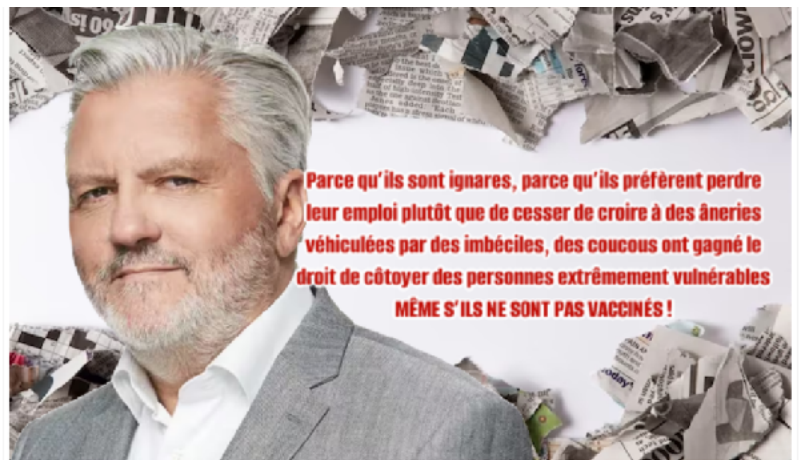
He defined propaganda as

Persuasive mass communication that filters and frames the issues of the day in a way that strongly favours particular interests, usually those of a government or corporations. Also, the intentional manipulation of public opinion through lies, half-truths, and the selective retelling of history.

According to Mr. Palmer, the CBC were putting forth as “experts” organizations such as First Draft, who provided propaganda information in place of actual news sources. The information provided by First Draft was in contradiction of other newspaper sources, such as articles in *The Washington Post* from April of 2020.

There were numerous reports in 2020 from publications such as *Vanity Fair*, which presented credible evidence contrary to reports by the CBC.

Mr. Palmer provided an article from the BBC from 2023, which directly contradicted the CBC reporting, and yet no retraction or further follow up from the CBC has been provided.



Richard Martineau, La victoire des coucous, Journal de Montréal, 14 octobre 2021.

Mr. Palmer cited internal correspondence from CBC concerning pandemic misinformation only weeks into the pandemic, a time when it would not have been possible to discern what was true or false information.

There are a number of industry groups that many of the traditional media in Canada are a part of that seem to be focusing on what they deem as “trust” issues, which Mr. Palmer asserted explains some of the monolithic reporting by many of these organizations.

According to Mr. Palmer, CBC took steps to report over 800 pieces of information found on social media that Internet service providers censored. It is difficult to understand how the CBC took on the role of censor.

Reporting was skewed toward developing public hate of people who were not in agreement with the government narrative, yet the CBC did not carry out an independent investigation of the information to confirm the truthfulness of the government narrative.

Qualifying language was used to promote the government narrative.

CBC also used articles to suppress alternative drug treatments for COVID-19. Mr. Palmer cited a CBC Radio News article from September 2, 2021.

Anita Krishna testified about the extent of the “hysteria” that was being promoted in the newsroom, right from the very start of the pandemic, prior to them having any real information available. She further stated that their newscasts were leaving out significant areas of information. In her opinion, the news was misleading, and she brought this opinion to management who disregarded her concerns and chastised her for bringing up alternative information.

Anita Krishna also spoke about how the new stories had been slanted to promote certain government narratives, and she had never before seen this level of propaganda and censorship within the newsroom.

Testimony from Marianne Klowak indicated that over her 34-year career at the CBC, she was always allowed to pursue stories without much restriction and that approval was always provided on the local level. During the pandemic, journalists were restricted as to what stories they could investigate and report upon as they related to the pandemic.

Ms. Klowak indicated that many of her stories were blocked and never made it to air; these included reporting on protests, reported COVID-19 vaccine injuries, safety concerns, and other pandemic-related issues.

Conclusions

Traditional media sources in Canada did not provide Canadians with fair and balanced news reporting during the pandemic.

According to witness David Leis, over 2,000 media outlets in Canada received federal government funding, and therefore, they are under great pressure to support the narrative being promoted by the government.

The government would not have been able to institute the unprecedented actions during the pandemic had it not been for the collusion between the traditional media and the government.

Traditional media sources promoted propaganda stories, promoted hate, targeted certain Canadians, and provided hateful and dangerous rhetoric.

Hateful and terrifying propaganda promoted terror in Canadians and prompted various people, organizations, and agencies to take steps based on that terror, instead of on science.

From the early stages of the pandemic until the current time, the traditional media has not yet taken any significant steps to correct the record for Canadians.

According to the Government of Canada, following is the definition of *terrorism*:

In Canada, section 83.01 of the *Criminal Code*^[1] defines *terrorism* as an act committed “in whole or in part for a political, religious, or ideological purpose, objective or cause” with the intention of intimidating the public “. . . with regard to its security, including its economic security, or compelling a person, a government or a domestic or an international organization to do or to refrain from doing any act.” Activities recognized as criminal within this context include death and bodily harm with the use of violence; endangering a person’s life; risks posed to the health and safety of the public; significant property damage; and interference or disruption of essential services, facilities or systems.

Given that the actions of the media caused terror and panic within all sectors of Canadian society and that this terror was the result of a political narrative handed down by the Government of Canada, consideration must be given to evaluate the detailed chain of decisions made, to determine if an act of terrorism was, in fact, carried out.

Recommendations

Canadian Broadcasting Corporation (CBC)

CBC as an organization must be held to account for their very damaging and dangerous actions. Significant steps must be taken to prevent this from ever happening again.

CBC was originally founded on November 2, 1936. Many of the principles under which the CBC was created and justified, no longer exist. With the advent of the Internet and the incredible reduction in the cost of creating quality content, the CBC no longer has a significant role to play in the promotion of Canadian content or the provision of media services to the rural and remote areas of Canada.

- A. **The CBC should be stripped** to its very fundamental functions of providing information to Canadians with a special focus on French language and Indigenous issues. All other current functions and productions of the CBC must be terminated immediately.
- B. **All current senior management positions** in the CBC must be removed in light of the revised operational mandate.
- C. **Dismiss all on air staff that participated** in the dissemination of propaganda during the pandemic.
- D. **Replace the CBC Ombudsmen** with a Board of Canadians chosen from across Canada, with two representatives chosen from each province and territory.
- E. **The first task of the Board is to investigate** the origins and relationships with the government and industry that influenced the actions of the CBC during the pandemic.
- F. **Remove the CBC from the “Trusted News Initiative”** and all other related organizations.

- G. **One of the original functions of the CBC** was to support Canadian content, and as such they should return to that role but not to the role as imagined in 1932; it must realize the reality of the 21st century. As such, the CBC mandate would be to help Canadians to develop Canadian content. We propose the following:
- a. CBC facilities and equipment, et cetera, might be made available as a resource to private media developers.
 - b. Utilize expertise that is currently embedded in the CBC to educate and provide training to private Canadian content producers.
 - c. CBC should use its resources to promote real Canadian content produced by Canadians, not the CBC.
- H. **A criminal investigation** must be undertaken to determine what areas of criminal hate speech law may have been violated based on the reporting of the CBC.

Other Traditional “Privately Owned” Media

Other traditional media outlets were as culpable as the CBC, but as private industry players, they do have the right to broadcast in accordance with the *Canadian Charter of Rights and Freedoms*. It would be extremely difficult to monitor their content on an ongoing basis, and it should not be the role of the government to regulate that content beyond required by current law.

- A. **However, any and all direct government support** to these media entities must be stopped immediately. There is no reason for Canadian taxpayers to be supporting these entities. They are privately owned and as such must survive in the free marketplace as every other private business must.
- B. **There is an uneasy monopolization** of traditional media that has occurred in Canada over the past 30 years. A complete investigation of the traditional media sources must be carried out under all federal legislation that deals with the development of monopolies in Canada.
- C. **A criminal investigation must be undertaken** to determine what areas of criminal hate speech law may have been violated based on the reporting of the traditional media venues.
- D. **Internet social media platforms** must not be censoring or editorializing content on their sites, unless the content is in contravention of the *Criminal Code*.
- E. **The Broadcasting Act must be rewritten** to accurately reflect the broadcasting environment of the 21st century. The *Broadcasting Act* should not be used as a tool of the government to censor content or to advance the promotion and production of Canadian content. The act must endeavour to accurately set out the rules and regulations and remove interpretation or development of regulations by an unelected body such as the CRTC.

- F. **The role of the CRTC must be reviewed**, and the CRTC possibly abolished if it is determined that the actual role of the CRTC is to simply develop regulations which are not specifically contained in legislation.
- G. **Bolster press freedom** and other media communications protections by enacting comprehensive legislation and constitutional provisions in alignment with the *Canadian Charter of Rights and Freedoms*, which ensures and upholds the rights of free expression, access to information, and editorial independence.
- H. **Safeguard journalists** from intimidation, harassment, and threats to their personal safety through effective law enforcement and judicial mechanisms.
- I. **Ensure that public broadcasting organizations**, such as the Canadian Broadcasting Corporation, operate independently and are insulated from political interference with editorial decisions made by experienced journalists.
- J. **Promote a diverse and inclusive media landscape** that reflects a wide range of perspectives and avoids undue concentration of ownership or control.
- K. **Increase transparency** in the allocation and utilization of public funds provided to the public broadcaster. This includes clearly disclosing the criteria and decision-making processes for funding distribution.
- L. **Establish independent bodies or committees** to oversee and evaluate the disbursement of public funds, ensuring accountability and preventing undue influence.
- M. **Foster the development** of non-profit and community-based media organizations to diversify the media landscape and provide alternative sources of information and perspectives.
- N. **Establish grant programs or tax incentives** to support the sustainability and growth of non-profit media outlets, enabling them to operate independently of government influence.
- O. **Promote media literacy education initiatives** that equip citizens with critical thinking skills to evaluate media sources, distinguish between fact and opinion, and understand the importance of independent journalism.
- P. **Promote adherence to professional journalistic standards and ethics**, including accuracy, fairness, and accountability.
- Q. **Support self-regulatory bodies**, such as the Canadian Association of Journalists (CAJ).
- R. **Enforce ethical guidelines** and provide recourse for individuals who believe they have been misrepresented or harmed by media coverage.
- S. **Engage in international forums** and collaborations to advocate for press freedom and protect independent journalism globally.

- T. **Support initiatives and organizations** that promote freedom of the press and other forms of media and provide assistance to journalists facing threats or persecution.
- U. **Encourage citizen participation** and engagement in media governance, including public consultations, forums, and advisory panels, to ensure diverse perspectives and community interests are taken into account.

By implementing these recommendations, Canada can foster a media landscape that is independent, diverse, and accountable, serving as a cornerstone of democracy and providing citizens with reliable, unbiased information. It is crucial to uphold the principles of press freedom and support traditional media outlets in their role as watchdogs and providers of independent journalism.

7.5. Health

Introduction

This section of the report is based on the testimony of more than 60 expert witnesses and dozens of citizens who have struggled with many health issues caused by health measures ranging from lockdowns, mask mandates, and vaccine mandates.

Emerging, from an overall assessment of the bulk of the testimonies, is a trend describing the evolution of most of the witnesses, at varying pace, of their respective understanding of this very complex and confusing COVID-19 pandemic health crisis. Whether it was expert witnesses or regular citizens, many were unaware of what was unfolding gradually, then suddenly, they came to appreciate that something odd was going on.

These informed individuals are still a fringe, yet there is a rapidly growing minority that are relentlessly sharing their understanding of the bizarre health crisis that we experienced.

Because of their habitual trust in the institutions, very few had detected the actual situation earlier on: the absurdity of the proposed non-pharmaceutical interventions (NPIs) along with the suppression of early treatment on baseless grounds.

Consensus grew with hundreds of thousands of people acknowledging in hindsight the absurdity of the pandemic management. Measures enacted by the government had massive collateral damage and hardly any demonstrated benefits. These measures were supported and presented to the public by a very powerful propaganda campaign. However, to this day, the majority of the population still believe that the NPIs were effective and vaccination was the only way out of the pandemic.

Disseminating the truth to the public will be a challenging endeavour. Unless individuals are willing to question the fundamental objectives of what the pandemic truly entailed and the reasoning behind altering established pandemic management plans to embark on an unprecedented and massive social engineering experiment, they will struggle to recognize the disastrous outcomes resulting from the mishandling of this crisis. Only by addressing these issues can we initiate the essential process of rectification.

List of Witnesses

In preparing this commentary, the authors relied on the following list of witnesses:

Lt. Col. David Redman

An expert on emergency preparedness, he testified on Canada's deviation from strategic pandemic response.

(Red Deer: April 27, 2023)

Dean Beaudry

He spoke about risk management and COVID-19 policies.
(Red Deer: April 26, 2023)

David Leis

An expert on public policy, he gave testimony on public policy during the pandemic.
(Winnipeg: April 15, 2023)

Dr. Natalie Björklund-Gordon

An expert in epidemiology and genetics, she revealed flaws in the COVID response.
(Winnipeg: April 14, 2023)

Michel Chossudovsky

An economics professor and director of the Centre for Research on Globalization, he reviewed the social and economic global collapse.
(Québec City: May 13, 2023)

James Corbett

An investigative reporter, he unveiled the global pandemic treaty and WHO's expanding authority.
(Ottawa: May 18, 2023)

Dr. Jérôme Sainton

A medical doctor, he analyzed the risk-benefit of vaccines.
(Québec City: May 13, 2023)

Christian Leray

A media specialist, he denounced the lack of transparency during COVID-19 pandemic.
(Québec City: May 11, 2023)

Dr. Jeff Wilson

A PhD in public health, he discussed the proper outbreak response.
(Ottawa: May 19, 2023)

Louise MacDonald

She broke down the misleading government data on vaccine statistics.
(Ottawa: May 17, 2023)

Dr. Stephen Malthouse

He gave a physician's perspective to challenging COVID policies.
(Ottawa: May 17, 2023)

Dr. Robert Malone

An expert in mRNA technology, he spoke about 5th-generation warfare.
(Toronto: March 30, 2023)

Dr. Steven Pelech

He discussed the science behind viruses and mRNA vaccines.

(Vancouver: May 3, 2023)

William Munroe

A population analyst, he provided insight into COVID death statistics.

(Vancouver: May 2, 2023)

Dr. Jonathan J. Couey

A neurobiologist, he gave a presentation on coronavirus, PCR testing, and pathogenesis.

(Red Deer: April 28, 2023)

Dr. Keren Epstein-Gilboa

An expert in developmental psychology, she gave a presentation on the impacts of the COVID measures on children.

(Ottawa: May 18, 2023)

Prof. Douglas Allen

An economics professor, he analyzed lockdown measures from a risk-benefit perspective.

(Vancouver: May 4, 2023)

Dr. Greg Passey

An expert in post-traumatic stress disorder, he spoke about narrative shaping and psychological damage from lockdowns.

(Vancouver: May 3, 2023)

Dr. Matthew Cockle

He discussed the conflicts of interest in global health research funding organizations.

(Vancouver: May 2, 2023)

Joseph Bourgault

He spoke on concerning CO₂ levels in paper masks.

(Saskatoon: April 20, 2023)

Irvin Studin

He spoke on the impact of school closures on children's education.

(Toronto: April 1, 2023)

Lynette Tremblay

She shared her heart-wrenching experience during lockdowns.

(Québec City: April 12, 2023)

Navid Sadikali

An expert in medical imaging, he explored pandemic rationale and the limitations of COVID injections.

(Ottawa: May 19, 2023)

Dr. David Speicher

He highlighted issues with PCR testing and COVID data.

(Ottawa: May 18, 2023)

Madison Peake

She gave a personal account of the lockdowns' psychological toll.

(Ottawa: May 17, 2023)

Kim Hunter

She discussed the detrimental effects of masking on children.

(Vancouver: May 3, 2023)

Ryan Orydzuk

He discussed occupational health and safety considerations.

(Saskatoon: April 21, 2023)

James Lunney

He explored the vital role of vitamin D for optimum health.

(Ottawa: May 19, 2023)

Dr. Francis Christian

He testified on the censorship of physicians, such as he and Dr. Paul Marik.

(Saskatoon: April 20, 2023)

Alan Cassels

He spoke about the UBC therapeutics initiative and provided a critical pharmaceutical analysis.

(Vancouver: May 2, 2023)

Bryan Baraniski

He spoke about alternative medication.

(Saskatoon: April 20, 2023)

Charles Hooper

He discussed the facts and fiction of ivermectin.

(Winnipeg: April 14, 2023)

Dr. Barry Bregar

He discussed the unnecessary fear, suppressed treatments, and vaccine dangers.

(Québec City: May 12, 2023)

Dr. Daniel Nagase

He discussed the unjust treatment of patients and doctors during COVID.
(Ottawa May 19, 2023)

Melanie Alexander

She shared the story of her husband's medical mistreatment during COVID.
(Ottawa: May 19, 2023)

Dr. Edward Leyton

He spoke of the influence of medical regulatory boards and ivermectin therapy.
(Ottawa: May 18, 2023)

Dr. Peter McCullough

He discussed a study into the autopsy results of vaccine injury deaths.
(NCI Virtual Testimony: July 19, 2023)

Dr. Justin Chin

He unveiled the truth regarding adverse reactions and the vaccine rollout.
(Red Deer: April 27, 2023)

Prof. Denis Rancourt

He presented findings on all-cause excess deaths in Canada during the pandemic.
(NCI Virtual Testimony: June 28, 2023)

Prof. Patrick Provost

An infectious disease specialist, he spoke about concerns with mRNA technology.
(Québec City: May 13, 2023)

Prof. Christian Linard

He discussed concerns about the potential risks and adverse effects of the mRNA vaccine, including its long-term impact on human health.
(Québec City: May 11, 2023)

Vincent Cantin

He testified about his severe vaccine injury.
(Québec City: May 13, 2023)

Dr. René Lavigueur

A family doctor, he shared his expert perspective on COVID-19 vaccine side effects.
(Québec City: May 12, 2023)

Dr. Sabine Hazan

A microbiome expert, she testified about effective therapies for COVID-19.
(Québec City: May 12, 2023)

Évelyne Therrien

She testified about her severe vaccine injury.
(Québec City: May 12, 2023)

Christine Cotton

She revealed flaws in Pfizer's clinical trials.
(Québec City: May 12, 2023)

Dr. Hélène Banoun

She discussed mRNA vaccines and their side effects.
(Québec City: May 12, 2023)

Carole Avoine

She testified about her severe vaccine injury.
(Québec City: May 12, 2023)

Colleen Brandse

She testified about her severe vaccine injury.
(Toronto: April 1, 2023)

Prof. Denis Rancourt

He presented findings regarding excess deaths during COVID pandemic.
(Québec City: May 11, 2023)

Caroline Foucault

She testified about her severe vaccine injury.
(Québec City: May 11, 2023)

Josée Belleville

She was a victim of vaccination obligations and discrimination in the army.
(Québec City: May 11, 2023)

Prof. Christian Perronne

He spoke on attacks, WHO infiltration, and the dangers of the COVID-19 injection.
(Québec City: May 11, 2023)

Prof. Jean-Marc Sabatier

He testified about the COVID virus and vaccine triggers.
(Québec City: May 11, 2023)

Pierre Chaillot

He testified on the misuse of statistics during COVID-19.
(Québec City: May 11, 2023)

Prof. Didier Raoult

He testified on the evolution of the COVID virus, treatments, and the vaccine.
(Québec City: May 11, 2023)

Mélissa Sansfaçon

She testified about her severe vaccine injury.
(Québec City: May 11, 2023)

Scarlett Martyn

A paramedic, she spoke about the impact of vaccine mandates.
(Toronto: April 1, 2023)

Kimberly Warren

She testified about her vaccine injury and severe kidney problems.
(Ottawa: May 19, 2023)

Aidan Coulter

He testified about his personal experiences as an unvaccinated student.
(Ottawa: May 19, 2023)

Pascal Najadi

He discussed the global implications regarding Swiss authorities and the enforcement of COVID vaccines.
(Ottawa: May 19, 2023)

Dr. Chris Shoemaker

He unveiled the risks and dangers of the COVID-19 vaccine.
(Ottawa: May 19, 2023)

Maurice Gatien

He provided historical context for what's happening and his work defending the vaccine injured.
(Ottawa: May 18, 2023)

Laurier Mantil

A letter carrier, she discussed balancing pregnancy and safety.
(Ottawa: May 18, 2023)

Capt. Scott Routly

He gave a pilot's perspective on navigating vaccine mandates.
(Ottawa: May 18, 2023)

Jean-Philippe Chabot

A former CBC employee, he gave insights into navigating his vaccine status disclosure.
(Ottawa: May 18, 2023)

Samantha Monaghan

She testified on the tragic loss of her son after a blood transfusion.
(Ottawa: May 18, 2023)

M Tisir Otahbachi

He shared his story of vaccine injury and what followed in the healthcare system.
(Ottawa: May 17, 2023)

Mallory Flank

A former paramedic, she shared her devastating vaccine injury story.
(Ottawa: May 17, 2023)

Sheila Lewis

She gave her heartbreaking story of her life-saving transplant being withdrawn.
(Ottawa: May 17, 2023)

Camille Mitchell

A pharmacist, she testified on vaccine mandates in healthcare.
(Vancouver: May 4, 2023)

Shawn Muldoon

He testified about his severe vaccine injury.
(Vancouver: May 4, 2023)

Paul Hollyoak

A coast guard rescue specialist, he testified about his severe vaccine injury.
(Vancouver: May 4, 2023)

Wayne Llewellyn

He testified about his struggles against vaccine mandates.
(Vancouver: May 4, 2023)

Zoran Boskovic

He shared his experience of losing his job due to vaccine mandates.
(Vancouver: May 4, 2023)

Ted Kuntz

He testified on Canada's lack of safety, efficacy, and Informed Consent for childhood vaccines.
(Vancouver: May 4, 2023)

Kristen Ditzel

She testified about her severe vaccine injury.
(Vancouver: May 4, 2023)

Patricia Leidl

She testified about her severe vaccine injury.
(Vancouver: May 4, 2023)

Dr. Ben Sutherland

He discussed the consequences of vaccine mandates.
(Vancouver: May 3, 2023)

Lisa Bernard

She testified on vaccine injury and the impact of lockdowns on patient care and mental health.
(Vancouver: May 3, 2023)

Dr. Charles Hoffe

He testified on natural immunity and COVID vaccine health issues.
(Vancouver: May 3, 2023)

James Jones

He spoke about the tragic consequences of the vaccine mandates and workplace bullying.
(Vancouver: May 3, 2023)

Edward Dowd

He discussed the alarming data behind increased death and disabilities.
(Vancouver: May 3, 2023)

Dr. Chris Shaw

A neuroscientist, he discussed his insights into the future of the vaccinated.
(Vancouver: May 2, 2023)

Deanna McLeod

She testified about the COVID vaccine approval and trials.
(Vancouver: May 2, 2023)

Serena Steven

A former nurse, she testified on vaccine-related injuries.
(Vancouver: May 2, 2023)

Philip Davidson

A public service employee, he discussed job loss due to vaccine mandate.
(Vancouver: May 2, 2023)

Vanessa Rocchio

She testified regarding COVID-19 genetic vaccine injury and cardiac damage.
(Vancouver: May 2, 2023)

Jennifer Curry

She testified about her severe vaccine injury.
(Red Deer: April 28, 2023)

Dr. Eric Payne

A pediatrician, he testified on the dangers of COVID-19 vaccines for children.
(Red Deer: May 28, 2023)

Dr. Misha Susoeff

A dentist, he discussed third-party Informed Consent.
(Red Deer: May 28, 2023)

Judy Soroka

She spoke of struggles with the vaccine mandate and medical treatment.
(Red Deer: April 26, 2023)

Dr. Gregory Chan

He spoke of his experience in healthcare during the COVID-19 genetic vaccine rollout.
(Red Deer: April 26, 2023)

Dr. Christopher Flowers

He testified regarding the clinical trial data reported by Pfizer.
(Saskatoon: April 22, 2023)

Dr. Maria Gutschi

She gave a presentation as a pharmacist and regulatory specialist.
(Saskatoon: April 21, 2023)

Steve Kirsch

He placed bets on "The Science" and discussed the statistics on vaccine data.
(Saskatoon: May 20, 2023)

Deanna McLeod

She testified about vaccine development and the changes to health safety regulations.
(Winnipeg: April 13, 2023)

Michael MacIver

An embalmer, he spoke about funeral industry abnormalities.
(Winnipeg: April 13, 2023)

Dr. Jay Bhattacharya

He spoke on the principles of the Great Barrington Declaration.
(Winnipeg: April 13, 2023)

Dr. Jessica Rose

She gave an in-depth presentation about VAERS data on COVID-19 vaccines.
(Winnipeg: April 13, 2023)

Dr. Joseph Fraiman

He shared his experience in the USA during COVID 2020.
(Truro: March 17, 2023)

Dr. Mark Trozzi

An ER physician, he gave a powerful testimony on mRNA vaccines.
(Toronto: April 1, 2023)

Laura Jeffery

A licensed funeral director, she spoke about post-vaccine embalming.
(Toronto: March 31, 2023)

Dr. Laura Braden

She addressed the natural origin of COVID and mRNA vaccines.
(Truro: March 18, 2023)

Dr. Patrick Phillips

A medical doctor, he had his medical licence suspended by the College of Physicians and Surgeons of Ontario (as of May 2022 in relation to his communications on social media)
(Truro: March 16, 2023)

Dr. William Makis

An oncologist, he spoke about vaccine mandates and Informed Consent.
(NCI Virtual Testimony: September 18, 2023)

7.5.1. Pandemic Preparedness Plan

Introduction

Pandemics are nothing new, and depending on the definition, there have been about five since the devastating Spanish flu of 1918.

There are historical records of other major pandemics; perhaps none are more notable than the Black Death (the Plague) of the late Middle-Ages that decimated a large portion of the European population. These major health crises usually happen in civilizations that have significant international commercial exchanges, when the overall health of the populations are under huge stresses like famine or war.

These pandemics have left a profound imprint on the human psyche and a warranted fear of disease and death that, historically, were mitigated by reasonable public control measures such as quarantining the sick. However, these troubled times have also been accompanied by irrational measures like “othering” and “scapegoating.”

After millions of years of natural evolution and culture, basic principles of immunity and hygiene were developed to ensure that we live in harmony with the biodiversity that surrounds us in the environment and in our own individual ecosystem made up of our microbiota.

Because of the high levels of human interaction across the world, there is a growing awareness that local epidemics can spread to larger geographic regions and become pandemics of global concern. At the international level, there are agreements in place to harmonize the management of pandemics, using the best practices from the international community.

Although human beings have an instinctual fear of sick people who could transmit diseases, contact with other healthy human beings is far from being dangerous, despite what some germaphobes obsessively espouse. Unless someone is afflicted by a permanent genetic immunosuppression or transient epigenetic immunosuppression due to poor life habits and comorbidities, the risk is negligible.

In fact, contact with other humans, animals, and plants enriches the biodiversity of the microbiota, which in turn educates the immune system—the ultimate foundation of health.

Recklessly isolating and cutting people off from interacting with society results in disease. And when people are sick, one essential condition for their healing is human care and a reassuring human presence; this reduces a sick person’s stress level, which is otherwise immunosuppressive.

The threat level of a pandemic ought to be gauged by the excess number of severe cases requiring medical treatments and excess deaths when the treatments failed. It’s not enough that a new pathogen erupts and produces a local outbreak, which then spreads to more than one country over the span of a few months.

If the levels of morbidity and mortality are not significantly manifested above the usual baseline population, it should not constitute a pandemic of international concern. It has to be managed locally with an appropriate epidemic management plan.

For respiratory diseases, which affect a significant proportion of the population, it could be challenging to accurately detect cases of a new respiratory virus, such as SARS-CoV-2, as many symptoms can be confused with symptoms triggered by other viruses such as influenza or other coronaviruses. Thus, the counting of excess sick people, above the baseline of other respiratory infections, can be inflated by erroneous attribution resulting from poor diagnostics.

The only objective way to monitor a pandemic on the local or global stage is to carry on in-depth analysis of all-cause mortality, as presented by Prof. Denis Rancourt and Pierre Chaillot.

The analysis of all-cause mortality, which cannot be biased by subjective attribution factors, leads to the conclusion that there was no COVID-19 pandemic caused by a particularly dangerous respiratory virus.

There were excess death peaks in various locations, but these excess deaths were better explained by the health measures deployed for example: the absence of early treatments; the use of ventilators; the use of end-of-life comfort medications like midazolam or Rivotril; the significant reduction in antibiotic use essential for the treatment of respiratory bacterial infection; and by the deaths of despair due to drug abuse and business closures in some sectors of the economy.

Interestingly, the analysis of all-cause mortality during the past century cannot detect significant excess deaths during all of the previous declared pandemics with the exception of the Spanish flu. This pandemic happened on the heels of WW1 on stressed populations that were weakened by fear, famines, and countless injuries, including respiratory airway damage due to the massive use of toxic gas.

And as we now know that the bulk of the influenza deaths during the Spanish flu pandemic were likely the result of opportunistic bacterial infections, treatable by antibiotics, the likelihood that a new respiratory viral pandemic will manifest a death toll similar to the Spanish flu is fairly unlikely.

This begs the question: Why were antibiotic prescriptions so drastically reduced during the COVID-19 pandemic, especially for populations that historically suffered from bacterial pneumonia?

World Health Organization Guidelines

For better or worse, over the past decades we have put in place pandemic plans at the supranational level, under the hospice of the WHO. We can now marshal the best scientific and risk management intelligence in case of a worldwide pandemic that threatens the entire human population. This appears, at first glance, a very noble and desirable objective.

Although this approach seems reasonable in theory, there are in practice two major issues with the centralization of pandemic management by a supranational organization of unelected bureaucrats.

The first one is the potential lack of accountability inherent in an organization staffed by unelected bureaucrats who may be perceived as are likely to be more loyal to the financial contributors of the organization, rather than to the member states. Since some contributors have major interests in the vaccine industry, this conflict of interest may be perceived to influence the agenda of the WHO, without firewalls to mitigate his unrestrained influence.

The second cardinal aspect is that proper management of pandemics cannot be effective if the management is not based on a localized approach. Indeed, many factors like the climate, the population density, age distribution, and cultural differences, to name a few, make the propagation of a disease very different from one country to the other. This cannot be managed centrally by distant bureaucrats that fail to consider the impact of local factors better appreciated by people closer to the terrain.

Furthermore, as people are fallible and corruptible, large unaccountable bureaucratic organizations are prone to foster abusive, self-serving policies that are exacerbated by incompetence and corruption. Nevertheless, individuals from these unelected groups, possessing varying degrees of expertise, are appointed to positions of authority without being held accountable to the public.

This conundrum cannot be corrected by the tax payer, who ends up financing these programs without real representation. As a result, the populations have little power to implement corrective measures when these programs are not delivering the best public health outcomes.

For every developed country, the healthcare system is the most significant budget item paid for by tax payers. As such, autonomy to manage healthcare services and public health measures should be the responsibility of elected officials who are accountable to their electors, not subjugated to supranational bureaucracies.

Provincial Pandemic Plans

Every province had an alternative pandemic plan available as of 2019 that was quite different than what was actually implemented. The national plan had been updated in 2016 based on sound public health practices that were developed from the hard lessons learned through previous pandemics. These plans were written together with all public health agencies and many other stakeholders, and they warned about the dangers of NPIs (for example, lockdowns).

By only considering the details of the mismanaged implementation plan, we are missing the real questions: Was the so-called “pandemic of international concern” properly defined? What was the real magnitude of the threat?

According to expert witness Lt. Col. David Redman, we failed miserably because there was no need to deploy these health measures in the first place, and on top of everything, the measures were not directed at the correct public health outcome.

In other words, before crafting, let alone deploying, a grandiose plan of social engineering on a massive scale, we need to ask in simple terms: To what problem is this plan the solution?

And if the problem is ill-defined, the solution is most certainly going to do more harm than good, especially in a fake emergency situation that granted permission to authorities to suspend our normal way of living and disregard personal responsibility. We were treated as a hazard, in and of itself, instead of an asset that would be part of the solution.

If the plan was to create havoc to destabilize the fabric of society, to produce significant morbidity and mortality while creating massive wealth transfer and concomitant impoverishment of the middle class through inflation and public debt, cynically, it was a success.

Strangely, what was actually implemented goes totally against the wisdom of the established pandemic plans that acknowledge that disrupting normal life is very costly both financially and from a public health perspective.

Therefore, from the perspective of public health and population autonomy, which are an essential need for the prosperity of a society, the management of the COVID-19 crisis was a total failure.

The "All Hazards" Approach

We all live in an environment filled with potential hazards, both short and long term. We need to respond to those many hazards with targeted mitigation strategies framed with risk-benefit analysis for each of these measures, be they passive or active. Obsessively focusing on one hazard is ill-advised and a recipe for collateral damage concomitant with neglecting other hazards or essential needs.

By neglecting to present a more balanced perspective of the emergence of a new respiratory virus, the WHO's successive announcements, starting early 2020, revealed their intention to act as merchants of fear.

On January 20, 2020, based on 1,076 cases, of which only 83 confirmed cases were outside China, (on a population of 6.4B excluding China), the WHO, declared that the window was closing on a health emergency of global reach. This has to be put in perspective with poor case assessment based on confusing symptoms and RT-PCR testing not clinically validated.

A RT-PCR (Reverse Transcription Polymerase Chain Reaction) test is a diagnostic tool used to detect the genetic material (RNA).

On March 11, 2020 based on 44,274 cumulative cases, out of a global population of approximately 8.1B people, obfuscating a likely high proportion of recovered people that would have dampened the danger signal, the COVID-19 pandemic was officially declared. This announcement, of a pandemic, precipitated the worst financial market collapse since 1929. It has been alleged that many people took advantage of the initial market crash through insider trading.

And based on the WHO's fear-mongering, gradually most of the 190 members states of the WHO initiated the ritual of lockdowns for two weeks, which extended to two years, to allegedly flatten the curve.

But what curve? In Canada, on March 9, 2020—two days before the pandemic declarations—there were 125 cases in a population of 38.5 million. The way these cases were determined may be suspect, and no information on the severity of the cases was provided. It is not known how or if these reported cases were clinically validated to be caused by the SARS-CoV-2 infection. Presumably this information could not be determined as the virus had not been identified at the time. Without this critical information, the public was led to believe that the virus was potentially mortal for everyone. This fear was magnified by media reports of people dropping dead in the street in China: fear-mongering on steroids.

In February of 2020, public health already knew that 95 per cent of people dying from what was later named COVID-19 were over 60 years old and had multiple comorbidities. This means that they should have been focussing on targeted protection.

The updates from the WHO showed the same profile every single week starting in March 2020. In Canada, the average age of death with COVID-19 is 82 years old with severe multiple comorbidities. A common characteristic of those who reported died is obesity—83 per cent for the most severely ill—but they didn't report this information. Why was this risk stratification Not broadcast by any health authorities.

To make matters worse, the health measures discouraged physical exercise. And the stress led to overeating, often of processed food, and increased consumption of alcohol, which contributed to significant unhealthy weight gain of the population.

At the time of writing this Report, Theresa Tam was still broadcasting 52,000 deaths in Canada to keep on scaring people. Meanwhile, on the official Canadian government website, the number was 32,659, almost 40 per cent less. Importantly, Canada ranked last of the Organisation for Economic Co-operation and Development (OECD) with 73 per cent of deaths occurring in long-term-care (LTC) homes. And of the deaths in Canada, 93 per cent were of people over 60 years old.

At the outset of the pandemic there was a good plan to address this declared public health emergency. It was based on controlling the spread of the disease—not cases—while reducing morbidity and mortality by providing access to appropriate prevention measures, care, and treatment. It also entailed mitigating social disruption through ensuring the continuity and recovery of critical services, minimizing adverse economic impact, and supporting an efficient and effective use of resources during response and recovery.

Yet instead of following established emergency plans, many countries followed the game plan elaborated in the Event 201 pandemic simulation, organized in the fall of 2019. Although well intended, the framework of this pandemic plan was misguided by business and military people, along with a few doctors and scientists that had a strong bias in favour of NPIs.

The result of their exercise made absolutely no sense to many experts in public health crisis management. Yet Canada followed it to the letter. Only a few states didn't: Sweden and Florida.

And in spite of the harsh criticism and claims that they would be responsible for unnecessary deaths from COVID-19, both Sweden and Florida were vindicated for not following the script as other states had. Their “all-cause excess mortality adjusted for age” revealed death numbers much lower than many comparable states that had been more diligent on lockdowns and masks.

In Canada, we failed at all of the basic tasks of Emergency Management Plan (EMP). It does not appear that any of Canada’s health agencies conducted a systematic analysis of peer-reviewed literature of potential treatments for similar coronaviruses like SARS-CoV-1 or MERS. Nor did they conduct in real time, a cost-benefit analysis of the health measures deployed, using the best independent experts who were free of conflicts of interest.

When the portrait of a public health crisis is not painted with solid data that is put in the right perspective, the fear instilled in the population by decision-makers broadcasting a distorted picture of events results in massive collateral damage, as we have seen.

But it’s also possible that many fearful people were blinded by the feel-good ideology of “saving lives” at all costs. The multi-faceted aspects that must have been considered, which included collateral damages both at the individual and collective levels, were ignored.

With a narrow mind-set excessively focussed on the alleged danger of COVID-19, the public was trapped in the perceived dilemma of exchanging economic damages for alleged life-saving procedures: the effectiveness of which were only hoped for and not demonstrated. Moreover, the fact that economic stress could lead to bankruptcy and become the gateway for future morbidity, due to anxiety, depression, substance abuse, and suicide, was also ignored. So whose lives were being saved in the end?

Government measures failed to protect our most vulnerable—as evidenced by the death toll in LTC homes—and sacrificed our younger generation’s future. What can compensate for the precious years of socialization, language learning, and education lost by our children, who will also have to carry the burden of a national debt that ballooned from \$750 billion to \$1.3 trillion in one year?

To have deployed one-size-fits-all public health measures, as if everyone were equally vulnerable, is at best incompetent, if not malevolent. Why was there such a focus on the wrong NPIs? Many officials erroneously assumed it would protect the healthcare system.

The push to “protect” the healthcare system was motivated by the fear that if the system collapsed under the pressure of caring for excess sick people, the ability to provide care for other medical needs would also suffer. Paradoxically, to prepare for the anticipated flood of COVID-19 patients, treatment of other medical concerns deemed not as urgent were postponed by administrative edicts.

On top of this, many people forfeited or avoided seeking medical care for other issues for fear of catching COVID-19 in the hospital. On what grounds did the administrative state know that the COVID-19 disease was a greater health threat than all of the other illnesses? Is it because they blindly believed so without proper assessment?

That irrational fear fuelled by the increasing number of RT-PCR positive COVID-19 cases, the majority of which were asymptomatic, led to a misplaced focus on future COVID-19 cases. Many of the COVID-19 deaths may have been generated in the first place by denying patients early outpatient treatment for the illness.

This was exacerbated by the continual perpetuation of fear and the disruption of normal social life, both of which contributed to the dampening of the immune system. For the most vulnerable, this no doubt led to increased susceptibility to diseases of all kinds, including COVID-19.

How Did That Happen?

According to the testimony of Lt. Col. Redman, it happened due to:

Incompetence: All of the premiers failed to do their own research to gain a deeper understanding of the pandemic's true threat. Then, many premiers put the wrong person in charge; premiers should have retained final control of the situation as elected representatives. The medical officers were incompetent by refusing to acknowledge they couldn't do it alone. Why did they, against the best practice recommendations garnered from previous pandemic management, use the wrong NPIs? When challenged in court, they could not produce a single cost-benefit analysis to justify it.

Hubris: Once you make a mistake, it's difficult to admit it. Governor DeSantis did it in Florida, but it's rare. After talking to the relevant experts, he admitted: "I got it wrong."

Without acknowledging the mistake, course correction is very difficult and doubling down seems the only strategy until one is confronted by the evidence from censured documents, such as "The Lockdown Files" in the UK and the flurry of documents from the Twitter files. But these revelations were late coming, and the decision-makers felt they would be off the hook long enough to avoid confronting the consequence of their mistakes.

Self-gain: Politicians were on TV every night and the carefully crafted message, vetted by numerous polls, assured them to win their elections by not admitting their mistakes. The spin on the message was: "We did the best we could under the dire global circumstances; nobody could have done better, and now the crisis is behind us, let's move on."

Emergency Management Plan (EMP) and Recommendations

And yet, massive collateral damage has been done; we will be experiencing the enduring effects for generations to come. Not acknowledging the damage only makes matters worse as it precludes the implementation of much needed corrective measures and raises the dark prospect of repeating the same mistakes, or even worse, next time.

The plan to protect public health in case of a severe threat like a pandemic was diverted and turned on its head to protect the healthcare system. Scared public health officials responded to the scared public by focusing the plan on protecting the healthcare system as a proxy of the public.

They failed to recognize that the best strategy to minimize the strain on the healthcare system, be it for physical or mental health conditions, would be to promote good life habits: healthy food, physical exercise, vibrant social life, and other stress reduction practices. That would have reduced the likelihood of people getting sick or progressing to more severe forms of illness.

What did they do instead? They failed to acknowledge that seasonal respiratory diseases are in part the result of low vitamin D levels due to lack of sun exposure. They also stopped providing vitamin D levels due to lack of sun exposure, they stopped providing vitamin D supplementation in many LTC homes and prevented people from going outside to get sun exposure and fresh air where the risk of contamination was non-existent. By contrast, these vulnerable people were locked in poorly ventilated indoor environments, denied social activities that included family and friend visits, and were scared non-stop by the media about the danger of the virus.

Is that really the best way to prevent progression to severe illness? When people got sick under these poor health conditions-not to mention the poor quality of food in many LTC homes-and because COVID-19 was deemed untreatable, the elderly were offered end-of-life comfort medication.Can that explain why in Canada 73 per cent of COVID-19 deaths were recorded in LTC homes?

We must question the wisdom of blindly following the marching orders of the WHO as if infallible, particularly since the WHO seemed to work in tandem with the mainstream media and government-controlled social media to expunge from public discourse any questions about the pandemic plan du jour.

As revealed by "The Lockdown Files,"¹³⁰ the pandemic was managed by uninformed people, and the WHO became the justification for all of the other states to follow the "clowns in chief," as Dr. Didier Raoult put it.

From an epidemic perspective, efficient local measures are much more effective; there is not a one-size-fits all approach. This is a clear example of the tension between two opposing governance philosophies: top-down global control under the pretext of security versus subsidiarity manifested in bottom-up local measures that respect liberty and individual responsibility.

Recommendations

- A. **Rectifying the Mistake of Discarding the Emergency Management Plan:** The decision to discard the Emergency Management Plan was a significant error that will require rectification.

¹³⁰ "The Lockdown Files" are a series of articles in *The Daily Telegraph* containing evidence, analysis, speculation, and opinion relating to more than 100,000 WhatsApp messages obtained from former health secretary Matt Hancock that were leaked to them.

- B. **Realigning the Purpose of Pandemic Measures:** The objective of pandemic measures should have been to minimize the impact of SARS-CoV-2 on society, rather than solely focusing on safeguarding the healthcare system.
- C. **Utilizing Hazard Assessment for Targeted Responses:** The Hazard Assessment, which continued to identify those most at risk, revealed that lockdowns did not effectively protect them. A more targeted response would have been more appropriate.
- D. **Learning from Past Pandemics:** The lessons learned from previous pandemics were regrettably disregarded.
- E. **Reevaluating Non-Pharmaceutical Interventions (NPIs):** The use of non-pharmaceutical interventions did not significantly reduce the spread of COVID-19. Employing them during the initial wave could have been seen as, at best, a mistake. After the first wave, it became a matter of grave concern.
- F. **Recognizing the Unintended Consequences of NPIs:** NPIs have resulted in substantial collateral harm and loss of life, often surpassing the impact of the virus itself. Public health was aware of this prior to COVID-19, and yet no cost-benefit analysis was conducted. This constituted a grave error.
- G. **Holding Leaders Accountable:** Public authorities bear responsibility for the response to the pandemic and the perpetuation of fear. Accountability should be enforced.
- H. **Safeguarding Our Society and Democracy:** Failure to revise our Emergency Management Plan and dispel false beliefs in non-pharmaceutical interventions places our society and democracy in jeopardy.

7.5.2. Follow the "Science": Real Science or Scientism?

Introduction

From the start of the scientific era, which followed the Renaissance's rediscovery of ancient Greek wisdom, to the industrial revolution that propelled us into unprecedented prosperity, our societies have increasingly depended on science and technology. In a world that's becoming more materialistic and moving away from traditional spiritual practices that used to provide the foundation for our understanding of life's meaning, we've even come to revere our technological achievements almost like sacred objects..

In a materialist world devoid of transcendence, the primary goals are the incessant accrual of power, status, and money, with everything they can buy. And everybody is closing the door of their golden cage while willingly accepting entrapment in it with all of their material comforts.

Paradoxically, as material comfort has become the ultimate hollow goal of life, the general knowledge of science and technology that underpins our material way of living has not received the attention required to equip citizens and decision-makers alike to propose optimal solutions in the face of complex problems.

To put it in simple terms, from the general public to the political class and everything in between, including the media, there is insufficient literacy in mathematics, the sciences, engineering, technology, and so on. Yet to those who master these disciplines, immense power awaits as they strive to capture the benefits of a growing monopoly on knowledge and technology. Hence, a new pseudo-religion and its mantra, "Follow the science," has subjugated the non-critical-thinking crowd.

As explained by many witnesses, confusion due to poor understanding of the scientific process as well as poor knowledge of cutting-edge science in epidemiology, virology, and immunology in the political class, institutions, the media, and not to mention the general public, was at the root of the mismanagement of this public health crisis. It was a situation exacerbated by widespread corruption, as we have witnessed.

Data, Information, Evidence, and Knowledge

Most people have been mesmerized by all the data yet fail to understand the distinction between data, information, evidence, and knowledge. Data is raw facts, statistics, context-free numbers. Information is data that has been processed to provide a proper framework of the context. Evidence is yet another level in which the information is framed to generate testable hypotheses upon which evidence can be fortified. From validated evidence, a body of knowledge accumulates over time as the evidence underpinning it withstands the trial of repeated testing and reproducibility.

Needless to say, during the pandemic, authorities frequently fed the public data that was of questionable quality, validity, interpretation, and scrutiny. Meanwhile, the mainstream media, clueless at the best of times, happily disseminated and endlessly commented upon the data with an air of authority.

Tragically, the population was misled by propagandized misinformation: not through so-called misinformation spreaders on social media but rather through the orchestrated work of official channels, in concert with mainstream media and the censorship of social media.

When a fact is yet to be verified, it is best to specify that all the explanations proposed are hypothesis yet to be verified. A golden rule in research is that one does not develop hypotheses on hypotheses but on validated facts--all of the relevant known and verified facts, that is to say, on observations and the description of phenomena validated by the scientific method. In addition, the methodology of the research and the population on which it was carried out are to be considered before making generalizations.

The sample choice, the experimental protocol—which hypotheses were tested—and the statistical analysis of the results are of paramount importance when it comes to generalizing a negative or positive result from a study to a complete population. Cross-correlations, observer biases, sample size, and many other factors must also be considered.

The study of human beings is complex and the study of an entire population even more so. In the end, ideally, rather than the observation should be free and unbiased. When our observations are unbiased, we avoid getting bogged down by more confusion than knowledge—even if for some it is more reassuring or gratifying to formulate fanciful, often simplistic, explanations to the detriment of scientific rigour.

The most insidious of ignorance is not what we do not know but what we hold to be true without question and which turns out to be false.

Science is constantly evolving through rigorous exploration of new theories, which are bound to gradually change in nuance or be invalidated by new evidence. Thus, the “consensus” of the moment, supported by the majority of scientists, may eventually prove to be outdated or downright false in the light of new empirical findings.

This is compounded because too often results published in very good peer-reviewed journals have proven to be non-reproducible. How much of a problem is that? This is unfortunately very common in medical research as revealed by the famous article: “Why most published findings are false,” written in 2005 by eminent epidemiologist John Ioannidis, one of the most cited scientists in the world in the field of clinical medicine and social sciences.

This article, the most downloaded from the *Public Library of Science Medicine* journal, is the most consulted article on the site with more than three million views. It has become an essential reference in relation to the difficulties linked to the reproducibility of scientific studies. Since the publication of this shocking article, a multitude of studies have come to corroborate this worrying observation.

In general, however, these difficulties are poorly documented because the system in place does not favour the dissemination of such information. Indeed, it is very difficult to publish results invalidating what has already been published in the scientific literature. This, therefore, singularly complicates the practice of scientific research and sets up researchers to embark on the wrong track.

This pre-mature publication of studies that cannot be faithfully reproduced is a serious problem, and it was greatly exacerbated in the COVID-19 era as a large number of experts from all walks of life rushed to contribute to the scientific effort to confront the pandemic. Discernment to avoid going astray requires research training and experience, which the vast majority of media commentators, who have little or no practical experience in scientific research, lack.

Any well-trained researcher is perfectly aware of the limitations unverified and unconfirmed data and examines with great circumspection studies that have not been reproduced by independent teams protected from conflicts of interest. Minimally, before fully embarking on a research project, it is necessary to begin by reproducing the crucial results at the basis of the hypotheses to be explored.

Ultimately, it's not primarily about being right or wrong; it's about fostering dialogue to gain a clearer collective understanding and to implement solutions that can improve the resolution of stubborn issues stemming from complex systems, which challenge our overly simplified analyses.

Despite anything the mainstream media, social networks, or our politicians might postulate, it is important to recognize that one cannot lie with physics or biology. We must be cognizant of what nature reveals to us, avoid the pitfalls of ideological filters that hide or distort reality, and act accordingly. We must be extra vigilant not to be bogged down by confusion, which is all the more comfortable when it is widely shared.

Scientism

We must make a clear distinction between the belief system or ideology of reductionist materialist science and the pursuit of knowledge that science engages in with an open-minded approach to all new discoveries.

This quest for knowledge, the which is built up through accumulated observations, the development of explanatory theories, experimentation and the generation of new data that confirm or invalidate current theories, should not be restricted to the physical material world alone.

The quest should encompass the entirety of reality, including the metaphysical and spiritual realms. However, this is where most materialistic scientists encounter difficulties. Despite new neurological evidence supporting both the placebo and non-placebo effects, many materialistic scientists still find it challenging to recognize the influence of the mind on physical health.

In this emerging pseudo-religion that materialist science has taken on, often presenting itself as the sole valid path to knowledge, we find ourselves marvelling at the immense capabilities of humanity. It's hard not to believe in our potential to achieve remarkable feats, given the extraordinary progress we've made since the Industrial Revolution.

We succumb to hubris, a trait warned against in ancient tales like the Tower of Babel or the story of Sisyphus, who challenged death. Armed with our science and advanced tools such as computers, we create models aimed at describing nature in immense detail, with the ambition of making highly precise predictions. In doing so, we believe we can alter the course of events with surgical precision, if needed.

We believe that everything would only have beneficial effects, without collateral damage. And we take ourselves for demiurges who can only make good decisions.

This intoxication of power pushes the limits of our ignorance into a blind spot. And the most ignorant are those who are convinced that they know enough but who understand only very superficially the evolving knowledge of science and especially its limits.

With their pseudo certainty, they derive narratives used to justify decisions and actions that cannot be doubted because they have followed the science. Any opposition to this scientific orthodoxy being decried as "conspiratorial" or backward is easy to denigrate, ignore, or censor. And the hunt for heretics is relaunched as in the days of the Inquisition.

It is as if the questioning of the dominant "consensus" of "accepted" science, of which the media is the mouthpiece, was in essence unscientific, ignoring that science fundamentally progresses according to an iterative process that does not sit well with a fixed dogmatism promoting a doxa to which we should adhere.

Knowledge is Not Wisdom

Wisdom invites us to cultivate the humility stemming from our ignorance, which is far greater than what we think we know. Complex phenomena cannot be reduced to simple causes that are supposedly invested with such high explanatory power that we can predict the future with an easily deployed computer model. For models to be valid, they should consider all parameters that can affect the system, as well as the degree of their combined interactions.

We often forget that at our stage of knowledge, these models have limited predictive power. They have to be constantly refined by empirical data, which is often difficult to obtain. However, it is sometimes possible to obtain the data when we take the trouble to compile and analyze relevant observations and the empirical tests of our theories. Retrospective and prospective studies are essential for closing the loop on our often risky predictions. These studies should teach us humility in the face of our cognitive limits and should influence us to exercise caution when we attempt to predict the future.

Unfortunately, the need to communicate, often on a daily basis, a simple message that is accessible to people who may not have the expertise (or the attention span) to appreciate the complexity of these systems, can lead one to propose simplistic, reductive explanations. Those can produce the illusion that we understand what is happening well enough to intervene only positively on the system. As Albert Einstein advised: we must strive to formulate explanations that are as simple as possible but not simplistic.

In our scientific exploration of complex phenomena, it is crucial to take advantage of the long experience of our ancestors who learned to develop strategies which, although imperfect, nevertheless made it possible to face difficult conditions whose complexity overwhelmed them. In other words, we must learn from past experiences, with their share of errors, so we do not have to rediscover knowledge already acquired at the cost of painful historical attempts at trial and error.

We must also be careful not to consider that new theories are necessarily better because they are more recent. The hegemony of these theories du jour is more often due to the philosophical, psychological, and cultural bias of the time than to their scientific merit.

There is a great body of ancient knowledge and wisdom that could be more valid than the new theories because it has stood the test of time. One must be wary of theories that deviate into militant ideologies under the guise of science. Above all, let's remember that while science describes nature with ever-increasing acuity, it is powerless to advise what to do with this necessarily partial and provisional knowledge and technology. Knowledge may be one of the important elements of the process, but it is certainly far from sufficient to access wisdom.

One wonders what sort of world we live in when people refuse to be exposed to different viewpoints and quickly resort to denigration and censorship as a way to protect themselves from information that would challenge their worldview—our “religion.” Our world seems to be under the influence of two dominant ideologies: scientism in synergy with wokeism.¹³¹ Both ideologies are completely at odds with science.

¹³¹ Wokeism: Usually Disparaging. Promotion of liberal progressive ideology and policy as an expression of sensitivity to systemic injustices and prejudices. <https://www.dictionary.com/browse/wokeism>. (accessed 2023)

The COVID-19 crisis exposed profound societal issues that existed before but had not been widely recognized. The pervasive sense of fear, especially among baby boomers, about death had in many ways numbed our ability to fully embrace and celebrate life. We saw a form of intergenerational prejudice during this pandemic in the willingness to mortgage the lives of the youngest to reassure the oldest.

This obsessive fear was rooted in the disconnection of the meaning of our lives as revealed in all the mythological, religious, and spiritual accounts of humanity, for millennia. In the dominant materialist narrative that we inhabited, there was nothing outside of the material dimension, and after the physical death of our bodies, that would be nothingness. This nihilism was frightening. It was also a source of fragility that the authorities exploited in order to govern through fear.

Recommendations

Considering the critical reliance of our modern society on science and technology, there is a need to distinguish knowledge derived from the rigorous scientific method from beliefs often influenced by ideologies and propaganda. To help distinguish between the two, we recommend the following:

- A. **Basic training in epistemology and critical thinking** should be incorporated into both humanities and scientific or technological education curricula.
- B. **Experts who participate in public forums** should undergo scrutiny based on the following four fundamental criteria:
 - Demonstrated cutting-edge knowledge and expertise, as evidenced by their involvement in past or ongoing scientific research, providing proof of their understanding of the subject under discussion.
 - Lack of conflicts of interest.
 - Willingness to engage in evidence-based public debates with other experts who may hold differing opinions. Such engagement should involve using rhetoric that avoids ad hominem attacks, appeals to authority, or invoking the mislabelled “scientific consensus.”
 - The detailed, unedited credentials of these public figures must be made known and available to the public. This will enable the public to ascertain the credibility of such experts.

7.5.3. Epidemiology 101 in the COVID-19 Era

Introduction

The concept of epidemiology dates back to Hippocrates, who observed that by and large, there were two types of diseases: endemic diseases, which occur continually in the population, and epidemic diseases, whose occurrences are sporadic, such as infections with unprecedented symptoms.

Although the science of epidemiology has made much progress since antiquity, understanding the occurrence and the evolution of a new disease that creates significant morbidity and mortality is still a huge challenge. The occurrence of a new pathogen—its transmission in human populations, the interaction with the infected host leading to diseases of varying seriousness, and the ultimate resolution of an epidemic as it progresses to the endemic state—is a highly complex multifactorial phenomena whose driving forces are difficult to identify. The relative contribution of the various factors is also very difficult to measure. We have learned a lot since the beginning of the modern scientific adventure, yet our knowledge is still very limited.

The paradigm of modern reductionist materialism, starting with Descartes, is that the world is like a machine whose parts interact with one another according to specific laws of nature written in the language of mathematics. According to this paradigm, all we need to do is identify the components and discover how they interact with one another. With that understanding, it's assumed we can control the world.

That worldview has several shortfalls as it applies, for example, to the science of epidemiology and as it converges at the intersection of statistics, physics, biology, engineering, psychology, sociology, and politics. The many unknowns in all of the parts of this idealized machine, let alone in the ways they interact, make any modelling attempts to describe and predict how that works is at best naive, if not totally misleading, in many respects.

A flurry of mainstream media commentators took centre stage to project the illusion that epidemiology was a mature science able to predict the evolution and control of pandemics with sophisticated models fuelled by powerful computing. The reality was that what we learned about epidemiology over the past decades had not made our understanding of the COVID-19 pandemic any different than previous pandemics. This illusion of knowledge fooled many people into thinking that they could attribute the rise and fall of epidemic waves to specific human interventions or lack thereof.

The main innovation during the COVID-19 pandemic was the questionable deployment of the RT-PCR diagnostic as a proxy to follow the epidemic waves. Strangely, instead of monitoring the waves of sick people, public health focused their attention on the presence of a viral genetic sequence to define a “case,” irrespective of its consequence on morbidity and mortality. Moreover, despite the poor predictive power of the RT-PCR tests to inform disease progression, they were used in attributing deaths from COVID-19 to respiratory illnesses of all kinds and without formal demonstration. This created systematic errors of attribution that biased official statistics all over the world.

Over-reliance on Modelling

We were misled by models. Without delving into too many details, it is necessary to discuss the concept of viral transmission. The physicochemical interaction of an ill-defined biological agent, the virus—which is sensitive to all kinds of environmental conditions, like UV and humidity—travels in the air to enter the airway of another biological being, which will interact with this virus in different ways, depending on the robustness of the mucosal immune system challenged with an unknown viral load.

Combining all these parameters, which we cannot properly measure in a web of interactions, quickly becomes a combinatorial explosion of probabilities that are impossible to determine. Assuming we could measure all of the parameters, which we cannot, modelling is then challenged by the mathematical laws governing the interaction of the different components.

A relatively simple example is the law of fluid dynamics to estimate the virus transmission in the air, depending on the gravitational force, wind velocity, and humidity. As the equations cannot be fully resolved, we have to assume several measurements. Without those precise measures, what are we going to input as a modelling parameter?

The bottom line is that modelling is a useful tool to generate a working hypothesis, based on approximate assessment, to be validated by empirical measures. Modelling cannot make accurate predictions of complex systems. The limitation is not only the computing power but also the uncertainty about the input parameters to run the model. If the assumptions are incorrect, the output of the model is useless for prediction and is referred to as a GIGO model (garbage in, garbage out).

The over-reliance on models can be due to the difficulty in testing model predictions experimentally or due to the time involved to collect data before the model’s accuracy can be formally assessed. Nonetheless, when a modeller consistently misses the target by a long shot, it would be wise to question the assumptions and mathematical process used to produce its prediction.

A stunning example was the misleading prediction that resulted from inaccurate modelling. This modelling team had been repeatedly off target in their predictions for more than 10 years: notably in the last flu pandemic of 2009 and the mad cow disease debacle that led to the unnecessary slaughter of cattle herds and huge economic losses for UK farmers.

Proper Monitoring of Pandemic Progression

It follows that we must be very wary of modelling. The only way to determine if any human intervention will influence the progression of a pandemic is to carry out well-designed observational studies in randomized trials whenever possible to eliminate the unknown influence of confounding factors, while carefully avoiding random errors and monitoring systematic errors resulting from selection or information biases.

Only true experts with established credentials and a track record can generate and properly interpret those epidemiological studies. Many of those experts informed us of what to expect by making analogies with similar epidemics of the past. The inescapable conclusion of the careful analyses of the best experts, like Prof. Denis Rancourt and Pierre Chaillot, was that there were no pandemics of extraordinary magnitude in 2020-2023, as the authorities promulgated for those three years.

The scale of the pandemic was exaggerated, and in rich countries—with notable exceptions such as Sweden, Japan, and a few American states—the health measures deployed caused more damage to the health of populations than COVID-19 itself. Although Sweden had a bad episode in long-term care homes during the first wave in early 2020, they refrained from imposing lockdowns and ended up with much better public health outcomes.

Statistics compiled at the global level showed that the median age of people who died of COVID-19 exceeded the age of life expectancy and that the vast majority of seriously ill people had several other pathologies. This led Richard Horton, editor-in-chief of the *Lancet*, to declare in his September 26, 2020, op-ed that the COVID-19 pandemic was truly a syndemic. That is, COVID-19 disproportionately affected the most vulnerable. Healthy young people were more than 1000 times less likely to be seriously ill or die from it. In these circumstances, he was advocating for more nuanced public health measures, as did the signatories to the Great Barrington Declaration.

Furthermore, the peak of excess deaths observed in different regions of the world coincided with the drastic measures put in place to manage the perceived threat. It's almost impossible that those excess deaths were caused by the dissemination of a deadly virus which didn't spread across borders and remained in discrete locations within a state or across states.

The drastic measures included (1) withholding early treatments, (2) inappropriate use of ventilators that restored anoxia in COVID-19 patients deprived of early treatments, (3) withholding antibiotics to treat incidental bacterial pneumonia, and (4) comfort end-of-life treatments for patients deemed incurable.

An accurate account of the COVID-19 pandemic revealed the story of a statistics fraud. What did they count? The definition of *pandemic* was changed. It became a statistical pandemic with cases. After changing the definition in 2009 by ignoring the gravity criteria and only counting numbers of sick people, the WHO further changed it in 2020 to count cases—including people who may not have been sick. Looking at all-cause mortality adjusted for the age pyramid, we note that 2020 was among the lowest since that statistic has been recorded. Nothing happened, anywhere in the world.

As for hospital saturation: for example, in France, even with the dubious attribution of hospitalization due to COVID-19, those patients made up only about two per cent of hospital occupancy. The only apparent hospital saturation was induced by an administrative decision to send all the respiratory-symptom patients (up to three million in France) to only seven of the 1500 hospitals.

Because of the planning already in place in anticipation of COVID-19 waves, hospitals were emptied, and people avoided them due to fear. As a result, the occupancy was much lower for many months—for example, 50 per cent empty in April 2020. No pandemic was evident when measured by an increase in respiratory disease by the sentinel network, a monitoring system. To put the data in perspective, during the worst previously reported pandemics, the sentinel system recorded up to 800 cases per 100,000 population, like in 2014–2015. During the COVID-19 pandemic, the number never exceeded 150 cases per 100,000 population. If one adhered to the definition of *epidemic* as an excess number of sick people, there was no epidemic in 2020, 2021, and 2022.

[Pandemic by Alleged Fraudulent Testing and Attribution of COVID-19 Cases](#)

Mainstream media reported alarming surges in COVID-19 deaths worldwide, which were determined not solely through initial RT-PCR testing but by the WHO's coding ICD-11, implemented on January 31, 2020. This method was seen as a broad and scientifically questionable way of attributing deaths to COVID-19, often based on superficial symptom diagnoses with or without confirmation via RT-PCR testing.

When all respiratory infections were broadly categorized as COVID-19 cases, it led to the creation of misleading “epidemic” curves on the *Our World in Data* website. In reality, the spread of a respiratory virus infection did not align with synchronous events in numerous countries; some were merely delayed in adopting the ICD-11 code, while others had not yet implemented rigorous health measures.

The statistics showed that following the implementation of ICD-11, all other respiratory diseases seemed to gradually disappear and become COVID-19, even when the virus had not been detected. Perverse financial incentives appeared to trigger a diligent transfer of coding attribution.

There was an increase in deaths in some places, like France, that had instituted strict measures in April 2020, but not in other countries, like Germany, that didn't implement those measures. The so-called first waves occurred in a minority of countries or regions. This could be seen all across Europe and even across different provinces in France, as only 14 out of 100 provinces showed excess deaths, and the spike of excess deaths correlated with the stringency of implementing health measures. The same thing happened in the USA.

Furthermore, excess deaths were overrepresented in "deaths at home" due to the lack of treatment because sick people refrained from going to the hospital. Even if most were attributed to COVID-19, there was no proof because autopsies were not performed.

For example, there were 5200 deaths at home during the COVID-19 period in France, and 4800 of those deaths were from "stroke and heart attack, non-treated" during the same period in a given database, while another database reported up to 6000 deaths from stroke and heart attack. Therefore, every one of the 5200 deaths at home could be accounted for by the lack of treatment.

In the same vein, the reported 5000 excess deaths in LTC homes for the elderly were equivalent to the number of people treated with midazolam instead of Rivotril, as the stock had been exhausted by the U.K., the USA, and Canada.

The rationale was that COVID-19 was a deadly, untreatable disease. Therefore, hospitals would be saturated, and there would be no room to treat the sick elderly; instead the reasoning was give them palliative care for this deadly incurable disease.

In France, the most prevalent place of excess deaths was in hospital. An incredible spike of 6000 out of 7000 excess deaths in three days was reported, with 3000 on the same day. This can only be explained by two reasons: (1) people coming to the hospital were already very sick, and (2) the common treatment in ICU to put patients on ventilators was associated with a high mortality rate. The three causes described—denial of early treatments, ventilators, and palliative care—accounted for the bulk of excess deaths.

The RT-PCR tests were the driver of the statistical fraud. A test was not the reality. For example, the pregnancy test although very accurate has both false positive and false negative results. If we tested everyone, we would get falsely positive pregnant men and falsely negative pregnant women.

We required additional medical data to establish the reliability of the RT-PCR test. By testing everyone, including those without symptoms, we identified a substantial group of asymptomatic COVID-19 cases who were even believed to be capable of spreading the virus. This raised questions about how they could transmit the illness if they didn't carry an infectious virus but rather viral RNA sequences. If non-ill individuals who tested positive could transmit their non-sickness to others, it implied that everyone had the potential to be a source of infection. Moreover, the RT-PCR test had not undergone formal validation with a gold standard, as was the case with pregnancy tests.

Say the PCR test is 95 per cent reliable, and we tested everybody indiscriminately and found that both asymptomatic and symptomatic people were positive, on average, less than 5 per cent of the time. We would say, then, that the test lacks coherence.

Positive PCR testing over-represented the asymptomatic—detecting, more frequently, people who were not sick while missing people with symptoms—75 per cent of the time. Therefore, these symptoms were most likely not representative of COVID-19 disease. It was a “case-demic.”

During the Omicron phase, the percentage of positive RT-PCR tests increased dramatically to more than 30 per cent in France. Was it truly due to increased viral circulation, or was it from modifying the testing protocol?

In France, the combination of RT-PCR tests, COVID-19 vaccines, and the vaccine pass produced strange epidemic curves that were better explained by human behaviour because the RT-PCR tests were not coherent. Putting the vaccine pass in place created an artificial vaccine efficacy. The only efficacy seen in the randomized clinical trials (RCTs) in France was a reduction in RT-PCR positive tests.

If vaccinated people were not obliged to get tested, a bias of positivity of unvaccinated people who were obliged to get tested would be created. Similarly, when it was revealed that the vaccine was not preventing transmission and that the vaccine efficacy waned over time, people who were anxious about the possibility of infection, got boosted. At the same time, people who refused boosters, which were mandatory for an up-to-date vaccine pass, had to be tested more often. As a result, the boosted people tested less than the double-vaccinated or the unvaccinated, and that created the illusion that the booster worked.

However, as soon as the vaccine pass was lifted, the curves inverted because the boosted people, being more anxious, were testing themselves more often than the double-vaccinated or unvaccinated people that no longer got tested when it was not mandatory. It was all a statistical illusion.

The chilling implication of this rigorous statistical analysis of the official data was that it was a sham pandemic perpetrated by the military and administrative state through a sophisticated psychological operation against the civilian population.

While some people may have died from a virus, which probably escaped from the Wuhan lab, the deaths did not show up in the excess-death data. Deaths from the three other declared pandemics since WW II also did not show up in excess-death data. But wars did, intense heat waves did, and earthquakes did, yet proclaimed pandemics did not, except the Spanish flu.

A pandemic should be characterized by a significant excess of sick and dead people, not unreliable RT-PCR positive cases. The definition was perverted by an unvalidated display of pandemic waves that instilled fear in people and compelled them to submit to never-before-accepted NPIs as a prelude to the vaccination campaign that was sold as a relief to the unsustainable harmful health measures.

Recommendations

Due to the confusion caused by improper testing for COVID-19, particularly using unvalidated RT-PCR testing, the following recommendations were made:

- A. **Pause the use of RT-PCR** or rapid antigen testing when it is not accompanied by a thorough medical evaluation of disease symptoms.
- B. **Conduct a rigorous validation of RT-PCR testing**, including standardized cultivation of the active virus. Establish a defined threshold for the number of amplification cycles that show due use.

Considering the confusion that arose from the lack of transparency in official public data, the following recommendations are added:

- C. **Ensure that all government data** is consistently and transparently shared with the public for independent evaluation by qualified experts in epidemiology and statistics.
- D. **Make any disparities between data analysis**, done by the government and data analysis done by independent citizens, subject to review by an impartial advisory committee composed of experts in epidemiology and data analysis. This committee should be regularly vetted through public forums to maintain transparency and accountability.

7.5.4. Non-Pharmaceutical Interventions

Introduction

The use of NPIs based on previous pandemic management had been studied for 20 years and updated in September 2019. One of the main concerns about the NPIs used in the COVID-19 pandemic was the glaring lack of a cost-benefit analysis for them.

According to the recommendations in the pandemic plan, there were NPIs which were not recommended to be used.

We were told that certain NPIs would not be used, such as contact tracing, quarantine of exposed individuals, workplace measures and closures, school measures and closures, entry and exit screening, internal travel restrictions, and border closings.

Shockingly, despite the updated pandemic management guidelines for NPIs, many optional and never-to-be-used NPIs were not only used but were mandatory. One of the worst measures was school closures, which will leave indelible traces on our children for decades to come unless we implement robust corrective measures.

From many published studies that compared countries with different NPIs policies, we relearned in September 2020 that the cost-benefit analysis of most NPIs was negative.

Collateral damage from NPIs included massive damage to our individual mental health and our social fabric; other severe health conditions; damage to our children's education and socialization; and our economic wellbeing as individuals, in business, and as a nation.

More than 400 studies documenting the collateral damage have been ignored by mainstream media.

Conclusion

There was malpractice by public health and individual healthcare practitioners. Relentless vaccination and denial of alternate treatment were rivalled only by bureaucratic stubbornness.

COVID-19 was not more serious than seasonal flu. Had we ever used such NPIs before, except during the Spanish flu? If they were deemed useful for COVID-19, why had we not used them for other pandemics? If COVID-19 had actually been a grave pandemic, what state-of-the-art NPIs would have been used?

Lockdowns

The stated reason that lockdowns were implemented in March 2020 was to flatten the curve in order to protect the healthcare system. Border closures and shutdowns of businesses not deemed to be essential were also mandated to close.

Then, to prevent a second wave, mask mandates were put in place to stop transmission of the virus. The absurdity of such a measure was displayed by its arbitrary rules: for example, masks could only be removed in a restaurant when seated at a table. Other arbitrary measures, like curfews and internal border restrictions based on colour-coded regional zoning, were also farcical.

What about the best practices learned from the past to control respiratory virus epidemics? In 2006, a WHO study on the Spanish flu concluded that lockdowns had no impact and were not practicable. A 2006 paper by the most renowned epidemiologists became the basis for the WHO 2007 plan, which was renewed without change in 2019. No study supported the confinement of sick people for extended periods of time to slow down a pandemic. Because the negative consequences were so dire, the recommendation was that it should never be used. Border closings and restrictions on travelling have always been inefficient.

Among all NPIs, only two have shown some efficacy: air filtration and isolation of sick people. Aggressive NPIs must be abolished, and their further adoption must be proscribed.

When a virus is already in the population, the most dangerous thing to do is confine sick people with non-sick people because the constant exposure within the same unfiltered air increases the likelihood of infection with an even higher viral load, which in turn would be more challenging to manage.

We had already discovered, at the beginning of the 20th century, that people sick from the flu or tuberculosis healed better if their sanatorium beds were put outside. That taught us that contamination was lower outside, in fresh air, so why did we strictly enforce lockdowns on the elderly and keep them indoors for weeks?

Mandatory lockdowns, without considering the impact, actually exacerbated the epidemic waves rather than improved the situation. Conversely, when people had the freedom to move, their exposure to the virus was less frequent, resulting in lower viral loads. In cases where everyone gathered in “essential” stores, like liquor stores, the crowds became more concentrated, leading to a higher risk of contamination with higher viral loads. A study in Spain demonstrated that essential workers were less likely to be infected compared to people who were under strict lockdown. To comprehend this phenomenon, it’s crucial for models to align with real-world observations.

Is Wearing a Mask Appropriate?

Where were the studies supporting the obligation to wear a mask? According to a WHO report published in 2019, just before the pandemic, the studies listed did not find masks effective in preventing the infection of influenza (a respiratory virus similar to the coronavirus). Arruda in Québec and Fauci in the U.S. initially told us the same thing before they changed their tune, without relying on new studies.

Moreover, the CDC chose to rely on the only subsequent study, done in Bangladesh and published after the decision to impose the mask. The CDC used it as a posteriori justification. This study was criticized by several experts, one of whom went so far as to demand either a major correction of its dubious conclusions or the withdrawal of the article published in *Science*, alleging serious shortcomings in the study.

Is it illogical to question the CDC's sound judgment regarding masks, considering its initial stance that vaccination offered better protection than natural immunity? Their position on the effectiveness of masks is primarily based on a single study it funded, despite the existence of over a hundred published studies during that period that indicated otherwise?

In addition, a recent study in Europe concluded that countries that practised diligent mask wearing did not present better epidemiological results than countries where mask wearing was less strict. The higher mortality in the most compliant countries even suggested a potentially deleterious effect associated with wearing a mask.

What Should We Think of this Study?

In Sweden, where masks were not worn at school, the epidemiological data were at least as good as, if not better than, Canada or the other Nordic countries. The results of these studies do not consider the collateral damage of wearing masks.

A Danish study concluded that the mask was ineffective, despite strong controversy in the media. Also a study from Finland, in two cities with comparable demographics, concluded that the efficacy of the mask was at best null or even negative.

Why were these studies not considered more seriously? Even more surprising was the absence of more randomized studies which would have made it possible to settle the debate in a more rigorous way. There were ample opportunities to do so during two-plus years of the pandemic.

Administrative State Confusion and Future Solutions

The state apparatus did not have a monopoly on scientific knowledge. That was partly because in the public service, promotion to decision-making positions was often based less on scientific excellence than on compliance with a certain doxa, which was subsequently exploited by politicians in support of their agenda. It was not just a Canadian problem; it was widespread throughout the world, and it has gone on for many decades.

Every time you hear "the experts say," ask yourself some questions: Which experts? What is their claim? Are they exempt from conflicts of interest? Are they prepared to fairly debate the basis of their expert opinion?

Among other things, the COVID crisis exposed worrying gaps in the science literacy of politicians and the media, as well as in the expertise of state agencies where scientists and doctors worked. This problem was exacerbated by a lack of leadership to access the best expertise available at the national and international level and, above all, to use it wisely.

It was not that there was a lack of competent and well-meaning people in the state apparatus; it was mainly that their voices were not sufficiently heard and considered in a centralized system where dissent was not valued. While the experts who promoted the “right message” got all the positive media attention, the whistleblowers and other dissenting voices were not only ignored but actively sanctioned. This meant that we heard them not at all or very little. We could therefore be fooled by the reassuring use of the phrase *scientific consensus*, which made us believe that the health authorities knew what to do. All that remained was to obey; otherwise, beware of the consequences

Understandably during the first weeks, we were in a phase of bafflement, which rallied us to the injunctions of public health. However, when the data became available, we could have adjusted the course to prevent the two weeks to flatten the curve from being unduly prolonged. How could we have seen more clearly through the confusion and propaganda?

This crisis was managed by relying on models disconnected from the reality on the ground and by inciting fear of an invisible deadly enemy. Fear, one of the most powerful emotions, was used to manipulate or influence us. The techniques were similar; it was just a matter of intention and honesty.

The distinction was notable in that manipulation sought to alter someone’s behaviour for the manipulator’s gain, often by feigning to act in the manipulated person’s best interests to extract their willing compliance. Conversely, influence sought to prompt changes in opinions, decisions, and actions that would benefit the influenced person, and it involved their voluntary choices rather than coercion.

When we talk about war, we’re essentially discussing the use of propaganda to immerse us in a narrative with questionable ethical foundations. This war narrative propaganda narrative proposed straightforward and seemingly advantageous answers, stemming from a limited perspective that had shaped our societies since the onset of the industrial revolution. It was constructed upon a reductionist and deterministic materialism that had evolved over recent centuries. This materialistic viewpoint, responsible for elevating humanity from dire poverty, also drove us toward relentless consumerism, even in areas like healthcare. As a result, we have strained the delicate equilibrium of our environment: our actions risk damaging it and we despoil it at our peril. And we now know our health is inextricably linked with our environment.

In the United States, the annual budgets devoted to health, including food, is approximately \$4.5 trillion, or about five times the defence budget. Health is one of the most important engines of the American economy and, by extension, of the world economy. This economic fervour has been irresponsible and has occurred without the recognition that humanity is an integral part of the natural world, and our actions risk damaging it.

The current crisis will necessitate fundamental changes to guide humanity toward a more harmonious coexistence with nature. This crisis has the potential to awaken our consciousness through spirituality, which goes beyond the realms of science and technology, drawing from the timeless wisdom of humanity, which is constantly evolving.

Our challenges run deep, and the transformations ahead will be protracted and marked by hardship. Consequently, it will be imperative to exercise patience and cultivate resilience.

In terms of scientific progress, we have entered an era of spectacular discoveries in genomics, which has opened up the world of epigenetics, the microbiome and the virome. Epigenetics has returned the natural environment as central to our health. We have also made considerable progress on knowledge about this wonder that is our immune system, the main source of our healing from infections and cancers.

Although there is still much to discover, we know enough to understand that the majority of diseases that afflict us—whether infections, cancers, or autoimmune diseases—result from erratic functioning of our immune system. The causes are sometimes genetic but are more frequently epigenetic, and we know with certainty that we can have a major impact on epigenetic causes through a healthy lifestyle.

Simply put, a good diet, including a supply of vitamins and minerals; restorative sleep; exercise and relaxation activities, such as walking or meditation; and nurturing social bonds, which helps to reduce stress have been clearly recognized as having an immunosuppressive impact.

During the last two years, have our health authorities seriously promoted a healthy lifestyle or, on the contrary, have they considered several of these protective factors as non-essential?

What price will be paid for delayed treatments of the various pathologies, the anxiety disorders of the young generations who suffered major disruptions in their social and emotional development, and the psychological distress of small entrepreneurs and their families who were forced into bankruptcy? This mental stress has had a major impact on our immune system and is likely to culminate in an outbreak of chronic psychosomatic illnesses in the years to come.

Reviewing the management of the COVID-19 pandemic, it would seem that the germ theory of infections, developed by Louis Pasteur, prevailed over the alternative paradigm promoted by Antoine Béchamp and Claude Bernard, two contemporaries of Pasteur who affirmed that “the microbe is nothing; the terrain is everything.”

According to some historians, Pasteur finally adopted this idea at the end of his life, but several of Pasteur’s heirs still do not have the memo. And yet, an increasing number of immunologists adhere to this idea that a properly functioning immune system, innate and acquired, confers upon an individual the ability to resist infectious pressures of all kinds, with rare exceptions, as well as the various cancers, which do not fail to develop with age in an environment polluted by all kinds of toxic substances.

The worst of these toxins are those that affect the balance of our microbiota, which plays a fundamental role in our homeostasis, including that of educating our immune system. Several scientists reflected that fact when they said that the greatest threat during the pandemic was not the virus but the measures that contributed to weakening our immune system.

The victims of COVID-19 were overwhelmingly elderly people, often sick, and people suffering from several health problems, particularly obesity. Obesity confers greater susceptibility to all sorts of ailments, including the progressive resistance to insulin and to leptin, a key hormone in lipogenesis and essential for the proliferation and homeostasis of immune system cells.

Therefore, the best possible preventive health measure for the next pandemic would be to put in place incentives to mitigate the current epidemic of chronic diseases mostly derived from the consumption of processed food full of fructose and poor in dietary fibres essential for the homeostasis of our microbiota.

Recommendations

In line with the “first, do no harm” principle and adhering to best medical practices and sound scientific practices, the following recommendations are proposed:

- A. **Avoid mandatory health measures**, such as lockdowns and universal mask mandates, unless they have been objectively demonstrated through rigorous studies to have a positive benefit-to-risk ratio.
- B. **Prioritize diligent implementation** of the two non-pharmaceutical interventions (NPIs) that have a well-established track record of efficacy in managing respiratory infections: air filtration and isolation of individuals who are both sick and contagious.
- C. **Establish a targeted research and development program** to investigate the adverse effects of ineffective NPIs, with a specific focus on the impacts of masking children and restricting physical and social activities. The goal is to formally assess the extent of physical and mental health damage and propose tailored remediation measures.
- D. **Ensure that scientists and healthcare professionals** working within government agencies have access to the best available scientific evidence, free from conflicts of interest, at both national and international levels. This access will enable them to provide politicians with the highest quality and most up-to-date knowledge for decision-making.
- E. **Instead of prohibiting them, mandate scientific debates** to facilitate the emergence of optimal health measures. Encourage open discussions among experts to foster innovation and evidence-based policy-making.
- F. **Actively promote healthy lifestyles** that can enhance the immune system through epigenetic mechanisms. A strong immune system forms the foundation for protection against infections, cancers, and autoimmune diseases.

7.5.5. Early Treatments

Introduction

According to a large number of attending physicians and researchers, an important pillar of pandemic management which was particularly evaded, not to say actively suppressed in most rich countries, was the off-label use of generic drugs whose harmlessness had been demonstrated by decades of use on large populations.

Recommending against early treatments was based on layers of lies, cowardice, and treason to the Hippocratic oath. Sadly, the decision to suppress early treatment exposed the corruption of our institutions, which enthusiastically persecuted the courageous doctors who dared treating COVID-19 patients with all kinds of generic drugs that had been part of the pharmacy for decades and for which the safety profile had already been well established.

Meanwhile, the majority of doctors sat in silence as accomplices of the colleges of physicians, doing treatments discreetly, underground, or doing nothing, out of fear of retribution.

Using an approved drug off-label was far from unusual, as the majority of drugs are prescribed off-label. The fact that drugs proposed as early treatments had not been officially approved by the health agencies for COVID-19 treatment was a bogus excuse to suppress their use.

Besides, we were in the middle of a pandemic, and in the past, the recommendation was to try any potential generic drugs to get some therapeutic benefits. However, the advent of any potential treatment posed a serious threat to the eventual interim authorization of the COVID-19 vaccines. The suppression of early treatment was not for public health reasons—quite the contrary. The data speaks volumes: the death toll was much lower across the world where early treatments were deployed en masse.

Unfortunately, for the longest time, the medical establishment in collaboration with the health authorities collaborated to justify their harassment of the courageous doctors. They claimed to have been protecting the public against alleged snake oil peddlers. To this day, the health authorities have downplayed the importance of vitamin D in the prevention of infectious seasonal diseases, which occur more frequently in the winter when vitamin D levels typically drop below the healthy threshold.

Even in the face of all the evidence on early treatments, advocates were ignored and vilified by the authorities. The c19early.org website regularly updated all observational studies, randomized trials and meta-analyses. As of August of 2023, there was a real-time compilation of 3013 studies examining 4468 potential COVID-19 treatments, of which 52 have already been approved as early treatments in 102 countries. Of all these treatments, ivermectin was among the most effective, with 62 per cent improvement observed in 99 combined studies enrolling 137,255 patients. Ivermectin was recommended in several countries, including Japan, where it was created.

In spite of the evidence, several attending physicians experienced enormous difficulties, including sanctions. In order to prevent the physicians from deploying ivermectin and the panoply of other treatments which were used freely in several countries, the authorities threatened to revoke, and sometimes did revoke, their licence to practise medicine.

Without speculating on the motivations that led to such a suppression of early treatments, it is likely that the recognition of any treatment whatsoever would have compromised the interim authorization of the experimental vaccines that, by April 2020, were being promoted as a panacea for the pandemic. This all-vaccination strategy required that any valid therapeutic approach be inoperative. And that was what happened, whatever the real intentions were behind those decisions.

It appears, and it is noteworthy, that not a single one of our health agencies did a systematic analysis of peer-reviewed literature of potential treatments. Some bureaucrats, when challenged in court, claimed they were unaware of the information on the c19early.org website. Instead, they cited as gospel the information on the Health Canada website.

Pioneers of Early Treatments

Many doctors faced being reprimanded by their regulators for treating their patients, and many paid the price for their courageous actions to respect their Hippocratic oath. In many states, even taking care of sick people in person was discouraged to fuel the perceived dangers of COVID-19 that propaganda equated with the Spanish flu.

Even earlier on, we knew that this was a lie. The data had clearly shown that in terms of adjusted life years lost, the death toll of the Spanish flu was about 100-fold higher than COVID-19, and they treated the sick people back then.

Considering that many frontline care workers treat Ebola-infected people at their peril, we have to appreciate the level of fear-mongering that made healthcare workers so afraid to take care of putative COVID-19 patients and led them to mistreat the “dangerous” unvaccinated.

Among the pioneers of early treatments was Professor Didier Raoult. By following the scientific literature, he found that hydroxychloroquine (HCQ), a drug he was familiar with for the treatment of malaria, had been shown to be an effective COVID-19 treatment by a Chinese team. He immediately tested it in his institute, the Institut Hospitalo-Universitaire en Maladies Infectieuses de Marseille (IHU of Marseilles), and found very interesting results, both alone or in combination with azithromycin (AZ).

His first report attracted some positive comments but also some surprisingly negative ones. While many other doctors in France and across the world followed up on these initial successes, a targeted campaign of denigration was put in place to suppress the use of HCQ by any means.

All of a sudden, HCQ not only had to be shown to be ineffective by fraudulent trials, but it also had to be shown to be toxic. The infamous *Lancet*-gate paper fraudulently claimed a 10 per cent cardiac toxicity based on fabricated data that had to be retracted in a few days. However, as soon as the *Lancet* paper was out, the Minister of Health used it as a pretext to suppress the use of HCQ in France for COVID-19. Astoundingly, after the paper was retracted, the Minister maintained his proscription of HCQ. This had a chilling effect on HCQ use in France, even to this day.

Prof. Raoult, against wind and tide, continued to use the HCQ-AZ therapy at the IHU. He published the largest observational study, with more than 30,000 IHU patients, showing an indisputable benefit of the combination of HCQ and AZ for the early treatment of COVID-19. In an unprecedented move, he had his study verified by a bailiff as a preemptive measure against the horde of fact-checkers paid by the corrupt mainstream media on behalf of the political establishment.

The saga continued. His study was attacked by the French medical establishment, fighting ferociously to avoid the judicial consequences of having suppressed this early treatment and be found responsible for preventable deaths of thousands of COVID-19 patients.

Another important pioneer in the development and use of early treatments was Dr. Peter McCullough. In August 2020, in front of the Texas Senate, he presented his work on the various phases of SARS-CoV-2 infection—viral proliferation, cytokine injuries, and thrombosis—that have discrete symptom manifestations but overlap over the 30 days of COVID-19 disease.

Dr. McCullough was among the first to actively promote to the medical community a panoply of various treatments that could lead to very effective therapeutic support for COVID-19 patients. His treatments included intracellular anti-infectives, antivirals, antibodies, corticosteroid, immunomodulators, and anti-platelet, anticoagulants. His clear message, based on his medical practice, was that many therapeutic interventions were available to avoid serious disease and death from COVID-19.

This message was echoed by other pioneers, like Dr. Pierre Kory and his colleagues at the Front Line COVID-19 Critical Care Alliance (FLCCC). Dr. Kory made a remarkable presentation in front of the U.S. Senate in December 2020 to promote the use of ivermectin, which had shown solid clinical results.

Although the promise of ivermectin had been strongly disputed by authorities in several countries, a flurry of examples demonstrated its clear effectiveness. Again, as with HCQ, ivermectin was attacked by the medical establishment in many creative ways to suppress its use.

After successes in Mexico, Peru, Japan, and India during the Delta wave where the majority of states treated with ivermectin, the waves lasted 40 days and caused comparatively half the number of deaths in the states that treated, such as in Uttar Pradesh, versus states like Kerala, which had banned ivermectin. At that time, only three per cent were vaccinated in India.

The Delta wave in India was much weaker than in France, which curiously experienced two delta waves that spread over several months, while the wave quickly subsided in India. During the first Delta wave, the vaccination rate in France was 40 per cent; during the stronger second wave, the vaccinated rate was 80 per cent. India's better performance could not be explained by a low rate of infection in the population because serological tests in June–July 2021 (in 21 of the 30 states in India, enrolling 37,000 people), 67 per cent of people were identified as infected and contributing to herd immunity.

In India, the Omicron variant arrived 10 days later. They had 20 per cent fewer cases than with Delta, and it subsided earlier than in France. France had 10 times more cases with Omicron than with the Delta. In India, natural immunity provided much better protection than did the genetic vaccines in France.

States that treated with ivermectin had much weaker Omicron waves than states that did not treat. For example, in Nigeria (220 million inhabitants) there were 10 times fewer deaths with Omicron (69) than with Delta (800) and 444 times fewer deaths than in France.

These observations strongly suggest that the combination of natural immunity with early treatments such as ivermectin, which is both preventive and therapeutic, was a very effective approach for the control of the COVID-19 pandemic.

Recommendations

Given the incontestable better outcomes in countries that deployed early treatments using a panoply of generic molecules with an established safety record for the management of the COVID-19 epidemic, our recommendations are to:

- A. **Reinstate positive incentives** to allow physicians to practise medicine according to an ethical, personalized, and evidence-based science and art, according to their Hippocratic oath. Repudiate algorithmic centralized protocols and punitive administrative edicts.
- B. **Investigate alleged corruption** that has interfered with the customary practice of medicine under the fallacious pretext of promoting public health while diverting the health measures to alternative political and commercial interests.
- C. **Promote preventative health measures** grounded in healthy lifestyles and real food, avoiding processed foods and sugar overconsumption and promoting adequate vitamin supplementation, physical exercise, sufficient sleep, stress management, and a vibrant social life.
- D. **Encourage open and evidence-based discussions** among healthcare professionals, researchers, and regulatory bodies regarding the use of generic drugs for early COVID-19 treatment.

- E. **Review and revise treatment guidelines** to include early intervention options that have demonstrated safety and efficacy in large populations. Consider the experience of countries that successfully employed such treatments.
- F. **Address institutional corruption** by investigating cases of corruption and suppression of early treatments within healthcare institutions and regulatory agencies. Implement measures to ensure transparency and ethical conduct in decision-making.
- G. **Support early treatment research** into the efficacy and safety of early treatment options for COVID-19 by allocating resources. Promote collaboration between medical professionals and researchers in this field.
- H. **Ensure patients give Informed Consent** for their chosen treatment by discussing all available treatment options, including early interventions.
- I. **Establish independent medical advisory committees**, free from conflicts of interest, to assess treatment recommendations and provide guidance to regulatory agencies. Enhance transparency in decision-making.
- J. **Promote awareness of vitamin D** and its importance in preventing infectious seasonal diseases, especially during the winter months when vitamin D levels tend to decrease. Encourage further research in this area.
- K. **Hold public health agencies accountable** for conducting systematic analyses of peer-reviewed literature on potential treatments. Ensure that decision-making is evidence-based and prioritizes public health over the public health establishment.

7.5.6. Natural Immunity and Early Treatments Rebuffed to Favour Generalized Vaccination

Introduction

One of the most disturbing aspects of the vaccination strategy debacle was the orchestrated propaganda launched early in the pandemic to undermine the well-established foundation of natural immunity and to denigrate early treatments. Generalized vaccination was sponsored as the unique and ultimate solution for the pandemic. This propaganda was propelled by layers of lies.

We were asked to believe that we were facing a new and exceptionally dangerous virus for which natural immunity would fail to protect us, that no viable treatments existed, and that only new wonder vaccines, developed at “warp speed,” could save us.

The first issue with this deceptive narrative is that the analysis of all-cause mortality across the world led to the conclusion that a not particularly virulent pathogen was in circulation. The pandemic was declared as a red flag signal for danger with fairly tenuous infection morbidity and fatality case numbers. When one considered the real prevalence of SARS-CoV-2 infection, it had been grossly underestimated, as was typically the case in early days of any pandemic declaration. This was mainly attributable to a vast underestimation of the true infection rate, understandable when infections were often asymptomatic or pauci-symptomatic (presenting few symptoms).

There was no need to contain this new virus by any extraordinary health measures. Normal personal hygiene and well-established public health protocols targeting the protection of the most vulnerable in an adequately protected environment were sufficient.

Whether the population had much higher preexisting immunity to this new coronavirus than reported or the virus was not as lethal as initially broadcast, conclusions from many studies, even early on, indicated a fatality rate in the same range as severe flu seasons, for which no overall excess deaths are discernible except for the elderly population. But clearly, public health authorities couldn't claim, on the one hand, that there was a serious pandemic of global concern and, on the other hand, say, “Don't worry. It's going to be business as usual. Be prudent, self-isolate when you are sick, and do not panic. Stress is bad for your immune system, which is the best line of defence against any potential infection, or cancer.”

Rather, public health authorities had to be perceived as saviours, in full control of what needed to be done in circumstances they declared as dire, and they did it in unison with the same pre-formatted messages in their fear campaign.

Even if, hypothetically, there was a strong case for vaccination to control a putative deadly virus, we should have acknowledged that for this type of virus in the family of coronaviruses, we have never been able to develop an effective vaccine, either for humans or animals. Typically, the genetic variability of coronaviruses based on RNA genomes confers only partial immunization. We have experienced this firsthand, suffering with recurring colds from the four endemic coronaviruses in the human population. Many expert virologists and vaccinologists knew that, but their voices were either silenced or dismissed.

We were also asked to believe that our scientific and technology progress enabled us to quickly develop a new generation of vaccines based on gene therapy technology that would be safe, effective, and readily produced on a commercial scale.

In reality, the support for these false hopes was on very shaky scientific and technological foundations. Nothing in the proposed gene-based vaccines was going to meaningfully address the shortcomings of natural immunity—for example, the recurrent infections, although of less severity, with variants in the coronavirus family. To make matters worse, the selection of the spike protein as the preferred viral antigen disregarded the known biological toxicity of this protein. Its uncontrolled production throughout the human body led to countless vaccine adverse reactions that became the object of intensive investigations.

Another problem is the known facilitating epitopes in the spike protein. These epitopes were known to likely trigger the production of antibodies that would make the infection worse. Also, the epitopes that were shared with human proteins ended up generating countless autoimmune diseases.

As for the rapid production of the gene therapy vaccines, the process for the adenovirus-based vaccines was fairly well-established by decades of research and clinical trials in gene therapy. However, early on, the adenovirus-based vaccines displayed significant toxicities, leading to their withdrawal in many countries.

By contrast, the mRNA lipid nanoparticle (LNP) vaccines had never been scaled-up, posing a significant challenge for their mass production, which continued to be plagued by many manufacturing issues.

We were also misled to believe that there were no possible treatments, a *sine qua non* condition to pave the way to the emergency-use authorization (EUA) of vaccines and unproven, patented, poorly tested antivirals, such as remdesivir, that ended up doing more harm than good. We already knew the SARS-CoV-2 virus shared extensive homology with other coronaviruses. Therefore, partial cross-immunity stemming from previous infections with other coronaviruses was likely.

Also, early studies based on generic molecules to treat the closely related SARS-CoV-1 had already established their potential treatment—HCQ, for example—to be effective against SARS-CoV-1 infection. Notably, all countries that made wide use of these generic drugs displayed a much better performance in controlling the COVID-19 pandemic.

[This COVID-19 Virus is Novel, Very Dangerous, and Not Treatable](#)

The message hammered home in the media was that there was no preexisting immunity in the population, that everybody was equally susceptible to serious illness and death following infection, and that we should, at all costs, prevent infection and transmission until a vaccine was available to confer protection. All of the NPIs were therefore deployed to control the spread of the virus until we could all get adequately protected by the COVID-19 vaccine.

Consequently, a surreal “COVID-zero” policy was aggressively promoted in many “democratic” countries—in the footsteps of the authoritarian CCP policies in China. The policy was promoted by the baseless allegation that this new public health policy would be successful if only we implemented it hard enough.

This fantasy was based on glaring ignorance or, at best, serious confusion of the functioning of the immune system, as well as the poorly understood theory of respiratory virus transmission. The immune system has evolved to respond to an almost infinite number of pathogens and is exquisitely adapted to respond effectively, in the vast majority of the cases, with every first encounter with any pathogen from the moment we are born. The first line of defence for a respiratory virus is the mucosal innate immunity. That eventually builds up a stronger adaptive response once mucosal IgAs (immunoglobulin A) targeting the pathogen help neutralize it.

As for suppressing the transmission of respiratory viruses, nothing short of the strict confinement in a BSL-4 (bio safety lab) laboratory works. That level of confinement, however, is impossible to implement in real-world settings. Most of the NPIs are, at best, delusional.

Furthermore, serological data proved the presence of the SARS-CoV-2 virus as early as the end of summer of 2019 without any clear indication of massive infection, morbidity, and mortality. The virus was running in the population at least nine months before the declaration of the pandemic, and as a result, a significant proportion of the population had already been naturally immunized without significant signs of the COVID-19 disease.

Throughout the pandemic saga, we were deceived countless times by a “scientific consensus” that was created by silencing dissenting voices questioning the hegemonic narrative. In the absence of healthy debates, a so-called consensus was only an indisputable dogma, and therefore unscientific.

There is, however, a scientific consensus to the effect that for the hundreds of putative pathogens we are exposed to, the immune system, innate and acquired, protect the vast majority of individuals rather well and for a long time. One notable and exceedingly rare exception was HIV infection, which could destroy our immune defences. But this was clearly not the case with SARS-CoV-2 or the other natural coronaviruses. Doubting this scientific consensus was like doubting the law of gravitational force.

Good health is dependent on a strong and resilient natural immune system, referred to as the terrain. It included a healthy microbiota, which plays a crucial role in educating the immune system. The optimal functioning of the natural immune system is empowered by a host of good habits like real food consumption with fibres essential for a healthy microbiota, vitamins and other supplements, sufficient sleep, nourishing social bonds, regular exercise, and stress-reduction practices. It is nothing new for populations that have shown remarkable longevity over the centuries.

Strangely, many of these healthy lifestyle habits were either suppressed or compromised by fiat. Instead, public health focused obsessively on avoiding COVID-19 by controlling transmission of the virus, ignoring the crucial importance of the terrain. This obsessive focus restricted the goal of public health to the avoidance of only one putative pathogen.

The epidemiological data spoke volumes. Healthy individuals were only mildly affected by the SARS-CoV-2 infection, and most infections were asymptomatic.

Given the futility and harmfulness of most NPIs, letting the virus run in the general population of low-risk individuals while protecting the most fragile should have been the preferred approach to build the so-called herd immunity, which was one of the best ramparts for the most vulnerable. That approach was taken in Sweden and many other countries that did not mandate NPIs.

Besides, a host of treatments and vitamins were available for those whose bodies were not strong enough to combat the infection. Sadly, these treatments were disqualified as “useless” by health authorities in many Western countries, like Canada. Fortunately, they were available for the most vulnerable during the course of the pandemic and were successfully deployed in many poor countries and in a limited number of hubs in Western countries.

[New Gene Therapy Vaccines: Better Than Traditional Vaccines?](#)

Knowing that traditional vaccines had failed at providing protection against coronaviruses, hype was generated around a new platform of mRNA genetic vaccines never shown to be successful for any infectious diseases. The promise of these genetic vaccines was, among other things, that they could be manufactured much faster and could therefore be more readily adapted to the ever-evolving variants of SARS-CoV-2 that could escape vaccine-induced immunity.

There are several misconceptions with that premise. Importantly, the promise of the wonder vaccines to end the pandemic was based on three interrelated lies. The first lie was that those so-called vaccines were sterilizing, preventing infection and transmission. This was impossible to begin with, but a well-funded propaganda campaign got the population to believe it. The mantras were incessant: “Nobody is safe until everybody is safe.” “To be safe, you must be vaccinated to protect yourself and others.” “This is a pandemic of the unvaccinated.”

Nothing was further from the truth. The selective pressure imposed by these non-sterilizing subunit vaccines was, fostering a selective milieu favourable for the selection of new variants escaping the suboptimal vaccine immunity—constantly promoting the emergence of new variants of concern. From the perspective of the pandemic dynamic, it is more accurate to describe it as a pandemic of the vaccinated.

The second lie was, we were promised that with the prowess of gene therapy technology and fuelled by very large financial resources, we could make available successful vaccine candidates in record time, at “warp speed,” without compromising the quality and safety of the products. We were told that we should focus primarily on vaccination. Natural immunity was fraudulently portrayed as much less protective.

A third essential lie was the misnaming of gene therapy-based products as vaccines. From a marketing point of view, the most important reasons to mislabel the mRNA gene therapy products as vaccines were (1) to facilitate public acceptance of the products (as traditional vaccines generally benefited from a positive reputation), and (2) to expedite regulatory approval by skipping the tedious and long-term studies of genotoxicity, tumorigenicity and autoimmunogenicity, which are mandatory for gene therapy products.

Thirdly, the mRNA vaccine platform offered the prospect of rapid vaccine production to catch up with the ever-mutating coronavirus variants that escaped immune protection, which had made it so challenging in the past to produce an effective vaccine.

In theory, it looked like a good idea, but in practice, it had several flaws. One was the assumption that mRNA manufacturing was so much faster than the manufacturing of traditional vaccines: new mRNA vaccines for the variant du jour could be made available more readily. However, this would have been a reasonable assumption only if robust current good manufacturing practices (cGMP) were in place for mRNA vaccines, better than for the other vaccine platforms. This was not the case, as was evident by the numerous quality issues with truncated spike mRNA sequences, plasmid DNA contamination, and sourcing of low-toxicity cGMP-grade (good manufacturing practice) lipids for the formulation of the LNPs (lipid nanoparticles).

Many unresolved quality issues were tolerated by regulatory agencies under the pretext of the alleged emergency. The result was batch variations that were far above the acceptable threshold of injectable products. The magnitude of the issues was difficult to formally assess as it had not been opened to systematic, transparent, and independent analysis.

This rapid scheme of vaccine production also required that the relevant “optimal sequence” for the next vaccine could be identified in a timely fashion. This was, at best, a big gamble with our current knowledge of coronavirus biology and epidemiology. By the time the sequence was selected for mass production and deployed, it was entirely possible that a new dominant variant would be so different that matching the vaccine to the variant in circulation would be suboptimal. It was a futile exercise of chasing a moving target.

Furthermore, this idealized scheme assumed, without documentation, that the new sequence would not affect the overall manufacturing process and safety profile of the new product. This was a leap of faith that was not compliant with a rigorous approval process, at least in the modus operandi of the legacy regulatory agency.

Another crucial issue with the mRNA platform was that neither the dose nor the bio-distribution of the viral antigen ultimately produced in people could be controlled. This was in contrast to traditional vaccines based on inactivated pathogens, as well as current recombinant protein-based vaccines like the COVID-19 NovoVax for sub-unit vaccines. That mattered a lot because we knew that overdose and/or inappropriate site of expression of the viral antigen could lead to many adverse events not observed with traditional vaccines.

It was well acknowledged that ectopic expression of the spike protein in the heart was responsible for a large number of cases of myocarditis and pericarditis with high morbidity and mortality outcomes, much higher than traditional vaccines. Furthermore, long-term side effects, most likely of autoimmune etiology, were manifested in countless neuropathies like Bell's palsy, and menstrual dysregulation, as well as countless other side effects are constantly growing.

Also, preliminary epidemiological data point to an alarming increase of cancers reappearing after remission, new types of cancers, and fulgurant cancers (or "turbo-cancers"). Even if the causal link with the mRNA vaccines needs to be more formally established, many possible mechanisms have been postulated to support the hypothesis of cancer induction. These genetic injections also perturb the usual immune response and could therefore hamper the ability of the immune system to combat other infections—especially with latent viruses—or keep cancers under control.

The perturbation of the immune system is observable both in the increased COVID-19 infection rate in the weeks following the injections and the propensity for increased infections with an increasing number of doses.

Several features of the mRNA platform potentially contribute to the innate immune system suppression brought about by the reduction of interferon production, which plays a central role in the control of viral infections and further stimulation of the adaptive immune response. For example, the codon optimization done for improved protein production resulted in the generation of secondary structures of mRNA called G-quadruplexes.

Also, a massive concentration of pseudouridine was incorporated to extend the half-life of the mRNA and to prolong its expression over weeks or months. This pseudouridine contributed to higher spike production, several orders of magnitude higher than natural infection. Together, these features of the synthetic mRNA contribute to reduced interferon production and suppress the innate immune response, at least temporarily, with a host of unknown consequences.

Even if it's been observed that repeated doses of injection increased the titer of antibodies (IgGs) binding the spike protein, the direct demonstration that more IgGs resulted in better protection was lacking. Clearly, it was not only a matter of the amount of IgG but also of binding quality or type of IgG, not to mention the essential contribution of cellular immunity, which was often overlooked.

Alarming concentrations of IgG4 have been measured in people after the third and fourth dose of injection. IgG4 has been associated with making the immune system tolerant to a given antigen, in this case the spike, as we see in protocols designed designed to reduce allergic reaction by repeated injection of an allergen. This could partly explain why people became more susceptible to COVID-19 infection following repeated injections of mRNA LNPs. Also troubling is the observation that the class switch from IgG1 and IgG3 to IgG4 is associated with higher incidence of aggressive cancers. Given the well-known role of IgG4 in cancer progression by immune tolerance, these observations warrant serious further investigation.

Finally, the entire concept of subunit vaccines depended on selecting the proper target antigen with the right balance of optimal immune induction that causes minimal toxicity. No significant study had been done to support the contention that the spike protein was the ideal target. Given the known toxicity of the spike protein, the rationale of this choice is questionable.

Avoiding most of the short- and long-term side effects would have been possible with the use of traditional vaccines. When evidence was lacking for selecting an optimal target antigen for a subunit vaccine and the safety and efficacy and cGMP production of an unproven vaccine platform were uncertain, it was much wiser to rely on an established technology like inactivated viruses produced in a well-established, large-scale cell culture platform. This was done by the Chinese company SinoVac. Their vaccine was ready at about the same time and was deployed in China as well as many other countries. Whether it was ultimately better than the mRNA vaccines remains to be studied more thoroughly. In any case, it demonstrated that the speed of development and production rivalled the mRNA platform, with much less uncertainty about the safety profile because it was based on a technology with a long track record.

Mass Vaccination to Reach Herd Immunity?

Some scientists and doctors claimed that mass vaccination, whether with traditional or subunit genetic vaccines, would restrict the chance of variants emerging by reducing the viral load sufficiently that the population of viruses would be so small that the probability of variants emerging would be practically nil. This hypothesis suffered from several serious conceptual shortcomings.

It's rather the opposite that was likely happening. We saw vaccine-immune escape variants flourishing in highly vaccinated countries, extending the infection waves long past the time the infection was mostly over in low-vaccinated countries, such as in Africa. Several experienced vaccinologists argued that it was unwise to mass vaccinate during a pandemic, especially with a non-sterilizing subunit vaccine, but their advice fell on deaf ears.

Hypothetically, even if the vaccines prevented transmission and even if we vaccinated 100 per cent of the human population, many animal reservoirs could serve as hosts to incubate the evolution of new variants. For example, new variants emerged from mink farms in Denmark and France and led to waves of localized outbreaks. Pursuing the fantasy of global vaccination to control the pandemic was scientifically baseless and absurd.

Any vaccine strategy is based on the concept that our immune system, after a primary infection, develops an effective response against re-exposure to a pathogen, thus preventing us from becoming ill again. For serious infectious diseases, a good vaccine would protect against infection and transmission (sterilizing) and against serious illness, thus preventing severe symptoms and deaths. It would therefore be prophylactic, as it could prevent us from getting sick following the first exposure to the pathogen.

Several but not all vaccines in our arsenal exhibit this profile. Those for influenza have fairly low relative efficacy that varies with seasonal strains. Either way, the best we could hope for from a vaccine is to rival the protection of natural immunity without the drawbacks associated with natural infection. This is really the level to reach, and there was no evidence that we had managed to do better.

For respiratory viruses, natural infection effectively protects against reinfection by stimulating local mucosal immunity. Without this robust mucosal immunity, featuring IgAs as one important component, neither infection nor transmission can be prevented. Those who doubted that the most widely deployed COVID-19 subunit genetic vaccines did not protect against infection or transmission needed only to look at the data on infections around the world.

The most vaccinated places were also the places where the highest incidence rates of COVID-19 were observed. Conversely, it was particularly striking to observe what was happening in Africa, which had much lower incidence rates despite the lowest vaccination rate (7%), ten times less than the continents more vaccinated. Undoubtedly, many factors contributed to Africa's good performance in managing COVID-19, but vaccination was not one of them.

One couldn't block the replication of a respiratory virus, such as SARS-CoV-2, unless one induced local mucosal immunity in the respiratory tract, which couldn't be done by injecting a vaccine into the muscle of the patient's shoulder. It was for this reason that among the approximately 143 COVID-19 genetic vaccines in clinical trials, several were being evaluated for nasal administration. One of these vaccines, developed by the Chinese company CanSino Biologics, had been approved for nasal administration and was planned to be deployed in China. In any case, if the name of the game, for whatever reasons, was to prevent SARS-CoV-2 infection to avoid the most deleterious effects from the infection, all of the COVID-19 genetic vaccines in use were unable to do that.

Therefore, in addition to the unavoidable risk of vaccine-induced adverse effects, they mostly failed to protect from the pathologies associated with the course of an untreated infection, assuming that the individual had generated an adequate immune response to begin with. Indeed, there had been reports of obese individuals who became fairly sick from COVID-19 in spite of having a fairly high level of neutralizing antibodies against the vaccine spike protein. Presumably, factors such as the optimal diversity of gut microbiota and robust cellular immunity were not at play in those individuals.

As we have seen from the data in clinical trials, no attempt was made to test the reduction of transmission, so this contention was not based on the highest criteria of scientific evidence, RCTs. The only conclusion presented from the Pfizer RCT was that these genetic vaccines reduced the occurrence of symptomatic infections, not transmission or severe forms of COVID-19. Symptomatic infections were at an absolute risk reduction of about 1 per cent. This anemic absolute risk reduction was due to the fairly low number of infection cases registered during the course of the clinical trial.

The absolute risk reduction, which should have been reported, but was glossed over in the marketing materials, was much less impressive than the widely reported relative reduction of 95 per cent and, at the very least, should have raised questions about the seriousness of SARS-CoV-2 infection cases in the midst of an alleged grave pandemic.

The evidence collected following the deployment of genetic vaccines in the general population also did not support the prevention of transmission, unless the data were manipulated in their collection, attribution, or representation. As for the more severe forms of COVID-19, the evidence for their reduction by genetic vaccines was rather weak to non-existent, particularly since the start of the Omicron wave.

We must also emphasize that the vaccine response decreased significantly over time. The same phenomenon was observed in many states, including Vermont, the most vaccinated American state, which reported higher infection rates than in the past, and Gibraltar, which had one of the most vaccinated populations. Even with the third dose, Gibraltar experienced a strong surge of positive cases but with a relatively lower morbidity and mortality.

As for the real-world data that provided the initial impression that infection and transmission were reduced following vaccination, many confounding factors could have distorted the picture. One important factor was statistical biases. We know that the false impression of reduction in transmission was mostly statistical illusions.

It was created by the arbitrary attribution of COVID-19 infections of the injected individuals labelled as unvaccinated for the first 14-21 days post injection, depending on the states. A simple delay in tabulation of COVID-19 cases of 14-21 days could create the statistical illusion. Interestingly, the Pfizer files obtained by court order revealed that a third of the adverse reactions after vaccination were COVID-19 infection. The high occurrence of COVID-19 infection in the first 14 days post injection was corroborated by data from health agencies in Alberta and Ontario.

That the COVID-19 genetic vaccines didn't prevent infection and transmission was no longer disputed in the Omicron phase because the high rate of infection made it impossible to claim any reduction of transmission. But it was also already apparent with the countless so-called "breakthrough infections" during the Delta wave in the summer of 2021. We learned, through a FOIA (Freedom of Information Act), that the CDC (Centers for Disease Control and Prevention), the NIH (National Institutes of Health), and probably the FDA (Food and Drug Administration) were aware of these breakthrough infections as early as January 2021, most likely from the Pfizer real-world data.

Examining the data from the Canadian government's website, the confusion about the effectiveness of genetic vaccines was understandable. Indeed, several official government data sites reported the figures in a way that left the impression that vaccination had prevented COVID cases (and therefore the transmission) or, at the very least, the more serious symptoms leading to hospitalization or death.

Even if we accepted the dubious attribution of exaggerated cases by overcycled RT-PCR tests or that hospitalizations or deaths with COVID-19 were really caused by COVID-19, a more appropriate representation of official data cast doubt on the merits of the intensive promotion of vaccination. Several tables from the government's site conveyed the illusion of vaccine efficacy but reported and interpreted data in a misleading way.

The tables failed to consider that (1) the vaccination deployment began at different times, starting from December 2020, and that (2) a valid comparison could not be made by aggregating the unvaccinated and vaccinated populations at the beginning when everyone was unvaccinated. A valid comparison of vaccinated and unvaccinated populations required matching time periods (during which the same variants circulate) and accounting for vaccination status (as multiple doses of genetic vaccines were administered).

When we re-plotted the cases by counting from the start of the declaration of cases with additional doses—for example, from June 5, 2022, instead of the start of the vaccination campaign (December 14, 2020)—we observed that people with three and four doses had more COVID-19 cases (and deaths) than unvaccinated people and people with only two doses. Again, the biased PHAC (Public Health Agency of Canada) report suggested the opposite: that more doses conferred greater protection.

It got worse over time as the rate of people recovering from a previous infection constantly increased. The fact that natural immunity was superior to vaccine-induced immunity was a major confounding factor that made the assessment of potential vaccine efficacy futile unless people were tested systematically for previous infections. Given the evidence, the authorities' relentless promotion of comprehensive vaccination for everyone was difficult to understand.

[Rationale for Vaccination and Challenges to Prove a Positive Vaccine Risk-Benefit](#)

From the get-go, any risk-benefit analysis of lockdowns or COVID-19 vaccines was fatally flawed because it was based on the false premise of an uncontrolled spread of a deadly virus. When the risk of dying from COVID was so low to begin with, how could any measure, whether lockdowns or vaccines, actually protect the general population? The potential benefits barely existed, so the harms were likely excessive.

The first principle of ethical medicine, "First, do no harm," was flouted. Focused protection, as advocated in the Great Barrington Declaration and as was done in the past, should have been the way to protect the most vulnerable. Strangely, the most appropriate and well-established personal and public health measures were brushed aside, and this cost countless lives. Focused protection would have advocated for targeted vaccination for the population most at risk from COVID-19 complications, assuming that a safe and effective vaccine had been available.

Any medical intervention has an intrinsic harm-benefit profile. For vaccines, the safety profile must be paramount because they are administered to healthy individuals. Vaccine-induced adverse effects had been documented for decades prior to COVID and were deemed to be rare.

The potential risks of an unknown vaccine platform and its long-term adverse effects could not be evaluated properly without years of pharmacosurveillance data. That means gambling on a potential positive risk-benefit ratio could only have been advocated to prevent severe diseases and deaths, a concern primarily for the most vulnerable and not for the general population. But vaccination had been pushed with the promise of preventing transmission and reaching the elusive herd immunity that would have put an end to the pandemic more quickly. Measuring potential benefits and risks of vaccination at the individual level is equally challenging on both accounts—of safety and efficacy.

Without a proper harm-benefit analysis, Informed Consent cannot be given. Health authorities lacked the knowledge to conduct a meaningful risk-benefit analysis for vaccination that would consider the profile of each individual. At the very least, people should have been tested for previous infection before vaccinating them. Logistically, this test should not have been more challenging than the pre-vaccine campaign of massive COVID-19 tests and the routine mandatory tests for people refusing the vaccines.

However, such a health measure would have been at odds with the propaganda claiming the inferiority of natural immunity compared to vaccines. Vaccine efficacy had not even been established by formal epidemiological studies. Efficacy had been assessed using an unsubstantiated biomarker proxy of efficacy—monitoring antibody titers.

From a public health perspective, the buildup of natural immunity would have likely outpaced the vaccine deployment to confer protection against severe diseases because most people infected by SARS-CoV-2 were not seriously sick and were even often asymptomatic. That perspective, of course, assumed the vaccines would have conferred protection, a contention which had not been demonstrated.

Importantly, for vaccination to be effective, an individual's immune system ought to be functioning properly. The conundrum of higher vulnerability to COVID-19, which was going to be remedied by vaccination, is that what makes people more susceptible to the disease is precisely their anemic immune response. That could be based on genetics, with immunodeficiency syndrome, for example, or epigenetic, as a result of poor diet and lack of sleep and exercise, which perturbs the equilibrium of gut microbiota, essential for proper immune homeostasis. In other words, what makes the terrain weak and renders an individual more susceptible to severe disease is not going to be fixed by a vaccine whose mechanism of action requires a good immune terrain to be responsive.

The phenomenon of vaccine non-responders has been widely documented for protein-based vaccines such as the hepatitis B vaccine. Up to 15 per cent are non-responders. It's noteworthy that healthcare worker mandates for hepatitis B vaccines acknowledge natural immunity, and those who have recovered from hepatitis B are exempted from vaccination if they provide proof of immunity. In an obvious contradiction of immunology science, such exemptions were systematically denied for COVID-19.

It is also well established that immune senescence of the elderly is a major issue for the effectiveness of flu vaccines. Large-scale epidemiological studies would be required to properly ascertain the likely extent to which this problem affected the efficacy of the COVID-19 vaccines. In the absence of such studies, the recommendations of health agencies for general vaccination are, at best, faith-based, not science-based.

The Challenge of Assessing Vaccine Efficacy and Safety

The ultimate test for assessing vaccine efficacy and safety is whether the vaccine protects against deliberate controlled exposure to the disease agent. The test is routinely performed on animals but is considered unethical to perform on humans. Vaccine effectiveness is easier to assess in animals because we can control the infection process by using an inoculum that has been ascertained to make the animals sick 50 per cent of the time. Also, it's possible to minimize variability of outcomes due to genetic and epigenetic factors by selecting animals with a similar genetic background and putting them in a similar environmental conditions. That avoids the problem of confounding factors.

Even under these ideal conditions, no safe and effective animal coronavirus vaccine has been granted approval for wide distribution, which suggests that the development of safe and effective vaccines for coronaviruses is even more challenging than for other pathogens. Nevertheless, we were asked to believe that the unproven mRNA platform would somehow overcome that biological hurdle.

To minimize the undue influence of confounding factors, randomized controlled trials (RCTs) are the gold standard to assess vaccine efficacy and safety and to establish the risk-benefit profile. Many issues have been raised about the efficacy and safety of all genetic vaccines, but we focused on the analysis of the mRNA platform as it was the most widely deployed.

What the Randomized Controlled Trials Proved and Didn't Prove

Many issues were highlighted with respect to the quality attributes of the vaccine product, the design of the clinical trials with their selected endpoints, the low level of absolute risk reduction, the irregularities in the execution of the clinical trials, and the underestimation of the vaccine-induced adverse effects. After the systematic suppression of any potential treatments paved the way for the EUA of the genetic vaccines, vaccination was promoted as the only way out the pandemic. It was sold as the way to prevent people from getting infected and seriously sick from COVID-19. It had to be expedited at an unprecedented pace, at warp speed, and against all odds.

Vaccination was going to allegedly protect both individuals and the healthcare system from being overwhelmed. To fulfil these hopes, the RCTs should have been designed with endpoints showing prevention of transmission and severe diseases and death. They were not. Instead, the only endpoint was reduction of RT-PCR confirmed cases with mild symptoms. Surprisingly, 162 RT-PCR positive cases were reported in the placebo group versus eight in the injected group. Although this represented an impressive relative risk reduction (RRR) of 95 per cent, it corresponded to an overall absolute risk reduction (ARR) of less than one per cent. These figures meant that we needed to vaccinate 123 people in order to avoid one infection (defined as RT-PCR positive cases with mild symptoms).

As the occurrence of severe symptoms leading to death was up to 100 to 1000 times lower, depending on the target population, we would have needed to vaccinate up to 123,000 people to avoid one case of severe disease. The RCT, with only about 40,000 participants, was not powered to make that assessment.

It's noteworthy that 170 total cases represented a COVID-19 positivity rate of only 0.004 per cent in six months of follow-up. With this anemic incidence rate, one would have to conclude that the COVID-19 pandemic wave was rather feeble during the RCT or that the testing was not thorough enough. At least, the testing was not as systematic as that which had been deployed to document the worrisome successive COVID-19 waves. Notwithstanding, it's striking that this low incidence rate yielded a very weak overall ARR.

Telling people who are afraid of getting sick with COVID-19 that (1) the mRNA vaccine would reduce their chance to be infected by less than one per cent, (2) it would not stop them from transmitting the virus, and (3) it was not tested for reducing severe disease or death conveyed a very different message than telling them that the mRNA vaccine was 95 per cent effective. By FDA rules, reporting both RRR and ARR was mandatory, but it was conveniently obfuscated. Informed consent was irremediably compromised with their misleading statements. In addition, the validity of vaccine mandates was shown to be baseless.

To make matters worse, mild symptoms like fever, sore throat, and sniffles overlapped with a host of respiratory infections from multiple different viruses or bacteria, which introduced sampling and attribution biases. Those could have been avoided by regularly testing everyone enrolled in the RCT. Instead, the method used to assess the endpoint was fairly limited in detecting COVID-19 cases, and that cast doubt on the soundness of RRR reported in the RCT.

This contention was bolstered by the surprising number of cases that were rejected from the report because of the lack of participant follow-up and the more than 10-fold number of suspected but unconfirmed cases. Indeed, 1594 in the inoculated arm were rejected versus 1816 in the placebo arm, a difference of 222. Also, there was a strikingly disproportionate number of participants excluded from efficacy evaluation for protocol deviations, with 311 in the vaccine arm versus 60 in the placebo arms, a 5-fold difference, or a 251 difference, in the number of participants.

This must be put in perspective when you consider the difference in the calculation of RRR versus the calculation of ARR. In a thought experiment, if one adds all of the confirmed and suspected cases, the RRR was only 19 per cent, much lower than the threshold of 50 per cent set by the FDA for the approval of the vaccine under EUA. Failure to systematically test all participants without subjective attribution of who needed to be tested or not, raised suspicion about the validity of the reported efficacy.

The massive RT-PCR testing on the population generated the waves of positive cases, most of which were asymptomatic, and created the illusion of asymptomatic transmission. This was the real-world proof that this kind of testing could have been deployed during the RCT to avoid attribution biases. Using a different methodologies to monitor vaccine efficacy and epidemic waves was a clear demonstration of a double standard, insofar as testing of asymptomatic people was mandatory in many settings—for travellers; unvaccinated healthcare workers, even those working remotely; and children in schools, where a few positive cases had been detected.

Furthermore, although not reported in the publication describing the result of the RCT, a different way of monitoring SARS-CoV-2 infection was also measured during the RCT, but it was only revealed by documents obtained by a court order. This other method was to test for antibodies binding to at least one of the viral proteins, such as the nucleocapsid protein N, as irrefutable proof of infection. If the RRR is calculated based on seropositivity to the N protein, the RRR in vaccine efficacy was 55 per cent instead of 95 per cent.

But even that assessment was overestimated. A large-scale clinical trial on more than 4000 people established that the seropositivity focusing on only the N protein underestimated the true infection rate (as measured by antibodies against all of the other viral proteins) by a factor of about two. That meant that during the Pfizer RCT, the real RRR was probably in the range of about 25 per cent—again, much lower than the threshold of 50 per cent set by the FDA for the approval of the vaccine under EUA. Pfizer was aware of that, or should have been, before the deployment of their vaccine in the population, but they concealed the information.

Lastly, another systematic bias in the assessment of vaccine efficacy was the time frame selected to monitor its efficacy. Given that COVID-19 infection rates had been demonstrated to be higher for the first few days after the injection, if “protection” was only monitored seven days after the second dose and the window of negative efficacy was not considered, the true picture of vaccine efficacy would be distorted.

As shown in the Pfizer documents obtained by a court order, while Pfizer and the FDA had hoped to keep the information confidential for 75 years, the third most frequent adverse effect observed in the first weeks following the injection was COVID-19 infection. Therefore, Pfizer was aware of this increased sensitivity to infection, a window of negative vaccine efficacy, in the first months of vaccine deployment.

Also, if after the peak in neutralizing antibodies, a constant decline occurred until the protection vanished and this was not properly monitored, a distorted report of vaccine efficacy would result. The waning protection would have called for repeated boosters, and this had been obfuscated.

Assuming, without evidence, that neutralizing antibodies to the vaccine spike would be a valid proxy of protection, monitoring the antibody response on a relatively short time frame could have led to a misrepresentation of the perceived vaccine benefit.

Incidentally, there has been a strange paucity of testing of neutralizing antibodies in the course of the RCT. They were monitored two months after the second dose and again at six months. The absence of systematic measures of antibody titers during the two-to-six-month interval precluded a proper assessment of the rate of antibody reduction as a proxy for waning vaccine protection—important information that could have contextualized the real efficacy of the vaccines over time. For most people, vaccines are expected to last for several years, not a few months.

Even more worrisome is that according to independent experts in clinical trial standard operating protocols (which are strictly regulated by ICH (The International Council for Harmonization) guidelines, followed by industry, and overseen by regulatory agencies), several irregularities had been communicated to authorities by whistleblowers and were ignored.

The first notable one about irregularities, denounced by Brook Jackson, from the contract research organization Ventavia, was commented on in the *British Medical Journal*. Not only were the issues raised by Jackson completely ignored by Ventavia, Pfizer, and the FDA, but she was also fired for raising troubling questions. At the time of this report, her allegations were being disputed in court.

There is also the widely publicized case of the vaccine-injured Maddie de Garay in the RCT, whose gravity of injury was not properly acknowledged—a clear breach of clinical practice protocol. A similar situation happened in Argentina at the unique, large clinical trial site managed by the military. Out of the 5700 enrolled participants, one participant, Augusto Roux, developed severe myocarditis and almost died during the RCT, yet this event was not reported. He was suing for fraud.

Collectively, all of these five clinical trial sites (three for Ventavia) enrolled over 7000 participants whose data integrity should be evaluated by proper audits that have not yet taken place.

Some commentators dismissed those problems by suggesting that even if we removed these sites from the trial report, which had not yet been done by Pfizer, the data would still support a highly positive RRR number. This is questionable. Removing more than 7000 participants from an RCT of about 42,000 in which 3410 participants had already been discounted would bring the number down to about 32,000 participants. That may or may not challenge the statistical significance of the results or the overall result of the RRR assessment.

Nevertheless, in spite of the speculative nature of these suspicions, there was enough of a smoking gun to justify a formal audit to ascertain whether or not these allegations of clinical trial malpractice were founded. A confirmation by an independent audit would compromise the validity of the whole RCT.

How plausible was it that Pfizer had not been honest? Since 1995, Pfizer had been fined in 40 court cases for 6.5 billion dollars of compensation—for scientific fraud, wild RCTs, corruption of decision-makers, and diffusion of false information. The pattern was well-established.

Current Good Manufacturing Process (cGMP), Chief Manufacturing Issues

Another troubling issue was the quality of the vaccine product. It had been questioned by the European Medicines Agency (EMA) when a number of quality attributes did not conform to expected norms. Notably, there was a significant discrepancy in the integrity of the mRNA as well as the degree of DNA contamination between the batches used in the RCT and the commercial batches for worldwide distribution. Even after Pfizer had been notified to fix these issues, they were unable to comply. Because of the alleged emergency, the EMA turned a blind eye.

Obviously, the significant discrepancy between the RCT batches and the commercial batches was proof that the manufacturing processes were different, which was acknowledged by Pfizer. This was a clear deviation of both normal clinical trials standard operating procedures and cGMP processes, and it raised major concerns about the batch quality and consistency.

Indeed, in a normal RCT protocol, although tolerated, it's highly recommended to avoid changing the manufacturing process in the path of moving from preclinical to the various phases of the clinical trials. At the very least, the process must remain the same from phase 3 to commercial manufacturing. Otherwise, a bridging study is needed to validate that the product will behave as it did in the phase 3 trial.

This consistency is even more important for a complex drug product such as these genetic vaccines. Unlike small molecule drugs, which are amenable to full physicochemical characterization, complex biologics such as the mRNA genetic vaccines cannot be fully characterized. For such products, the "product is the process." Changing the process in the course of product development almost guarantees that the product quality will vary unless the new manufacturing process is well mastered, which was far from being the case for the mRNA-LNP products.

Pfizer acknowledged that their process 1, which was hastily developed for the product used in the clinical trials, could not be scaled up to the level required for commercial manufacturing (process 2). They therefore did a small bridging study during the RCT on 250 participants who received the products manufactured using process 2. That meant that almost 90 per cent of the RCT was done with a different product than the one that was used on the general population. Does anyone besides the regulatory agencies think that testing this product in a RCT with only 250 participants would yield reliable, statistically significant data?

The regulatory agencies advertise on their website that they audited the manufacturing batches; however, the reports of such audits are not made public. It's therefore unclear to what extent the batch quality issues are limited or widespread.

Independent analyses by several experts have revealed that the issues of RNA integrity and DNA contamination have persisted in many batches. Most notably, functional plasmid DNA harbouring antibiotic-resistant genes as well as the SV40 strong promoter sequence have been detected at more than 10-fold the level of the acceptable norm. Both the short- and long-term consequences of the poor batch quality have not yet been fully examined.

One big concern is that, unlike mRNA, DNA can integrate in the cell genome without the step of reverse transcription, so this event could occur at a higher frequency. Also, the SV40 strong promoter sequence, once integrated, could activate distant genes and perturb normal gene expression in unknown ways. Only rigorous genotoxicity and tumorigenicity analyses could determine the long-term consequences of such events. Such studies have been waived, so we are left to just hope for the best.

The complacency of the health authorities does not augur well for redressing the pitfalls of the cGMP issues that they have been so far reluctant to require to get resolved. This was further exacerbated by the silent approval of new bivalent mRNA vaccines that use the same suboptimal manufacturing process. There was no acknowledgement that changing the RNA sequence was not a minor modification with untold and unexamined consequences. How can we conclude that changing the RNA sequence is a minor modification without assessing it with RCTs (which have been deemed unnecessary)?

Despite what has been claimed by governments and echoed in the mainstream media, corners have been cut, and the trend has been worsening. How can any health regulatory agency endorse the alleged safety and efficacy label of a product with questionable quality and consistency and in blatant contraventions of quality standards established in the industry for decades? Perhaps that is part of the new normal—regulatory bodies no longer enforcing the high-quality standards essential for public safety and endorsing an accelerated process development and approval cycle. If it is justified by an emergency, what is the emergency?

Underestimation of Vaccine-Induced Harms

Underestimating the occurrence and hazards of vaccine adverse reactions has been the modus operandi of the Pharma industry in concert with public health authorities for decades. This was done under the guise of the greater good to suppress vaccine hesitancy at all costs and to promote vaccination as widely as possible as an indisputably beneficial health measure. And, to that noble end, anything in the play book is acceptable. This includes attacking dissenting voices with derogatory terms among which the label "anti-vax" sits at the pinnacle.

Nothing can be more unscientific than resorting to ad hominem attacks to silence legitimate debate. Sadly, character assassination is not the only tactic. People who dared to question the orthodoxy that controls the granting system, along with the other institutions, have found their scientific careers ruined.

The quasi-religious faith in the virtues of vaccination undermines any decent assessment of its risk-benefit ratio. As vaccines are presumed to be safe and effective without rigorous testing, vaccine safety research is impeded by the lack of granting support, unlike the well-funded field of vaccine development, hence the paucity of vaccine safety studies.

An honest risk-benefit assessment of the mRNA genetic vaccine was plagued by bias measures that tended to amplify merits while downplaying adverse effects. Any positive risk-benefit analysis was so questionable that thousands of doctors and scientists across the world joined their voices to call for an immediate suspension of COVID-19 genetic vaccines until a proper risk-benefit assessment was conducted.

In the absence of solid evidence from RCTs, the opinion of health authorities relied on real-world data whose completeness and accuracies were questionable. It was more a matter of expert opinion than hard scientific evidence.

High-profile medical and scientific experts without conflicts of interest examined the data and concluded that these mRNA-LNP genetic vaccines are neither safe nor effective. The same data was examined by medical authorities and government officials in Canada and across the world who trusted the "safety and efficacy" narrative without reliable data from the Pharma companies. Who were more credible?

At the time of writing this report, some COVID-19 genetic vaccines had been restricted in a limited number of states for unfavourable risk-benefit profiles in some segments of the population, mostly younger people. Citizens were calling for a more complete ban on COVID-19 mRNA vaccines, whereas the adenovirus-based vaccines were no longer on offer in many countries, including Canada.

It was an uphill battle. Meanwhile, the FDA was examining which sequence of Omicron variant to offer for the fall booster as the original Wuhan and bivalent vaccines were no longer promoted. In Canada, the National Advisory Committee for Immunization (NACI), whose members were as plagued by conflicts of interest as the FDA panel members, were following along the same lines as the FDA. Their implicit message was that the only problem with the mRNA-LNP products was matching the sequence of RNA with the variant du jour.

In spite of all the attempts to minimize the extent of the mRNA genetic vaccine adverse reactions, the acknowledgment of severe symptoms and the unprecedented death rate was growing. Were the high number and diversity of vaccine adverse events (VAEs) a big surprise? Not really, insofar as most of the potential adverse events to be monitored were listed on the FDA website in October 2020, and they were what we observed after the vaccine deployment: myocarditis, pericarditis, thrombosis, autoimmune diseases, and a host of invalidating neurological conditions.

These were also spelled out in the record of the Pfizer documents, obtained by court order. Pfizer's post-marketing pharmacovigilance study showed an impressive number of serious adverse reactions in the first months of vaccination, including more than 1200 deaths. Contrast that with the flu vaccination campaign of 1976, which was suspended after fewer than 100 deaths. The precautionary principle was still in effect at that time.

In retrospect, there were some glimpses of severe adverse effects from the Pfizer RCT, even though the formal assessment of long-term adverse reactions was abruptly interrupted during the course of the RCT. An astonishing decision to offer the vaccine to the placebo arms interfered with one of the trial's important objective of assessing long-term safety. Vaccinating the placebo arms after six months in the course of the RCT effectively eliminated most of the placebo arm control that would have allowed us to compare the occurrence of adverse effects for the two-year duration initially planned.

However, all of the data at the six-month interval pointed to significantly higher illness, which the vaccine was supposed to reduce. What good was a vaccine that reduced the infection cases without any indication of reducing the illness?

Although not statistically significant, it's noteworthy that there were more deaths in the vaccine arms than the placebo arm, 20 versus 14. Interestingly, cardiovascular events were the cause of nine of those deaths in the vaccine arm and five in the placebo arm. Given the context that myocarditis and pericarditis were among the first vaccine severe adverse effects (VAEs) acknowledged by health authorities, this confirmed the importance of such cardiovascular events. In any case, even if the analysis was deemed not statistically significant, with such data, any claim of vaccination reducing illness and death was unsubstantiated by the RCT.

More telling was what was not reported or even examined. Given that clear symptoms were the endpoints of the pathological process, it was routine medical practice to assess the early signs of pathologies using validated biomarkers. It was mind-boggling that standard biomarkers had not been deployed to monitor the myriad of expected potential side effects listed by the FDA. For example, D-dimer provides evidence of enhanced coagulation/clotting, C-reactive protein for evidence of enhanced inflammation, and troponins for evidence of cardiac damage. If biomarkers of early signs of disease are not tracked, then biosafety monitoring is of poor quality. Consequently, the assessment of vaccine safety is far from exhaustive.

From Anecdotal to Large Statistics of All-Cause Disability and Mortality

Besides the astonishing lack of acknowledgment of vaccine-injured people, the cruelest aspect was the gaslighting. How can one listen to the horror stories of people whose lives have been destroyed by vaccine injuries without being moved and shocked by the wall of indifference, or even hostility, that they had to face while desperately attempting to be heard by medical authorities?

Even more frightening was the apparent incapacity to properly diagnose the myriad of symptoms, many of which were rare or never seen before. This attitude provided little hope that treatments would be proposed for injuries that were not properly acknowledged.

Many came to share their stories with candour and despair. Although the total number and extent of vaccine-induced disabilities were challenged by the authorities, given that many had taken the injections for the cause or were coerced by social pressure or government mandates, the least that a compassionate society must do is acknowledge them, treat them, and properly compensate them –not leave them to their misery. People were mourning the death of close relatives following the injections with unresolved sentiments of guilt, helplessness, rage, and sorrow of not being recognized by the authorities.

Vaccine-injury denial was part of the propaganda of denigrating people with the anti-vax label in the effort to combat vaccine hesitancy—purportedly dangerous for public health. Vaccine-injury denial has been around for a long time, at least since 1984, but it was on steroids during the COVID-19 health crisis.

Vaccine-injured people are more than just a number in a table of vaccine-correlated symptoms. Beyond the cold statistics, there are humans who suffered twice—first, from their vaccine injuries, and then, from the denial of the authorities and the population to recognize their miserable state.

This denial is being challenged in courts all over the world, and with time, silence will be broken and justice will prevail. Otherwise, we will face another health crisis debacle when the next pandemic is declared.

While the state was diligent in procuring excess stocks of vaccines, which were subsequently destroyed when they expired, or generously given to Africa before they expired, what resources were devoted to dealing with the deleterious consequences of vaccine injuries, in terms of care and compensation disability?

The population had already paid for these free vaccines with their taxes, and they were set up to continue paying on a personal and collective level because the manufacturers had signed contracts exonerating them from prosecution.

If, despite the urgency of the authorization, these vaccines were well designed and manufactured to be safe and effective, why did the manufacturers have to protect themselves from legal prosecutions by passing the bill on to the public, who still has to pay and be further impoverished by the indebtedness of the state?

In the context of strained resources for healthcare, which monopolizes a substantial part of state budgets, one cannot ignore the significant direct and indirect costs of the unjustified massive vaccination campaign. Hasn't this vaccination campaign resulted in a vast wealth transfer to the pharmaceutical industry? Not only is there no benefit to public health, but we will be paying for the increasingly heavy toll of damages for decades to come.

Due to a toxic combination of willful blindness and collective guilt of the medical establishment that took part in the vaccination campaign and fiercely fought vaccine hesitancy, calling it irresponsible and harmful for public health, the lack of acknowledgment and the gaslighting of the vaccine injured has been a major obstacle to their therapeutic care. From the analysis of the VAEs in the RCTs to the endless lists of injuries reported in the various pharmacosurveillance systems, the alarming number and diversity of disabilities induced by the COVID-19 genetic vaccines are unquestionable.

An independent reanalysis of Pfizer and Moderna RCTs done by Fraiman and collaborators revealed that SAEs (severe adverse events) occurring at a rate of one in 556 is categorized as "uncommon," according to the accepted classification, not "rare," as was displayed on the various government websites. Since this rate is 18-fold higher than was used in the past for withdrawing other vaccines, why were the COVID-19 genetic vaccines not withdrawn?

Experts monitoring all of the governmental pharmacosurveillance systems worldwide—for example, VAERS in the USA, Yellow Card in UK, EudraVigilance and the WHO VigiBase system—have recorded numbers of injuries, disabilities, and deaths that are more than 20 times higher than for traditional vaccines. There were enough safety signals in VAERS in January 2021—almost 700 deaths—to stop the rollout of the Pfizer vaccines. Based on that, the Moderna vaccines should not have been rolled out. However, all of the historical safety signals for suspending vaccines were ignored.

As a result, countless VAEs piled up for more than two years before the CDC was forced to release the data from their V-safe system. It revealed more than 700 safety signals from over 10 million self-reported VAEs, of which 7.7 per cent were deemed severe adverse events.

It's noteworthy that both the number and the diversity of VAEs were much higher. The types of VAEs linked to COVID-19 mRNA-LNP were up to 15,042, which is greater than 10 times more diverse than for all other traditional vaccines. This diversity in adverse events was probably liver related. As it turned out, the mRNA-LNP vaccine was very stable and had an ill-defined pharmacodistribution profile. Accumulation of spike proteins in the ovaries was a concern, but the liver was the second site of greatest accumulation after the injection site. Accumulation in the ovaries was likely the reason for the menstrual dysregulation and partly explained the significant reduction in fertility rates in many highly vaccinated countries. It also correlated with increased stillbirth rates.

This increase in stillbirths was documented in a study co-authored by Dr. McCullough in which it was reported that COVID-19 genetic vaccines had a greater than two-fold, or 100 percent increase, in VAEs as compared to traditional flu vaccines. This represented a clear safety signal requiring further investigation, according to the CDC. Furthermore, a major increase in stillbirth rates were observed in many states, correlating with higher vaccination rates of pregnant women.

While the result of the RCT conducted by Pfizer on pregnant women was not disclosed even many months after the trial has been terminated, it's unfathomable that the vaccines were promoted to pregnant women without any safety or efficacy data. That was in blatant disregard of the precautionary principle. Also unfathomable was the willful blindness of the medical establishment who endorsed it without scientific evidence. Their faith in the Pharma industry and the regulatory agencies was misguided.

It was shown that spike mRNA was persistent in the liver, and liver accumulation is likely the main reason for the diverse pathophysiological symptoms. Among the main physiological systems in the liver, we found a number of proteins involved in the regulation of the ACE2 renin-angiotensin system (RAS), a key system that was most likely disrupted by the spike protein by virtue of its binding to the ACE2 receptor.

Also, the liver was the production centre of many proteins involved in the coagulation cascade; its dysregulation could lead to all kinds of clotting issues. Numerous VAEs had common etiology involving aberrant coagulation and wound healing. Further research is required to decipher the specific mechanisms involved.

Interestingly, the perturbation triggered by spike-induced liver inflammation which affected normal liver coagulation homeostasis, combined with the propensity of the spike protein for aberrant folding, could provide some fertile research hypotheses to explore the underlying mechanisms of the unusual clot formations that has been observed by embalmers.

Ectopic over-expression of the spike protein in other tissues, such as the endothelium of veins and arteries, is likely involved in many coagulation pathologies. Similarly, ectopic over-expression of the spike protein in the brain could be at the root of a host of neurological diseases. Again, this will only be unravelled by much-needed additional research.

Even in the absence of the precise pathophysiological mechanisms of injuries that need to be further investigated for the myriad of VAEs, a significant number of autopsies documented the plausible causal link of the COVID-19 genetic vaccines in many cases of suspicious sudden deaths. The COVID-19 genetic vaccines were also a plausible explanation for the abnormal surge of non-COVID excess deaths in 2022 in most of the highly vaccinated countries, especially noticeable in the younger population.

From the more than 4,300 peer-reviewed papers examining vaccine injuries, a study co-authored by Dr. McCullough found that in the 44 papers describing autopsy reports, 74 per cent of the 325 autopsies were adjudicated to be mostly caused by COVID-19 vaccination. The deaths occurred within a mean average of 14 days of the last injection, with the majority occurring within a week. The close temporal association made the adjudication more plausible. For all of these cases, 53 per cent of the time, cardiac issues were the main cause of death, followed by hematological issues (17 per cent).

The magnitude of death and injuries can be realized from the May 5, 2023, VAERS. It counted more than 1.5 million VAEs, including 35,324 deaths in the U.S. With a conservative under-reporting factor of 20, this represented 706,480 deaths in the U.S. alone, a staggeringly high death toll if proven correct.

In the absence of data transparency—governments refusing to report the vaccination status of people dying of all-causes—it was very difficult to appreciate if vaccinated people were dying proportionally more than unvaccinated people. It was therefore difficult to assess the magnitude of health damages generated by the broad vaccination campaigns.

However, this information was obtained from the analysis of insurance companies and the U.S. Bureau of Labor Statistic (BLS), as testified to by Edward Dowd. Indeed, the careful investigation of the tables led to the disturbing conclusion that in 2021, 2022, and continuing in 2023, it was detrimental to your health to be employed in the United States. Financial analysts referred to it as a black swan event.

Given that the working population in the U.S. was likely to be the healthiest, finding that they were dying at a higher rate than the unemployed was astonishing. For example, in the third quarter of 2021 (Q3), there was 40 per cent excess mortality in the population aged 25 to 64. To put this in context, a 10 per cent increase in excess mortality was a 1-in-200-year event, hence very rare; a 40 per cent increase was off the charts. And these off-the-chart excess mortality rates happened immediately after the vaccine mandates, which were systematically implemented for every federal government employee and for private companies of more than 100 employees.

The best explanation for such a coincidence is that the vaccine-hesitant millennials were coerced to take the job or lose their job, and the rapid vaccine uptake resulted in the increase of all-cause mortality in the subsequent quarters. No other event could meaningfully account for that.

Furthermore, the staggering amount of lost work-time data from the BLS showed a huge increase in lost workdays in 2021 and 2022 (due to approximately 26 million vaccine-injured people, when we considered a 30-40 underreporting factor in VAERS): it was another black swan event. This significant disability of almost 10 per cent of the workforce was going to result in major loss of productivity for the U.S. economy in years to come. No one meaningfully challenged the quality of this financial analysis, yet no authority was willing to acknowledge the consequences of this dire situation and propose a remedy.

Finally, because of unavoidable attribution biases, a clear correlation of COVID-19 genetic vaccines and deaths could ultimately be best established by a statistical analysis of all-cause mortality worldwide, as testified by Dr. Denis Rancourt. From his careful and detailed analysis of the statistics on all-cause mortality over a century, by age and discrete temporal categories, he concluded, beyond a shadow of a doubt, that the worldwide vaccination campaigns were responsible for a massive amount of deaths (and still counting).

The first insight about vaccination as the main culprit of an increase in all-cause deaths came from a study in India in which a huge peak of excess deaths (3.7 million) was linked to the vaccine rollout that targeted mainly elderly and frail people in the first wave of vaccination, called the “Vaccine Festival.” As it turned out, the vaccine-dose fatality rate (vDFR), as calculated using a large body of data, was much higher in older people.

The vDFR increases exponentially with age, ranging up to 3 per cent for the most vulnerable elderly, with a doubling time of five years. In the Indian vaccination campaign, the vDFR was, on average, one per cent because of the target population.

The statistics for Australia went from zero excess deaths to a huge excess in deaths immediately following the vaccine rollout. The trend continued and was very visible after the third dose. In Mississippi, the “Vaccine Equity Campaign”—again, for the most vulnerable in the population aged 24 to 65—also yielded a huge excess in deaths immediately following the vaccine rollout. Similar profiles were also easily discernible in Alabama and Michigan.

In Canada, the excess mortality seen in 2020, did not decrease in 2021–22 following vaccination. In fact, in 2022, there was significantly higher mortality than in 2020 or 2021. As soon as the vaccination was rolled out, we saw an extra peak of mortality. The rollout of the third dose gave the highest peak of mortality, suggesting that the toxicity was dose dependent.

The data from many Western countries allowed Dr. Rancourt to calculate a vDRR between 0.05–0.1 per cent and 1 per cent (and up to 3 per cent for the most vulnerable). Excess deaths were 13 million worldwide—3.7 million in India, 330,000 in the USA, and around 28,000 to 31,000 in Canada—for a vDFR of 0.03 per cent or 1 death per 3000 doses. Again, the astonishing numbers of COVID-19 genetic vaccine deaths were not meaningfully challenged.

In most countries, excess mortality was dropping and returning to normal, but there were a few countries like Canada where excess mortality was higher in 2022, and the reason behind this phenomenon was being explored.

Poor Modelling Says Millions Saved by Mass Vaccination

As the data on vaccine serious adverse effects piled up, the health authorities reluctantly started to acknowledge their existence. With the growing evidence on causality, they tried to evade responsibility. Their justification went something like this: “Of course, no vaccine is perfectly safe, but causality has not yet been demonstrated in the majority of the cases, and overall, they save many more lives, even if the vaccines, potentially, are causing some deaths.”

The incentive to make such baseless claims was also motivated by the systematic suppression of life-saving treatments, which potentially cost millions of lives. The suppression was a necessary condition to get COVID-19 genetic vaccine approval under EUA.

It would have been possible to conduct rigorous statistical analysis to prove that a reduction in COVID-19 or all-cause mortality following vaccine rollout in 2021 was strongly correlated with the vaccine rollout. The fact that no such study was published by any government in the world was a clear indication that prevention of COVID-19 mortality by vaccination was not observed in the real world.

Ignoring the data, health authorities resorted to “garbage in, garbage out” modelling, like the one published by Neil Ferguson at the beginning of the pandemic that predicted COVID-19 mortality. Due to incorrect assumptions, his model exaggerated deaths by a factor of 10 to 20.

The same playbook was used in the infamous *Lancet* paper that claimed that the COVID-19 genetic vaccines would save up to 14.4 million lives in 2021. This modelling was based on false assumptions about the infection fatality rate (IFR) and vaccine efficacy that resulted in at least a 200-fold overestimation of vaccine’s putative benefit on death reduction. These absurd modelling results were widely publicized in the mainstream media.

Similarly, a paper co-authored by Theresa Tam, falsely claimed that Canada’s drastic health measures, in terms of NPIs and vaccination, had a combined benefit of preventing 1.1 million COVID-19 deaths. The figure was produced by massively overestimating IFR and putative effectiveness of both NPIs and vaccines. The claim that those drastic measures brought down the excess-death statistics to exactly the expected historical level was simply absurd, as testified to by Dr. Denis Rancourt. The fact that such a poor-quality paper was published in the peer-reviewed literature was mind-boggling.

Conclusions

There was malpractice by public health and individual healthcare practitioners. Relentless vaccination and denial of early outpatient treatment for COVID-19 were rivalled only by bureaucratic stubbornness.

Given the limited evidence-based justification for widespread vaccination and concerns regarding the experimental mRNA-LNP gene therapy injections, we concluded that:

- These injections did not undergo the standard approval process for gene therapy products.
- Manufacturing issues led to quality concerns that deviated from historical regulatory standards for protecting human health.
- The unprecedented level of reported morbidity and mortality, particularly among vulnerable populations, surpassed what was observed with traditional vaccines or COVID-19 infections.

- Rigorous randomized controlled trials (RCTs) failed to demonstrate their efficacy in stopping transmission or reducing severe illness, hospitalization, or death. Instead, the vaccines were associated with more harm than benefit.
- The injections were administered without obtaining free and Informed Consent, contravening the principles of the Nuremberg code.
- During the early days of the pandemic, politicians said that one death from COVID-19 was one too many, implying an all-out war on COVID, regardless of collateral damages. Although they claimed that drastic measures were necessary to prevent COVID-19 deaths, the vaccine-caused deaths were ignored—a double standard at play. Those deaths were tolerated for the “greater good.” Certainly, no effort was made to avoid vaccine deaths at all costs.

In theory, reporting of VAEs was compulsory, but many doctors didn’t report adverse events because the process was cumbersome and because they couldn’t or wouldn’t believe that VAEs were linked to vaccines. However, it was not up to doctors to make the call to skip the reporting process.

The net result of the authorities’ use of inappropriate criteria was a substantial underreporting of side effects. Because the time frame of occurrence was established on the false premise that these genetic vaccines were like traditional vaccines, any side effect reported after a few weeks was arbitrarily deemed unrelated. The estimate was between a 10- to 100-fold underreporting of VAEs.

The decision to suspend a vaccine depended on the danger signals analyzed from VAE statistics. Every VAE had to be analyzed to formally incriminate the vaccine as a causal agent, but the process was long and tedious. Normally, the likelihood of suspending vaccines increased with greater numbers of injuries. During the COVID crisis, however, even though the threshold of danger signals was well above traditional vaccines, the formal process of their removal was not activated, except for some limited restrictions in some states.

Outrageously, the precautionary principle was flouted for pregnant and breastfeeding women. Without any clinical trial safety data, these vaccines were promoted after unsubstantiated data alleged pregnant and breastfeeding women were more at risk from COVID-19 than the general population. The reckless decision to recommend the vaccine to pregnant and breastfeeding women resulted in a notable increase in miscarriages, stillbirths, and serious health problems for babies.

The contention that the COVID-19 genetic vaccines had shown any positive risk-benefit in any segment of the population was refuted by the bulk of the evidence provided by independent expert witnesses. Their overall conclusion was that these genetic vaccines did more harm than good. They remarked on the limited efficacy and imminent danger of these vaccines, and they called for an immediate withdrawal from the market until rigorous studies proved the vaccines were safe and effective.

The onus of proof was seen to be on the vaccine manufacturers. The regulatory agencies were admonished by expert witnesses to get back to the best practices of protecting the public from the harms of a product hastily developed, tested, and manufactured.

Working at “the speed of science” was denounced by expert witnesses. People would be justifiably reluctant to fly in a plane under construction that had not been fully tested for safety. People were similarly justified in their vaccine hesitancy. At best, these mRNA vaccines were poorly tested experimental prototypes that should have been sent back to the drawing board. This was unlikely to happen unless the perverse incentives for these products were eliminated.

Unfortunately, suspending the vaccines would have required government officials to admit their initial reckless mistake. The further they persisted without acknowledging their error, the more they doubled down and pushed the approval of new mRNA formulations without proper RCTs. We saw this with the approval of vaccines for children and the approval of the bivalent Omicron vaccines.

They wanted us to believe that because the initial concoction had been declared safe and effective, the new mRNA sequences in the same LNP platform would also be safe. They were saying, without proof, that new mRNA coding sequences didn’t make any difference. This approach violated the spirit of the historical drug approval process that had been practised for decades (although with some gaps) to protect public safety. A new drug was presumed unsafe and ineffective until proven otherwise, and changing anything in the content of the product made it new.

Recommendations

We recommend the suspension of any further vaccination for COVID-19 until (1) the issues of cGMP production are resolved; (2) the genotoxicity, auto-immunogenicity, and tumorigenicity assays are conducted to the appropriate level for gene therapy products; and (3) rigorous RCTs demonstrate the reduction of morbidity and mortality in a representative population, including the most vulnerable.

Given that there was no efficacy study in the RCT with the mRNA-LNP produced in the commercial manufacturing process and that there were irregularities in the clinical trial process, we recommend that Health Canada require an independent audit of the RCT.

Victims have to be compensated more readily. We also recommend that the government set up a special centre to take care of the vaccine-injured.

Regulatory agencies must revisit the warp-speed-development mindset of the COVID-19 genetic vaccines and rebut the allegation that the mRNA-LNP products have been proven safe and effective and that they can therefore be further used as a vaccine platform for other diseases without proper safety testing.

A Pandora’s box has been opened, and promoting any future products based on that mRNA-LNP platform technology for expedited marketing, within one year, without the proper efficacy and safety assessment will only perpetuate bad health outcomes of similar magnitude.

In alignment with the views of numerous medical doctors and scientists worldwide, the following recommendations are made:

- A. **Immediately halt the use of experimental mRNA-LNP** gene therapy injections for COVID-19 prevention.
- B. **Approve any future applications of these injections through** the standard gene therapy product approval process.
- C. **Ensure that the regulatory approval process** and recommendations by vaccine immunization committees are reviewed by independent medical and scientific advisory committees without conflicts of interest.
- D. **Establish clear safety signal thresholds** that would necessitate the automatic removal of any vaccine or therapeutic product from the market, with legal accountability for officials failing to adhere to these pre-established norms.
- E. **Acknowledge, treat, and adequately compensate individuals** who have experienced vaccine-related injuries.

7.5.7. Interim Authorization of COVID-19 Vaccine

Introduction

The Commission received detailed information about the procedure through which “approval”¹³² for COVID-19 vaccines was granted in Canada. According to the testimony, the conventional evaluation and endorsement process for the COVID-19 vaccines was not adhered to by the Canadian Government. Instead, a new process was established whereby Health Canada “authorized” the COVID-19 vaccines under an Interim Order (which was later adopted as a permanent regulation). It is important to understand that the COVID-19 vaccines were never approved under the traditional approval process for drugs in Canada. Under the alternative authorization process, the necessity to establish the safety and efficacy of COVID-19 vaccines through an objective manner appears to have been set aside.

Objectively and independently proving the safety and efficacy of any new drug before its introduction into the market is an essential cornerstone of responsible healthcare and public safety. This rigorous requirement serves as a critical safeguard for individuals’ wellbeing, ensuring that potential risks are thoroughly assessed and weighed against the benefits. This principle becomes even more pivotal when the drug is intended for widespread use across all segments of the population.

The blanket use of a drug, especially one like the COVID-19 genetic vaccines, necessitates an unassailable foundation of evidence. Rigorous testing, transparent evaluation, and independent verification of safety and efficacy are fundamental to instilling trust among both healthcare professionals and the general public. This approach ensures that medical interventions are based on the most accurate and reliable information available.

In the context of a global health crisis, these principles are vital to ensuring that public health measures are not only effective but also respectful of individuals’ rights and dignity. It is imperative that all drugs proposed to be released to the public be objectively and independently proven to be both safe and effective. It is for this reason that strict proof of safety and efficacy have been required by our drug approval regulations. The need to prove both safety and efficacy take on particular importance for drugs intended for the entire population, including children and pregnant women. This approach forms the bedrock of responsible medical practice and contributes to a society that values health, science, and the dignity of each person.

Testimony Concerning Interim Authorization of COVID-19 Vaccines

The following vaccines were authorized by Health Canada under the Interim Order:

¹³² Throughout this Report, the terms *approval* and *authorization* are used synonymously to describe the process by which Health Canada made the COVID-19 vaccines available for use in the Canadian population. Health Canada appeared to also use the terms somewhat synonymously; however, the distinction between drug approval under the normal procedures and COVID-19 drug authorization under the Interim Order and the new regulation is discussed in this section.

1. Pfizer-BioNTech on December 9, 2020, for ages 16 and older and May 5, 2021, for ages 12-15,
2. Moderna on December 23, 2020, for ages 18 and over and August 27, 2021, for ages 12-17,
3. AstraZeneca on February 26, 2021, for ages 18 and older, and
4. Janssen (Johnson & Johnson) on March 5, 2021, for ages 18 and older.

The Commission received testimony from two key witnesses, Shawn Buckley and Deanna McLeod, regarding the procedure through which the authorization of COVID-19 genetic vaccines took place in Canada.

The initial authorization of all COVID-19 vaccines was provided under a temporary Interim Order, which exempted them from the traditional regulations that demand manufacturers demonstrate objective evidence of safety and effectiveness. The result was that while chief medical officers across the country repeatedly assured Canadians that the COVID-19 vaccines were “safe and effective,” the general Canadian population had no understanding that their authorization process had not required objective proof of safety nor efficacy.

Shawn Buckley

A constitutional lawyer, he discussed the changes in Canada’s *Food and Drug Regulations* for the approval of COVID-19 vaccines.
(Quebec City: May 12, 2023)

The normal regulatory process for approving a new drug in Canada is set out in Division 8 of Canada’s *Food and Drug Regulations* (the Regulations).¹³³

https://laws-lois.justice.gc.ca/eng/regulations/C.R.C.,_c._870/index.html

In order to get approval of a new drug in Canada, the Regulations require evidence of both the drug’s safety and effectiveness to be demonstrated to the Minister of Health.¹³⁴ Once evidence of safety and efficacy is provided, the Minister considers whether the benefits outweigh the risks. If evidence of safety and effectiveness has been provided which shows that benefits outweigh the risks, the Minister may grant market approval of a new drug.

¹³³ *Food and Drug Regulations*, C.R.C., c-870.

¹³⁴ *Regulation C.08.002(2)(g) and (h)*.

These first steps of demonstrating safety and effectiveness, before approval, are essential to ensuring that Canadians are not exposed to unknown risks in the name of unknown effectiveness. The Federal Government's creation of the Interim Order required Health Canada to approve the COVID-19 vaccines without proof of either safety or of efficacy which resulted in millions of Canadians taking a new drug whose safety and effectiveness could not be known.

The unfortunate result of authorizing the COVID-19 vaccines through the Interim Order (instead of within the traditional approval process under the Regulations) was revealed through NCI testimony –many Canadians were injured or killed while at the same time the COVID-19 vaccine was revealed not to be effective in preventing infection and transmission nor reducing the severity of illness. The benefit of hindsight demonstrates clearly why the traditional tests under the Regulations are needed for all new drug approvals and why Canada should not authorize drugs under Interim Orders, even in cases of public health emergencies.

The Traditional Drug Approval Process

The requirements that must be met to approve a new drug in Canada are found in C.08.002(2) of the Regulations. Of particular importance are high requirements for proof of both safety and efficacy. These are found as follows:

C.08.002(2) A new drug submission shall contain sufficient information and material to enable the Minister to assess the safety and effectiveness of the new drug, including the following:

- g) detailed reports of the tests made to establish the safety of the new drug for the purpose and under the conditions of use recommended;
- h) substantial evidence of the clinical effectiveness of the new drug for the purpose and under the conditions of use recommended.

Under the traditional approval process in the Regulations, the first step is to establish the safety profile of the new drug and demonstrate to the Minister of Health that the drug is safe for use in the human population. The second step is to establish the new drug's benefit profile: in other words, Is it effective? Does it work? The third step, although not specifically included in the Regulations, is to evaluate the risk-benefit profile for the drug. The regulatory review has to establish that the benefits of using the drug outweigh the risks of using the drug.

One cannot satisfy the requirement for a risk-benefit analysis without a complete understanding of the drug's safety and benefit profile.

Interim Order: Importation, Sale, & Advertising of Drugs in Relation to COVID-19

Instead of following the Regulations, on September 16, 2021, the Minister of Health made an Interim Order exempting all COVID-19 drugs (including COVID-19 vaccines) from the normal review and approval process.

The Interim Order was made under section 30.1 of the *Food and Drugs Act*, R.S.C., 1985, c. F-27, which permits the Minister of Health to make an interim order that overrides normal regulations. This section reads:

30.1 (1) The Minister may make an interim order that contains any provision that may be contained in a regulation made under this Act if the Minister believes that immediate action is required to deal with a significant risk, direct or indirect, to health, safety, or the environment.

The term *significant risk* is not defined in the Act, nor is there any proportionality built into this section. Thus, there does not appear to be any legislative safeguards or guidelines for when this power to override is used by the Minister of Health.

Under this broad power, the Minister made the Interim Order which, rather than requiring significant evidence of safety and efficacy of the COVID-19 vaccines as mandatory requirements for approval, only required the vaccine manufacturers to provide:

3(1) sufficient information and material to enable the Minister to determine whether to issue the authorization, including,

(o) the known information in relation to the quality, safety, and effectiveness of the drug.

By letting the Minister make a decision based on “known information” about safety and effectiveness, this allowed the COVID-19 vaccines to be authorized in advance of actual knowledge about their safety or effectiveness. The Interim Order attempted to make up for this by having manufacturers promise to do more follow-up research as follows:

3(2) If, at the time an application is initially submitted to the Minister, the applicant is unable to provide information or material referred to in any of paragraphs (1)(g) to (k) and (m) to (o) or that information or material is incomplete, the applicant must include in the initial part of the application a plan as to how and when they will provide the Minister with the missing information or material.

However, as will be discussed further below, the Interim Order also prevented the Minister from revoking authorization once given, meaning that the Minister was absolved of the responsibility to protect the public if subsequent safety problems were discovered in the COVID-19 vaccines.

It's vital to recognize that when the Interim Order was issued, the Minister of Health was the Honourable Patricia A. Hajdu.¹³⁵ Ms. Hajdu attended Lakehead University, graduating with a Bachelor of Arts. In 2015, she received a Master of Public Administration from the University of Victoria. To our understanding, she possesses no medical training credentials that would be pertinent to making the required determinations under the regulations.

¹³⁵ https://en.wikipedia.org/wiki/Patty_Hajdu (accessed 2023)

Approval of COVID-19 Vaccines was Virtually Guaranteed Under the Interim Order

Remarkably, the Interim Order effectively required Health Canada to authorize a COVID-19 vaccine for use in the Canadian population even **in the absence of detailed evidence of safety and substantial evidence of efficacy**.

Section 5 of the Interim Order provides:

5. The Minister must issue an authorization in respect of a COVID-19 drug if the following requirements are met:

- (a) the applicant has submitted an application to the Minister that meets the requirements set out in subsection 3(1) or 4(2);
- (b) the applicant has provided the Minister with all information or material, including samples, requested under subsection 13(1) in the time, form and manner specified under subsection 13(2); and
- (c) the Minister has sufficient evidence to support the conclusion that the benefits associated with the drug outweigh the risks, having regard to the uncertainties relating to the benefits and risks and the necessity of addressing the urgent public health need related to COVID-19.

The test set out in (c) above is startling when compared to the traditional test for new drugs under the Regulations. Under the traditional test, evidence of safety and efficacy must be proven. Under the Interim Order, there only needs to be “evidence to support the conclusion” that the benefits outweigh the risks. This does not mean the Minister (Health Canada) has to be convinced and actually reach the conclusion. If the test was to convince Health Canada, the test would read:

“the Minister has sufficient evidence to conclude.”

The difference in language is important. Under this test, it appears that a vaccine would have to be authorized as long as there was sufficient evidence to support an argument that the benefits outweighed the risks.

In addition, the risk versus benefit test need not be robust, as the Minister is to “have regard” for the “uncertainties” of the benefits and risks. It is not clear how the Minister is expected to perform a risk versus benefit analysis when there is insufficient safety and efficacy evidence to determine true risks versus benefits. It is even more unclear how to perform a risk versus benefit analysis while “having regard to the uncertainties” of the risks versus benefits.

Ultimately, the Interim Order reveals that the Minister’s priority was the “necessity of addressing the urgent public health need related to COVID-19.” The problem, of course, is that under this test, the government placed its perceived “urgent public health need” ahead of safety and efficacy of the COVID-19 vaccines. This appears to be what the Government of Canada actually did.

Regardless of whether the need for a drug is urgent, this cannot override a proper assessment of safety, particularly when Canadians are under the impression that a drug has been proven safe. The National Citizens Inquiry (NCI) was not made aware of any public health authority in Canada cautioning Canadians that the vaccines had been authorized without the traditional need to prove their safety.

Instead, the Government of Canada was under enormous pressure in the media to secure vaccines and make them available to Canadians. In response, it placed orders for millions of doses from the manufacturers. This placed the Government in a conflict of interest because it had purchased and imported unapproved vaccines while it waited for itself to approve the vaccines. The Interim Order appears to have been designed to ensure that the vaccines would have no problem in receiving authorization.

As indicated above, in the traditional drug approval process, chances are not taken. If there is uncertainty about either safety or efficacy, the drug is not approved. There must be strict objective evidence of both safety and efficacy. It must also be objectively clear that the benefits outweigh the risks before a new drug is approved. It can only be objectively clear that the benefits of a drug outweigh the risks when the benefits and risks are objectively known.

The test for COVID-19 genetic vaccines abandoned this need for objective certainty instead of requiring objective **proof** of¹³⁶

- safety,
- efficacy, and
- benefit outweighing risk.

The COVID-19 genetic vaccines were authorized under a **subjective**¹³⁷ test which mandated that authorization must be granted if an argument could be made to support the conclusion that the benefits outweighed the risk. The question arises: what if there was evidence that went both ways? In other words, what if there was evidence that pointed towards greater benefits, but there was also evidence that pointed towards risks? Under the Interim Order, it seems the Minister must then take into account the subjective factors of uncertainty and the urgent public health need for a vaccine. This cannot be an appropriate standard for approving a drug that the Government intends to administer to the entire population.

¹³⁶ An objective test is a type of assessment consisting of a set of items or questions that have specific correct answers (for example, How much is $2 + 2$?), such that no interpretation, judgment, or personal impressions are involved in scoring.

¹³⁷ A subjective test is an assessment tool that is scored according to personal judgment or to standards that are less systematic than those used in objective tests.

It is difficult to conceive of a less-scientific test for drug authorization than that found in the Interim Order.

The Interim Order also ensured that the authorization of a COVID-19 genetic vaccine could not be revoked due to

- evidence the vaccine was unsafe or not-effective, and
- assessments that the benefits did not outweigh the risks.

This resulted from the fact that once a vaccine was authorized under the Interim Order, most of the Regulations did not apply, including C.08.006. This particular regulation is the safeguard that allows the Minister of Health to cancel a drug's market authorization if evidence is uncovered that the drug is not safe. Instead, the Interim Order contained its own vague safeguards allowing for cancellation only in a few limited circumstances. The exclusion of the Minister's normal powers to revoke authorization, and the reliance on more restricted revocation powers under the Interim Order, means that Canadians could not have confidence that the COVID-19 vaccines would be pulled from the market if there was evidence that they were not safe. This situation persisted for roughly a year.

Were the COVID-19 Genetic Vaccines Approved Without Proof of Safety or Efficacy?

In addition to the Interim Order, Health Canada created a document called "Guidance for market authorization requirements for COVID-19 vaccines."¹³⁸ This document is intended to provide guidance to pharmaceutical companies applying for market authorization. As it must, it follows the new subjective test for the vaccines. For example, the current version includes:

About market authorizations for a COVID-19 genetic vaccine

Health Canada will grant authorizations only if we determine that the benefits of the vaccine outweigh its potential risks. We will base our decision on the evidence provided on the vaccine's safety, quality, and efficacy. For vaccines relying on the modified requirements in C.08.002 (2.1) of the *Food and Drug Regulations*, the risk-benefit analysis weighs the uncertainties about a potential vaccine against the public health need for a vaccine at the time of the decision.

Modified requirements for COVID-19 drugs make it possible for initial authorization, based on early data, while the manufacturer continues working on developing a vaccine. We will use terms and conditions to manage uncertainties or risk mitigation measures related to the vaccine in the context of public health.

¹³⁸ Health Canada document, "Guidance for market authorization requirements for COVID-19 vaccines." <https://www.canada.ca/en/health-canada/services/drugs-health-products/covid19-industry/drugs-vaccines-treatments/guidance-market-authorization-vaccines.html>

The NCI heard testimony that the Health Canada employee who authorized all of the COVID-19 genetic vaccines swore an Affidavit for a lawsuit for Federal Court File No. T-145-22 in which she described the basis of Health Canada's authorization of the Pfizer/BioNTech and Moderna vaccines. Instead of setting out the evidence relied on in support of the authorization, she simply parrots the words of the test. In the case of Pfizer/BioNTech, she stated that Health Canada reviewed "quality (chemistry and manufacturing), non-clinical (pharmacology and toxicology), and clinical (immunogenicity, safety, and efficacy) information" and then concluded that "the evidence supports the conclusion that the benefits associated with the Pfizer/BioNTech COVID-19 Vaccine outweigh the risks, having regard to a shorter term (median of two months) follow up of safety and efficacy at authorization, and the necessity of addressing the urgent public need related to COVID-19."

In the case of Moderna, she stated similarly that "the evidence supported the conclusion that the benefits associated with the Moderna COVID-19 Vaccine outweighed the risks, having regard to a shorter term (median of two months) follow-up of safety and efficacy at authorization, and the necessity of addressing the urgent public health need related to COVID-19."

Notably, what she does not cite in support of the vaccine authorization is

1. objective proof of safety,
2. objective proof of efficacy, and
3. objective proof that the benefits outweigh the risks.

Based on testimony to the NCI, and without further evidence from Health Canada, we cannot conclude that Health Canada properly evaluated the safety and efficacy of the COVID-19 vaccines before authorization. To the contrary, the authorization of the vaccines appears to have been all but pre-assured by the creation of the Interim Order.

[The Interim Order Has Become Permanent](#)

The Interim Order can only last for a maximum of one year. The Interim Order, therefore, was replaced on March 17, 2021, with permanent regulations that codify the subjective authorization test discussed above.¹³⁹

The only notable change between the test in the Interim Order and the new permanent regulation is that the "public health need" that needs to be addressed is no longer described as urgent. Recall that the Interim Order required an examination of risks and benefits, while:

having regard to "the necessity of addressing the urgent public health need related to COVID-19."

¹³⁹ SOR/2021-45.

Now the test simply requires Health Canada to give consideration to

“the public health need related to COVID-19.”

Thus, under the permanent test, Health Canada no longer has to be swayed by urgency, but simply by the public health need related to COVID-19. In this way, it seems that so long as COVID-19 is a circulating virus, Health Canada must authorize any vaccine for which there is an argument to support the conclusion that its benefits outweigh its risks. In effect, we fear that there will never be a need for COVID-19 vaccine manufacturers to prove safety or efficacy of their products.

On a positive note, the NCI heard that the Minister’s ability to revoke authorization of COVID-19 vaccines is now subject to the same regular rules as other drugs that are approved for the market. It does beg the question, however, of why that particular rule was modified for COVID-19 vaccines in the first place?

Conflict of Interests for the Approval of Experimental Vaccines

Canada normally prohibits drugs from being imported into Canada unless they have been approved by Health Canada for use in humans.

Despite this, the Interim Order allowed unapproved and unauthorized COVID-19 genetic vaccines to be imported into Canada as long as the Canadian Government was the purchaser. This was called “prepositioning” in the Interim Order, and later in the Regulations codifying the Interim Order.¹⁴⁰

The rationale was to assist Canada in expediting its response to the perceived COVID-19 crisis, by pre-purchasing and distributing the vaccines so they would be ready as soon as they were authorized.

However, this created a tremendous conflict of interest.

Once the vaccines were purchased, imported and ready for distribution, the Government of Canada would have suffered significant political blowback if it was unable to authorize them. Thus, it needed to authorize the COVID-19 vaccines, and it needed to do it quickly. The Government of Canada essentially put itself in charge of authorizing a drug that it had spent millions of public dollars on, had promised publicly on many occasions, and that it wanted to administer to every Canadian citizen.

The authorization of the COVID-19 vaccines was all but guaranteed. The Government of Canada ordered the vaccines, imported them, created new regulations to authorize them, and then took significant measures to convince and coerce every Canadian to take multiple doses. The political stakes were high, and the federal government had every motivation to get the vaccines authorized, regardless of their actual efficacy or safety.

¹⁴⁰ SOR/2021-45.

There was no opportunity for sober second thought. There was no impartial oversight. The entire authorization process appears to have been “gamed” for one result, and one result only: authorization of vaccines for every Canadian, including children. Once the federal government made mass-vaccination its priority, it should no longer have been solely responsible for their authorization.

Timing of the Interim Order

The timing of the Interim Order is also curious and coincident. Notably, the September 16, 2020, Interim Order was created just two weeks before AstraZeneca’s authorization application was filed with Health Canada and just three weeks before Pfizer filed on October 8, 2020.

Since the authorization applications were made under the Interim Order, they would have been structured to meet the requirements of the Interim Order. Perhaps an authorization application is a standard document; however, the NCI suspects that it would be difficult for a company to prepare a detailed authorization application without knowing what the authorization requirements were going to be.

For this reason, there are further questions that need to be answered about how the applications could have been filed so quickly in a manner that satisfied the subjective test and whether there was participation in creating, or knowledge of, the contents of the test in advance.

Phase Three Trial Data Alleged Manipulation of Data

Deanna McLeod:

She reviewed the data on phase 3 clinical trials of COVID-19 vaccines.
(Vancouver: May 2, 2023)

Deanna McLeod’s testimony has raised important concerns about the means and methods used in testing COVID-19 vaccines. Her testimony primarily centred on potential conflicts of interest and biases within the teams responsible for conducting and reporting phase 3 test data, which was submitted to Health Canada.

Additionally, McLeod shed light on Pfizer’s historical legal issues and the broader issue of potential conflicts of interest within the regulatory and approval sector. Her testimony echoed Mr. Shawn Buckley’s prior statement that objective tests demonstrating safety and efficacy were omitted from these products. Financial incentives, at various stages of the testing and authorization process, were also discussed, prompting the need for a thorough examination of motivations.

McLeod’s testimony serves as a reminder of the importance of transparency, objectivity, and independence in the testing and approval of medical products, especially when it concerns a global health crisis. The potential for conflicts of interest and biases within such a critical process can erode public trust and compromise the credibility of the regulatory framework.

The reference to Pfizer's past legal issues underscores the necessity for scrutinizing the track record of pharmaceutical companies involved in the development of vaccines or drugs. The public has a right to be informed about any potential historical shortcomings or ethical concerns that might impact the reliability of the products in question.

The removal of objective safety and efficacy tests from the products raises alarming questions about the standards applied to these vaccines. Rigorous testing is the cornerstone of any vaccine's credibility and the foundation of public trust. Omitting such tests potentially undermines the credibility of the entire testing and approval process.

The mention of financial motivations at various levels of testing and approval emphasizes the need for greater transparency and accountability within the industry. The potential for financial incentives to influence decision-making is a cause for concern and demands further investigation to ensure that public health is prioritized over financial gain.

Lastly, the allusion to Statistics Canada data provided during the testimony highlights the need for comprehensive, reliable, and complete data when assessing the impact of any medical intervention. It is crucial to base decisions on thorough and unbiased information to ensure the wellbeing of the population.

In conclusion, Deanna McLeod's testimony raises vital questions about the processes, motivations, and ethics involved in COVID-19 vaccine testing and authorization. Her testimony underscores the necessity for transparent, objective, and unbiased approaches in these critical endeavours. The concerns raised must prompt a broader discussion about regulatory practices, industry accountability, and the integrity of medical interventions in the interest of public health and safety.

Conclusions

There appeared to be a disconnect between Health Canada's messaging concerning vaccine approval and the actual test used for authorization. As indicated above, safety, efficacy, and whether the benefits of the vaccines outweighed the risks did not need to be proven under the Interim Authorization process employed by Health Canada.

Despite the novel nature of the vaccines—in particular those using mRNA—the pharmaceutical companies did not have to objectively prove their safety and efficacy. It should be noted that the special authorization process created under the Interim Order was not mandatory, and pharmaceutical companies still had the option to apply for approval under the regular test which required objective proof of safety, efficacy, and cost-benefit.

The pharmaceutical companies did not choose to objectively prove safety, efficacy, and cost-benefit. They chose to apply under the Interim Order test, and regulators did not require it of them.

Of great concern is the disconnect between Health Canada's public messaging about the COVID-19 vaccines as safe and effective when the regulatory authorization process clearly does not require these be objectively demonstrated. Health Canada continues to message to the public that the regular drug approval requirements of safety and efficacy were met. For example, at the top of Health Canada's website page for the Pfizer vaccine, Health Canada states:

All COVID-19 genetic vaccines authorized in Canada **are proven safe, effective and of high quality**. (Please note that emphasis is provided in the original text.)

Recommendations

- A. **Newly implemented revisions** to the *Food and Drug Regulations* related to the authorization of COVID-19 genetic vaccines must be rescinded as they permanently exempt COVID-19 vaccines from the requirements to objectively prove the safety or efficacy as required under the *Food and Drug Regulations*.
- B. **The current use of COVID-19 genetic vaccines** in Canada that were authorized under the revised provisions of the Interim Order and the newly revised *Food and Drug Regulations* should be stopped immediately.
- C. **A full judicial investigation** of the process under which the COVID-19 vaccinations were authorized in Canada must be carried out. Criminal liability, if discovered, may be dealt with under existing Canadian law.
- D. **All documentation concerning the authorization process** and information provided to the regulatory agencies by the manufacturers should be made publicly available.
- E. **Legislation should be developed**, or amended, to prevent the elimination of the legal requirements to prove that a new drug is objectively safe and that the efficacy of that drug is objectively proven.
- F. **The requirement for the regulatory board** to carry out a risk-benefit analysis for any and all new drugs under consideration for approval should be codified into law. Written minimum requirements for such a review are to be established. The final decisions should be made on the basis of citizen health considerations not political motivations. The results of the risk-benefit must be made public.
- G. **We should review and revise** the current relationship between licensing fees paid by pharmaceutical companies and the total budget allocated to Health Canada for drug-related matters. This is necessary to prevent pharmaceutical companies from exerting undue financial influence on the approval agency.
- H. **Legislation must be included or revised** which re-establishes Canada's approval agency as an independent, fact-based agency without reliance on approval agencies from outside of Canada.

- I. **Investigate any perceived or existing conflicts of interest** that may exist between senior staff of Health Canada and pharmaceutical manufacturers. This may extend to a prescribed time limit prohibition of government agency staff from leaving government service for positions with the pharmaceutical manufacturers.
- J. **All investigations recommended in this section** are to include the power to compel timely production of information and the power to subpoena witnesses.

7.5.8. Canada's Future Approval of New Pharmaceuticals

Introduction

The Commission heard testimony regarding Canada's intended changes to the process under which certain pharmaceuticals are given approval in Canada.

Based on the testimony, the Commission has concerns that the Government of Canada intends to apply a fast-track approval system to bring other, new pharmaceutical products to Canadian markets based on a new regulatory framework that appears to limit or eliminate the need to prove safety and efficacy.

Deanna McLeod

She explains how a new, expedited pathway allows for changes in traditional clinical trial processes. These changes remove the need to prove drug safety with level 1 evidence (RCTs). (Winnipeg: April 13, 2023)

As discussed elsewhere in this Report, normally, vaccine development has a timeline of 5–10 years which involves first demonstrating safety in cells, tissues, and animals—through in vitro and animal testing—followed by three phases of human trials. This system is intended to test and prove the safety of drugs prior to approval for use in human populations.

The NCI heard that in-vitro and animal testing—prior to human trials—is critical to demonstrate safety in non-humans prior to proceeding to test in humans. This provides some degree of safety when designing studies in humans to monitor potential safety issues. This is a cornerstone of the clinical development process. The process follows the precautionary principle to determine possible safety signals to be monitored, not only in the short-term but also over time.

When Health Canada considers approving a drug, the drug company must demonstrate safety through each of the phases of testing. Approval is generally based on randomized-controlled trials, which are the only evidence that can prove safety and efficacy. In order to receive authorization to market a drug in Canada, a manufacturer must demonstrate safety, efficacy, and that the benefits of drug outweigh the risks.

The precautionary principle that underpins today's approval regulations resulted from regulatory reform implemented after the drug Thalidomide caused widespread harm to women and babies—as a result of being approved to treat morning sickness without first demonstrating that it was safe.

The precautionary principle is particularly important in the area of drugs known as biologics since these products have the ability to affect the human body in a profound way. The NCI heard that an abundance of caution should govern the testing and approval of novel biologics, which include gene therapy. The standard for safety testing set out by the FDA for biologics is 15 years.

Industry-Designed Backdoor Approval

The NCI heard that starting in 2016, industry-advocacy groups pushed for changes to the regulatory framework in Canada. Pressure was placed on Canada to attract new investment by overcoming barriers to innovation. The barriers to innovation include Canada's high safety standards for drug approval.

This spurred the formation of several initiatives such as the Advisory Council for Economic Growth and the Health and Biosciences, Economic Strategy Table to study and produce reports relating potential reform of Canada's regulatory process.

A new regulatory pathway was subsequently created as a type of backdoor approval for certain drugs. The new pathway allows for expedited clinical trials and product authorizations. The new process was adopted into law by burying it in an omnibus bill in December 2020. Under this new rule, the Minister of Health can designate a drug to follow the new approval process. Notably the Minister of Health in Canada at this time had no medical background but was an economics expert.

Therefore, Canada's new approach to advanced therapeutic treatments is to

- Maintain appropriate, yet flexible, regulatory oversight,
- Promote innovation in drug and medical device development,
- Ensure high standards for patient safety, product quality, efficacy, and effectiveness, and
- Reduce barriers to bringing advanced therapeutic treatments to market in Canada, thus providing access to new, potentially life-changing treatments

It is notable that three of the four points above relate to promoting economic development and profit relating to therapeutics.

The COVID-19 vaccines were the first therapeutics that followed this new process. The concerns that have arisen from the safety of the COVID-19 vaccines demonstrate exactly the problem with prioritizing innovation and economics over safety.

The Commission heard testimony that the Government of Canada intends to use this expedited approval framework for more novel products in the future. The motivation behind creating this new regulatory process appears to be economic, namely, to grow Canada's economy and attract foreign investment. While these may be laudable goals, the Commission is concerned that prudent safety standards are being sacrificed in order to meet economic goals.

Recommendations

- A. **Revocation of New COVID-19 Regulations:** The Commission recommends that the new regulatory process be revoked and that Health Canada return to approving all therapeutics on its historical safety requirements.

- B. **Maintain Rigorous Safety Standards:** Prioritize patient safety by maintaining rigorous safety standards for drug approval. The safety of new pharmaceuticals should be thoroughly demonstrated through preclinical and clinical trials before approval.
- C. **Transparency in Regulatory Changes:** Ensure transparency in any regulatory changes related to pharmaceutical approvals. Changes in the approval process should be subject to public consultation and should be clearly communicated to stakeholders, including healthcare professionals and the public.
- D. **Independent Expertise:** Appoint experts with relevant medical and scientific backgrounds to key positions in the regulatory process. Decision-makers, such as the Minister of Health, should have a strong understanding of medical and scientific principles to make informed decisions about drug approvals.
- E. **Balancing Innovation and Safety:** Find a balance between promoting innovation and ensuring safety. While innovation is important for advancing healthcare, it should not come at the expense of patient safety. Consider the potential long-term effects of novel drugs on public health.
- F. **Monitoring and Post-Market Surveillance:** Strengthen post-market surveillance of approved pharmaceuticals. Continuous monitoring of drugs once they are on the market is crucial to detect and address any safety concerns that may arise over time.
- G. **Independent Safety Review:** Establish an independent body or commission responsible for conducting safety reviews of pharmaceuticals, especially novel biologics and gene therapies. This body should be free from industry influence and focused solely on patient safety.
- H. **Public Health Impact Assessment:** Conduct thorough assessments of the potential public health impact of new drugs, particularly in the context of pandemics or health emergencies. Consider both short-term and long-term consequences on public health.
- I. **Ethical Considerations:** Incorporate ethical considerations into the approval process. Ensure that the potential benefits of new pharmaceuticals outweigh the risks and that patient autonomy and Informed Consent are respected.
- J. **Regular Reviews of Regulatory Frameworks:** Periodically review and update regulatory frameworks to adapt to advances in medical science and changing public health needs. Regulatory changes should prioritize safety while facilitating timely access to beneficial treatments.
- K. **International Best Practices:** Benchmark Canada's regulatory processes against international best practices. Learn from the experiences of other countries with strong pharmaceutical regulatory systems.

- L. **Public Awareness and Education:** Enhance public awareness and education about the drug approval process, including the rigorous testing and safety measures in place. Informed patients can make better decisions about their healthcare.
- M. **Monitoring Economic Impact:** While promoting economic development is important, closely monitor the economic impact of regulatory changes. Ensure that economic goals do not compromise patient safety, and make necessary adjustments if conflicts arise.

These recommendations aim to strike a balance between promoting innovation and safeguarding patient safety in Canada's pharmaceutical approval process. It's crucial to prioritize public health and long-term safety while fostering an environment conducive to innovation and economic growth in the pharmaceutical industry.

7.5.9. Medical Practice and Ethics During COVID-19

Introduction

Once the COVID-19 pandemic was announced in March of 2020, the medical profession unilaterally changed and/or abandoned the fundamental tenets under which medicine is practised in Canada and in most parts of the world.

The relationship between a medical practitioner and their patient is a unique and sacred one. The patient trusts the medical professional to provide the patient with the best quality of care available and to deliver those services with a high level of skill and professionalism.

The patient must trust that the medical practitioner is providing them with the latest unbiased information, based on current independent scientific evidence. There can be no allowance for blurring of science with political propaganda when it comes to this information.

The very nature of this relationship is that the patient is reliant on the medical professional to provide them with facts and the unbiased information required, explained in a way that the patient can understand, which then permits a patient to decide what care is most appropriate to them. As each patient is unique, the medical professional must take into account the patient's actual situation and level of understanding when presenting information.

The process of a medical practitioner providing a patient with accurate, non-biased information and assuring that the patient understands that information while at the same time is making their own personal decisions concerning their healthcare is often referred to as **"Informed Consent."**

Often the information that a patient exchanges with their medical provider is profoundly personal, and there has always been a strict policy of absolute privacy between a patient and their medical practitioner.

The absolute requirement for privacy of the patient-doctor exchange is necessary as the patient must feel confident to share the most intimate details of their life with the medical practitioner. If the patient does not have this guarantee of privacy, they may not properly explain the details of their condition to the medical practitioner or may not seek professional assistance at all due to their embarrassment.

This doctrine is often referred to as **"Patient-Doctor Confidentiality."**

The Commission heard testimony from both patients and medical practitioners concerning the widespread violation of each of these two fundamental doctrines of medicine, which occurred in all regions of Canada throughout the pandemic.

Healthcare providers in Canada have a legal duty to provide a certain standard of skill and care to their patients. This is normally referred to as **"Duty of Care."**

This Duty of Care is usually considered to comprised of duties including

- attending,
- diagnosing,
- referring,
- treating, and
- instructing the patient.

If a healthcare provider breaches that Duty of Care and a patient suffers an injury as a result of that breach, then the healthcare provider may be guilty of negligence.

These principles, and many others, are not simply guidelines but are legally enforceable under law. The laws which apply and are enforceable in Canada include Canadian, Provincial, and Territorial law, and International Laws and Treaties to which Canada is a signatory.

Testimony Concerning Medical Practice and Ethics During COVID-19

Witnesses who testified concerning medial practice and ethics during COVID-19 included a range of different perspectives, including

- patients,
- doctors,
- nurses,
- paramedics,
- administrators, and
- instructors.

In general, the testimony described a medical system that has completely abandoned the basic tenets of medicine and has violated the laws and regulations which govern the ethical practice of medicine across Canada.

The practice of medicine is regulated within each province and territory by regulatory bodies, which are empowered under certain provincial and territorial legislation.

These regulatory bodies are in place to regulate most healthcare professionals in Canada. This includes doctors, nurses, paramedics, pharmacists, and many more.

Informed Consent

Each province has their own specific regulations, but most are similar to each other.

As an example, below is a link to the *Health Care Consent Act, 1996*, from Ontario.¹⁴¹

Excerpts from the Ontario *Health Care Consent Act* include the following provisions:

¹⁴¹ <https://www.canlii.org/en/on/laws/stat/so-1996-c-2-sch-a/latest/so-1996-c-2-sch-a.html>.
(accessed 2023)

No treatment without consent

10 (1) A health practitioner who proposes a treatment for a person shall not administer the treatment, and shall take reasonable steps to ensure that it is not administered, unless,

(a) he or she is of the opinion that the person is capable with respect to the treatment, and the person has given consent; or

(b) he or she is of the opinion that the person is incapable with respect to the treatment, and the person's substitute decision-maker has given consent on the person's behalf in accordance with this Act. 1996, c. 2, Sched. A, s. 10 (1).

Elements of consent

11 (1) The following are the elements required for consent to treatment:

1. The consent must relate to the treatment.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not be obtained through misrepresentation or fraud. 1996, c. 2, Sched. A, s. 11 (1).

Informed consent

(2) A consent to treatment is informed if, before giving it,

(a) the person received the information about the matters set out in subsection (3) that a reasonable person in the same circumstances would require in order to make a decision about the treatment; and

(b) the person received responses to his or her requests for additional information about those matters. 1996, c. 2, Sched. A, s. 11 (2).

Same

(3) The matters referred to in subsection (2) are:

1. The nature of the treatment.
2. The expected benefits of the treatment.
3. The material risks of the treatment.
4. The material side effects of the treatment.
5. Alternative courses of action.
6. The likely consequences of not having the treatment. 1996, c. 2, Sched. A, s. 11 (3).

Withdrawal of consent

14 A consent that has been given by or on behalf of the person for whom the treatment was proposed may be withdrawn at any time,

- (a) by the person, if the person is capable with respect to the treatment at the time of the withdrawal;
- (b) by the person's substitute decision-maker, if the person is incapable with respect to the treatment at the time of the withdrawal. 1996, c. 2, Sched. A, s. 14.

Continuing the example of the above Ontario regulations, the Ontario College of Physicians and Surgeons (CPSO), who are charged with the regulation of the practice of medicine in Ontario, provide additional information and guidance to physicians related to Informed Consent.

Under the "What We Do" section of the CPSO website it states:

What we do:

Registration—Physicians are required to be members of the College to practise medicine in Ontario. The College's Registration Department handles all inquiries regarding the registration process.

Quality—CPSO has a legislated mandate to ensure quality care is provided by physicians. Our Quality Control Program is a proactive needs-based approach, which will contribute to improved quality of care, patient safety and will result in significant benefits to patients, providers and ultimately the healthcare system itself.

Investigations & Discipline—A central responsibility of CPSO is to respond to concerns and investigate complaints from members of the public about doctors in Ontario. If necessary, cases are referred to the Ontario Physicians and Surgeons Discipline Tribunal.¹⁴²

Guiding Professional Conduct—Develop policies to provide guidance to physicians about legislative/regulatory requirements and the expectations of the medical profession.

Under the the section of the website titled "Policies," CPSO has the following policy:

Consent to Treatment

General Expectations

¹⁴² <https://opsdt.ca/>. (accessed 2023)

1. Physicians **must** be aware of, and comply with, all of the requirements in the *Health Care Consent Act, 1996 (HCCA)*.
2. Physicians **must** obtain valid consent before a treatment is provided.
3. Patients and substitute decision-makers (SDMs) have the legal right to refuse, withhold, or withdraw consent to a treatment, and physicians **must** respect this decision even if they do not agree with it.
4. Physicians are **advised** to consider and address language and/or communication issues that may impede a patient's ability to give valid consent.
 - Physicians **must** use their professional judgment to determine whether it is appropriate to use family members as interpreters, and are **advised** to take the potential limitations of doing so into account in the specific circumstances (for example, the family dynamics, the seriousness of the condition and/or treatment, etc.).
5. Physicians are **advised** to obtain independent legal advice if they are unsure of their legal obligations in specific circumstances. The obligation to ensure that valid consent is obtained always rests with the physician proposing the treatment.

Obtaining Consent

6. For consent to be valid, physicians **must** ensure that it:
 - Is obtained from the patient, if they are capable with respect to treatment, or from the patient's SDM, if the patient is incapable with respect to treatment.
 - Relates to the specific treatment being proposed.
 - Is informed.
 - Is given voluntarily and not under duress.
 - If physicians believe that consent is not being freely given, they **must** ensure that there has been no coercion.
 - Is not obtained through misrepresentation or fraud.
 - Physicians **must** be frank and honest when interacting with patients, including when conveying information about the proposed treatment.

7. To ensure that consent is informed, physicians **must**:

- provide information about the nature of the treatment, its expected benefits, its material risks and material side effects, alternative courses of action and the likely consequences of not having the treatment prior to obtaining consent, which includes:
 - providing information that a reasonable person in the same circumstances would require in order to make a decision about the treatment;
 - considering the specific circumstances of the patient, on a case-by-case basis, and using their clinical judgment in determining what information to provide; and
 - providing information relating to material risks that are relevant for a broad range of patients and those that are particularly relevant for the specific patient;
- engage in a dialogue with the patient or the SDM (as the case may be) about the information specified in 7.a., regardless of whether physicians use supporting documents (such as consent forms, patient education materials or pamphlets) to facilitate the provision of this information;
- provide a response to requests for additional information about the treatment; and
- be satisfied that the information provided is understood and, as such, take reasonable steps to facilitate the comprehension of the information provided.

Testimony was received indicating that the principle of Informed Consent was violated through force and / or coercion of patients into taking the vaccine and by the absence of sufficient truthful information concerning the unique and experimental nature of the mRNA vaccines.

Based on witness evidence, widespread information that was being published and presented to clients concerning the potential adverse effect of the vaccines was not accurate and not complete.

Several witnesses testified that they were given little or no information concerning the risks associated with taking the COVID-19 genetic vaccines, prior to taking it.

Witness testimony indicated that the blanket statement of “safe and effective” was constantly used and that they were never informed about the potential risks of the vaccine, the experimental nature of the vaccine, or that the vaccines were approved under an Interim Order which exempted the manufacturers from satisfying the normal requirements for vaccine safety testing.

Pregnant women were not informed that the COVID-19 genetic vaccines had not been expressly tested on pregnant women and that no long-term testing had been carried out to determine if there was any risk to the unborn child or to breastfeeding mothers.

People were not informed that the vaccine carried a risk of death as a potential and reported side effect.

People were not informed that their risk of dying from the disease was directly linked to their age and the existence of any comorbidities.

Dr. Francis Christian provided a document "Consent for COVID-19 genetic vaccine for Children." The document is from Saskatchewan Health. The document states the following:

It is recommended that parents/guardians discuss consent for immunization with their children. Efforts are first made to get parental/guardian consent for immunizations. **However, children 13 years and older who are able to understand the benefits and possible reactions for each vaccine and the risks of not getting immunized, can legally consent**¹⁴³ to receive or refuse immunizations in Saskatchewan by providing mature minor Informed Consent to a healthcare provider.

This statement is an attack on parental rights. It essentially states that if the parent, or guardian, does not agree to the medical procedure that the healthcare provider can ignore the parental directive as long as the child is over 13 years of age.

What child, at the age of 13, can understand the nuances of the information being provided by the government concerning the potential risk that COVID-19 posed to children versus the risk of death or other significant reported side effects of taking the experimental vaccine?

Dr. Francis Christian testified concerning what he felt was the minimum information that should have been given to children to accommodate the requirements of Informed Consent. Following is a list of these minimum requirements, based on information available since June 2021:

- The risk of your child dying of COVID is almost zero.
- The vaccine has a new gene technology that has never been used clinically before.
- The vaccine was approved using "emergency use" or "interim use" authorization. It is experimental. Its medium- and long-term adverse effects are unknown.
- To qualify for emergency use authorization, there must be an emergency—there is no emergency in healthy children.
- Children are of no danger to adults.

¹⁴³ Please note that the highlights above have been added by the authors.

- There are thousands of deaths associated with the vaccine (VAERS and other reports).
- Myocarditis is a serious condition and can be caused by the vaccine. Its real incidence is unknown—1/5,000 to 1/250. Myocarditis can be fatal. Many other serious vaccine adverse events are happening.
- The risk of the vaccine for your healthy child is likely more than the risk of COVID.

This minimum information was not given to parents concerning vaccination of their children.

The Ontario college of Physicians and Surgeons (CPSO) on their website, under the heading of COVID-19 FAQ'S for Physicians, Pandemic-Related Practice Issues, Update March 23, 2022, stated, the following about what a physician should do when facing a patient who did not want to get the COVID-19 genetic vaccine:

It is also important that physicians work with their patients to **manage anxieties related to the vaccine and not enable avoidance behaviour. In cases of serious concern, responsible use of prescription medications and/or referral to psychotherapy are available options.**¹⁴⁴ Overall, physicians have a responsibility to allow their patients to be properly informed about vaccines and not have those anxieties empowered by an exemption.

There are a number of issues within this **CPSO** statement that are problematic when it comes to the requirement for obtaining "Informed Consent."

First, the **CPSO** refers to people who choose not to take the vaccine as needing to manage their anxieties, and they are calling the decision to not take the vaccine as "avoidance behaviour." This type of language can only serve to stigmatize the patient and undermine what is supposed to be a free and uncoerced decision about a medical procedure.

Secondly, they are inferring that the decision to not take the COVID-19 vaccine is a mental illness which the physician should consider treating with prescription medications or psychotherapy.

These statements by the CPSO are chilling, to say the least. They are in direct contravention of the Ontario *Health Care Consent Act* which states the following:

11 (1) The following are the elements required for consent to treatment:

1. The consent must relate to the treatment.
2. The consent must be informed.
3. The consent must be given voluntarily.
4. The consent must not be obtained through misrepresentation or fraud. 1996, c. 2, Sched. A, s. 11(1).

¹⁴⁴ Please note that the highlights above have been added by the authors.

The use of prescription medications and subjecting a patient to psychotherapy in order to convince the patient to change their mind can hardly be considered “voluntary consent.”

Under CPSO’s own website within the section “Policies,” concerning Informed Consent, CPSO states the following:

8. Patients and substitute decision-makers (SDMs) have the legal right to refuse, withhold, or withdraw consent to a treatment, and physicians **must** respect this decision even if they do not agree with it.

How does suggesting that physicians treat the legitimate concerns and decision of a patient as an anxiety condition, which can be treated with prescription drugs and psychotherapy, respect the patients’ choice?

Patients were threatened with loss of employment, social isolation, stigmatization, or other non-specified threats if they did not comply with the vaccine mandates. These threats were pervasive, as previously discussed. Media actively promoted hate and even violence against people who would not get vaccines.

Prime Minister Trudeau called people “racists” and “misogynists” and suggested that the government would have to decide what to do with them—remarks that reasonable people might find threatening.

In many instances, governments couched the information concerning COVID-19 vaccinations in language that stated the vaccines were safe and effective as demonstrated by decades of experience with safe and effective vaccinations. These statements hid the fact that mRNA injections were not like any traditional vaccination that had been used prior to this time.

According to Dr. Peter McCullough, these mRNA vaccines should rightly have been dealt with using the regulations related to biologic drugs, and it was, in his opinion, medical malfeasance to have approved them under the protocols used for vaccines.

It also hid the fact that based on the Interim Order under which the COVID-19 genetic vaccines had been approved, the manufacturers were not required to prove that the vaccines were safe and effective.

Further, the government did not carry out a risk-benefit analysis of the vaccines since they did not have enough information to do so.

The vaccines had not been approved based on proven scientific evidence, they were approved on the basis of a political agenda.

The public could not have given the required Informed Consent since they were under threat and coercion and were never provided with enough truthful and adequate information to form consent.

The media and government officials inflamed the situation and created an atmosphere of terror and hate which permeated every aspect of Canadian society; this further caused patients to be unable to form a reasoned decision concerning this novel medical gene therapy.

Patient-Doctor Confidentiality

Testimony was provided by a variety of witnesses indicating that their confidential medical records were reviewed by third parties without their consent or that they were required to disclose private medical information to third parties under the mandated policies.

Witnesses, including patients and physicians, described how the principal of medical confidentiality was violated.

In general terms, the testimony described the following instances:

Citizens were required, by government mandate, to disclose personal information about their medical history, including disclosure of the results of genetic testing and the disclosure of information concerning certain medical procedures.

These disclosures were required to be made to third parties, including both medical and non-medical personnel to whom personal medical information was mandated to be disclosed to included

- restaurant staff.
- store clerks,
- school staff,
- church volunteers, and
- bus drivers.

Disclosure was required by just about anyone, without any consideration of privacy or qualification. This was required for persons to participate in the most basic and fundamental activities within our society.

How did the government protect the confidentiality of this information?

What actions did the Colleges of Physicians and Surgeons in Canada take to advise their members and safeguard the public against these non-confidential disclosures?

People were required to disclose their vaccination status and the status of any genetic testing that they underwent concerning COVID-19. This is contrary to the Canadian *Genetic Non-Discrimination Act* which states the following:

<https://www.laws-lois.justice.gc.ca/eng/acts/G-2.5/page-1.html#h-247317>

Genetic test

3 (1) It is prohibited for any person to require an individual to undergo a genetic test as a condition of

- **(a)** providing goods or services to that individual;
- **(b)** entering into or continuing a contract or agreement with that individual; or
- **(c)** offering or continuing specific terms or conditions in a contract or agreement with that individual.

Refusal to undergo genetic test

(2) It is prohibited for any person to refuse to engage in an activity described in any of paragraphs (1)(a) to (c) in respect of an individual on the grounds that the individual has refused to undergo a genetic test.

Disclosure of results

4 (1) It is prohibited for any person to require an individual to disclose the results of a genetic test as a condition of engaging in an activity described in any of paragraphs 3(1)(a) to (c).

Refusal to disclose results

(2) It is prohibited for any person to refuse to engage in an activity described in any of paragraphs 3(1)(a) to (c) in respect of an individual on the grounds that the individual has refused to disclose the results of a genetic test.

The Act defines a genetic test as the following:

genetic test means a test that analyzes DNA, RNA or chromosomes for purposes such as the prediction of disease or vertical transmission risks, or monitoring, diagnosis or prognosis. (*test génétique*)

Physicians and surgeons described how a third party, an unknown staff member from the government or public health department, would directly contact a patient and provide advice that often contradicted the advice given by the physician to the patient.

This public health staff member did not have previous contact with the patient nor had they been consulted by the patient or the doctor; however, they were countermanding the physician's advice to that patient.

Dr. Gregory Chan testified that he had submitted 56 Adverse Reaction Reports to Alberta Health Services. He testified that half of the 56 reports were never acknowledged. Of the remaining 28 reports of adverse reactions, Alberta Health Services told Dr. Chan that for 16 of these 28 Adverse Reaction Reports that the patient should receive a second injection of the COVID-19 genetic vaccine. This advice from Alberta Health Services was provided to Dr. Chan without anyone from Alberta Health Services actually seeing the patient in question.

Dr. Chan specifically spoke about a young man who was a professional level hockey player who was told to get the COVID-19 injections, despite having recovered from a previous COVID-19 infection. Within 24 to 48 hours of receiving the COVID-19 genetic vaccine injection, the young man was unconscious and taken to the hospital due to cardiac issues. Alberta Health Services advised the young man to get a second injection of the vaccine, without having examined the young man or consulting with the physician treating him.

Dr. Chan described two other instances, one concerning a nurse and the other concerning a police officer, in which Dr. Chan felt the symptoms were caused by the vaccine; however, the Alberta Health Services advised that these patients should receive a second dose of the vaccine.

In Dr. Chan's opinion, staff from Alberta Health Services were providing patient diagnosis and recommendations without ever having seen the patient.

Dr. Francis Christian stated, during his testimony, that the medical profession allowed a third party to insert itself between the patient and the physician through algorithmic guidelines. Most guidelines were developed from industry-funded physician groups, which, in essence, violates the sanctity of the patient-physician relationship. The guidelines soon became enforceable restrictions by the regulatory bodies, so physicians no longer had an option to treat their patients based on their own diagnosis.

Dr. Patrick Phillips testified that he had reported 10 Adverse Event Reports to the public health system after having examined each of the 10 patients. Public health rejected 9 of the 10 reports without actually having examined any of the patients, and Dr. Phillips was not given any specific criteria for those rejections. After having examined a patient, based on that examination, Dr. Phillips prescribed a course of ivermectin and vitamins for a treatment of that particular patient. A pharmacist reported that prescription, and the hospital ordered that the diagnosis and prescription be rescinded without any consultation. Dr. Phillips was later suspended by the regulatory body.

Dr. Chris Milburn, in his testimony, indicated that the College of Physicians and Surgeons had stated that it was a physician's duty to follow their policies despite the actual evidence and examination of a particular patient by that physician. Thus, the policy of the College of Physicians and Surgeons had inserted itself between the physician and patient, dictating care protocols.

Duty of Care

Healthcare providers have a special duty of care to their patients because of the imbalance of knowledge that exists between a patient and the healthcare provider. Access to, and understanding

of, complex medical information favours the healthcare provider, and healthcare providers know that their patients are reliant on the knowledge of the healthcare provider.

Healthcare providers must take into account that patients are vulnerable to their opinions. The patient relies on the understanding that the healthcare provider will put the needs of the patient first and that any services provided to the patient will be based on a factual and individual assessment of the patient's unique situation.

According to the College of Physicians and Surgeons of Ontario:

Physicians should be skilled clinicians committed to the values of the profession.

Physicians should be committed to lifelong learning and be responsible for maintaining the medical knowledge and clinical skills necessary to provide the highest possible quality of care to patients.

At all times physicians should:

- be aware of deficiencies in knowledge or ability;
- obtain help when needed; and
- ensure that their practice matches their level of competence.

In terms of individual patient care, physicians should provide medical care based on objective evidence whenever possible. This includes demonstrating a sense of inquiry and taking a scientific approach to solving clinical issues for the benefit of the patient.

Physicians have a duty to seek out new evidence and knowledge, to share this knowledge with others and to apply it in practice.

Physicians are expected to keep abreast of current developments in their field, which includes maintaining an awareness of relevant practice guidelines and implementing them as appropriate. All research must be initiated and pursued in an ethical manner.

Many of the witnesses testified how the regulatory bodies were dictating what a healthcare provider could say, diagnose, report, and prescribe. These mandates further severely restricted the healthcare provider from offering patients exemptions to the political pandemic mandates, based on the unique circumstances of the particular patient.

Healthcare providers were discouraged from carrying out any research into the nature of the COVID-19 pandemic and restricted from, or in some cases prevented from, undertaking any research that might have challenged the politically dictated mandates and narratives.

By blindly following these mandates without due regard to the evolving information available on populations at risk and different alternative treatment options, healthcare providers failed to uphold the requirement under their responsibility of Duty of Care.

Healthcare providers have a duty to carry out their own research to confirm the claims being made by a particular manufacturer or purveyor of information concerning patient treatments; they are not entitled to blindly believe the literature provided to them by industry representatives.

In the case of the COVID-19 pandemic, many healthcare providers and their regulators made no apparent attempts at evaluating the information that was being provided to them by their political leaders and industry representatives.

They blindly imposed these prescriptions upon their membership and the membership followed the instruction in lockstep.

Few healthcare providers challenged the political narrative, and those that did faced severe consequences including revocation of their licence to practise medicine.

Witnesses who testified concerning Medical Practice During COVID-19:

Gail Davidson

A lawyer, she reviewed Canada's obligations under international human rights law.
(Vancouver: May 4, 2023)

Natasha Gonek

She presented her findings on regulatory failures.
(Ottawa: May 17, 2023)

Maurice Gatien

A lawyer, he discussed his defence of the vaccine-injured.
(Ottawa: May 18, 2023)

Dr. Keren Epstein-Gilboa

A developmental psychologist, she described the impact of COVID measures on children.
(Ottawa: May 18, 2023)

Allison Petton

A registered nurse, she discussed informed consent to a medical procedure.
(Truro: March 17, 2023)

Dr. Edward Leyton

A physician, he reviewed the influence of medical institutions and the use of ivermectin.
(Ottawa: May 18, 2023)

Dr. Chris Shoemaker

A physician, he discussed the dangers of the COVID vaccine.
(Ottawa: May 19, 2023)

Dr. Misha Susoeff

A dentist, he discussed third party and Informed Consent.
(Red Deer: April, 28)

Melanie Alexander

She revealed the story of her husband's medical mistreatment during COVID.
(Ottawa: May 19, 2023)

Dr. Daniel Nagase

A physician, he discussed the unjust treatment of patients and doctors during COVID.
(Ottawa: May 19, 2023)

Samantha Monaghan

She described the loss of her son after a blood transfusion.
(Ottawa: May 18, 2023)

M Tisir Otahbachi

He shared his story of vaccine injury and his mistreatment by the healthcare system.
(Ottawa: May 17, 2023)

Adam Zimpel

A severely disabled man, he described his social isolation due to COVID measures.
(Ottawa: May 17, 2023)

Mallory Flank

A former paramedic, she reported on her vaccine injury.
(Ottawa: May 17, 2023)

Kristen Nagle

A nurse, she was defamed for speaking out about COVID measures.
(Ottawa: May 17, 2023)

Sheila Lewis

She described her heartbreaking story of being removed from the transplant list.
(Ottawa: May 17, 2023)

Dr. Stephen Malthouse

A physician, he described how he challenged COVID policies.
(Ottawa: May 17, 2023)

Camille Mitchell

A pharmacist, she described the impact of COVID mandates.
(Vancouver: May 4, 2023)

Shawn Muldoon

He talked about his experience with severe vaccine injury.
(Vancouver: May 4, 2023)

Paul Hollyoak

A coast guard rescue specialist, he reported on his vaccine injury.
(Vancouver: May 4, 2023)

Ted Kuntz

He reviewed the lack of safety, efficacy, and informed consent for childhood vaccines.
(Vancouver: May 4, 2023)

Kristin Ditzel

She spoke about her neurological disability after taking a COVID vaccine.
(Vancouver: May 4, 2023)

Patricia Leidl

She spoke about the trials of finding medical treatment for her severe vaccine injury.
(Vancouver: May 4, 2023)

Dr. Ben Sutherland

A researcher for Oceans and Fisheries Canada, he spoke about the consequences of vaccine mandates on his work.
(Vancouver: May 3, 2023)

Lisa Bernard

A nurse, she testified on vaccine injury and the impact of lockdowns on patient care.
(Vancouver: May 3, 2023)

Dr. Charles Hoffe

A physician, he discussed natural immunity and COVID vaccine health issues.
(Vancouver: May 3, 2023)

Aurora Bisson-Montpetit

A former nurse, fired from her job due to mandates, she investigated the public health authorities responsible for COVID measures.
(Vancouver: May 3, 2023)

Dr. Greg Passey

A physician specializing in post-traumatic stress disorder, he reviewed the narrative shaping and psychological damage from lockdowns.

(Vancouver: May 3, 2023)

Serena Steven

A former nurse, she described her vaccine-related injuries and hospital care during early lockdowns.

(Vancouver: May 2, 2023)

Philip Davidson

A former public service employee, he testified about job loss due to vaccine mandates.

(Vancouver: May 2, 2023)

Vanessa Rocchio

She described her cardiac problems after taking a COVID-19 vaccine.

(Vancouver: May 2, 2023)

Jennifer Curry

She spoke about her severe vaccine injury and its impact on her life.

(Red Deer: April 28, 2023)

Darcy Harsch

He testified about the impact of being put on unpaid leave due to vaccine mandates.

(Red Deer: April 28, 2023)

Suzanne Brauti

She described how she was denied a religious exemption and lost her job.

(Red Deer: April 28, 2023)

Grace Neustaedter

A registered nurse, she testified on the workplace pressures to comply with vaccine mandates.

(Red Deer: April 28, 2023)

John Carpay

A lawyer, he testified on legal issues regarding vaccine mandates.

(Red Deer: April 28, 2023)

Judy Soroka

A former nurse, she spoke about how her health condition deteriorated without access to treatment, resulting in pain and disability.

(Red Deer: April 28, 2023)

Dr. Gregory Chan

A physician, he testified on the problems of reporting vaccine adverse events.
(Red Deer: April 26, 2023)

Dr. Maria Gutschi

A pharmacist and drug regulatory specialist, she discussed problems with the development and manufacturing of the mRNA vaccines.
(Saskatoon: April 21, 2023)

James Kitchen

A lawyer, he spoke about the courts' failure to uphold individual Charter rights and the capture of professional regulatory bodies.
(Red Deer: April 21, 2023)

Ann McCormack

A former pharmacist, she spoke about Informed Consent.
(Red Deer: April 20, 2023)

Marjaleena Repo

She testified on how she was mistreated because of her mask exemption.
(Red Deer: April 20, 2023)

Dr. Francis Christian

A physician, he talked about the censorship of physicians, his concerns over vaccinating children, and the doctor-patient relationship.
(Red Deer: April 20, 2023)

Dr. Dion Davidson

A vascular surgeon, he stressed the importance of Informed Consent, the problems of vaccine adverse events, and the difficulties of reporting them.
(Truro: March 18, 2023)

David Leis

He spoke about government overreach and the failure of our institutions to serve the public.
(Winnipeg: April 15, 2023)

Elizabeth Cummings

She took a COVID vaccine based on false information from her doctor and suffered a vaccine injury.
(Truro: March 17, 2023)

Peter Van Caulert

He was coerced into taking the vaccine due to travel restrictions.
(Truro: March 17, 2023)

Terry LaChappelle

As a federal public servant, he was forced to get the vaccine or lose his job.
(Truro: March 17, 2023)

Paula Doiron

She took a vaccine due to false information and suffered an vaccine injury.
(Truro: March 17, 2023)

Leigh-Anne Coolen

She was forced by her employer to get vaccine and suffered a vaccine injury.
(Truro: March 16, 2023)

Michael Alexander

A lawyer, he testified that medical regulators charged health professionals with misinformation and harming the public when they spoke out against the public health narrative.
(Toronto: March 31, 2023)

Dan Hartman

He testified that his 17-year-old son was required to take a COVID vaccine to play hockey and died four days later.
(Toronto: April 1, 2023)

Artur Anselm

He was forced to take a vaccine to keep his job.
(Truro: March 16, 2023)

Chet Chisholm

A paramedic, the pandemic affected his ability to get treatment for post-traumatic stress disorder, preventing him to return to work; he also suffered a vaccine injury.
(Truro: March 16, 2023)

Vonnie Allen

A nurse, she was fired for refusing to take a COVID-19 genetic vaccine.
(Truro: March 16, 2023)

Cathy Careen

Despite having a vaccine medical exemption, she lost her job for refusing to take a COVID vaccine.
(Truro: March 16, 2023)

Dr. Patrick Phillips

A physician, he spoke about Informed Consent, his reporting of vaccine adverse reactions, and the suspension of his medical licence for speaking out about COVID policies.
(Truro: March 16, 2023)

Dr. Chris Milburn

A physician, he was fired from the ER for voicing his concerns about COVID-19 policies.
(Truro: March 16, 2023)

Conclusion

Long held and codified principles of medical practice were systematically and universally set aside during the COVID-19 pandemic.

The patient-healthcare provider relationship has severely eroded, and it is not clear how, or when, this may be restored. Patients were given false, incomplete, or misleading information, and the political narrative and patently false information was allowed to prevail with little or no push back from the professions.

Political leaders, healthcare regulatory boards, delivery institutions, and individual practitioners violated their fundamental responsibilities to the citizens of Canada in favour of a politically motivated policy that required as many citizens to be vaccinated as possible.

Draconian measures were imposed on the healthcare industry from political and industry players, and by not questioning those policies, the health and wellness of Canadians was severely impacted: many died, many continue to suffer, and there are reports of ongoing vaccine injuries and deaths.

These impacts include death of patients either directly due to mandated measures (for example, vaccine) or indirect effects (for example, mental health, suicide, lack of care, and activity).

The most vulnerable members of Canadian society were the most severely affected. Seniors, people with special needs, those requiring healthcare, and children were treated in accordance with centrally dictated policies rather than by healthcare practitioners in the field.

Steps are required to make sure that these overall institutional failures are never allowed to happen again.

Recommendations

- A. **A civilian-led detailed investigation** must be carried out to determine who (at all levels) were responsible for these breaches of medical ethics and to recommend criminal investigations as appropriate.
- B. **Existing senior members of healthcare regulatory agencies** responsible for the abandonment of long-held and honoured principles of medical care should, as appropriate, stand criminal investigation.
- C. **Each province and territory**, including the federal government must establish civilian control and oversight to the existing regulatory agencies, including regularly scheduled and publicly available reviews of their activities. These appointments cannot be politically motivated and should be carried out in public with real input from citizens.
- D. **Each Province must Establish an office** of the independent Ombudsmen available to both practitioners and patients.
- E. **Develop laws making it illegal** to deny elderly residents of care facilities from seeing visitors.
- F. **Regulatory Agencies must Enforce existing laws** concerning patient confidentiality, requirement for Informed Consent, and the level of care that is required by each healthcare professional.
- G. **Establish laws ending centralized control** of individual patient care. Patient care is a matter between a patient and their healthcare provider. This relationship cannot be violated through central government planning edicts. The public health service should never be directing patient care, which is a personal matter between the healthcare provider and the patient.
- H. **Ensure that RAW data** is promptly and fully disclosed, eliminating the necessity for Access to Information Act (AIA) requests and associated fees, especially when such requests come from patients or researchers.
- I. **Mandatory independent experts** must be added to all panels who are screened for conflict of interest.
- J. **There must be a criminal investigation** of the manufacturers and distributors of any of the vaccines that were administered to the public under false and misleading information. If manufacturers and distributors are found to have acted inappropriately, they should bear the costs of these investigations, as well as any damages assessed. The burden of investigation expenses should be placed on the guilty parties.
- K. **Ensure Protection for healthcare professionals** and journalists acting in good conscience.
- L. **No removal of liability protections** against manufacturers and regulators.

- M. **Strengthen the requirement** for healthcare practitioners to independently review and approve of any treatment or procedure that they are recommending to a patient.
- N. **Establish an annual requirement** for medical ethics training for all healthcare providers; this should be a career long requirement and may be made up of several modules completed through a multi-year process.
- O. **Political figures who are responsible** for the implementation of these mandatory programs must be held accountable in an open and public forum.
- P. **All members of the committees** that implemented the mandates must be exposed to the public, including all records of internal discussions and recommendations. An investigation into these actions needs to be carried out and if criminal, unethical, or incompetent actions are identified, punitive actions must be implemented.
- Q. **Develop and regularly update comprehensive ethical guidelines** and standards that cover a wide range of medical and healthcare practices, including areas such as consent, confidentiality, end-of-life care, resource allocation, and conflicts of interest.
- R. **Ensure that ethical guidelines are widely accessible** to healthcare professionals, patients, and members of the public, fostering transparency and accountability.
- S. **Establish and support institutional ethics committees** in healthcare organizations, consisting of diverse stakeholders, including healthcare professionals, ethicists, legal experts, members of the public, and patient representatives. Empower these committees to provide guidance, consultation, and ethical review of complex cases, research protocols, and policy development.
- T. **Strengthen practices and policies that ensure patients' rights** to make informed decisions about their healthcare, including the right to refuse treatment, access their medical records, and participate in shared decision-making.
- U. **Promote clear communication** between healthcare practitioners and patients to enhance understanding and respect for patient autonomy.
- V. **Safeguard patient confidentiality and privacy** by maintaining strict protocols for the storage, access, and sharing of medical information, in accordance with applicable laws and regulations.
- W. **Provide ongoing education and training** to healthcare professionals on the importance of maintaining patient confidentiality and the potential implications of breaches.
- X. **Ensure rigorous ethical review processes** for research involving human subjects, promoting Informed Consent, minimizing risks, protecting vulnerable populations, and upholding the principles of beneficence and nonmaleficence.

- Y. **Support the work of Research Ethics Boards** (REBs) in reviewing research proposals, monitoring ongoing studies, and ensuring compliance with ethical guidelines.
- Z. **Foster a culture of ethical leadership** and professional conduct in healthcare organizations, emphasizing integrity, honesty, empathy, and accountability at all levels.
- AA. **Establish mechanisms to address and investigate** ethical misconduct or breaches of professional standards, ensuring appropriate consequences and opportunities for remediation.
- BB. **Engage patients and the public in discussions** and decision-making processes related to medical ethics, promoting shared decision-making and incorporating diverse perspectives.

By implementing these recommendations, Canada can maintain and strengthen medical ethics, ensuring the highest standards of patient care, while fostering trust between patients and healthcare professionals and upholding the ethical principles that underpin the healthcare system. Regular review, continuous education, and engagement of stakeholders are vital to address evolving ethical challenges and promote ethical behaviour in the medical field.

7.5.10. Canada's Vaccine Adverse Reactions Reporting System

Introduction

A robust vaccine adverse reaction reporting system in Canada is crucial to ensure the ongoing safety and efficacy of vaccines. The need for it was particularly acute during the COVID-19 pandemic since the pharmaceutical industry developed an injection that utilized novel technologies.

The basis of these injections was the mRNA technology, which had never before been deployed within the general population. As well, the development and testing of the Pfizer-BioNTech and Moderna COVID-19 injections were completed in less than one year, which is exceptionally rapid for a new type of medical treatment. The normal period of time for the development and testing of new biological drugs and vaccines is between five and ten years.

Furthermore, within that one year time period, not only was the scientific development of the vaccine completed but so was the development of the requisite mass manufacturing processes and facilities.

According to witnesses, a truncated testing of the laboratory-produced vaccines was carried out over a limited two-month test period, and no testing was carried out on the final product from the manufacturing facilities.

The requirement for the manufacturers to demonstrate objective proof of the safety and efficacy of the new product was waived by the Interim Authorization Order. On September 16, 2021, the Minister of Health issued an Interim Order Respecting the Importation, Sale and Advertising of Drugs for Use in Relation to COVID-19. This Interim Order exempted the COVID-19 vaccines from Health Canada's normal review and approval process.

According to Dr. Peter McCullough, given the characteristics and functions of the mRNA vaccines, they should be classified as biologics, necessitating a significantly greater in-depth testing protocol than traditional vaccines due to the risk of adverse effects.

The Canadian public was never made aware of these issues.

On December 9, 2020, the Government of Canada issued a press release concerning Health Canada's authorization of the first COVID-19 genetic vaccine.

Here are relevant excerpts from it:

Thanks to advances in science and technology, and an unprecedented level of global cooperation, today, Canada reached a critical milestone in its fight against COVID-19 with the authorization of the first COVID-19 genetic vaccine.

Health Canada received Pfizer's submission on October 9, 2020 and after a thorough, independent review of the evidence, Health Canada has determined that the Pfizer-BioNTech vaccine meets the Department's stringent safety, efficacy and quality requirements for use in Canada.

As part of its continued commitment to openness and transparency, Health Canada is publishing a number of documents¹⁴⁵ related to this decision, including a high-level summary of the evidence that Health Canada reviewed to support the authorization of the vaccine. More detailed information will be available in the coming weeks, including a detailed scientific summary and the full clinical trial data package.

The press release¹⁴⁶ goes on to insist that

Canadians can feel confident that the review process was rigorous and that we have strong monitoring systems in place. Health Canada and the Public Health Agency of Canada will closely monitor the safety of the vaccine once it is on the market and will not hesitate to take action if any safety concerns are identified.

This section of the report examines the statement by the Government of Canada that they had "strong monitoring systems in place."

¹⁴⁵ <https://www.canada.ca/en/health-canada/services/drugs-health-products/covid19-industry/drugs-vaccines-treatments/vaccines/pfizer-biontech.html>. (accessed 2023)

¹⁴⁶ <https://www.canada.ca/en/health-canada/news/2020/12/health-canada-authorizes-first-covid-19-vaccine0.html> (accessed 2023)

Testimony Concerning Canada's Vaccine Adverse Reactions Reporting System

Although the discussion of this subject by its very nature is convoluted, it is not necessarily complex. To properly understand the issues surrounding Canada's vaccine adverse reactions reporting system, one must first understand why such a system was necessary in the case of the COVID-19 injections.

What follows is a discussion of the COVID-19 injections, the process by which they were approved, the evolving definitions used to justify their use, a description of the system that Health Canada told Canadians was in place, and a discussion of the actual system that was in place as described by witness testimony.

In the normal course of events, it is imperative that a rigorous reporting system be available to monitor the safety of any drug administered to the general population.

The "normal course of events" would have included years of laboratory development; peer-reviewed, independent testing; monitoring of any and all adverse events in the various test groups over a number of years to guard against unknown long-term effects; and the proper classification of the new treatment based on the way it acts on and effects the body. Historically, this process takes between 5-10 years, and sometimes more, depending on the nature of the treatment being evaluated.

The safety and efficacy of any treatment must be proven to regulators based on a cost-risk-benefit analysis carried out on objective and independent evaluations prior to its approval for use.

These conditions were not met in the case of the COVID-19 injections.

The COVID-19 injections were exempted from the normal requirement of their objective proof of safety and efficacy, even though these mRNA-type injections had never before been used in the general population. In addition, regulators classified these treatments in such a way that they required less stringent criteria for their approval despite their novelty.

Witnesses testified that these injections should have been classified as a biologic treatment rather than a simple vaccine as well as that the actual definition of a vaccine was revised to include these new and unproven experimental injections.

The primary difference between a biologic and a traditional vaccine lies in their composition, manufacturing process, and mechanism of action. What follows is a breakdown of the distinction between them.

Biologics:

Biologics are medicinal products derived from living organisms such as proteins, nucleic acids, cells, or tissues. They can include monoclonal antibodies, recombinant proteins, hormones, growth factors, and gene therapies.

Biologics are manufactured using complex and highly regulated processes that involve living organisms or their components. These processes often require advanced biotechnology techniques, such as cell culture, recombinant DNA technology, or gene expression systems.

Biologics typically act by targeting specific molecules, receptors, or pathways in the body. They can modulate the immune system, inhibit or enhance specific cellular functions, or replace deficient proteins or cells.

The mRNA injections have all of these characteristics and therefore should have been treated and approved as biologics instead of as vaccines.

Traditional Vaccine:

Traditional vaccines are typically composed of weakened or inactivated forms of infectious agents, such as viruses or bacteria, or specific components derived from these pathogens. They may also contain adjuvants or additives to enhance the immune response.

Traditional vaccines are produced using well-established techniques, including viral or bacterial propagation, inactivation, attenuation, or extraction of specific components. Some vaccines are also produced using recombinant DNA technology.

The CDC previously had defined a vaccine as

A product that produces immunity therefore protecting the body from the disease. Vaccines are administered through needle injections, by mouth and by aerosol.

Key Differences:

Biologics are more complex in structure and have much more complex manufacturing processes compared to traditional vaccines.

Biologics often target specific molecules, pathways, or cells in the body, whereas vaccines primarily focus on generating an immune response against specific pathogens.

Compared to vaccines, biologics have a broader range of therapeutic applications beyond infectious diseases, which include treatments for cancer, autoimmune disorders, and genetic diseases. Vaccines, in contrast, primarily focus on preventing or treating infectious diseases.

Before the COVID-19 injections, biologics and vaccines followed distinct, separate regulatory pathways. Biologics are typically regulated as biological products, while vaccines have specific regulatory guidelines and requirements.

Vaccine Definition Changed

In the years leading up to the declaration of the COVID-19 pandemic, the CDC changed the definitions of *immunization*, *vaccination* and *vaccine* multiple times.

Here is a comparison of some of the changes in these definitions.

Traditional Definition of a Vaccine:

The traditional definition of a vaccine referred to a substance that contains weakened or inactivated forms of pathogens (viruses or bacteria) or specific components derived from them. The primary goal of traditional vaccines was to stimulate the immune system, leading to the production of antibodies and the development of immunological memory. This immune response provided protection against subsequent exposure to the actual infectious agent, thereby preventing disease.

In July 2014, the CDC provided the following definition of *immunization*, *vaccination*, and *vaccine*:

Immunization: The process by which a person or animal becomes protected against a disease. This term is often used interchangeably with *vaccination* or *inoculation*.

Vaccination: Injection of a killed or weakened infectious organism in order to prevent the disease.

Vaccine: A product that produces immunity therefore protecting the body from the disease. Vaccines are administered through needle injections, by mouth and by aerosol.

Revised Definition of a Vaccine:

The current definition of *vaccine* encompasses a broad range of technologies and mechanisms. It includes traditional vaccines as well as a variety of new, experimental treatments, which have no relation to what or how traditional vaccines are developed or affect the body. Presenting them to the public under the familiar and widely trusted definition of *vaccine* disguises their true experimental nature.

Experimental vaccine platforms in the revised definition include

- A. **Viral Vector Vaccines:** These use a modified “harmless” virus (the vector) to deliver genetic material from the target pathogen into cells, triggering an immune response.
- B. **mRNA Vaccines:** These introduce a small piece of genetic material (messenger RNA) that encodes the production of a specific viral protein. This mRNA is taken up by cells, which then produce the viral protein, triggering an immune response.
- C. **Protein Subunit Vaccines:** These contain specific proteins derived from the target pathogen, rather than the whole pathogen. These proteins can, by themselves, elicit an immune response.
- D. **DNA Vaccines:** These introduce a small piece of DNA that encodes the production of specific proteins from a targeted pathogen. The cells take up the DNA and produce the viral protein, initiating an immune response.

- E. Vector-based DNA/RNA Vaccines: These combine elements of Viral Vector and DNA/RNA technologies to deliver genetic material into cells for protein production and immune stimulation.

The new, revised definition includes various technologies that trigger an immune response, generate immunological memory, and thereby confer protection against specific pathogens. It includes treatments and delivery methods that are new and experimental and had never before been used on the general population, at least in theory.

At the time these treatments were introduced to the general public, there had been no long-term studies to determine the risk they posed.

During the pandemic, the CDC changed and revised the definition of these terms on the fly, adjusting the definition of *vaccine* in order to include the COVID-19 injections, thereby justifying their introduction despite the lack of long-term safety data.

To illustrate how relevant definitions have changed, the CDC provided the following definition of *immunization*, *vaccination* and *vaccine* in July 2014:

Immunization: The process by which a person or animal becomes protected against a disease. This term is often used interchangeably with vaccination or inoculation.

Vaccination: Injection of a killed or weakened infectious organism in order to prevent the disease.

Vaccine: A product that produces immunity therefore protecting the body from the disease. Vaccines are administered through needle injections, by mouth, and by aerosol.

From May 16, 2018 to September 1, 2021 the CDC used the following definition for *immunity*, *vaccine*, *vaccination* and *immunization*:

Immunity: Protection from an infectious disease. If you are immune to a disease, you can be exposed to it without becoming infected.

Vaccine: A product that stimulates a person's immune system to produce immunity to a specific disease, protecting the person from that disease. Vaccines are usually administered through needle injections, but can also be administered by mouth or sprayed into the nose.

Vaccination: The act of introducing a vaccine into the body to produce immunity to a specific disease.

Immunization: A process by which a person becomes protected against a disease through vaccination. This term is often used interchangeably with *vaccination* or *inoculation*.

This was later revised to the following:

Immunity: Protection from an infectious disease. If you are immune to a disease, you can be exposed to it without becoming infected.

Vaccine: A preparation that is used to stimulate the body's immune response against diseases. Vaccines are usually administered through needle injections, but some can be administered by mouth or sprayed into the nose.

Vaccination: The act of introducing a vaccine into the body to produce protection from a specific disease.

Immunization: A process by which a person becomes protected against a disease through vaccination. This term is often used interchangeably with *vaccination* or *inoculation*.

Rather than ensuring that a novel treatment could satisfy the definition of what a vaccine can do, the CDC adjusted the definition of *vaccine*, tailoring it to suit new technologies developed and promoted by the pharmaceutical industry, which the CDC is supposed to regulate.

The definition of these terms was revised dozens of times between 2014 and 2023.

The revised definitions have blurred the lines between biologics and vaccines. Drugs that can now be called vaccines, like those based on viral vectors or mRNA technology, exhibit characteristics of both traditional vaccines and biologics. The distinction lies in their composition, manufacturing, and mechanism of action.

The above discussion demonstrates how the process that led to the manufacture and development of the COVID-19 vaccines was unlike any drug development or approval process ever before undertaken.

The COVID-19 vaccines were based on novel technologies, which had never been used in the general population before; the process of development and testing was shortened from 5–10 years to a year or less; the key requirements of the approval process related to safety and efficacy were set aside; long term testing on population groups approximating the general population were never done; and the very definition of what the drugs were and supposed to do, kept changing.

These and many other issues contributed to an unprecedented level of risk and uncertainty with these new drugs.

The need to have a robust safety monitoring system was extreme.

Safety issues related to the development, manufacturing, and distribution of prescription drugs can arise from various technological, manufacturing, and distribution factors. Here are some key areas where safety concerns may arise:

Technological Issues:

- A. Formulation and Stability: Inadequate understanding of the drug's chemical properties or formulation can lead to stability issues, resulting in reduced efficacy or potential safety risks.
- B. Drug-Device Interactions: If a drug requires specialized delivery devices or technologies, compatibility issues between the drug and the device can arise, affecting drug effectiveness and patient safety.
- C. Nanotechnology and Biologics: Advancements in nanotechnology and biologics have introduced complex manufacturing processes and potential safety concerns due to their unique characteristics and potential interactions with the human body.

Manufacturing Issues:

- A. Contamination and Cross-Contamination: Improper handling or contamination during the manufacturing process can introduce impurities, foreign substances, or microbial contaminants, compromising the drug's safety and quality.
- B. Quality Control and Assurance: Insufficient quality control measures or inadequate adherence to Good Manufacturing Practices (GMP) can lead to inconsistencies in drug potency, purity, or dosage, posing risks to patients.
- C. Scale-up Challenges: Transitioning from laboratory-scale production to commercial-scale manufacturing may introduce unforeseen safety issues if the process is not properly optimized or validated.

Distribution Issues:

- A. Counterfeit Drugs: Illegitimate or counterfeit drugs can enter the distribution chain, potentially lacking active ingredients, containing harmful substances, or having incorrect labelling, leading to patient harm.
- B. Storage and Transportation: Inadequate storage conditions, temperature excursions, or mishandling during transportation can compromise drug integrity and efficacy, impacting patient safety.
- C. Supply Chain Integrity: Complex global supply chains increase the risk of drug diversion, unauthorized tampering, or substitution, compromising the safety and authenticity of the medication.

Post-Marketing Surveillance:

- A. Adverse Drug Reactions (ADR): Even after thorough premarket clinical trials, some adverse reactions may only emerge once a drug is widely used. Robust post-marketing surveillance systems are crucial for detecting and monitoring ADRs to ensure timely intervention and patient safety.
- B. Labelling and Risk Communication: Inaccurate or insufficient drug labelling, which include warnings, contraindications, and precautions, can lead to improper use, misunderstandings, or increased safety risks for patients and healthcare providers.

To address these safety issues, regulatory bodies like Health Canada are tasked with establishing and enforcing stringent regulations and guidelines.

Pharmaceutical companies are also responsible for implementing quality management systems, conducting thorough risk assessments, and continuously monitoring and improving their manufacturing processes to ensure drug safety.

Collaborative efforts between regulatory agencies, manufacturers, healthcare professionals, and the public are essential to minimize safety risks associated with prescription drugs and ensure the highest possible level of patient safety throughout the drug development, manufacturing, and distribution lifecycle.

The most important part of a safety monitoring system must engage areas of society which will be subjected to the new drug. This includes patients, healthcare providers, pharmacies, regulators, and the manufacturers themselves.

Following are the goals of a functioning adverse events monitoring system:

Safety Monitoring: Vaccines undergo testing before they are approved for public use, but monitoring their safety post-approval is equally important. A reporting system allows healthcare professionals and individuals to report any adverse reactions they observe after vaccination.

By collecting and analyzing this data, health authorities can identify potential safety concerns, evaluate the risks versus benefits, and take necessary actions to protect the population.

Early Detection of all Side Effects: In a completely new drug based on a never-before-implemented technology utilizing a highly complex manufacturing process, it is impossible to predict beforehand exactly what level and types of adverse events may occur in the diverse general population. A comprehensive reporting system helps identify and investigate all side effects that may not have been detected during the initial clinical trials due to limited sample sizes. Early detection enables swift responses, which includes further investigation, changes in vaccination strategies, or updates to vaccine recommendations.

This is especially important for COVID-19 injections as no mid-term or long-term testing was carried out prior to approval for use in the general population.

Building Public Trust: Transparent and effective monitoring of vaccine adverse reactions helps build public trust in vaccination programs. When people have confidence that their concerns are being acknowledged, investigated, and acted upon, they are more likely to participate in adverse events reporting efforts. A robust reporting system assures the public that their safety is a priority and that the healthcare system is committed to addressing any potential risks associated with vaccines.

Data-driven Decision Making: Accurate and timely reporting of adverse reactions provides valuable data for decision-making processes. Health authorities can analyze the reported cases to understand the characteristics of adverse reactions, such as their frequency, severity, demographics, and potential risk factors. This data can inform vaccine recommendations, guide public health policies, and support regulatory decisions regarding vaccine safety.

Continuous Vaccine Improvement: A reporting system facilitates continuous monitoring and improvement of vaccines. By collecting information on adverse reactions, health authorities can identify patterns, assess the effectiveness of existing vaccines, and guide the development of future vaccines. This knowledge helps researchers and manufacturers make necessary adjustments to vaccines to enhance their safety profiles and minimize potential side effects.

Global Collaboration: Adverse reaction reporting systems also contribute to international collaboration and information sharing. By participating in global networks, Canada can share its data and benefit from the experiences and knowledge of other countries. This collaboration strengthens global vaccine safety monitoring efforts and enables the identification of potential adverse events that may be specific to certain populations or regions.

The need for a robust vaccine adverse reaction reporting system in Canada is essential for monitoring vaccine safety, detecting all side effects, building public trust, making data-driven decisions, improving vaccines, and facilitating global collaboration. It serves as a critical tool in ensuring the ongoing success of vaccination programs and protecting the health of the population.

What the Adverse Events Monitoring System was Supposed to Be

In Canada, vaccine safety monitoring is supposed to be conducted through various mechanisms and systems. Below are some key components of vaccine safety monitoring in Canada:

A. Canadian Adverse Events Following Immunization Surveillance System (CAEFISS):

- CAEFISS is also known as the Canadian Immunization Monitoring Program.
- Active (IMPACT) is a national surveillance program for monitoring adverse events following immunization (AEFIs) in children. It collects AEFI data from 12 pediatric tertiary care centres across Canada and analyzes the data to identify patterns, trends, and potential safety signals related to vaccines.

B. Vaccine Adverse Event Reporting System (VAERS) United States:

- VAERS is a national passive surveillance system that allows healthcare providers, vaccine manufacturers, and the public to voluntarily report adverse events following immunization.
- It serves as an important tool for detecting and monitoring potential safety concerns associated with vaccines.

C. Provincial and Territorial Vaccine Safety Surveillance:

- Each Canadian province and territory has its own vaccine safety surveillance system, which monitor and investigate adverse events related to vaccines administered within their jurisdictions.
- These systems contribute to the overall vaccine safety monitoring efforts in Canada.

D. Vaccine Safety Research and Studies:

- Canadian researchers conduct studies and research projects to investigate vaccine safety concerns, assess the effectiveness of vaccines, and monitor long-term safety outcomes.
- These studies often involve collaborations with academic institutions, healthcare providers, and government agencies.

E. Collaboration with International Vaccine Safety Networks:

- Canada actively participates in international collaborations and networks, such as the World Health Organization's Global Vaccine Safety Initiative and the Vaccine Safety Datalink in the United States.
- These collaborations facilitate the exchange of information, including the sharing of best practices, and joint investigations of vaccine safety issues.

F. Regulatory Oversight and Post-Market Surveillance:

- Health Canada, the federal regulatory agency, oversees the approval and ongoing monitoring of vaccines.
- Health Canada conducts post-market surveillance activities to monitor the safety of vaccines after they are approved and distributed.
- It collaborates with provincial and territorial health authorities, healthcare professionals, and other stakeholders to ensure comprehensive vaccine safety monitoring.

G. Adverse Event Following Immunization (AEFI) Reporting:

- Healthcare providers are responsible for reporting any adverse events following immunization to the local public health authorities or relevant surveillance systems.
- Timely and accurate reporting of AEFIs is crucial for monitoring and investigating potential safety concerns.

Through these mechanisms, Health Canada claims to ensure continuous vaccine safety monitoring, early detection of potential adverse events, and prompt response to emerging safety concerns.

Health Canada also claims that their regular data analysis, collaboration, research, and regulatory oversight play significant roles in maintaining a robust vaccine safety monitoring system in the country.

The system described above, certainly sounds like the robust safety monitoring system that Health Canada reassured Canadians that they had in place to protect Canadians.

The reality of the system on the ground, as described by the testimony of witnesses, was that of a broken, impossible to use system, with gate-keepers who prevented accurate and timely reporting of adverse events.

[The Broken Monitoring System Canadians Got](#)

The entire adverse events reporting and monitoring system has a fatal flaw: it relies only on reports of adverse events received by healthcare professionals. Furthermore, these reports were discouraged, hindered, and rejected by local public health officers, and healthcare professionals were punished for reporting adverse events.

Patient Reporting of Adverse Events

Patients are not able to directly report adverse events to the CAEFISS reporting system. These reports must be funnelled through the healthcare providers.

According to Health Canada:

CAEFISS reports are submitted by public health authorities in provinces and territories, who in turn receive them from local public health units. Provincial and territorial authorities also receive reports from federal authorities that provide immunization within their jurisdiction, including:

- the RCMP,
- Indigenous Services Canada, and
- Correctional Service Canada.

Most of these reports are generated by nurses, physicians, or pharmacists who provide immunizations or who care for individuals with AEFIs. AEFIs received by National Defence and the Canadian Armed Forces are reported directly to PHAC.

Several witnesses testified that healthcare providers would outright deny or even refuse to consider claims of adverse reactions.

Concerns from patients related to adverse reactions were played down or dismissed by doctors, despite the fact that since the mRNA vaccines were a new technology, healthcare professionals could never have known, for certain, what issues might present in patients.

Based on the incredibly fast and unique method that was used to approve both the vaccines and their manufacturing processes, it was highly possible that even if the basic technology of these novel vaccines was safe, any variety of adverse events might occur as a result of the manufacturing, distribution, handling, or injection of these drugs.

It is unbelievable that healthcare workers would simply dismiss patient claims when considering the dozens of mechanisms and potential issues with these drugs.

Some witnesses reported that when they had experienced an adverse reaction to the injection, their own doctors told them they would not report it as an adverse reaction due to fear of reprisal or ridicule.

Nurse Angela Taylor described how she had experienced a severe reaction to the COVID-19 Injection. Doctors not only refused to report the event but also tried to coerce her into taking a 2nd and 3rd injection.

Kristin Ditzel experienced a severe reaction to the injection within 25 minutes of receiving the shot but was told her reaction was not due to the vaccine..

Healthcare Workers Reporting of Adverse Events

Many physicians testified that they had been prevented from or punished for reporting adverse reactions to the COVID-19 injections.

Dr. Patrick Phillips testified that he had reported five adverse events due to vaccine and the public health officer had rejected all of them, without explanation. A complaint to the regulator against Dr. Phillips was made due to the submission of these adverse event reports. The public health officer did not actually see any of the patients.

Dr. Patrick Provost testified that none of his five vaccine adverse events (VAES) to the mRNA-LPN injection were reported by his treating endocrinologist. One reaction was an exacerbation of his type-1 diabetes that he managed to control himself by fine-tuning his insulin dosing. Not only did his endocrinologist refuse to report his VAES, but he also refused to provide him an exemption for his second dose, arguing that the issue with complication of his type-1 diabetes was now under control with proper dosing of insulin.

When Patrick managed to find a healthcare worker who reported his VAES to the INSPQ (Institut national de santé publique du Québec), he was told by a nurse from the INSPQ, that some of his VAES were not going to be recorded as they happened six weeks after vaccination, which is the accepted window for traditional vaccines.

Dr. Provost then did a large retrospective analysis of VAES as monitored by patients' modifications to their drug prescriptions. In his study, published in the peer-reviewed journal IJVTPr (International Journal of Vaccine Theory, Practice, and Research) on January 2023, he discovered that the six weeks' window is too short as 75 per cent of VAES occurred after six weeks

In a second study published in IJVTPr, based on two cases studies of unreported VAES, he identified up to 40 obstacles of reporting VAES properly. He also showed that underreporting of VAES is really the blind spot of the COVID-19 vaccination campaign. Dr. Provost said that we knew before the COVID-19 vaccination that the underreporting factor was at least 10, but we now realized that it's more than 40-100.

Dr. Dion Davidson testified that he had difficulty trying to fill out the online form to report to the adverse events reporting system. He indicated that making a report would take upwards of 45 minutes to do, so most healthcare workers would not do it.

Testimony from first responders detailed that the type of calls for help changed significantly once the vaccines were rolled out to the public and that no reporting of those events as adverse reactions to the COVID-19 injections was carried out.

Dr. Chong Wong testified that he told one of his patients that she should not take any more COVID-19 injections, after she developed blood-clots following the first injection. The patient had been contacted by and told by the public health nurse to take the second shot despite the adverse reaction. The public health nurse had not actually seen the patient or Doctor Wong prior to her giving this advice to the patient.

Dr. Gregory Chan further stated that as of May 2021, he and his colleagues could not use the federal reporting system, so he started to use the Alberta provincial system, Adverse Events Following Immunization (AEFI).

Dr. Gregory Chan testified that he could not navigate the provincial reporting site and could not actually make reports on the website. He finally printed the forms and filled them out manually. He had made 56 reports of adverse reactions due to the COVID-19 injections. He reported that of the 56 reports, he received no acknowledgment from public health on approximately half of them; of the second half of the 56 reports, six were accepted into the system, six were rejected, and nine have not been addressed..

Of the 28 reports acknowledged by Alberta Health, public health advised 16 of them to get the next injection, despite not having actually seen any of these patients.

Dr. Chan reviewed the online criteria systems as set out by Alberta Health and confirmed his 56 reports qualified as adverse reactions as defined by the website.

Dr. Chan further testified that as of May 2021, he and his colleagues could not use the federal reporting system. He reported that five months into the rollout of the vaccines, the CAEFISS system was frustrating as it went from link to link resulting in him having to print off a form to complete by hand.

Dr. Justin Chin testified that both patients and doctors were failing to identify adverse events caused by COVID-19 vaccinations.

Nurse Serena Steven experienced a severe adverse reaction within one hour of receiving the injection, was sent home from the emergency room, and no report of the adverse event was made by medical staff.

Dr. Charles Hoffe noticed significant issues in his patients and sent a private email to 18 of his colleagues questioning if any of them were seeing any of these issues. One of these 18 doctors sent the email to the regional health authorities, who called him in for a meeting; he was told that he was putting patients at risk by questioning the injections.

A complaint was filed with the College of Physicians and Surgeons, and he was told not to discuss any of this with any of his colleagues. He was directed to pose any future questions to the public health officer. Dr. Hoffe noted significant neurological issues in his long-time patients, so he sent a letter to the medical health officer asking for assistance. There was no response, and his letter was forwarded by the public health officer to the College of Physicians and Surgeons as a new complaint against him.

Dr. Hoffe was referred to a vaccine safety specialist who claimed that Dr. Hoffe's observations were incorrect, although she had not seen any of his patients. He was told he should make an adverse reactions report but that these reports would not trigger an investigation.

Dr. Rene Lavigueur testified that if he told the truth about adverse reactions, he was in conflict with public health and at risk of losing his licence. He said he was being forced to simply follow orders. He filled out 16 adverse events reports, but everyone else was too afraid to do it or to even speak about it. He had patients come to him to say their regular doctor had refused to report their adverse events.

Dr. Lavigueur stated that the public health officials were evaluating the reports of COVID-19 vaccine injuries based on checklists that had been developed with regard to traditional vaccine reactions, failing to understand that COVID-19 injections were not traditional vaccines.

Conclusions

Based on the high level of risk associated with the development, manufacture, and distribution of the novel COVID-19 injections, it was extremely important that any reporting system was designed to collect and examine all reports of alleged vaccine injuries.

Such a system would have to be open to everyone who is affected by the vaccines, including patients, and the system would have to be readily available and easy to interact with.

Healthcare professionals should have been encouraged to report their findings, and all reports should have been entered into the overall system without filtering by frontline staff or public health officials.

The adverse events reporting system, with the exception of the pediatric system, is not only based on a passive reporting model, but healthcare providers were also actively being discouraged from making these reports. Some physicians were reprimanded by their regulators, and others lost their jobs or lost their licence for reporting adverse events.

The system utilized to report adverse events due to COVID-19 injections has failed for a wide range of reasons: some are functional shortcomings in the system; other reasons include willful dismissal of the data and an unwillingness to acknowledge that the initial expectations and analysis were in error. More specifically the problems include:

Underreporting: Like many passive surveillance systems, the adverse event reporting system relies on healthcare professionals voluntarily reporting AEFIs. Underreporting remains a challenge, leading to potential gaps in data and an incomplete understanding of vaccine safety profiles.

Based on the testimony of many witnesses, doctors were actively discouraged and punished for reporting adverse events.

Representativeness: The data collected by the system primarily came from a very limited number of healthcare professionals who had the courage to report. This data cannot be expected to fully capture adverse events experienced by the broader population.

Data Quality and Standardization: Ensuring consistent data collection methods and standardized reporting is essential to improve data quality and comparability. Efforts should be made to streamline data collection and harmonize reporting practices across different sites.

Vaccine Hesitancy and Misinformation: Instead of listening to what doctors and patients were reporting, public health officials decided to categorize many of these injuries as being related to vaccine hesitancy and misinformation, which impacted reporting rates and the overall perception of vaccine safety.

Timeliness: Prompt reporting and analysis of AEFIs are crucial for timely identification and response to potential safety concerns. Ensuring efficient data collection, analysis, and dissemination of findings is needed to address delays and improve the timeliness of vaccine safety monitoring.

Recommendations

To improve the vaccine adverse reactions reporting system, several recommendations must be considered:

A. Enhance Healthcare Provider Education and Awareness:

- Provide comprehensive education and training to healthcare providers on the importance of adverse event reporting, including the recognition and reporting of vaccine-related adverse events.
- Streamline the reporting process to make it more user-friendly and efficient.
- Provide mandatory ongoing education of public health officials to provide insights into the risks associated with novel drug implementation so that they understand the difference between traditional vaccine-type medications and new biologic medications.
- Ensure that on the release of any new drug that all parties involved with the administration or monitoring are fully aware of the actual nature of the drugs under consideration. Some of the shortfalls in the system during COVID-19 had to do with a lack of understanding concerning the nature of these injections.
- Provide re-education for colleges of physicians and surgeons across Canada on the principle behind procedures required and the importance of the adverse event monitoring system.

B. Promote Public Awareness and Engagement:

- Launch public awareness campaigns to educate the general public about the importance of reporting vaccine adverse events.
- Provide accessible information on how and where to report adverse events, emphasizing the role individuals play in vaccine safety monitoring.

- Provide a portal through which patients can directly report their alleged vaccine injuries to the system.
- Encourage vaccine recipients and caregivers to report any adverse events they observe following vaccination.

C. Improve Reporting Infrastructure:

- Develop user-friendly online reporting platforms or mobile applications to simplify and streamline the reporting process for healthcare providers and the public.
- Ensure reporting mechanisms are easily accessible, with clear instructions and options for reporting adverse events, including user-friendly interfaces and multilingual support.

D. Implement Active Surveillance Systems:

- Augment passive surveillance systems with active surveillance components to actively identify and monitor adverse events, especially rare or serious events that may be missed through passive reporting alone.
- Augment passive surveillance systems with active surveillance components to actively identify and monitor patient complaints and trends or patterns of patient complaints following a drug rollout.
- Implement proactive strategies, such as automated electronic health record data mining, to identify potential safety signals and conduct targeted investigations.

E. Strengthen Collaboration and Data Sharing:

- Foster collaboration between different stakeholders, including healthcare providers, public health agencies, vaccine manufacturers, and research institutions, to facilitate seamless data sharing and exchange of information.
- Immediately end the practice of public health officials directly contacting patients and advising them to undertake medical procedures contrary to the attending physician's instructions.
- Enhance integration between national and international vaccine safety networks to leverage collective expertise, share best practices, and collaborate on investigations of global vaccine safety concerns.

F. Ensure Timely Analysis and Communication of Findings:

- Prioritize timely analysis of reported adverse events to identify potential safety signals promptly.
- Ensure that those evaluating the data are capable of recognizing and analyzing the data, despite their professional biases.

- Ensure clear and transparent communication of findings to healthcare providers, the public, and other relevant stakeholders, while considering the balance between timely communication and the need for thorough investigation.

G. Continuous Evaluation and Improvement:

- Regularly assess the performance and effectiveness of the reporting system, including feedback from healthcare providers, the public, and other stakeholders, to identify areas for improvement.
- Incorporate advancements in technology and data analytics to enhance the efficiency and accuracy of adverse event reporting and analysis.

By implementing these recommendations, the vaccine adverse reporting system can become more robust, efficient, and responsive, leading to improved vaccine safety monitoring and better protection of public health.

7.5.11. Delivery of Healthcare Services During the Pandemic

Introduction

The announcement of the COVID-19 pandemic in late 2019 and the subsequent imposition of non-pharmaceutical interventions had a profound impact on all aspects of society, with the healthcare system being one of the most severely disrupted sectors.

As a result of the country-wide media/propaganda campaign, citizens were unduly alarmed and terrorized at the prospect of a novel coronavirus. This terror permeated all of society including healthcare professionals.

False information propagated by government agencies led Canadians to believe they were facing the most dangerous pandemic since the Spanish flu pandemic of 1918. It could be argued that in the very early part of 2020, healthcare officials did not yet understand the nature of the virus; however, based on the statistics being published by Health Canada, by the end of March 2020, healthcare officials already understood who was at risk and who was not at risk from COVID-19.

Governments, healthcare providers, and patients worldwide were forced to grapple with numerous challenges and adapt to new realities brought about by the interventions imposed by the governments.

Furthermore, public health officials were given control over planning for and execution of the government's emergency response. Public health officials are not experienced in, or trained to undertake, the massive task of first understanding a potential emergency of this magnitude and taking the appropriate steps to deal with it. This inexperience and incompetence was evident from the very beginning of the pandemic.

The main goal of public health officials in designing and implementing the pandemic response was to protect the **"healthcare system"**. The goal of the response should have been to protect/minimize the effects of the COVID-19 pandemic on the **"public"**.

This fatal flaw in setting the wrong strategic goal for the pandemic response resulted in major disruptions in service, the misallocation of resources, plus the unnecessary terrorizing of an entire population.

Major disruptions to the delivery of healthcare in Canada were the result of these and many more failures.

Testimony Concerning the Delivery of Healthcare Services During the Pandemic

Quickly after the imposition of the public health officials' mandates, large areas of the healthcare system began to shut down.

Sections of hospitals designated as “non-essential” were closed down, and staff were allocated to emergency care and ICU areas, waiting for the predicted wave of COVID-19 cases, which never came. Witnesses reported that prior to COVID-19, the emergency rooms were extremely busy, and following the imposition of the lockdown and mandates, the emergency rooms were empty and staff were idle; staff not allocated to these areas were sent home.

What were deemed to be “non-essential” procedures, tests, and treatments were cancelled and/or postponed indefinitely.

Some patients who were injured or developed medical conditions refused to go to the hospital or see their doctors out of fear. Some people did not go to the hospital because the media had been telling them that hospitals were overwhelmed with COVID-19 cases; that was untrue, based on testimony..

Routine office-based medical services were also temporarily halted. Many doctors were afraid to see patients. According to witness testimony, some doctors refused to see patients, and others attempted to meet with patients over the phone.

When vaccines became available, an entirely new and cruel set of issues presented themselves. The terror and hatred that appeared to have been so carefully cultivated by certain politicians and mainstream media, set those who were injected against those who chose not to be injected.

Witnesses stated that patients presenting themselves in emergency rooms were treated with disrespect and, in some cases, disdain. Witnesses, both patients and staff, described a toxic atmosphere of hate and bullying. Patients who were not injected were isolated, labelled, and in some cases refused medical attention.

As the government responses extended to forced vaccinations, staffing shortages began to arise. Hundreds, if not thousands, of staff who were now being forced to get the injection or lose their jobs, resigned, quit, took early retirement, or were fired.

At a time when the media was telling Canadians that there was a shortage of healthcare professionals, they were covering up the fact that the government’s own policies were in fact causing those shortages to occur. Often the system lost the most experienced and knowledgeable staff members to early retirement.

What the government was further keeping from the public was that prior to and leading into the pandemic, there were chronic shortages of staff and resources already.

The pandemic response also affected healthcare in a number of other ways: through disruption of supply systems and through the creation of shortages of all types of necessary supplies, including personal protective equipment.

Finally, there was the enormous reallocation of equipment, facilities, staff, and financial resources into the mandated testing and vaccination program.

Since the healthcare officials already knew what segment of the population was at risk to COVID-19, they should also have focused their attention on that specific segment of the population.

Based on the data provided by the vaccine manufactures to Health Canada, it was obvious that the vaccines were not effective in protecting people from the infection, and the safety profile of the vaccines was unknown. Furthermore, no testing had been carried out to determine if the injections actually prevented or reduced the spread of the disease.

Based on all of these known facts, implementing a universal testing and vaccination program was pointless, at best, and potentially life threatening to Canadians.

Among these disruptions, three major issues stand out: the postponement of regular treatments, patient fear of hospitals, and the shutdowns of elective surgeries.

Postponement of Regular Treatments:

One significant disruption to the healthcare system caused by COVID-19 measures is the postponement or cancellation of regular treatments for non-COVID-related conditions.

As the government implemented their pandemic policies, healthcare facilities were refocused to deal with a predicted overwhelming influx of COVID-19 patients, which never came. This resulted in a shutdown or slowdown on resources such as hospital beds, medical equipment, and healthcare personnel. Hospitals had to repurpose resources and prioritize the care of predicted COVID-19 patients, often leading to the postponement of non-urgent procedures and treatments.

This delay had serious consequences for patients suffering from chronic illnesses, such as cancer, cardiovascular diseases, and other conditions, potentially leading to disease progression, reduced quality of life, and even increased mortality rates.

Patient Fear of Hospitals:

Another significant disruption resulting from the fear propagated by the government and media was the widespread fear and hesitancy among patients to seek medical care in hospitals and healthcare settings. The government and media had exaggerated the contagious nature and lethality of the virus. This coupled with the uncertainty surrounding its transmission initially led to a general perception that hospitals were high-risk environments for contracting COVID-19.

Fearful of exposure, many individuals with health concerns opted to delay or altogether avoid seeking medical attention, even for urgent conditions. This fear resulted in a decline in routine check-ups, preventive screenings, and early detection of diseases, which could lead to long-term health consequences as undiagnosed conditions progress untreated.

Shutdowns of Elective Surgeries:

Elective surgeries, which are planned procedures that are not immediately life-threatening but necessary for patients' wellbeing, have been significantly disrupted by the COVID-19 response. To preserve resources, minimize the risk of exposure to the virus, and ensure sufficient capacity to handle COVID-19 cases, many healthcare systems implemented temporary shutdowns or restrictions on elective surgeries. This measure aimed to redirect medical staff, equipment, and hospital beds to COVID-19 response efforts.

This strategy resulted in substantial backlogs of elective procedures, negatively impacting patients who required surgeries for conditions such as joint replacements, cataracts, and hernias. The delays in these surgeries have caused prolonged suffering, decreased quality of life, and increased wait times for those in need of essential care.

This strategy was the direct result of the incorrect planning of the pandemic response. In other words, the response was designed to protect the healthcare system, it was not designed to protect patients.

Conclusion

The government's response to the COVID-19 pandemic has disrupted the healthcare system in various ways, including the postponement of regular treatments, patient fear of hospitals, and the shutdown of elective surgeries. These disruptions have had severe consequences for patients, leading to disease progression, decreased preventive care, and increased wait times for necessary procedures.

Recommendations

Based on the experience of the COVID-19 pandemic in Canada, several recommendations could be made to improve the healthcare system and prevent similar disruptions to normal healthcare services in the future.

These recommendations focus on building resilience, preparedness, and adaptability in the healthcare system. Here are some key suggestions:

- A. **Ensure Proper Emergency Response, Planning, and Implementation:** Public health officials are not trained in the planning and implementing of national integrated emergency response to major public health emergencies. In future, the responsibility for planning and implementing such emergency plans must be undertaken by the emergency measures organizations that already exist for this purpose. Public health must play an active role as technical consultant to the Emergency Measures apparatus but should never be placed in control of it.
- B. **Invest in Healthcare Infrastructure:** Strengthen the healthcare infrastructure by first rationalizing the current inventory and capacity of the system, and then increasing the capacity of hospitals, clinics, and healthcare facilities, if required. This may include investing in more beds, medical equipment, and essential supplies to handle potential surges in patient volumes and designating alternative facilities and mechanisms to share resources across provincial jurisdictions.
- C. **Enhance Telehealth Services:** Expand and promote telehealth services to provide virtual consultations and healthcare support. Telehealth can reduce the burden on physical healthcare facilities, increase accessibility to healthcare services, and ensure continuity of care during emergencies.
- D. **Improve Data Collection and Analysis:** Establish a robust data collection and analysis system to monitor healthcare resources, disease outbreaks, and public health trends. Timely and accurate data can help inform evidence-based decision-making and resource allocation during crises.
- E. **Maintain Strategic Stockpiles:** Create and maintain strategic stockpiles of essential medical supplies, including personal protective equipment (PPE), ventilators, and medications. These stockpiles can help mitigate shortages during emergencies and protect healthcare workers.
- F. **Support Healthcare Workforce:** Ensure the wellbeing and resilience of healthcare workers by providing mental health support, appropriate training for handling emergencies, and fair compensation. A strong and supported workforce is crucial in times of crisis.
- G. **Improve Collaboration and Communication:** Enhance coordination and communication between federal, provincial, and territorial governments, as well as with healthcare providers and public health agencies. Effective communication channels can facilitate rapid response and the dissemination of critical information.

- H. **Pandemic Preparedness Plans:** Develop and regularly update comprehensive pandemic preparedness plans at all levels of the healthcare system. These plans should outline specific strategies and protocols for managing various types of pandemics and health emergencies.
- I. **Training and Dissemination of Emergency Plans:** As seen during the COVID-19 pandemic, existing plans were sidelined and many healthcare workers were not aware of the existence of any plans. Emergency plans must be distributed widely and reviewed with healthcare workers at all levels, and the public should have access to seminars and information sessions. The best plan in the world if unseen and unrehearsed is useless.
- J. **Public Health Education and Awareness:** Strengthen public health education and awareness programs to inform the general population about disease prevention, natural immune system upkeep, and appropriate healthcare-seeking behaviour during outbreaks.
- K. **Supply Chain Resilience:** Diversify and strengthen the supply chain for essential medical equipment and pharmaceuticals to reduce dependence on foreign suppliers and minimize disruptions during global crises.
- L. **Regional Response Capacity:** Establish regional response capacities to handle healthcare crises, allowing for more focused responses in areas heavily affected by outbreaks while maintaining healthcare services in other regions.
- M. **Long-Term Care Facilities:** Implement improved infection control measures in long-term care facilities to protect vulnerable populations during outbreaks and prioritize their healthcare needs.
- N. **Flexible Healthcare Services:** Develop flexible healthcare service models that can quickly adapt to changing circumstances. This could involve creating mobile healthcare units, flexible staffing arrangements, and alternative care facilities during emergencies.

Implementing these recommendations requires a collective effort from governments, healthcare providers, communities, and individuals. By learning from the challenges faced during the COVID-19 pandemic and taking proactive measures, Canada can enhance its healthcare system's resilience and better protect the health and wellbeing of its citizens in the face of future health emergencies.

7.5.12. Public Workplaces and Pandemic Measures

Introduction

Canadian Blood Services (CBS) is a not-for-profit, charitable organization that operates independently from government. Created through a memorandum of understanding between the federal, provincial, and territorial governments, CBS was established in 1998. Funding comes primarily from the provincial and territorial governments.

CBS identifies the organization as one part of Canada's broader network of healthcare systems. It is the only national manufacturer of biological products funded by Canada's provincial and territorial governments. CBS provides blood and plasma, as well as transfusion and stem cell registry services, on behalf of all provincial and territorial governments (excluding Québec). CBS national transplant registry for interprovincial organ sharing and related programs extends to all provinces and territories. CBS works closely with Hema-Québec in times of need.

CBS is responsible for the safety, quality, identity, purity, potency, and accessibility requirements of all blood products and services offered.

From its website, CBS is "committed to reflecting Canada's population in our organization and fostering an environment where all employees can be their authentic selves, with equal opportunities to succeed and contribute."

In relation to COVID-19, CBS in June 2020 formed a research partnership with the COVID-19 Immunity Task Force (CITF), a research arm of the Public Health Agency of Canada. Since then, more than 720,000 blood samples have been analyzed and tested under CBS' seroprevalence study to determine whether donors have developed an immune system response to COVID-19 through infection or vaccination. CBS reports the results indicate that more than 78 per cent of blood donors have antibodies due to COVID-19 [infection] and 100 per cent have antibodies as the result of vaccination. CBS attributes these results to the high uptake of vaccination as well as the extent to which COVID-19/SARS-CoV-2 has spread throughout the population of adult blood donors.¹⁴⁷

Witness Testimony

Jessica Kraft (Day 3, Winnipeg, MB) is a 31-year-old with two daughters. She began her employment journey with Canadian Blood Services in October 2013. Ms. Kraft received six weeks of classroom and on-the-job training. She enjoyed her role as a Donor Care associate. Ms. Kraft's clinical responsibilities included needle insertion (phlebotomy) and donor screening procedures.

¹⁴⁷ Canadian Blood Services, June 20, 2023, Ottawa, ON Link: <https://www.blood.ca/en/about-us/media/newsroom/blood-donors-are-helping-us-prepare-future-pandemics> (accessed July 14, 2023)

In December 2019, Ms. Kraft gave birth to a second daughter. Consequently, she went on maternity leave. She returned to work in March 2021 following the implementation of workplace safety protocols for COVID-19. Mandates included the wearing of masks by staff and donors, social distancing protocols, the introduction of wellness checkpoints within the clinic, and ensuring donors were in good health before they came into the facility.

When she first started with Canadian Blood Services, she found the environment to be a fun and a supportive place to work. Her colleagues formed a good team. She noted that while she was on parental leave, there was a change in management. This in turn led to a push for more first-time donors. Other notable clinic changes included the exclusion of family and friends attending the clinic to support donors and the lack of refreshments for donors after donating whole blood, plasma, or red blood cells (which is critically important to ensuring the donor's health). On a broader level, Ms. Kraft noted a change in how CBS portrayed itself as an institution—from a non-profit contributing to the of health needs of Canadian patients to being labelled a biologics manufacturing company.

As well, Ms. Kraft observed the clinic had become rigid and sterile. There was an increase in donor reactions (donors feeling faint and/or passing out). However, during this time, there were no specific changes in her job description or the way she collected blood.

In September 2021, Canadian Blood Services posted a mandatory vaccine notice to employees. Under the new mandate, requirements included attesting one's vaccination status to the employer and submitting to regular rapid tests. Employees were required to be fully vaccinated by late fall. There was an option for applying for medical or religious exemption. Ms. Kraft pursued an exemption.

When she went to see her physician for a regular checkup, she mentioned the new healthcare worker mandate. The doctor dodged Ms. Kraft's questions about getting an exemption for her condition. Ms. Kraft has a pre-existing medical condition known as functioning heart murmur. Her doctor denied her heart condition, a diagnosis she has had for her whole life. Ms. Kraft's medical doctor would not give her an exemption for two reasons. First, the exemption would have to be cleared by other physicians and second, even if she did provide a medical exemption, it would likely not be approved by Ms. Kraft's employer.

She then tried to get permission for exemption from Canadian Blood Services. She approached her immediate supervisor, managers, and the CBS doctors on-site with questions. In response, she received a lot of copy-and-paste-type statements and impersonal email replies. At work, she was asked publicly if she planned to get vaccinated. This same question was posed in front of donors. Feeling awkward, Ms. Kraft would change the subject.

Ms. Kraft reiterated she was not opposed to vaccines. She was up to date on all her other vaccines. Her children were vaccinated.

Ms. Kraft testified that even though she knew disciplinary action was coming, she was still devastated when it happened. What caused the decision to be so difficult? Ms. Kraft objected to disclosing personal and private health information to her employer and subsequently having to submit to regular rapid testing. She cited the *Personal Health Information Act* as justification for not attesting. The Act states employees are not required to disclose personal health information to employers. Regarding the testing requirement, she didn't think it set a good precedent in the workplace. Ms. Kraft was never previously required to prove any other vaccine compliance to her employer. At one point, CBS encouraged employees to receive a Hep-A or Hep-B vaccine, but neither of these vaccinations were mandated or enforced.

Overall, Ms. Kraft said her unvaccinated status affected her relationship with colleagues. She did not know whom she could trust. On Thanksgiving Monday, Ms. Kraft received a call from her supervisor, stating she would not be allowed back to work, primarily because she had not consented to any of the imposed measures.

Ms. Kraft filed a grievance with her union and was told she would receive an education package. This never came. She was later informed her complaint would not be going to arbitration. She was not eligible for Employment Insurance. She would not get her job back. When she went into the workplace to pick up her personal belongings, she was ostracized and treated like she was infectious. Since her termination, Ms. Kraft has sought employment on and off but is grateful to have been given this time with her children.

In response to Commissioner questions, Ms. Kraft said she was CBS trained as a phlebotomist. She had signed the CBS code of conduct. CBS had not changed the terms of her employment or job description. The union did not address her complaint. The compliance orders came from CBS Head Office. To the best of Ms. Kraft's knowledge, CBS was regulated by Health Canada. She said it was unfortunate to see donors dwindling. She confirmed severe reactions were documented in incident reports.

In closing remarks, Ms. Kraft said she was privileged to use her time off to be with her children but others who lost their jobs and homes were not as fortunate. She said it was for those individuals and families that she chose to speak at the NCI hearings.

Canadian Blood Services terminated her position in October 2021.

Analysis

Ms. Kraft's employer Canadian Blood Services (CBS) is a not-for-profit regulated by Health Canada. CBS is a publicly funded institution. CBS entered into a partnership with the Public Health Agency of Canada (via CTIF) in 2020. The CBS website currently states, "Canadian Blood Services is a COVID-19 vaccinated organization."¹⁴⁸

¹⁴⁸ Excerpted July 14, 2022, Link: Canadian Blood Services and COVID-19 Information

Moreover, CBS is committed to the principles of diversity, equity, inclusion, and I CARE (Integrity; Collaboration; Adaptability; Respect; Excellence). CBS positions its societal contributions “as the connection between donors and patients, healthcare professionals and medical researchers.” As well, CBS advocates for an environment where all employees can be their authentic selves, with equal opportunities to succeed and contribute.

CBS guarantees a further commitment to basic human rights, including equity, inclusivity, and diversity in the workplace. Together, these statements are particularly critical in understanding the legal obligations and duties of employers in Canada.

Yet, as we understand from the testimony, Ms. Kraft was harassed and made to feel uncomfortable by colleagues, without consequence to the perpetrators. Her workplace did not portray an inclusive environment. Diverse or dissenting viewpoints were not welcomed. Indeed, in this example, CBS did not adhere to their own commitment to provide a work environment wherein all personnel are treated with respect and dignity, permitted to be their authentic selves, with equal opportunities to succeed and contribute.

When Ms. Kraft asked legitimate health-related questions of her immediate supervisors and management team (who are required by occupational-related legislation to be adequately trained in health and safety as well as informed of their respective responsibilities), in writing, she received copy-and-paste email responses that failed to inform. Witness testimony indicates there was no one directive from CBS Senior Management that summarized the risks and benefits of the COVID-19 genetic vaccine(s) or elaborated on the guiding principles of Informed Consent. The Commission is not aware of any actions taken by CBS or the union to bring about a satisfactory resolution or accommodation for Ms. Kraft.

Similarly, Ms. Kraft’s union failed her by not ensuring she received information that could have further educated her personal choices. Perhaps, by acting in the best interests of Ms. Kraft, the union could have protected her from termination. As if this wasn’t enough, EI decision-makers, responsible for ensuring employees/clients who lose their job receive Employment Insurance benefits to tide them over until equivalent employment can be found, also denied her EI benefits—for misconduct.

From the witness testimony, there is no shortage of questions to pursue. For example, did CBS ever consider the extent to which unvaccinated CBS personnel posed a health risk to donors and colleagues? Did either CBS or the union conduct an exhaustive review of the scientific evidence? What were the findings? Were either CBS or the union aware that all four COVID-19 vaccination choices were still in clinical trials in the fall of 2021?

Were questions raised that, perhaps, CBS policies for vaccination amounted to coercion by the employer or that the vaccination dictate could have been inconsistent with or contrary to provisions of the collective agreement? Or possibly was contrary to the principles of Informed Consent?

Observations

1. Medical freedom, Informed Consent, the right to choose as it pertains to COVID-19 vaccinations:

Informed Consent means persons administering medical treatments or procedures must inform individuals beforehand of the benefits and risks associated with the medical treatment, interventions, or procedures. In this case, the employer CBS mandated that all employees must be vaccinated with one of the four identified Health Canada approved vaccinations and/or undergo regular rapid testing. These demands occurred during a timeframe when all four proposed vaccinations were still in clinical trials. [FDA Clinical Trial website reported vaccinations manufactured by Moderna, AstraZeneca, Pfizer, and Janssen (aka Johnson & Johnson) were still in clinical trials in October 2021.]

The witness clarified the mandates came from CBS Head Office, so in essence, the order came from senior management, who by extension, dictated that employees could not exercise their right to choose when it came to COVID-19 vaccinations. Medical freedom was not an option. Together, these contravene elements of consent which include obtaining informed and explicit consent prior to treatment. It also violates the principle that consent must be voluntary. Consent cannot be considered valid when it is given under conditions of fear or pressure, and this includes threats of disciplinary action or the possibility of losing one's job.

Section 265(3) of the *Criminal Code* of Canada defines consent in relation to assault as:

(23) For the purposes of this section, no consent is obtained where the complainant submits or does not resist by reason of (a) the application of force to the complainant or to a person other than the complainant (b) threats or fear of the application of force to the complainant or to a person other than the complainant (c) fraud, or (d) the exercise of authority.

As well, in responding effectively to Ms. Kraft's questions, CBS should have provided evidence proving that mandatory COVID-19 vaccinations had been fully, independently, and rigorously tested against control groups and released the subsequent outcomes of those tests, including long-term results, a list of potential adverse effects, carcinogenicity, and the impact on fertility, given that Ms. Kraft was still of childbearing age. At the very minimum, the risks and benefits of taking the COVID-19 genetic vaccine should have been communicated to CBS employees and the decision for bodily autonomy left for them to decide.

2. Occupational Health & Safety & The Employee's Right to Refuse Unsafe Work Conditions:

The right to refuse to perform job duties is embedded in Occupational Health and Safety legislation. Although it has not [yet] been inextricably linked to the more recent employers' demands that employees be vaccinated—violating an employee's ability to weigh the risks and benefits in relation to their own health and safety—it doesn't negate the possibility of a viable argument for revising the legislation going forward.

As it currently stands, employees in a workplace can refuse to perform their duties if they are of the belief or opinion that a certain job task can cause physical harm to themselves or others, and/or it's a safety risk. This is not new. Indeed, employees weighing health and safety risks while performing their job duties and responsibilities in a workplace have filed refusal to work arguments for decades, and employers have often responded favourably.

By extending this line of thinking, what if the same employee holds a widely held belief that the COVID-19 genetic vaccine poses similar health or safety risks, or as it is in this example, the vaccination options have still not been proven to be safe and effective. Shouldn't labour protections allow for employees to file a refusal to work for similar concerns?

Notable here, as stated in testimony, Ms. Kraft had a pre-existing medical condition. The vaccines were still experimental and in clinical trials. Adverse side effects of the vaccines were relatively unknown. Research studies and scientific papers were still contradictory with no clear consensus being reached—except by governments and media who are not medical experts.

Ms. Kraft was coerced into unlawfully disclosing a medical treatment to her employer against her will, even though there was still no evidence that a COVID-19 vaccination prevented transmission at the community level. Neither was there any proof that COVID-19 vaccinations protected against the current variants because as the media continuously reported, the virus was constantly mutating in response to vaccine-induced selective immune pressure.

Certainly, it had become evident from the daily and weekly statistics that COVID-19 vaccinations were not reducing hospitalizations or the burden on the healthcare system, raising even more questions given the initial two weeks to flatten the curve mantra. Again, Ms. Kraft was a professional working alongside physicians and nurses within a key component of healthcare (blood services), so her ability to discern health directives would have been heightened. She also cited privacy concerns, referring to the *Personal Health Information Act* specifically.

Still, for Ms. Kraft, it was the myriad of copy-and-paste responses that raised alarms, which is why she sought clarification from her supervisors and management team. Sadly, in her case, she was not given the option to refuse work in the hope of creating a constructive dialogue. Instead, she was terminated.

Given this eventual outcome, it could be suggested the termination was a way of avoiding listening to the viewpoints of a staff member who disagreed with the direction CBS was taking. Occupational laws are designed to protect employees from coercion or, as stated, from employees undergoing undue risk to their own health and safety.

3. Publicly funded institutions, administrative law, neutrality, and discretionary powers:

By virtue of their primary funding sources, publicly funded institutions must legally remain neutral and appear to be at arm's length from government dictates. Further, decision-makers within the public service must act in accordance with governing legislation. This means agent(s) of government(s) cannot negate their legislated duty in the fulfillment of their responsibilities and second, these duties must be performed without bias and/or reliance on discretionary powers.

What we learned from the testimony is EI denied Ms. Kraft's application for benefits—for misconduct. We do not know if her life-long medical condition was a consideration in the decision. Neither are we aware if Ms. Kraft's denial of EI benefits for misconduct was arbitrary, based on earlier precedent-setting decisions made against unvaccinated claimants.

EI legislation points to a process for determining EI status: 1. Show the balance of probabilities [the credibility of the information must be genuine, reasonable, plausible, and based on the facts]; give both the employer and employee an opportunity to provide information as to the reasons for the loss of employment; evaluate the evidence without prejudice; and make the decision based on the weight of evidence. Section ss49(2) of the EI Act states the benefit of the doubt is given to the claimant.

As well, if the EI officer can answer yes to both of the following questions, the claimant is disqualified: Does the information in the file support the finding that the claimant committed actions or omissions as defined by the interpretation given to the word misconduct? Does the information in the file support the finding that the claimant lost their employment because of these actions or omission?

Regarding the establishment of misconduct, it must be shown (a) that the conduct in question constituted a breach of the employer-employee relationship; (b) that the conduct was wilful (c) that there was a causal relationship between the alleged conduct and the dismissal; (d) that the alleged misconduct was not a mere excuse or pretext for the dismissal.

In some cases, an EI decision can involve who initiated the act of severing the employment and the reasons behind this action.

Recommendations

- A. **Employers mandating vaccinations** for all employees in the workplace must provide verifiable data proving vaccine safety and efficacy, outlining the risks and benefits, including any and all adverse effects and provide employees with satisfactory options in the event of vaccine hesitancy and/or refusal.
- B. **Ensure employers' duty** to adequately train staff in workplace health and safety procedures and to inform supervisors and managers of their respective responsibilities includes establishing the importance and applicability of all related legislation, including the *Canada Constitution, 1867*, and specific Acts such as the *Personal Health Information Act*.

- C. **Unions have an obligation** to balance employee protections with arbitrary decisions and compliance orders made by employers. Unions must be required to undertake an exhaustive inquiry of the facts contributing to a grievance particularly when the complaint involves personal choice, bodily autonomy, constitutional protections, and the right to refuse unsafe work conditions.
- D. **When employer-employee conflicts arise** from employer mandates requiring vaccination, the union must intervene with the intention of seeking a satisfactory resolution, inclusive of reviewing employer policies and collective bargaining agreements relating to sick leave and disability benefits to determine eligibility [re: extenuating circumstances].
- E. **Terminated unvaccinated claimants** who were denied EI benefits based on misconduct must have their files re-assessed to determine whether the alleged breach in the employer-employee relationship came about because of employer forced mandates, coercion, and a person's right to choose bodily autonomy; a new decision must be rendered.
- F. **Ensure affirmative defences** are available for all employees working in publicly funded institutions, including transparent appeal processes.
- G. **When non-arm's length publicly funded agencies** enter into a partnership [such as the partnership between CBS and the Public Health Agency of Canada], there should be legislative assurances that the objectives of the newly intertwined relationships are not contradictory.

7.5.13. Alleged Denial of Medical Treatment Due to Pandemic Measures

Introduction

The allegations brought forward by Ms. Sheila Lewis highlighted a critical and highly complex issue at the intersection of public health, medical ethics, and individual rights, which emerged in the context of the COVID-19 pandemic. This situation underscored the intense debate regarding healthcare access for the unvaccinated, particularly in relation to emergency treatments and life saving procedures such as organ transplants.

From a public health standpoint, the intent behind vaccination policies in healthcare settings is to protect the safety and wellbeing of all patients, particularly those who are immunocompromised, like transplant recipients.

However, the COVID-19 genetic vaccine has been shown to be neither safe nor effective. The COVID-19 genetic vaccines do not significantly reduce the severity of the disease; they do not decrease transmission rates; and they have little or no effect on mortality rates. The effectiveness of the vaccines is also temporary and reported to wane within months of being administered.

In fact, testimony was presented concerning the significant rates of adverse reactions to the vaccines that included death of the patient.

Ms. Lewis testified that she refused to take the COVID-19 genetic vaccine out of a fear of potential adverse reaction to the vaccine. Furthermore, given the fact that the government declared that the pandemic was ended and vaccine mandates had been rescinded, there was no medical need for her to have taken the COVID-19 genetic vaccine, at the time of her testimony.

Discussion

Ms. Sheila Lewis needed an organ transplant to live. She was not alone. Indeed, many other Canadians, essentially strangers to Ms. Lewis, were also on the transplant list. During COVID, the prerequisites to remain registered changed. COVID-19 genetic vaccines had become mandatory. Two vaccinations were required immediately and a third prior to the organ transplant. Ms. Lewis now faced a dilemma. She legitimately questioned the safety and efficacy of these vaccines, noting the clinical trials were still underway.

Ms. Lewis was not the only casualty. Many physician witnesses testified of the abuse and oppression they faced from health and regulatory bodies. Coerced, suspended, disciplined, and/or fired—whatever the eventual outcome—these professional and experienced physicians, as much needed pillars within society, were publicly shamed for standing against the united forces of conformity. At issue was the multi-lateral players, the diatribe of authoritarian messaging, and the political machinations that had slowly become entrenched within the Canadian social fabric.

From an ever-increasing list of casualties, credentialed physicians, chiropractors, and dentists refused to trivialize or withhold life-sustaining medications from patients. Scientists with PhDs and post-doctoral status investigated the pharmaceutical evidence and found it severely lacking. What motivated each of them to stand against the prevailing narrative? Each valued human dignity, recognizing the critical importance of life and breath. Similarly, they understood the principles of being human. That is, every individual is equal before and under the law and similarly has the right to equal protection and equal benefit of the law—without discrimination.

Many questions emerged. Who is a physician legally bound to protect? Who is the college of physicians and surgeons mandated to serve? Shouldn't regulatory authorities making serious allegations against their members be forced to apply a higher standard of proof? And of course, one question we all ask: What legal recourses are available when alleged accusations are proven wrong?

All the while, increasing messaging from governments and health authorities alike demanded compliance. Liberties were suspended. Dissenting voices silenced. Freedom of speech, beliefs, thoughts, opinions, and conscience—the very attributes that make us human and alive—were arbitrarily removed. Oppression replaced grace. Injustice replaced human dignity and wellbeing.

Families were divided; businesses shut down. Public shaming and cancel-culture became the norm. In the wake, our human willingness to advance peace, generosity, and social cohesion were displaced. Forced coercion and intimidation began taking hold. In short, our beloved democratic nation of Canada slowly lost its soul. At the same time, political machinations appeared to be on a path towards enslaving the populace, but many people remained unaware of this taking place.

Thankfully, not everyone complied to the ever-changing government dictates. Like Ms. Lewis, many Canadians began to raise a cry for freedom and liberty. Hardworking Canadians, who through their own understanding of self-constitution and personal convictions, were prepared to affirm the worth and dignity of every individual.

Within this context, readers are invited to listen, in order to hear the voices of brave souls willingly standing in the gap for our nation. This Report provides an opportunity to understand the courageous and compelling journey of courageous Canadian citizens who were willing to speak truth to power during a time when open and transparent dialogue was met with negativity and ridicule.

On a human level, the denial of lifesaving treatment due to vaccination status is understandably deeply troubling. Medical care is fundamentally based on principles of beneficence (doing good), non-maleficence (doing no harm), autonomy (respecting the patient's rights to make decisions about their healthcare) and justice (equal treatment). The case of Ms. Lewis raises profound questions about the importance of retaining a balance of these principles during a public health crisis.

The “Right to Life” is guaranteed in section 7 of the *Canadian Charter of Rights and Freedoms*. Professor Gail Davidson testified concerning the International Agreements and Treaties which Canada is obliged to uphold. These treaties contain similar requirements (International Human Rights Law) to guarantee the right to Informed Consent to medical treatment as an essential component of other rights, including the right to health, life, and freedom from torture or ill-treatment.

To address such situations, clear and compassionate dialogue between healthcare providers and patients is crucial. Patients should be fully informed of the risks associated with their decision not to get vaccinated, particularly in relation to procedures like transplants where the post-operative immune system is vulnerable.

Healthcare institutions and policy makers must continuously seek to review the logic and necessity of vaccination policies to ensure these policies are ethically sound and to consider exemptions in cases where denying treatment may result in loss of life.

Open and constructive dialogue must be encouraged in society to address the actual current understanding of issues surrounding vaccines, including discussion of existing knowledge and data on safety and efficacy.

Given the critical nature of issues involved and the consequences of service denial, it is absolutely imperative that previously set policies be continually revised and evaluated, especially considering the new body of knowledge available in the present day, rather than relying on earlier pandemic information.

Independent bodies, such as medical ethics committees or legal authorities, should review cases like Ms. Lewis’s to ensure fair treatment. It is vital to remember that every life is valuable, and even in times of crisis, we must strive to uphold the principles of empathy, respect, and justice that underpin the practice of medicine.

Summary of the Testimony of Shelia Lewis

Sheila Lewis, resident in Alberta, and a potential transplant recipient, was removed from a patient transplant waiting list for not taking the COVID-19 vaccination. Medically, Ms. Lewis could not survive without the transplant. Despite facing a court-issued gag order limiting her ability to speak freely, Ms. Lewis testified of the intricate process involved in being a transplant candidate.

In testimony, Ms. Lewis reiterated her requirement for a transplant in order to live. While on a waiting list for a transplant, Ms. Lewis was removed from the waiting list because of her refusal to take the COVID-19 vaccinations. She stated that a court order prevented her from naming the organ she required, from naming doctors involved, and from naming the hospitals or hospital locations involved.

As part of the organ transplant process, Ms. Lewis was required to submit her vaccination records. Gathering her vaccination records took about a year. When it came to the discussion of COVID-19 genetic vaccines, Ms. Lewis questioned their safety. She explained that there was no data available to prove the safety of the vaccines, and that “we don’t know anything about them” and was essentially informed that she must “take it or die.”

The Justice Centre for Constitutional Freedoms (JCCF) intervened for Ms. Lewis in the courts. JCCF introduced a constitutional argument to the King’s Bench, including the *Bill of Rights*. The court agreed with the doctors—that Ms. Lewis should take the COVID-19 vaccinations. The courts also imposed a gag order preventing Ms. Lewis from speaking publicly on specific aspects of her case.

In response to the unanimous decision by the lower court, Ms. Lewis reiterated, “No longer my choice, my body.” She then appealed the decision. At the Court of Appeal, judges did not know whether they could or even should intervene in a medical procedure. Therefore, instead of examining the merits of the case, the Court of Appeal upheld the lower court decision. The gag order remained.

Ms. Lewis had COVID, and therefore had natural immunity. She was informed by a medical professional that her antibodies were higher than most. She applied to the Supreme Court of Canada, wherein, at the time of her NCI testimony, Ms. Lewis was still waiting for a decision. Because the three appellate judges were unanimous in their decision, Ms. Lewis had to make an application to be heard at the Supreme Court of Canada.

“There’s something else wrong here, and it comes from the top,” stated Ms. Lewis, “Doctors and nurses are losing their licences for speaking out.”

She asked the question, “When has there ever been a time in history when this has happened?” She shared that other individuals likewise were taken off the transplant list because of their refusal to take the COVID-19 vaccination. “They deserve to get a transplant too.”

“Dear God, there’s a lot of people who need help and I feel for every one of them because I know what I’m going through, and they are going through the same damned thing.”

Ms. Lewis referred to the doctors’ actions in her situation as “evil.” She confirmed that people were dying for no reason, referring to the physicians’ Hippocratic Oath and commitment to do no harm. Weeping, Ms. Lewis concluded by saying she wants to receive the gift of life. “I don’t want to die, God help me.”

Testimony of Mr. John Carpay (Lawyer for Ms. Lewis)

On April 28, 2023, Mr. John Carpay, a lawyer with the Justice Centre for Constitutional Freedoms (JCCF) testified at the NCI hearings. Mr. Carpay alluded to the JCCF representing Alberta resident Sheila Lewis, who was denied a life-saving organ transplant because of her COVID-19 vaccination status.

JCCF also defends the free speech rights of doctors and nurses threatened with loss of employment. Mr. Carpay reiterated that the doctor-patient relationship, and all other healthcare-patient relationships must be respected. Members monitored by professional regulatory associations, such as the colleges of physicians and surgeons, must be empowered to uphold the tenets of Informed Consent, including the right to make ethical and moral decisions according to their conscience. Why? Because it is the physicians and surgeons who have the specialized medical expertise and knowledge to successfully treat patients, not administrators.

Mr. Carpay recommends that when a public emergency is declared, legislative changes be designed to protect the fundamental human rights and constitutional freedoms of Canadians. These include, in part: health authorities disclosing the evidence or data they are using to justify their recommendations; health authorities identifying the source and documents upon which they rely for imposing mandates; chief medical officers submitting to weekly questioning by an all-party committee in the Legislative Assembly; automatic re-examination of emergency declarations every 30 days; and last but not least, governments producing a cost-benefit analysis when the rights of individuals within a free and democratic society are violated. He also advocates for monthly reports from government(s) showing the public how lockdown measures and vaccine passports negatively affect vulnerable populations.

Mr. Carpay also referred to the World Health Organization definition of health in his testimony, as “a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity.”

For the record, both of Sheila Lewis’s judicial cases were under a gag order by the courts. The restriction on publication states: “Identification Ban—By Court Order, information that could identify the Respondent Physicians, including their medical specialization, the specific organ at issue, and the location of the transplant program, must not be published, broadcast, or transmitted in any way.”

Discussion of Testimony

Ms. Lewis’s testimony was heartbreaking. Her pleas for help had many in the audience praying intensely for her healing. Bravely, she spoke of numerous individuals like herself who were awaiting an organ transplant. She emphasized the continued need for compassion. In court, the arguments focused on the *Charter of Rights and Freedoms*. The same sections of the Charter formed the basis of her later appeal. Ms. Lewis’s rationale for taking a stance was that she wanted to live to see her grandchildren grow up.

It is easy to blame government(s). This is not to suggest that the governmental response to COVID-19 was not a significant factor contributing to or leading organ transplant teams (TP) to demand that all organ recipients receive COVID-19 genetic vaccines. Governments were ultimately responsible for establishing measures that dictated how citizens responded to the pandemic. Accordingly, governments must share the blame for any measures they imposed in particular when extreme consequences resulted from those measures.

When Charter arguments are raised in court, Charter infringements require a direct link to government discrimination. For example, violation of the Charter is not a valid argument when the imposing entity is not a non-government, third party entity. In this case, the third party making the decision was the organ transplant team. This team decided policy and set the precondition requirements for organ transplant recipients.

Ms. Lewis only raised the question of safety and efficacy when the COVID-19 vaccinations became mandatory. Like every other person requiring an organ, she was informed that she needed two COVID-19 injections to remain on the transplant list, and a third dose prior to the organ transplant. This was the requirement decided by those responsible for organ transplants. In Alberta, there were no exceptions.

Since Ms. Lewis willingly complied to retaking her childhood vaccinations without hesitation, she could not credibly argue for a religious or medical exemption (if available) when it came to the [experimental] COVID-19 genetic vaccines. Without citing the potential for long-term health risks, the question becomes how does one argue bodily autonomy, the potential for higher risks, and adverse reactions when Ms. Lewis willingly conceded to a second round of childhood vaccines?

Beyond what could appear as picking and choosing which vaccines were safe and which were not, Ms. Lewis after receiving an organ transplant would be required to follow an intensive medication regimen for the remainder of her life. Even though some of these medications may still be undergoing clinical trials, Ms. Lewis did not raise any contentions about safety and efficacy with regard to these medications.

Ultimately, Ms. Lewis was removed from the transplant list, not because of discrimination or a Charter violation directly imposed by governments, but rather, as the Courts ruled, because she refused to abide by the preconditions set in place for organ transplants.

At this juncture legitimate questions emerge. Was the safety of the COVID-19 genetic vaccine on trial? No. Was government the reason Ms. Lewis was dying? No. Were governments directly linked to the violation of Ms. Lewis's Charter rights? No. Was government interfering with the transplant requirements? It did not appear so. Did the transplant team discriminate against Ms. Lewis specifically, with a requirement for her to submit to more conditions than other potential transplant recipients? No.

Perhaps if the Court was made aware that the Alberta Health Services was systematically removing medically-documented adverse reactions to COVID injections from its provincial reporting system (as other witnesses attested) and/or that the AHS/TP criteria for organ transplants did not include a Charter-required accommodation process (re: religious and medical exemptions), the legal arguments may have garnered a more positive decision.

Nevertheless, as stated, judges are not medical physicians. Nor do they profess to be. Judges are not trained in the investigation of medical and scientific matters. Subsequently, when the scarcity of organ statistics was raised, showing that 40 percent of recipients who were vaccinated with the required COVID-19 vaccinations died while waiting for an organ, this data spoke volumes. While this latter point might raise other equally disturbing medical concerns (re: adverse reactions as a consequence of COVID-19 vaccination), the court was only privy to Charter arguments as a defence, which are only applicable to discriminatory decisions wholly made by governments.

In terms of neutrality, the lack of arm's length relationship between Health Canada, the Public Health Agency, and Canadian Blood Services (all publicly-funded stakeholders instrumental in establishing organ transfusion criteria) may have offered some relevance. Yet, it would not likely have changed the outcome because the evidence put before the Court had to show that transplant teams were unduly influenced by government(s), or that these entities may have arbitrarily created pressure for doctors to include COVID-19 genetic vaccines on the transplant team list of mandatory injections. As an aside, this too would have required varied legal arguments apart from a constitutional challenge.

Even so, it is this conscious decision by the Courts, choosing not to review the volumes of contradictory scientific and medical evidence, which invites valid criticism. By extension, the judges' own personal choices to take the COVID-19 vaccinations might have weighed heavily into this component of the ruling. After all, courts are entrusted to review all the evidence set before them, and as such, only then to make informed judgments. However, this did not happen.

Instead, the refusal to examine the volumes of evidence (conflicting or otherwise) could be considered a barrier or prohibition to Ms. Lewis's quest for justice. It certainly is not the type of legal precedent expected by the public, who at considerable expense to themselves often pursue questions of legality, on principle. Going forward, does this mean every time parties introduce "volumes of contradictory evidence," the Court can state that such evidence has no bearing? Are Courts by nature, adversarial?

Alternatively viewed, rulings require breadth and depth of wisdom to morally decide a fair outcome when faced with contradictory and conflicting, yet compelling evidence.

Extending this thought further, the increasing silencing of the voices of prominent physicians is causing a ripple effect, resulting in other doctors with similar concerns becoming afraid to speak. What happens when physicians can no longer make informed decisions in the best interests of their patients? What about patients with pre-existing medical conditions who cannot take a vaccine and/or persons who can't take vaccines because of an earlier adverse reaction—are these persons also excluded from receiving an organ transplant?

Can it honestly be said that pressure from governments did not contribute to the inclusion of COVID-19 genetic vaccines on the list of required vaccinations for transplant recipients? And are the judges suggesting that those who are vaccinated would not be fully protected by the COVID-19 genetic vaccine? In considering these points and more, the conflicting evidence before the judges could have provided additional insight into Ms. Lewis's deeply held beliefs, leaving the question to be asked why only the government narrative prevailed.

An old cliché comes to mind, that without double standards there would be no standards at all. This begs the question: Were no lessons learned from past mistakes like the Stanley Milgram obedience experiments; the spraying of agent orange on an unsuspecting population; or from the use of thalidomide—a Health Canada approved pharmaceutical designed to alleviate morning sickness in pregnant women, which inevitably caused birth defects in infants? To be clear, rejecting volumes of medical and scientific evidence in preference to promoting the prevailing government narrative appears by all accounts to be prejudicial and discriminatory.

While admittedly, the judiciary is bound by the law and by legal arguments before the court, one must query what happens when the law becomes so narrowly construed that the only recourse for judges in the face of gross injustice is to overcompensate by writing a lengthy, detailed decision.

Justice Dickson in the often-cited Oakes test¹⁴⁹ reaffirmed as essential principles in a free and democratic society, the "accommodation of a wide variety of beliefs." Big M. stated that, "a truly free society is one which can accommodate a wide variety of beliefs, diversity of tastes and pursuits, customs, and codes of conduct."

Whenever the law itself coerces judges against deciding a morally right outcome, simply because Constitutional arguments before the Court can be nullified by legal precedents, how can this support confidence or faith in public and Canadian institutions, including an independent, objective judiciary?

In other words, the Charter was designed for the unremitting protection of individual rights and liberties, which must, by virtue of a nation under the Supremacy of God and rule of law, include the accommodation for a wide variety of thoughts, beliefs, and opinions. Therefore, an individual's right to hold widely held convictions is non-negotiable. Whether one agrees with the proponent of said beliefs or not, the Charter includes the right of citizens to challenge the status quo, which in this case is the legitimacy, safety, and efficacy of a vaccine that is still undergoing clinical trials.

¹⁴⁹ <https://canliiconnects.org/en/summaries/32554>. (accessed 2023)

This accommodation to widely held beliefs is important because the *Charter of Rights and Freedoms* was intended to protect the public from government(s) that elevate the state as the sole arbitrary authority and tutelary power to whom the people are subsequently commanded to be subject, beholden, and obedient. This was the crux of Ms. Lewis's plea before the Court: that the populace, by virtue of their Constitutional rights and freedoms, are not required by law to blindly obey state decrees mandating conformity and compliance.

In coming to terms with the inauguration of the Charter, which ushered in a new era of law and basic human rights, Justice Gerard V. La Forest wrote:

Thus far, our basic rights have by and large been protected by our traditions of liberty and the political understandings that have undergirded the supremacy of Parliament and the legislatures. The courts, acting within the confines of these traditions, have long protected the citizens from arbitrary executive and administrative action by insisting that such action be authorized by law, including a series of principles of fair procedure falling under the rubric of natural justice.¹⁵⁰

Even with the Charter, La Forest reiterates that courts have a long-standing obligatory duty in Canada to protect citizens from arbitrary executive and administrative actions by insisting that such action be authorized by law. Accordingly, the Court's unwillingness to publicly discern contradictory scientific and medical evidence begs another crucial question—who will governments successfully silence next? Will judicial independence be sacrificed on the altar too, at the behest of larger global interests? At the very least, the censoring of scientific and medical literature and peer-reviewed articles should be disconcerting for any person considered intellectual and/or privileged.

Clearly, Canada is at a crossroads between a publicly funded host of bureaucrats, regulatory bodies, agencies, tribunals, committees and a public service collectively exercising and demanding increased control over people's lives versus the inherent, God-given right of Canadian citizens to make personal choices without coercion when governments have clearly overstepped our fundamental human rights and freedoms. As the evidence proves, the societal changes we are witnessing are not accidental.

The Charter, as part of the Canadian Constitution, is still the supreme law of this nation. Therefore, any law inconsistent with it is, to the extent of that inconsistency, of no force and effect. To this latter point, the judiciary has twice failed to investigate the volumes of evidentiary scientific and medical data before the court. Their reasons for this inaction are immaterial. What matters most is that neither court was willing to rigorously investigate the conflicting scientific and medical evidence before them with the intent of finding a reasonable and rational consensus, and offering hope.

¹⁵⁰ Gerard V. LaForest, *The Canadian Charter of Rights and Freedoms: An Overview*. Fredericton, New Brunswick

With this information, readers are encouraged to listen intently to the many brave and courageous physicians and scientists who, in standing for this country and its citizens, have fought hard against the systematic oppression heightened by governments during the COVID pandemic, whose priorities it appears (under the pretext of global experiment and geopolitical transformation) were to make Canada unrecognizable as a democratic society and to make all Canadians vulnerable.

The testimonies (both individually and collectively) in this Report serve as a stark contrast to the destruction of individual rights and freedoms that Canadians have endured over the last three years. They also serve to remind us all, that as truly free people, we require nothing more in the way of independence. The only way in which the Constitution of a free, intelligent, and independent people can be changed at all is by revolution or the consent of the people.¹⁵¹

Each physician follows the order of testimony during the NCI hearings. At the end of each witness testimony, there is an instructive takeaway. The overarching question posed by Dr. Daniel Nagase is this: “Where is the justice?”

Recommendations

To prevent situations such as the one faced by Ms. Sheila Lewis from arising in the future, a comprehensive, balanced, and transparent approach needs to be taken. The Commission makes the following recommendations:

- A. **Effective Communication and Education:** Both healthcare providers and patients must be committed to effectively communicating with each other. Given the grave consequences of any decisions made, each side must be committed to educating themselves with ALL SIDES of the discussion, which also requires listening to and understanding alternative opinions, and a mandatory review of the latest information available. This must be combined with a detailed and comprehensive list of objective reasons for any decision being made. Following policy is not a defence.
- B. **Policy Review and Transparency:** Vaccination policies within healthcare institutions should be regularly reviewed and updated based on evolving scientific evidence. The reasoning behind these policies should be transparent and easily accessible to patients. Policies should be implemented in a non-discriminatory manner and should consider unique circumstances and exceptions.
- C. **Ethics Consultations:** Complex decisions involving individual rights and public health should involve consultation with ethics committees. These independent bodies can provide guidance on balancing the competing values at stake, ensuring that any decisions made are fair and respectful of patients’ rights.

¹⁵¹ William Gilbert, House of Assembly, March 26, 1866

- D. **Legal Framework:** Legislation should clearly outline the rights and responsibilities of patients and healthcare providers in the context of public health interventions like vaccinations. Clear legal guidelines can help prevent potential abuses and ensure that individuals' rights are respected and protected.
- E. **Patient Advocacy:** Encourage and support the role of patient advocates who can provide a voice for patients, ensuring that they understand their rights and are adequately represented in discussions about their healthcare.
- F. **Psychosocial Support:** Provide support services for patients who may be experiencing distress or facing potential discrimination due to their vaccination status.
- G. **Community Engagement:** Engage with communities to understand their concerns and attitudes towards vaccination. This can inform more effective communication strategies and foster trust.
- H. **"Citizen Overview Committee" or "Public Health Review Board":** Establish independent review boards to provide an additional level of oversight and accountability for public health decisions, ensuring that these decisions balance public safety with individual rights. Here's how such a committee might operate:
- **Composition:** The committee should be comprised of diverse representatives from various backgrounds, including but not limited to healthcare, public policy, law, ethics, social work and patient advocacy. Members should include individuals from different age groups, socioeconomic statuses, ethnicities, and professional backgrounds to ensure a broad range of perspectives. Importantly, the committee should include members of the public who can represent the citizens' perspective. Each province should be required to set up these boards.
 - **Operation:** The committee should be convened quickly in response to situations that warrant review. This requires a streamlined protocol for initiating reviews and an efficient method of communication among committee members. Given the urgency of public health decisions, the committee should aim to conclude reviews and deliver a decision within 21 days or less, depending on the situation.
 - **Authority:** The committee should have a clearly defined mandate, including the power to request documents, to call witnesses, and to access relevant information. The decisions of the committee should be advisory but carry significant weight in policy decisions.
 - **Transparency:** The committee's deliberations should be conducted with a high degree of transparency, while respecting necessary privacy laws. Decisions should be publicly accessible, and the reasoning behind each decision should be clearly explained.

- **Training:** Committee members should receive training to equip them with the necessary skills and knowledge to effectively review public health policy decisions. This could include training in healthcare ethics, public health policy, legal aspects of healthcare, and conflict resolution.
- **Review and Accountability:** The operation of the committee should be periodically reviewed to ensure that it is fulfilling its mandate effectively. This could involve surveys of stakeholders, review of decisions, and an analysis of the impact of the committee's recommendations.

The justification for a Citizen Overview Committee for public health decisions hinges upon several key democratic principles: representation, accountability, transparency and promotion of the public good.

- **Representation:** Democracy operates on the principle of "government by the people, for the people." Having decisions that affect public health made by (or under the review of) the very individuals it impacts ensures that a diverse range of perspectives and experiences are considered. This can lead to more balanced and equitable policy outcomes.
- **Accountability:** Public officials, even if unelected, should be accountable to the citizens they serve. A Citizen Overview Committee provides a mechanism for holding these officials accountable for their decisions. This creates a system of checks and balances, ensuring that public health decisions are being made in the best interest of the community.
- **Transparency:** The decision-making process should be transparent to the public. This fosters trust in the system and ensures that policies are implemented fairly and with clear justification. A Citizen Overview Committee, particularly one that makes its findings public, promotes this transparency.
- **Promotion of the Public Good:** Public health decisions should be aimed at promoting the public good. However, the definition of "public good" can vary widely among individuals and communities. A Citizen Overview Committee helps to define the public good in a way that reflects the values and needs of the community.
- **Accessibility and Inclusion:** The committee ensures the voices of marginalized or underrepresented groups are heard in policy-making. This can lead to more inclusive decisions that consider the impacts on all community members.

By basing public health decision-making in democratic principles, a Citizen Overview Committee can ensure that policies are equitable, just, and truly reflective of the community's needs and values. This approach provides a mechanism to challenge and rectify decisions that may be deemed as unduly harmful or unfair, fostering greater trust and cohesion within the community.

This type of committee could help to ensure that public health policy decisions are subject to rigorous and transparent review, thereby increasing public trust and ensuring a more balanced approach to managing public health crises.

Preventing situations like this from arising in the future requires a commitment and concerted effort from healthcare providers, policymakers, and the community. An approach that respects individual rights while protecting public health is essential. It is a vital and delicate balance, but with empathy, transparency, and open dialogue, it is fully achievable.

8. Recommendations

The intention of this section of the report is to provide a convenient and easy reference or listing of all of the recommendations made in Section 7.

Each of the separate subsections contained in Section 7 are reproduced here, but only the recommendations themselves are included. For a detailed discussion of the rationale for the recommendations and the basis in testimony, we refer the reader to Section 7.

8.1. Civil

8.1.1. Canada's Justice System

Recommendations

Based on the witness testimony and the preceding discussion regarding Canada's justice system and its actions during the pandemic, here are 10 recommendations for improvements:

- A. **Uphold the Rule of Law:** Reiterate and reinforce the importance of the rule of law in Canada's justice system, emphasizing that all individuals, including the government, are subject to the law.
- B. **Review and Rebuild Confidence in Courts:** Conduct a thorough review of the Canadian courts' handling of pandemic-related cases and their impact on the rule of law. Rebuild public confidence in the justice system by addressing concerns raised during the pandemic.
- C. **Separation of Powers:** Reassert the separation of powers among the legislative, judicial, and executive branches, ensuring that each branch functions independently within its prescribed role.
- D. **Limit Executive Authority:** Examine and reform the extent of executive authority during emergencies, ensuring proper checks and balances to prevent unelected officials from making far-reaching decisions without accountability or oversight.
- E. **Non-Delegation Doctrine:** Study the implementation of a non-delegation doctrine in Canada, similar to some USA states, to ensure that legislative powers are not unduly delegated to unelected administrative bodies.
- F. **Accountability of Administrative Bodies:** Enact legislation that requires administrative bodies to demonstrate their expertise and rationale for decisions, particularly when those decisions infringe on individual rights.

- G. **Public Health Authorities Oversight:** Establish a clear framework for oversight of public health authorities' decision-making processes during emergencies to balance public health needs with individual rights and freedoms.
- H. **Transparency in College Governance:** Conduct an independent, multidisciplinary inquiry into the governance of professional colleges, especially those governing medical professionals, to ensure transparency, independence, and accountability in their decision-making. The activities of the colleges must adhere to the Charter of Rights and Freedoms.
- I. **Freedom of Expression for Healthcare Professionals:** Safeguard healthcare professionals' freedom of expression, while ensuring that they provide accurate and evidence-based information to the public.
- J. **Protecting the Patient-Practitioner Relationship:** Review the ability of regulators to interfere in the patient-practitioner relationship, ensuring that professional judgment remains independent and guided by the best interests of the patient.

These recommendations aim to address the concerns raised in the discussion and promote a more balanced, accountable, and transparent approach to governance and decision-making during public health emergencies in Canada.

8.1.2. The Response of Canadian Courts

Recommendations

Following are recommendations to improve the situations described under each of the separate headings.

A. Protection of Constitutional Rights

- **Judicial Review:** Reinforce the role of Canadian courts as constitutional guardians by actively engaging in judicial review of government actions, especially those that may infringe upon Canadians' constitutional rights.
- **Robust Assessment:** Develop a rigorous and evidence-based assessment process for cases involving rights violations, ensuring that the burden of proof is not disproportionately placed on individuals. Courts should critically evaluate government actions.

B. Access to Justice and Court Shutdowns

- **Timely Responses:** Implement measures to ensure that court closures, especially during emergencies like the pandemic, do not result in undue delays in access to justice. Develop contingency plans for virtual proceedings, and prioritize cases with immediate consequences.
- **Independent Assessment:** Courts should independently assess the impact of public health measures on their ability to provide justice. Review the necessity and effectiveness of measures like mask requirements and vaccine mandates in a courtroom setting to ensure fair hearings.
- **Public Engagement:** Involve legal experts, practitioners, and the public in discussions about maintaining access to justice during crises.

C. Judicial Deference to the Government

- **Balanced Review:** Encourage a balanced and impartial review process for government policies and actions, rather than automatically deferring to the government's position. The burden of proof should not unfairly rest on individuals or groups challenging government decisions.
- **Comparative Analysis:** Consider international precedents, such as the approach taken by courts in the USA, where pandemic measures were subject to rigorous legal scrutiny. Analyze and learn from the experiences of other jurisdictions when addressing similar issues.
- **Transparency and Accountability:** Promote transparency in court decisions, ensuring they include clear reasoning and explanations for rulings, especially in cases that involve significant rights infringements. This helps build public trust and understanding.

D. Crisis of Confidence in the Judicial System

- **Public Education:** Launch educational initiatives to inform the public about the role of courts in safeguarding constitutional rights, especially during emergencies. Promote an understanding of the court's duty to question government actions and protect citizens.
- **Judicial Independence:** Emphasize the importance of judicial independence in preserving the rule of law and protecting individual rights. Judges should be selected and trained to have confidence in their role as independent arbiters of justice.
- **Public Engagement:** Create opportunities for the public to engage with the judicial system, such as public consultations or information campaigns. This can help demystify the legal process and foster public participation.

These recommendations aim to strengthen the Canadian judicial system's ability to protect citizens' rights, maintain access to justice, and enhance public trust during times of crisis. Implementing these measures would help ensure that courts fulfil their dual role of enforcing laws, while safeguarding constitutional rights effectively.

E. The Standard of Review in Judicial Review Applications

The *Vavilov* standard of review that pays excessive deference to the decisions of unelected administrative officials prevented Canadians from meaningful access to justice and review of their cases. This was particularly egregious where Canadians were fighting for their rights to bodily autonomy, to work, and to participate as free citizens in society.

The Commission recommends that:

- Legislation be enacted to amend the standard of review in cases where the rights of citizens have been affected. This could be implemented in the applicable *Interpretation Acts* and in the applicable *Bills of Rights*.
- The burden of proof should be placed on the administrative body to demonstrate reasonableness in cases where the rights of citizens are affected.
- Statutory protections should be removed for the decisions of health officers to the extent that they cause harm to persons.

F. Judicial Notice

- The Commission recommends that legislation be enacted to set strict parameters on the use of judicial notice by courts. Judicial notice should never be allowed in respect of evidence that is being challenged. The normal rules of evidence require a party who asserts a fact to prove that fact. This rule underlies the rule of law and should not be relaxed, even in times of emergency.

G. Mootness

- **Legislate Parameters:** Consider legislation to modify or limit the doctrine of mootness, especially when cases involve violations of Charter rights. This could include prohibiting mootness in such cases.
- **Timely Hearings:** Address the issue of slow-moving justice by implementing measures to expedite hearings, ensuring that cases are heard before measures or mandates are suspended or removed.

H. Judicial Independence

- **Diverse Selection Committee:** Ensure that the judicial selection committee includes members from various political parties and lay citizens, not just the government, to minimize political bias.
- **Transparent Appointment Process:** Implement a more transparent judicial appointment process, including public debates and hearings, especially for appellate judges, to reduce political bias and enhance fairness.

I. Judicial Appointments Versus Elections

- **Independent Review Panel:** Establish an independent panel or inquiry composed of experts, academics, and experienced practitioners to review the judicial appointment process. Evaluate whether reforms, such as introducing elections at certain levels, are necessary.
- **Balancing Appointments:** Ensure that appointments reflect a balance of judicial independence and government accountability.

J. Federal Appointments of Provincial Judges

- **Provincial Appointment Authority:** Consider devolving the appointment of provincial judges to the provinces, while maintaining appropriate selection processes and advisory committees to safeguard quality and independence.

K. The Judiciary Cannot Act in Tandem with the Government Prosecution Service

- **Enhance Judicial Independence:** Promote and protect the independence of the judiciary, particularly in cases involving government actions, to ensure that citizens have faith in the fairness of the justice system.
- **Resource Allocation:** Allocate resources to support citizens in cases involving violations of Charter rights and freedoms, ensuring they have access to legal representation.

L. Societal Pressure on the Judiciary

- **Impartial Selection:** Emphasize the importance of selecting judges who demonstrate the ability to remain impartial, open-minded, and fair during times of societal pressure.
- **Non-Partisan Selection:** Promote a non-partisan selection process aimed at minimizing political influence when appointing judges who possess strong principles to uphold laws as they are written, while also emphasizing fairness.

M. The Role of Chief Justices

- **Review Case-Assignment Practices:** Encourage courts to review their case-assignment practices to ensure fairness and balance in the decisions made, particularly regarding Charter rights.

N. Fear Felt by Legal Practitioners

- **Support Legal Professionals:** Ensure that legal professionals can perform their roles in the justice system without fear of career repercussions or threats to their safety.

These recommendations aim to uphold the principles of justice, fairness, and the rule of law, while addressing the specific challenges outlined in each section. Implementing them may require legislative changes, policy reforms, and a commitment to preserving judicial independence and protecting the legal profession's vital role in society.

8.1.3. Labour Law and the Failure of Unions

Recommendations

Based on the testimony concerning labour law and the challenges faced by union members during the pandemic, these recommendations were formulated to address these issues:

- A. **Legislation to Protect Union Members:** The Commission recommends that legislation be adopted to include ensuring the protection of union members where the member asserts
 - that Charter rights have been violated as a result of actions of the employer or the union, and
 - a grievance against his or her employer that the union fails to, or refuses to, defend.
- B. **Review and Strengthen Labour Laws:** The government should review labour laws to ensure that they provide adequate protection to both unionized and non-unionized employees during health emergencies like the pandemic. This should include mechanisms for addressing workplace issues related to mandates and safety concerns.
- C. **Enhance Union Accountability:** Labour laws should be amended to hold unions more accountable for representing their members effectively. This could involve regular assessments of a union's performance in advocating for its members' rights during crises. Unions should be required to demonstrate that they are acting in the best interests of all of their members.
- D. **Ensure Union Transparency:** Unions should be transparent about their decision-making processes and actions during crises. Members have a right to know how their union is advocating for them. Transparency can help build trust between members and their unions.
- E. **Access to Legal Recourse:** Labour laws should be revised to allow union members to have access to legal recourse in cases where their union fails to adequately represent their interests. This could include the ability to bring direct actions against employers under certain circumstances, such as when the union refuses to take up their case.
- F. **Legal Aid for Union Members:** Governments should consider providing legal aid or support to union members who need to take legal action against their union or employer. This would help level the playing field for employees who find themselves in such situations.
- G. **Mediation and Dispute Resolution:** Establish mediation or dispute resolution mechanisms specifically tailored to labour disputes arising from health emergencies. This can provide a more efficient and cost-effective way to address employer-employee issues than lengthy court battles. Reasons for decisions must be made public.
- H. **Educate Union Members:** Unions should play a proactive role in educating their members about their rights and the grievance process. Well-informed members are better equipped to hold their unions accountable and make informed decisions during crises.

- I. **Encourage Collaboration:** Governments, unions, and employers should work together to develop clear guidelines and protocols for dealing with workplace issues during health emergencies. Collaboration can help prevent conflicts and ensure the best interests of workers are protected.
- J. **Whistleblower Protections:** Strengthen protections for whistleblowers within unions and workplaces. This can encourage employees to come forward with concerns without fear of retaliation.
- K. **Public Inquiry:** Consider launching a public inquiry into the specific challenges faced by unionized employees during the pandemic. This can help identify systemic issues and inform policy changes.

These recommendations aim to address the shortcomings in labour laws and union representation highlighted during the pandemic. They seek to strike a balance between protecting individual employee rights and maintaining the integrity of collective bargaining agreements.

8.1.4. The Constitution

Recommendations

The Commission recommends that legislation be enacted prohibiting employers from imposing vaccine mandates on employees.

- A. **Canada should establish** an independent review of its judicial appointment process.
- B. **The federal and provincial courts** should conduct a national inquiry into their response to pandemic measures, including a review of:
 - a) What role did the court play in protecting the rights of individuals?
 - b) What role should the court play when a government imposes vast rights-violating measures?
 - c) Should the government have the ability to impose pandemic measures on courts and the judiciary?
 - d) What level of independence do the courts have over their own process in implementing publicly recommended or ordered measures?
 - e) Should guidelines or best practices be adopted for case assignment, particularly in cases that involve alleged violations of Charter rights?
- C. **Judges in provincial courts** should be appointed by provincial governments and not the federal government. This recommendation is subject to review as part of the overall review of the judicial appointment process.
- D. **The judicial selection** process should involve a review by a panel that involves a wide array of citizens and legal experts with different political views and backgrounds. Recommendations for appointments should be made public.
- E. **Canada should establish a fund** to pay for legal services for Canadian citizens who bring cases against the government for a violation of Charter rights or who are defending prosecutions that violate Charter rights. Further study could be undertaken to determine the structure and principles governing the fund. Some fundamental principles should include:
 - a) The fund is governed/overseen by a board which has equal representation from constitutional scholars, lawyers, government representatives, academics, and citizens.
- F. **Canada and the provinces** should legislate parameters for mootness, including a prohibition on mootness when a case involves a violation of the Charter rights of an individual.
- G. **An independent inquiry should** be conducted into the response of the medical colleges in each province, including a review of

- a) What role did the college play in protecting the rights of its members?
- b) What role should the college play when a government makes recommendations for medical practice?
- c) Should there be specific limits placed on the powers of the colleges?
- d) What regulations can be put in place to assure that the colleges adhere to the *Canadian Charter of Rights and Freedoms*?

8.1.5. Undermining Democratic Institutions

Recommendations

- A. **Informed Consent:** Political parties should enshrine the principle of Informed Consent into party rules and constitutions, guaranteeing each member the freedom to make their own decision and to be free from coercion or mandates to receive a medical treatment.
- B. **Protection of Elected Representatives' Independence:** The parties should adopt regulations to protect the independence of elected representatives so that elected officials are able to express their views and concerns freely without fear of retribution from their own political parties.
- C. **Whistleblower Protections:** Clear whistleblower protections for politicians and party members who raise concerns about government actions or policies should be established, with protections extending to all levels of government and including all elected officials at all levels of government.
- D. **Transparency and Accountability:** Decisions by political parties, municipalities, and school boards should be transparent. Parties should be required to provide clear reasons for any actions taken against their members. This includes publicizing party decisions and disciplinary actions.
- E. **Strengthen Party Democracy:** Encourage internal party democracy by allowing members to openly debate and express dissenting opinions on significant issues, especially during crises like a pandemic.
- F. **Reform Legislative Procedures:** Review and reform legislative procedures, particularly during emergencies, to ensure that there is sufficient time for members to review and debate bills. Emergency legislation should not bypass the regular legislative process.
- G. **Public Consultation and Accountability:** Ensure that significant decisions related to public health measures and emergencies are subject to public consultation and accountability. Decisions should be based on a transparent and evidence-based approach.
- H. **Protection of Parliamentary Sessions:** Protect the integrity of parliamentary sessions by maintaining regular working hours and ensuring that important votes are conducted when a significant number of members are present.
- I. **Review Emergency Powers:** Review and assess the powers granted to governments during emergencies, such as those under the *Emergencies Act*, to ensure that they are not overly broad and they respect democratic principles. Consider legal mechanisms for parliamentary oversight.

- J. **Education on Legislative Processes:** Educate elected representatives and the public about legislative processes and the implications of emergency measures. This includes training for politicians on their roles and responsibilities during crises.
- K. **Independent Oversight:** Consider the establishment of an independent oversight body or commission to monitor and evaluate government actions during emergencies, ensuring that democratic principles are upheld.
- L. **Protection of Opposition Rights:** Strengthen the rights and protections of opposition parties to allow them to effectively scrutinize government actions, especially during emergencies. This includes timely access to information and the ability to hold the government accountable.
- M. **Public Inquiry:** Consider launching a public inquiry to investigate the undermining of democratic institutions during the pandemic. The findings of such an inquiry can inform necessary reforms.

These recommendations aim to safeguard democratic institutions, protect the independence of elected representatives, and ensure that decision-making during emergencies is transparent, accountable, and based on democratic principles.

8.1.6. International Law

Recommendations

Based on the information provided in the testimony and other considerations, here are some recommendations on what Canada could do concerning international laws and treaties, especially in the context of the COVID-19 pandemic and potential future health crises:

- A. **Pandemic Convention:**¹⁵² The NCI recommends that Canada register immediate reservation against the Pandemic Convention and the amendments to the International Health Regulations once they are put forth by the WHO to allow time for proper consideration of the initiatives and their potential impact on Canada. At the same time, Canada should conduct a public inquiry and consultation into the benefits and risks of both its current obligations under the WHO, and the proposed Pandemic Convention and proposed amendments to the *International Health Regulations*.
- B. **Review and Comply with International Human Rights Law:** Canada should thoroughly review its COVID-19 response measures in light of international human rights law. It should ensure that measures taken during the pandemic—such as vaccine measures, lockdowns, and restrictions on movement—consider international human rights standards. If any violations are identified, corrective actions should be taken.
- C. **Strengthen Informed Consent:** Canada should reinforce the importance of Informed Consent, especially in the context of medical treatments like vaccines. It should ensure that individuals have access to comprehensive information about medical treatments, including potential risks and benefits, and have the right to refuse treatment without coercion.
- D. **Enhance Vaccine Injury Compensation:** Canada should assess and improve its vaccine injury compensation program to make it more accessible to those who have suffered harm due to vaccinations. This should include a transparent, streamlined claims process, and increased transparency.
- E. **Conduct a Comprehensive Inquiry:** Canada should initiate a comprehensive and independent public inquiry into its pandemic response measures. This inquiry should have the authority to compel testimony and access relevant information. It should identify responsible parties for any human rights violations and recommend appropriate remedies.
- F. **Monitor WHO Developments Closely:** Canada should closely monitor and participate in negotiations related to the World Health Organization's Pandemic Convention and amendments to the *International Health Regulations*. It should advocate for transparency, respect for national sovereignty, and the protection of individual rights in these international agreements.

¹⁵² https://apps.who.int/gb/inb/pdf_files/inb3/A_INB3_3-en.pdf (accessed 2023)

- G. **Protect National Sovereignty:** Canada should maintain its sovereignty over public health decisions. While international coordination can be valuable, it should not infringe on Canada's ability to tailor its responses to its unique circumstances. Any international agreements should be voluntary and non-binding.
- H. **Balance Health and Human Rights:** Canada should strike a balance between public health measures and human rights. While protecting public health is crucial, measures taken during health emergencies should be lawful, legitimate, necessary, proportional, and temporary. Canada should avoid disproportionately infringing on human rights.
- I. **Promote Transparency and Debate:** Canada should ensure that information relevant to pandemic measures is disclosed to the public, allowing for informed debate and discussion. Public health measures should be debated openly in democratic forums, allowing for diverse perspectives to be considered.
- J. **Provide Redress for Victims:** Canada should ensure that victims of human rights violations, including those resulting from pandemic measures, have access to effective remedies. This includes compensation for losses and harm suffered due to these violations.
- K. **Engage with Civil Society:** Canada should engage with civil liberties organizations, human rights advocates, medical professionals, and other relevant stakeholders, including the public, to ensure that responses to health crises are well-informed and respectful of human rights.

These recommendations are aimed at ensuring that Canada's responses to health emergencies uphold international human rights standards, protect individual freedoms, and safeguard national sovereignty, while promoting public health. It's important for Canada to strike a balance between these critical considerations in its domestic and international actions.

8.1.7. Coercion Does Not Equal Consent

Recommendations

The report highlights various instances of coercion and its impact on individuals' decisions regarding COVID-19 vaccination. To address these issues and mitigate the failures of the system, here are eight recommendations:

A. Protect Individual Rights

- **Legislation Against Coercion:** Introduce legislation that explicitly prohibits coercive tactics, whether by employers, educational institutions, or any other entity, in relation to medical treatments, such as vaccinations. Ensure that individuals have the freedom to make informed choices without undue pressure.

B. Transparency and Accountability

- **Require Organizations to Provide Legal Basis of Mandates Imposed:** Conduct a comprehensive review of the legal opinions obtained by employers who implemented vaccine mandates. Ensure these opinions align with fundamental principles of consent and individual rights. Publish these legal opinions for public scrutiny.

C. Access to Education and Work

- **Online Learning Options:** Ensure that individuals who choose not to get vaccinated have access to online education, especially in institutes of higher education, to avoid coercion through denial of educational opportunities.
- **Job Protection:** Enact legislation to protect employment insurance benefits for individuals who choose not to get vaccinated. Losing employment due to vaccine refusal should not lead to financial hardship.

D. Informed Decision-Making

- **Factual Communication:** Government and public health authorities should communicate drug information transparently and factually. Encourage vaccination through education, emphasizing the benefits of vaccination rather than resorting to coercion.
- **Accurate Data Reporting:** Ensure accurate reporting of COVID-19 data, including vaccine effectiveness, and avoid any manipulation or misrepresentation that may lead to coercion.

E. Address Vulnerabilities

- **Support Vulnerable Groups:** Recognize and support vulnerable populations, such as those with addiction issues, with strategies that do not resort to coercion. Ensure they have access to essential services and support networks.

F. Independent Oversight

- **Ombudsman or Commission:** Establish an independent body, like an ombudsman or commission, to investigate cases of coercion and violations of individual rights related to vaccination. Provide a channel for individuals to report coercion and seek redress.

G. Avoid Political Exploitation

- **Ethical Political Discourse:** Encourage ethical political discourse around public health measures, including vaccinations. Ensure that political campaigns do not exploit vaccination issues or use coercion for political gain.

H. Rebuild Trust

- **Public Apology:** Governments should issue public apologies to individuals who felt coerced into vaccination and acknowledge the harms caused by these coercive measures. Rebuilding trust should be a priority.

These recommendations aim to strike a balance between promoting vaccination for public health and respecting individual rights and choices. They seek to prevent coercion, protect individual freedoms, and rebuild trust between the government and its citizens, especially in the context of medical treatments like vaccines.

8.1.8. Emergency Planning & Plan Execution

Recommendations

Based on the totality of the witness testimony, the following recommendations are presented:

- A. **Emergency measures organizations** (EMOs) must be in charge of planning, implementation, and recovery from any and all “emergencies.”
- B. **Public health officials** should never be put in charge of emergency response. They should be a critical component of the planning but should never be charged with running a response.
- C. **Emergency Management Act** powers must supersede the powers of the various public health officers. The public health officers must come under the authority of the emergency management agencies.
- D. **Elected officials** must remain in charge of all emergency measures.
- E. **Follow existing emergency plans.**
- F. **Make sure all emergency plans** are publicized and the contents well known by stakeholders in all affected areas.
- G. **Require mandatory training** of emergency response personnel.
- H. **Follow all emergency measures** legislation in each jurisdiction.
- I. **Emergency planning** must be driven from the bottom up.
- J. **Federal government should not** be leading emergency response. They should be limited to supporting the requirements of the local authorities.
- K. **Media and government cannot be allowed to collude** to present a pre-approved information campaign.
- L. **The consultation process** should involve the public, and the comprehensive plan to tackle the pandemic emergency should be regularly, consistently, and promptly communicated to the public.
- M. **In any future emergencies**, the government should focus on mitigating public fear and anxiety rather than resorting to fear and terror as a means to secure compliance.
- N. **Require mandatory cost-benefit analysis** of any and all emergency measures considered and/or imposed.
- O. **Require transparency in decision-making.**
- P. **Support open public discourse**, without censorship.

- Q. **Require a mandatory recovery plan** to fix the collateral damage done by the pandemic measures.
- R. **Require a mitigation plan** for all societal damage done by the pandemic measures.
- S. **Establish regulations to ensure** that the elected officials are never sidelined or abrogate their powers to unelected bureaucrats.
- T. **Commission an independent study** which is required to include members of the emergency measures organizations from across Canada.
- U. **Rebuild emergency response** organizations across Canada.

8.1.9. COVID-19 Pandemic Mandates in the Workplace

Recommendations

We recommend the following:

- A. **Immediate development of a judicial panel**, overseen by citizens, with the responsibility to investigate the human rights violations that were committed by both governments and private corporations during the pandemic.
- B. **Develop and implement** a constitutional and international law education course for all judiciary positions across Canada. The intent is to educate judges and Crown attorneys as to their responsibilities under the constitution and international treaties to which Canada is a signatory nation.
- C. **Carry out immediate judicial reviews** of all pandemic-related court cases that were denied on the basis of mootness or judicial notice.

8.1.10. Policing During COVID-19 Pandemic: Balancing Authority and Citizens' Rights

Recommendations

- A. **Independent Judicial Investigations:** Conduct independent and transparent judicial investigations into allegations of illegal activities by law enforcement officers during the pandemic, ensuring accountability and adherence to the rule of law. This investigation must have the power to enforce subpoenas to obtain witness testimony and critical documents.
- B. **Review and Revise Policing Protocols:** Collaborate with law enforcement agencies to review and revise their protocols and guidelines for enforcing government mandates, with a focus on respecting individual rights and freedoms while safeguarding public health.
- C. **Enhance Training and Education:** Provide comprehensive training on handling public health crises to law enforcement officers, emphasizing respect for human rights, de-escalation techniques, and community engagement.
- D. **Public Awareness Campaigns:** Launch public awareness campaigns to educate citizens about their rights and responsibilities during health emergencies, promoting dialogue and cooperation between the police and the community.
- E. **Community Policing Initiatives:** Promote community policing initiatives that foster positive relationships between law enforcement agencies and the communities they serve, enhancing trust and cooperation.
- F. **Clear Accountability Mechanisms:** Establish clear mechanisms for holding law enforcement agencies accountable for their actions during the pandemic, ensuring transparency and fairness in the disciplinary process.
- G. **Civilian Oversight:** Strengthen civilian oversight bodies to independently monitor police conduct during public health crises, ensuring adherence to legal and ethical standards.
- H. **Regular Reporting and Transparency:** Mandate law enforcement agencies to regularly report on their activities during health emergencies, providing transparency and accountability to the public, while respecting privacy and security concerns.

By implementing these recommendations, authorities can strike a balance between maintaining public safety during health crises and upholding the fundamental rights and freedoms of citizens, ensuring a more just and equitable response to future pandemics.

8.2. Social Impacts

8.2.1. Neglect and Isolation of Seniors in Canada Amidst COVID-19 Measures

Recommendations

- A. **To alleviate the neglect and isolation** faced by seniors, it is crucial for the federal, provincial and territorial governments, communities, and individuals to take proactive steps. First and foremost, healthcare systems should prioritize healthcare needs of seniors, ensuring that seniors have access to essential medical care and support services.
- B. **Moreover, efforts should be made to enhance** the social connections of seniors. This can include facilitating safe visitation policies in long-term-care homes, promoting intergenerational programs, and encouraging community organizations to provide support and companionship to isolated seniors. Volunteering initiatives, teleconferencing platforms, and community outreach programs can help bridge the gap between seniors and their support networks.
- C. **Financial assistance programs should be expanded** to specifically address the needs of seniors who have been adversely affected by the pandemic mandates. Providing targeted financial support, job training, and re-employment opportunities can help seniors regain their financial stability and alleviate some of the stress they face.
- D. **Bridging the digital divide among seniors** should be a priority. Initiatives aimed at enhancing digital literacy and providing seniors with the necessary tools and resources to access online services can empower them to connect with their loved ones, access information, and engage in virtual social activities.
- E. **It is imperative that a judicial investigation** be carried out immediately to determine if any criminal wrongdoing was perpetrated on our senior populations during the pandemic. Witness statements from staff, seniors, and family must be immediately obtained and archived, to be used as evidence in any future prosecutions.
- F. **An investigation should be conducted** into how the various regulatory agencies abandoned their roles of protectors of seniors and never appeared to visit facilities to check on the operation and level of care being given out.
- G. **Those caregivers who simply followed** the orders given to them to isolate and dehumanize our seniors in their care must be re-educated or removed from the system and not allowed to continue to provide "care" to seniors.
- H. **Like other professions**, caregivers and administrators working with seniors should be mandated to participate in annual professional development and training programs

8.2.2. The Effects of Sustained Propaganda and Terror

Recommendations

Preventing governments from using propaganda and terror against their people requires a multifaceted approach that involves promoting accountability, safeguarding human rights, and fostering democratic institutions. Here are some key strategies:

- A. **Establish and uphold a robust human rights framework** that protects the fundamental rights and freedoms of individuals. This includes enshrining indelible human rights in constitutions, implementing international human rights conventions, and ensuring an independent judiciary to safeguard citizens' rights.
- B. **Foster a strong rule of law** by ensuring that government officials and security forces are held accountable for their actions. This includes establishing independent oversight bodies, conducting transparent investigations into allegations of human rights abuses, and prosecuting those responsible for violations.
- C. **Promote freedom of expression** and an independent media that can serve as a watchdog to hold governments accountable. Protect journalists, bloggers, and activists from harassment, censorship, financial repercussions, and violence, and ensure their ability to report on government actions without fear of reprisal.
- D. **Support and empower civil society organizations**, including human rights groups, advocacy organizations, and community-based initiatives. These organizations play a crucial role in monitoring government actions, advocating for human rights, and providing support to victims of abuse.
- E. **Promote and strengthen democratic governance** by ensuring free and fair elections, transparent electoral processes, and respect for the will of the people. This includes promoting political participation, guaranteeing the independence of electoral bodies, and providing opportunities for citizens to engage in decision-making processes.
- F. **Leverage international cooperation** and pressure to address human rights violations. Encourage diplomatic efforts, international organizations, and regional mechanisms to hold governments accountable for their actions, and impose targeted sanctions or other measures against those responsible for terrorizing their own populations.
- G. **Support international human rights mechanisms**, and provide them with the necessary resources and authority to investigate and address human rights violations perpetrated by governments. Collaborate with these mechanisms to bring attention to abuses and advocate for meaningful action.

H. **Promote human rights education** and awareness among citizens, government officials, and security forces. Encourage a culture of respect for human rights, tolerance, and non-violence through educational programs, public campaigns, and training initiatives.

Preventing governments from using terror against their people requires ongoing commitment and vigilance. It is a collective effort that involves the active participation of citizens, civil society, international actors, and the government itself. By upholding human rights, promoting accountability, and fostering democratic values, societies can strive towards preventing and addressing government-led terror.

8.2.3. Social Effects of Mandates on Canadian Institutions

Recommendations

The process of restoring trust in Canadian institutions is a very difficult and complex one. What was destroyed in a very short period of time will take a generation to restore, and only if these institutions make a concerted effort to restore that trust through their day-to-day actions.

Momentary publicity campaigns and propaganda blitzes will not serve either the institutions or the people of Canada's best interests.

If these concerns are not addressed in a forthright manner, the very existence of Canada as a free and democratic nation is at risk.

The commission recommend the following:

- A. **It is not an option** to take a "business as usual" posture and simply carry on as if nothing happened. Institutions must recognize and publicly admit their culpability in what was perpetrated on Canadians and, if appropriate, must face criminal and civil penalties for their actions.
- B. **Transparency and Accountability:** Information related to the institutions' actions during the COVID-19 pandemic must be made publicly available, creating a culture of transparency and accountability within public institutions.
- C. **Ensure that decision-making processes** are open and accessible to the public, and that the actions and performance of public officials are subject to scrutiny.
- D. **Establish mechanisms for oversight**, such as independent audits or ombudsman offices, to hold institutions accountable for their actions.
- E. **Ethical Conduct:** Promote and enforce high ethical standards within public institutions. Implement robust codes of conduct that govern the behaviour and decisions of public officials and employees. Provide ethics training to ensure that individuals understand their responsibilities and the expectations placed upon them.
- F. **Effective Governance:** Strengthen governance structures and mechanisms to ensure efficient and effective functioning of public institutions.
- G. **Enhance the professionalism** and expertise of public servants through training and development programs. Foster a merit-based culture that rewards competence and performance.

- H. **Public Engagement:** Actively engage with the public and involve stakeholders in decision-making processes. Seek public input through consultations, town hall meetings, surveys, and other participatory mechanisms. Demonstrate that public institutions are responsive to the needs and concerns of the people they serve.
- I. **Communication and Information Dissemination:** Establish clear and consistent communication channels to keep the public informed about the work and activities of public institutions. Provide timely and accurate information, particularly in times of crisis or controversy. Use plain language and accessible formats to ensure that information is easily understandable by all segments of society.
- J. **Collaboration and Partnerships:** Foster collaboration and partnerships with civil society organizations, academia, and other stakeholders. Engage in meaningful dialogue and involve external expertise in policy development and implementation. Collaborative approaches can help build trust and ensure that institutions benefit from diverse perspectives.
- K. **Learn from Mistakes:** Acknowledge and learn from past mistakes or failures. Publicly address any instances of wrongdoing or misconduct, and take corrective actions. Demonstrate a commitment to learning, improvement, and the prevention of similar issues in the future.
- L. **Long-Term Vision and Consistency:** Develop and communicate a clear long-term vision for the institution's role and purpose. Demonstrate consistency in actions and decision-making, avoiding unnecessary reversals or abrupt changes. Consistency helps build trust by showing that institutions are reliable, accountable, and predictable.
- M. **Independent Oversight and Checks and Balances:** Strengthen the role of independent oversight bodies, such as auditors general, ombudsman offices, or anti-corruption commissions. These bodies can provide an additional layer of accountability and help prevent abuses of power or corruption.

Rebuilding trust in public institutions is a long-term endeavour that requires sustained commitment and effort. By implementing these strategies, institutions can work towards restoring faith in their integrity, competence, and ability to serve the public interest.

8.2.4. The Impact of COVID-19 Measures on the Military

Recommendations

The fact that a citizen has put on a uniform and vowed to serve and protect Canada should not strip them of all rights and leave them with no legal avenues. The Commission makes the following recommendations:

- A. **Grievances by service members** should be outside of their chain of command and to an independent reviewer, such as the Office of Inspector General.
- B. **Whistleblower legislation should be strengthened** to allow soldiers to report on abuses within their chain of command without fear of discipline or retaliation.
- C. **Comprehensive healthcare should be provided** to all injured service members, for as long as necessary.
- D. **An apology** should be issued for implementing the vaccine mandate.
- E. **Where a medical product is provided** to members of the Armed Forces, mandatory monitoring and reporting of injuries and sickness should be performed.

8.2.5. Impact of COVID-19 Measures on the Education System

Recommendations

- A. **Avoid Prolonged School Closures:** Recognize that extended school closures should not be imposed in the future, as they have profound and far-reaching negative impacts on the socialization and education of children.
- B. **Prioritize In-Person Learning:** Ensure that in-person learning remains the primary mode of education, even during public health crises. Remote learning should only be used as a last resort and for a limited duration, and in conjunction with parental consultation.
- C. **Data-Informed Decision-Making:** Base any decisions related to school closures on comprehensive and up-to-date data, considering the specific needs and circumstances of each region or community.
- D. **Support Vulnerable Populations:** Develop targeted support systems for vulnerable students, including those with disabilities and students from low-income backgrounds. Recognize that these populations may be at higher risk than the general student population and provide specific measures to protect them. Do not impose these measures on the entire student population.
- E. **Enhance Mental Health Services:** Invest in mental health support services within schools to help students cope with the emotional toll of the pandemic and the challenges of social isolation.
- F. **Prioritize Social and Emotional Learning:** Incorporate social and emotional learning into the curriculum to help students build resilience and emotional intelligence, especially in the aftermath of the COVID-19 pandemic.
- G. **Maintain Transparent Communication:** Keep parents, students, and the community informed with clear and transparent communication regarding the reasons behind any decisions related to school closures or restrictions.
- H. **Plan for Crisis Scenarios:** Develop contingency plans that prioritize education and socialization, while maintaining health and safety during future crises.
- I. **Learn from Past Mistakes:** Conduct a comprehensive review of the government's response to the COVID-19 pandemic in education, and use the lessons learned to shape future policies that prioritize the wellbeing and education of our children.

By implementing these recommendations, we can work towards a future where our education system remains resilient in the face of emergencies, ensuring that our children's socialization and development are protected and nurtured.

8.2.6. The Restructuring of Traditional Educational Institutions Due to COVID-19 Measures

Recommendations

- A. **As publicly funded institutions**, both universities and colleges must adhere to the law of neutrality before demanding compliance for policies that potentially may not be legally enforceable.
- B. **In all publicly funded institutions**, whereby the mission includes scholarly inquiry and academic freedom as institutional tenets, there must be room for dissenting voices, debate, dialogue, and, most particularly, policy revisions when the evidence points to a change in the data and statistics that led to restrictive policies initially.
- C. **There must be a cost-benefit analysis** of any policy that leads to school closures, and discussions must include the public and education stakeholders.
- D. **In the interest of academic freedom and integrity**, post-secondary institutions and faculty should be able to ask pointed questions free from any fear of repercussions.
- E. **Investigate scientific findings** that contradict the narrative, and provide internal grant funding to ensure the evidence relied upon by governments and health authorities is accurate.
- F. **Post-secondary institutions** should not be allowed to impose additional mandates or extend mandates beyond that imposed by the government regulators. During the COVID-19 pandemic, once the initial two-week to flatten the curve period had concluded, post-secondary institutions should have lifted all policy restrictions. Similarly, when the emergency orders were lifted, post-secondary COVID policies should also have been terminated.
- G. **Offer an array of learning platforms** and alternative arrangements for academic study, including in-person classes, and online, distance, and hybrid options.
- H. **Ensure all students have an opportunity** to reach their potential without discrimination or bias due to vaccination status.
- I. **Any faculty or staff member who suffered a job loss**, was terminated, or was placed on unpaid leave and subsequently barred from campus should be immediately restored to good standing. Additionally, any negative or potentially stigmatizing comments regarding the employee's COVID stance should be removed forthwith from that employee's files. Pensions should be fully restored to pre-COVID status.
- J. **Post-secondary institutions should focus** on student achievement and not the removal of students from programs for not being compliant with newly established vaccination policies. No student should lose academic standing or lose successfully completed academic credits for non-compliance to a policy.

- K. **Students in residence should have opportunities** to socialize with other residents under the auspices of cohorts. Students should never be restricted to their rooms.
- L. **Reimburse students who paid for residence** in good faith but because of a change in COVID policies combined with an individual's unvaccinated status, were forced to vacate the premises.
- M. **Accommodation in accordance with the *Charter of Rights and Freedoms*** must be made. It is a constitutionally protected right for all persons. Therefore, faculty, staff, and students requesting accommodation should not only have their concerns heard but taken seriously when blanket COVID policies are initiated. This includes accepting medical, religious, and personal exemptions. It also means consideration for other circumstances, including personal choice, convictions, conscience, deeply held beliefs, or health risks (for example, previous adverse reaction to a vaccine).
- N. **Health policies should provide allowances** for bodily autonomy and personal choices. Employees and contractors—including faculty members, staff, and students—should not be required to disclose their medical information to obtain an allowance.
- O. **Policies that lead to the segregation** of a specific group of students is discriminatory. Therefore, any policy promoting segregation must be immediately removed.
- P. **Post-secondary institutions** should have to provide justification in writing for responding to government mandates with inflexible approaches.
- Q. **Any policy must be subject to revision** when it becomes apparent that restrictions are not necessary. For example, there should be a mandatory review process every 30 days.
- R. **Meet with stakeholder groups—including faculty**, staff, and students—who made different choices regarding vaccines and COVID policies.
- S. **Eliminate all policies and procedures** that directly violate human rights legislation, including denial of a service or services.
- T. **Employment loss and/or disciplinary action** (including unpaid leave) must follow the same human rights procedures for all faculty and staff. Vaccination status should not be a sufficient excuse or justification for applying union procedures differently.
- U. **A union's mission is to protect and defend the rights** of staff and faculty across campus. The union does not have the right to arbitrarily deny unvaccinated staff and faculty the right to file a grievance and to have the grievance heard.
- V. **Employees with long-standing service** should not suffer a loss of pension and other benefits because of personal health choices.

- W. **Third-bucket youth** who were not educated during the pandemic need to be found and their circumstances addressed so they can be educated and subsequently prepared for the future.
- X. **Schools should not be closed** for periods of time exceeding one week in duration.
- Y. **Virtual schooling is not advantageous** to youth experiencing learning disabilities, having language barriers, or living in an unsafe or abusive situation. These additional barriers to learning need to be taken into consideration.
- Z. **Young, healthy people should not be shut out** of schools for as long as they were. Studies as early as May 2020 showed that suicides, eating disorders, opioid deaths, and substance abuse were skyrocketing among young people. Students should have been allowed to go back to in-person learning with no more interruptions.
- AA. **Special needs children and adults** require additional guidance and direction. Therefore, one-size-fits-all blanket policies need to be reconsidered.
- BB. **Public shaming and labelling of citizens** by government officials contributes to lawlessness. Government officials and those in positions of authority need to be held to a higher standard. At the same time, governments should not be permitted to blatantly work against their populations.
- CC. **Educators need to publicly defend** the precautionary principle for all children and youth.

8.2.7. COVID Impact on the Social Fabric

Recommendations

The discussion raises important concerns about the negative impacts of the federal government's pandemic response on the fabric of Canadian society. These impacts encompass a wide range of areas, from personal freedoms and trust in institutions to economic, social, and health consequences. To prevent such issues from happening in the future, we put forth the following 12 recommendations.

- A. **National Crisis Oversight Council:** Commission a study to determine the validity of setting up a National Crisis Oversight Council (NCOC), with a rationale and expected format as follows:

Rationale

Establishing the NCOC is essential to safeguarding democratic principles, protecting individual rights, and maintaining public trust during future emergencies, such as pandemics. The NCOC will serve as an independent, multidisciplinary body tasked with monitoring, policing, and investigating government actions during crises.

Basic Characteristics and Principles

Representation: The NCOC will comprise representatives from diverse sectors of society, including law, medicine, science, faith, business, media, arts, and culture. Each member will undergo a public appointment process, with credentials and potential conflicts of interest transparently disclosed.

Subpoena powers: The council will possess subpoena powers, allowing it to compel testimony and evidence from all sectors, including government officials, the judiciary, and other relevant stakeholders.

Public access: To ensure transparency and accountability, the NCOC will offer the public direct and unfiltered access. A user-friendly platform will enable citizens to express concerns, provide observations, and access council proceedings.

Legislative clarity: The powers and responsibilities of the NCOC will be clearly outlined in legislation, eliminating the need for regulatory details to be determined separately. This legal foundation will establish the council's authority and scope.

Empowerment for change: The NCOC will have mechanisms to influence government actions during emergencies. It will be empowered to make recommendations, demand corrective actions, and trigger public awareness campaigns when necessary. Its primary goal will be to uphold democratic values and individual rights and freedoms, and help ensure the wellbeing of citizens.

Media access: The council will be expected to have unrestricted access to all forms of media to maintain public trust and transparency. Regular briefings, reports, and public statements will keep citizens informed of its activities and findings.

Purpose and Benefits

The NCOC would be founded on the principle that a robust system of checks and balances is vital in times of crisis. Its purpose would be to:

Safeguard democracy: Ensure that democratic principles are upheld during emergencies, preventing overreach and abuse of power.

Protect individual rights: Safeguard citizens' fundamental rights and liberties, even when extraordinary measures are deemed necessary.

Maintain public trust: Enhance transparency and accountability in government actions, fostering public confidence in crisis management.

Promote evidence-based decisions: Encourage government responses to be grounded in science, data, and expert advice.

Support effective governance: Assist in identifying gaps and weaknesses in government responses—leading to more effective crisis management.

Advance public discourse: Facilitate open dialogue between government, experts, and the public to promote informed decision-making.

In summary, the establishment of the NCOC would be a proactive response to ensure that during future emergencies, the rights and values of Canadian society are upheld. It strengthens democracy, promotes transparency, and empowers the public to actively participate in safeguarding their wellbeing and fundamental rights.

- B. **Transparency and honest communication:** Governments should prioritize transparent and honest communication with the public during crises. Information about the nature of the crisis, measures being taken, and the expected duration of those measures should be clearly and consistently conveyed.
- C. **Accountability mechanisms:** Establish mechanisms for holding public officials accountable for their decisions during crises. This includes oversight bodies that can review actions taken by governments and ensure they align with constitutional rights and freedoms.
- D. **Respect for constitutional rights:** Safeguard constitutional rights and freedoms, even during emergencies. Governments should not infringe on these rights without clear and justifiable reasons, and any restrictions should be proportional and time-limited.

- E. **Balanced approach:** Develop and implement a balanced approach to crisis management that considers public health alongside economic, social, and mental wellbeing. Decisions should be evidence-based and consider the broad spectrum of societal impacts.
- F. **Community engagement:** Engage with communities, civil society organizations, and a wide range of experts in decision-making processes. Encourage open dialogue and ensure that policies and measures are sensitive to the unique needs and circumstances of different groups within society.
- G. **Education and awareness:** Promote public education and awareness about public health measures, their rationale, and the expected outcomes. Informed citizens are more likely to be able to make informed decisions and hold officials accountable for their actions.
- H. **Support for vulnerable populations:** Develop strategies to support vulnerable populations during crises—such as the homeless, those struggling with addiction, and victims of domestic abuse. Ensure that access to essential services is maintained.
- I. **Healthcare infrastructure:** Invest in and strengthen healthcare infrastructure to ensure capacity and readiness for future public health emergencies. This includes resources for mental health services, addiction treatment, and domestic violence support.
- J. **Mandatory ethics training for health care workers:** To enhance the ethical standards and ensure the protection of fundamental patient rights and access to care, we strongly recommend the implementation of annual mandatory ethics training for all healthcare workers. This training should apply to frontline, administrative, and managerial staff across the healthcare system, resulting in the following benefits:
 - Ethical awareness: Annual ethics training will promote awareness of ethical principles, ensuring that all healthcare workers have a comprehensive understanding of their ethical responsibilities toward patients, colleagues, family members, and the healthcare system as a whole.
 - Patient-centred care: Ethical training will underscore the importance of prioritizing patients' wellbeing, rights, and dignity in all healthcare decisions and actions. It will reinforce the commitment to patient-centred care.
 - Legal and regulatory compliance: Ethical training will help healthcare workers understand and comply with legal and regulatory requirements related to patient rights and access to care, reducing the likelihood of breaches and legal issues.
 - Improved communication: Ethical training can enhance communication skills, fostering open and honest dialogue with patients and their families. This will contribute to better-informed decision-making and greater patient satisfaction.

- **Crisis preparedness:** In times of crises like the COVID-19 pandemic, healthcare workers will be better prepared to make difficult ethical decisions under pressure, ensuring that patient rights and access to care are upheld even in challenging circumstances.
 - **Accountability:** Mandatory training establishes clear expectations and accountability for ethical behaviour. It provides a basis for addressing breaches and taking corrective actions promptly.
 - **Continual improvement:** Annual training allows healthcare workers to stay updated on evolving ethical guidelines and best practices, facilitating a culture of continual improvement in patient care.
 - **Organizational culture:** Ethical training can contribute to building a culture of respect, compassion, and integrity within healthcare institutions, benefiting both patients and staff.
- K. **Scientific integrity:** Protect the integrity of scientific research and expert opinions. Encourage open debate and diverse perspectives within the scientific community to ensure that policy decisions are well informed.
- L. **Legislative safeguards:** Review and update emergency powers legislation to strike a balance between swift response and protection of individual rights. Ensure that such powers are subject to regular parliamentary review and oversight.

In essence, the goal is to develop a comprehensive strategy that prioritizes the health and wellbeing of citizens while respecting democratic values, individual rights, and the resilience of Canadian society as a whole. These recommendations aim to foster a society where crises are managed with care, accountability, and a commitment to the long-term welfare of all citizens.

8.2.8. The Effects of Government Pandemic Measures on Faith Communities

Recommendations

- A. **Recognition of all religions**, including the Body of Christ Church, by all levels of government is paramount in a free and democratic society and must be afforded all protections and shields guaranteed under the *Criminal Code*, the *Constitution Act, 1867*, the *Bill of Rights*, and the *Canadian Charter of Rights and Freedoms*.
- B. **Churches do not require the permission of governments** to open or close. However, when churches decided to respond favourably to the governments' call—two weeks to flatten the curve—these same churches must also have had the decision-making authority to reopen when projected COVID death and illness numbers don't come to fruition.
- C. **Revisions of the *Emergencies Act***. In May 2020, the launching of the *Emergencies Act* granted Cabinet powers to evacuate people and remove personal property from any specific area, acquire property, direct any person or any class of persons to render essential services, regulate distribution and availability of essential goods, services, and resources, authorize emergency payments, establish shelters and hospitals, and impose criminal sanctions. Moreover, the Act allows the federal government to essentially nationalize parts of the economy wherever it thinks it's necessary, including Cabinet assuming the control, restoration, and maintenance of public utilities and services to ensure the wellbeing of Canadians.

Later, citizens witnessed governments creating travel passes to curtail movement under the *Emergencies Act*. There needs to be parliamentary and legislative revisions to the *Emergencies Act* in an effort to reduce the unprecedented sweeping powers of the federal government over provincial jurisdictions and the citizenry and the unbridled discretion of authorities and powers administering new criminal laws without established opportunities for redress.

- D. **All governments should be required** to provide full disclosure of all the relevant data that led to the declaration of emergency measures, the degree of parliamentary oversight, the dialogue regarding the risks and legitimacy of the lockdowns, and how temporariness was factored into the invoking of the Act.
- E. **Governments and public sector employees** by virtue of public funding must remain neutral. Freedom of religion is a protected right that supersedes the authority and actions of governments. Public policy can neither be discriminatory in how the law is applied. For example, all churches regardless of the number of congregants, the square footage of the building, or the ability for each individual church to accommodate citizens within the boundaries of ever-changing COVID restrictions were painted with the same brush. On its face, the essential and non-essential list of organizations afforded carte blanche government approval appears discriminatory, and therefore, should be challenged under human rights legislation.

- F. **Remedy discriminatory conduct** through mandatory education programs. For example, the duty to accommodate is a legal concept that aims to ensure every citizen has equal access to benefits, services, and opportunities. In the context of the Canadian Charter of Rights and Freedoms, the duty to accommodate refers to the principle that individuals and groups should not be treated unfairly or denied opportunities because of their personal characteristics or religious beliefs. In fact, the duty to accommodate places a duty on all employers and service providers, including governments and institutions, to make reasonable adjustments to the policies and practices without unnecessarily imposing hardship on the legitimate interests of a workplace.

Throughout COVID, legitimate questions were ignored. Yet, discretionary discriminatory actions were evident, imposing undue hardship on those who requested religious accommodation. Therefore, mandatory religious education courses for all public sector employees to ensure citizens are not discriminated against for religious practices and beliefs would send a much-needed message to public sector employees who discriminately targeted men and women of faith.

- G. **Going forward, there must be a clear**, evidence-based rationale for locking down citizens and society. And subsequently, when the *Emergencies Act* is revoked, there must be ample opportunities for redress, public conversations, and debate in the public square that will counter future restrictions on the citizenry.
- H. **Criminal Code section 176** must be retained.
- I. **Every individual has an inherent right** to end-of-life, spiritual and/or pastoral care or God at bedside services that align with their specific faith. Therefore, all publicly funded institutions, including hospitals, and long-term care facilities must comply.
- J. **Courts must accept deeply held beliefs** for religious convictions and respect that not every citizen, when writing an affidavit to support their views, is familiar with conveying the breadth and depth of their convictions in a manner that would overwhelmingly influence the Court.
- K. **The presumption of innocence** must be adhered to in all judicial proceedings occurring in every province and territory but Québec, where the latter operates under civil law. From the evidence, it appears prosecutors have too much influence on how the court uses its time. For example, the statement that constitutional arguments are a waste of court time and, therefore, should not be heard is not acceptable. Again, if a citizen's constitutional rights have been violated by virtue of their personal beliefs, thoughts, opinions, or expression, the actions of governments must be called into account, or else the law is being brought into disrepute.
- L. **Bail conditions must be reasonable and fair** and cannot prevent an individual from performing their employment duties and responsibilities. This includes pastoral service within a religious context.

- M. **Separation of courts**, the separation of courts from the public service.
- N. **Regarding procedural fairness and natural justice**, it's time for a comprehensive national dialogue to take place involving the church and Canadians who firmly believe the church is foundational and necessary for the social and economic wellbeing within communities. The church is uniquely qualified and capable of making decisions that impact the social fabric.
- O. **The prevailing belief** that there is a higher spiritual accountability in this life which determines our individual standing for eternal life cannot and should not be negated by government or judiciary.
- P. **Churches and citizens are encouraged** to create a public policy watch for any legislation that potentially negates the rights and freedoms of faith groups. The attempt to silence religious speech over the last three years should not go unnoticed.

8.3. Economic Impacts

8.3.1. Impacts of Mandates on Small and Medium-Sized Businesses

Recommendations

A. Financial Support:

- a) Simplify and expedite access to financial assistance programs, ensuring that small businesses can easily navigate the application processes.
- b) Provide targeted financial aid to sectors that have been disproportionately affected.
- c) Extend and expand wage subsidies to encourage businesses to retain employees and minimize layoffs.

B. Flexible Regulations:

- a) Implement flexible regulations and licensing requirements to support businesses in adapting to changing circumstances and exploring new revenue streams.
- b) Streamline bureaucratic processes to reduce administrative burdens on small businesses and expedite approvals.
- c) In cases where governing authorities decided businesses were non-essential, there needs to be accommodation made to allow these businesses to reestablish themselves or in cases where the business has closed, gone bankrupt, et cetera, an understanding within the public service that this is not a consequence of the business owner not wanting to work but a direct result of decisions made by governing authorities.

C. Access to Capital and Credit:

- a) Enhance access to affordable capital and credit for small businesses through low-interest loans, loan guarantees, or grant programs.
- b) Collaborate with financial institutions to develop tailored financial products specifically designed to address the needs of small businesses during recovery.

D. Promote Local Online Shopping:

- a) Encourage consumers to support local businesses by promoting the importance of shopping locally.
- b) Develop and implement marketing campaigns to raise awareness of online platforms and e-commerce solutions that facilitate purchases from local businesses.

E. Training and Skill Development:

- a) Offer training programs and workshops to small business owners and employees to enhance their skills in areas such as digital marketing, e-commerce, and remote work.
- b) Collaborate with educational institutions and industry associations to develop training initiatives specifically tailored to the needs of small businesses.

F. Collaboration and Networking:

- a) Facilitate networking opportunities among small business owners, allowing them to share experiences, insights, and best practices.
- b) Foster collaboration between small businesses and larger corporations through partnerships, supplier diversity initiatives, or mentorship programs.

8.3.2. Impacts of Mandates on Canadian Citizens

Recommendations

- A. **An independent judicial investigation** must be undertaken to determine responsibility and criminality. Any and all institutions, individuals, or organizations that were responsible for breaking of the law need to be brought to justice.
- B. **Laws need to be strengthened** to specifically prohibit the mandating of medical procedures and the exposure of private health information. There are current laws in place, but somehow these laws did not protect Canadians.
- C. **Canada must affirm its adherence** to international law and human rights and invite an investigation of the actions of the government according to these treaties.
- D. **An intensive program** aimed at addressing the developmental damage done to our children must be undertaken and implemented immediately. It is not acceptable to simply move on with business as usual. Children have been emotionally, developmentally, and educationally damaged, and remedial actions are required.
- E. **An investigation into the actions of the CBC** and privately held media companies in Canada must be undertaken to determine criminality under the current hate speech and terrorism laws in Canada. It was the relentless stream of hate, propaganda, and terror which was responsible for much of the damage done.
- F. **All employees who were terminated** due to refusal to take a medical procedure must be rehired and paid compensation. All costs of these actions need to be paid for by the parties who mandated and implemented the terminations.
- G. **The regulations concerning the operation of elderly persons' care homes** need to be reformed. Never again should these institutions be allowed to lockdown, isolate, and ignore the needs of the residents and their relatives. Compensation needs to be paid and criminal charges laid as appropriate.
- H. **A mandatory course on the Canadian Charter of Rights and Freedoms** is to be developed and become mandatory for all public service employees, as part of the effort to assure that these actions are never supported again.
- I. **A high-school level course must be developed** to teach the *Canadian Charter of Rights and Freedoms* and civics to all high school students in Canada. This course must be mandatory nationwide.
- J. **The history of what happened** during the pandemic, including an accounting of who was responsible, must be developed and included as a module in all high school history courses. This history is to be mandatory.

K. **Government officials**, the judiciary, and regulatory boards did not adequately safeguard the interests of Canadians. It is imperative to implement measures that establish civilian oversight for many of these institutions, ensuring their independence from political influence and interference.

L. **Financial Support:**

- Ensure efficient and accessible delivery of financial assistance programs to individuals impacted by the mandates, including those who have lost their jobs or experienced reduced income.
- Expand income support programs and consider targeted initiatives for vulnerable populations, such as low-income individuals, single parents, and seasonal economy workers.
- Provide rent and mortgage relief programs to ease the financial burden on individuals facing housing insecurity.

M. **Mental Health Support:**

- Increase access to mental health services, including telehealth options, to support individuals experiencing heightened stress, anxiety, and other mental health challenges.
- Implement public awareness campaigns to reduce stigma associated with seeking mental health support and promote available resources.
- Invest in community-based mental health programs and initiatives that address the specific needs of diverse populations.

N. **Educational Resources and Support:**

- Ensure access to remote learning resources and technologies for students to minimize educational disruptions.
- Provide additional support and resources for students from disadvantaged backgrounds to address students experiencing educational disparities and issues related to technology.
- Invest in educational and vocational training programs to support individuals in re-skilling or up-skilling to adapt to changing job market demands.

O. **Healthcare Access and Outreach:**

- Prioritize and expedite non-urgent medical procedures and screenings that were delayed or cancelled during the mandates to address healthcare needs and prevent further complications.
- Increase outreach efforts to promote preventive healthcare measures such as regular check-ups.
- Enhance access to telehealth services and digital health platforms to facilitate remote consultations and healthcare support.

P. Community Support and Engagement:

- Facilitate virtual community engagement initiatives to foster social connections, combat social isolation, and promote community resilience.
- Provide funding and resources to community organizations and non-profit groups that offer support services, food banks, and other essential resources for those in need.
- Encourage employers to prioritize employee wellbeing by implementing flexible work arrangements, promoting work-life balance, and supporting mental health initiatives.

Q. Communication and Information Dissemination:

- Ensure clear, consistent, and timely communication about public health guidelines, mandates, and available resources to keep citizens informed and reduce confusion.
- Utilize diverse communication channels to reach different segments of the population, including multilingual communication and accessibility measures for individuals with disabilities.
- Combat misinformation and promote evidence-based information through public health campaigns and collaborations with trusted sources.

R. Long-Term Preparedness and Resilience:

- Invest in healthcare infrastructure, including increased hospital capacity and resources, to improve pandemic preparedness and response capabilities.
- Establish contingency plans and strategies to manage future crises effectively, balancing public health priorities with minimizing social and economic disruptions.
- Foster collaboration between government, businesses, and community stakeholders to develop comprehensive and coordinated approaches for future emergencies.

By implementing these recommendations, the Canadian government and relevant stakeholders can provide support and assistance to citizens impacted by the COVID-19 interventions, helping individuals navigate the challenges, promote wellbeing, and build resilience during and beyond the pandemic.

8.3.3. Financial Impact of the COVID-19 Pandemic Response on Canada

Recommendations

- A. **Restraints must be placed on public health officers.** They must be required to immediately justify their recommendations with legitimate cost-benefit analyses, and their decisions must be subject to the authority of publicly elected officials and the transparent scrutiny of the public.
- B. **All scientific studies on either side** of a crisis must be made available to the public so that the effect of propaganda can be minimized.
- C. **Public health officials should never be placed in charge** of an Emergency Response. Emergency Response must remain the purview of professionals trained in medical and emergency procedures who understand how to set goals and achieve them.
- D. **Lockdowns and mandates** must require direct legislative authority. These steps cannot be allowed to be carried out under regulations.
- E. **The media must be held to account** for their collusion in the propaganda that caused the panic among citizens and authorities.
- F. **A detailed financial audit must be undertaken** on each and every dollar that was spent on the pandemic. It must be determined whether any mishandling of these funds occurred.
- G. **Identify and prioritize essential expenditures** directly related to public health and safety, such as healthcare infrastructure and support for vulnerable populations.
- H. **Evaluate the effectiveness and efficiency** of existing programs and initiatives to ensure resources are allocated wisely, redirecting funds from less effective areas to more impactful measures.
- I. **Focus financial support** on the most affected sectors and individuals, such as small businesses, low-income households, and those facing unemployment or reduced income due to the mandates.
- J. **Streamline administrative processes** to reduce red tape, bureaucratic delays, and associated costs, ensuring funds are disbursed promptly to those in need.
- K. **Enhance transparency and accountability** in spending by providing regular public reporting on the allocation and utilization of funds, enabling citizens to monitor government expenditures.
- L. **Invest in long-term emergency planning** and preparedness measures to mitigate the impact of future pandemics or health emergencies. This may include strengthening public health infrastructure, establishing emergency funds, and enhancing the capacity for rapid response and data collection.

- M. **Ensure that future public health emergencies** are operated by the existing Emergency Management Apparatus and that the public health authorities provide input into that apparatus but are not able to lead or control it.
- N. **Response to future public emergencies** must be driven by and directed by local emergency planning personnel on the ground and not driven by federal government political processes.
- O. **Consider the potential cost-saving benefits** of investing in preventive healthcare measures, public health education, and research and development in the healthcare sector.
- P. **Continuously monitor the effectiveness and impact** of government spending on COVID-19 mandates and measures, adjusting allocations as needed based on evolving circumstances, scientific evidence, and changing priorities.
- Q. **Engage in rigorous and public evaluation** and assessment of programs and policies to identify areas of inefficiency or ineffectiveness, making data-driven decisions to optimize resource utilization.
- R. **Focus on measures that stimulate economic recovery** and job creation, such as infrastructure investments, targeted incentives for business growth and innovation, and initiatives to promote consumer spending and tourism.
- S. **Balance short-term relief measures** with long-term economic strategies to foster sustainable growth and resilience in the post-pandemic era.
- T. **Canada must adopt a Canada First policy** where our national interest drives overall policy agendas. This applies to all aspects of our nation, including fiscal, financial, social and environmental policy. Global planning and response with a lack of Canadian input created the situation that we now find ourselves in.
- U. **Canada is a country** whose economy is dependant on natural resource extraction and production. Canada must implement policies to upgrade and expand these core economic drivers so that export income can be quickly injected into the Canadian economy, addressing these historic debts caused by the government's actions during the pandemic.
- V. **Some of the damage and hardships** experienced by Canadians was caused by an acute lack of independence and diversity of critical aspects of our economy. Canada must rigorously review and apply the anti-combines laws (*Competition Act*) to limit Canadians exposure to undue influence from the many monopolies that currently exist across critical sectors of our economy.

By implementing these recommendations, governments can exercise restraint in spending while ensuring that essential needs are addressed, support is provided to those most affected, and long-term preparedness measures are in place. It is crucial to strike a balance between fiscal responsibility and the necessary investments to protect public health, support the economy, and promote the overall wellbeing of citizens.

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8.4. Media Actions During the Pandemic

Recommendations

CBC

CBC as an organization must be held to account for their very damaging and dangerous actions. Significant steps must be taken to prevent this from ever happening again.

CBC was originally founded on November 2, 1936. Many of the principles under which the CBC was created and justified, no longer exist. With the advent of the Internet and the incredible reduction in the cost of creating quality content, the CBC no longer has a significant role to play in the promotion of Canadian content or the provision of media services to the rural and remote areas of Canada.

- A. **The CBC should be stripped** to its very fundamental functions of providing information to Canadians with a special focus on French language and Indigenous issues. All other current functions and productions of the CBC must be terminated immediately.
- B. **All current senior management positions** in the CBC must be removed in light of the revised operational mandate.
- C. **Dismiss all on air staff that participated** in the dissemination of propaganda during the pandemic.
- D. **Replace the CBC Ombudsmen** with a Board of Canadians chosen from across Canada, with two representatives chosen from each province and territory.
- E. **The first task of the Board is to investigate** the origins and relationships with the government and industry that influenced the actions of the CBC during the pandemic.
- F. **Remove the CBC from the “Trusted News Initiative”** and all other related organizations.
- G. **One of the original functions of the CBC** was to support Canadian content, and as such they should return to that role but not to the role as imagined in 1932; it must realize the reality of the 21st century. As such, the CBC mandate would be to help Canadians to develop Canadian content. We propose the following:
 - a. CBC facilities and equipment, et cetera, might be made available as a resource to private media developers.
 - b. Utilize expertise that is currently embedded in the CBC to educate and provide training to private Canadian content producers.
 - c. CBC should use its resources to promote real Canadian content produced by Canadians, not the CBC.

- H. **A criminal investigation** must be undertaken to determine what areas of criminal hate speech law may have been violated based on the reporting of the CBC.

Other Traditional “Privately Owned” Media

Other traditional media outlets were as culpable as the CBC, but as private industry players, they do have the right to broadcast in accordance with the *Canadian Charter of Rights and Freedoms*. It would be extremely difficult to monitor their content on an ongoing basis, and it should not be the role of the government to regulate that content beyond required by current law.

- A. **However, any and all direct government support** to these media entities must be stopped immediately. There is no reason for Canadian taxpayers to be supporting these entities. They are privately owned and as such must survive in the free marketplace as every other private business must.
- B. **There is an uneasy monopolization** of traditional media that has occurred in Canada over the past 30 years. A complete investigation of the traditional media sources must be carried out under all federal legislation that deals with the development of monopolies in Canada.
- C. **A criminal investigation must be undertaken** to determine what areas of criminal hate speech law may have been violated based on the reporting of the traditional media venues.
- D. **Internet social media platforms** must not be censoring or editorializing content on their sites, unless the content is in contravention of the *Criminal Code*.
- E. **The Broadcasting Act must be rewritten** to accurately reflect the broadcasting environment of the 21st century. The *Broadcasting Act* should not be used as a tool of the government to censor content or to advance the promotion and production of Canadian content. The act must endeavour to accurately set out the rules and regulations and remove interpretation or development of regulations by an unelected body such as the CRTC.
- F. **The role of the CRTC must be reviewed**, and the CRTC possibly abolished if it is determined that the actual role of the CRTC is to simply develop regulations which are not specifically contained in legislation.
- G. **Bolster press freedom** and other media communications protections by enacting comprehensive legislation and constitutional provisions in alignment with the *Canadian Charter of Rights and Freedoms*, which ensures and upholds the rights of free expression, access to information, and editorial independence.
- H. **Safeguard journalists** from intimidation, harassment, and threats to their personal safety through effective law enforcement and judicial mechanisms.
- I. **Ensure that public broadcasting organizations**, such as the Canadian Broadcasting Corporation, operate independently and are insulated from political interference with editorial decisions made by experienced journalists.

- J. **Promote a diverse and inclusive media landscape** that reflects a wide range of perspectives and avoids undue concentration of ownership or control.
- K. **Increase transparency** in the allocation and utilization of public funds provided to the public broadcaster. This includes clearly disclosing the criteria and decision-making processes for funding distribution.
- L. **Establish independent bodies or committees** to oversee and evaluate the disbursement of public funds, ensuring accountability and preventing undue influence.
- M. **Foster the development** of non-profit and community-based media organizations to diversify the media landscape and provide alternative sources of information and perspectives.
- N. **Establish grant programs or tax incentives** to support the sustainability and growth of non-profit media outlets, enabling them to operate independently of government influence.
- O. **Promote media literacy education initiatives** that equip citizens with critical thinking skills to evaluate media sources, distinguish between fact and opinion, and understand the importance of independent journalism.
- P. **Promote adherence to professional journalistic standards and ethics**, including accuracy, fairness, and accountability.
- Q. **Support self-regulatory bodies**, such as the Canadian Association of Journalists (CAJ).
- R. **Enforce ethical guidelines** and provide recourse for individuals who believe they have been misrepresented or harmed by media coverage.
- S. **Engage in international forums** and collaborations to advocate for press freedom and protect independent journalism globally.
- T. **Support initiatives and organizations** that promote freedom of the press and other forms of media and provide assistance to journalists facing threats or persecution.
- U. **Encourage citizen participation** and engagement in media governance, including public consultations, forums, and advisory panels, to ensure diverse perspectives and community interests are taken into account.

By implementing these recommendations, Canada can foster a media landscape that is independent, diverse, and accountable, serving as a cornerstone of democracy and providing citizens with reliable, unbiased information. It is crucial to uphold the principles of press freedom and support traditional media outlets in their role as watchdogs and providers of independent journalism.

8.5. Health

8.5.1. Pandemic Preparedness Plan

Recommendations

- A. **Rectifying the Mistake of Discarding the Emergency Management Plan:** The decision to discard the Emergency Management Plan was a significant error that will require rectification.
- B. **Realigning the Purpose of Pandemic Measures:** The objective of pandemic measures should have been to minimize the impact of SARS-CoV-2 on society, rather than solely focusing on safeguarding the healthcare system.
- C. **Utilizing Hazard Assessment for Targeted Responses:** The Hazard Assessment, which continued to identify those most at risk, revealed that lockdowns did not effectively protect them. A more targeted response would have been more appropriate.
- D. **Learning from Past Pandemics:** The lessons learned from previous pandemics were regrettably disregarded.
- E. **Reevaluating Non-Pharmaceutical Interventions (NPIs):** The use of non-pharmaceutical interventions did not significantly reduce the spread of COVID-19. Employing them during the initial wave could have been seen as, at best, a mistake. After the first wave, it became a matter of grave concern.
- F. **Recognizing the Unintended Consequences of NPIs:** NPIs have resulted in substantial collateral harm and loss of life, often surpassing the impact of the virus itself. Public health was aware of this prior to COVID-19, and yet no cost-benefit analysis was conducted. This constituted a grave error.
- G. **Holding Leaders Accountable:** Public authorities bear responsibility for the response to the pandemic and the perpetuation of fear. Accountability should be enforced.
- H. **Safeguarding Our Society and Democracy:** Failure to revise our Emergency Management Plan and dispel false beliefs in non-pharmaceutical interventions places our society and democracy in jeopardy.

8.5.2. Follow the “Science”: Real Science or Scientism?

Recommendations

Considering the critical reliance of our modern society on science and technology, there is a need to distinguish knowledge derived from the rigorous scientific method from beliefs often influenced by ideologies and propaganda. To help distinguish between the two, we recommend the following:

- A. **Basic training in epistemology and critical thinking** should be incorporated into both humanities and scientific or technological education curricula.
- B. **Experts who participate in public forums** should undergo scrutiny based on the following four fundamental criteria:
 - Demonstrated cutting-edge knowledge and expertise, as evidenced by their involvement in past or ongoing scientific research, providing proof of their understanding of the subject under discussion.
 - Lack of conflicts of interest.
 - Willingness to engage in evidence-based public debates with other experts who may hold differing opinions. Such engagement should involve using rhetoric that avoids ad hominem attacks, appeals to authority, or invoking the mislabelled “scientific consensus.”
 - The detailed, unedited credentials of these public figures must be made known and available to the public. This will enable the public to ascertain the credibility of such experts.

8.5.3. Epidemiology 101 in the COVID-19 Era

Recommendations

Due to the confusion caused by improper testing for COVID-19, particularly using unvalidated RT-PCR testing, the following recommendations were made:

- A. **Pause the use of RT-PCR** or rapid antigen testing when it is not accompanied by a thorough medical evaluation of disease symptoms.
- B. **Conduct a rigorous validation of RT-PCR testing**, including standardized cultivation of the active virus. Establish a defined threshold for the number of amplification cycles that show due use.

Considering the confusion that arose from the lack of transparency in official public data, the following recommendations are added:

- C. **Ensure that all government data** is consistently and transparently shared with the public for independent evaluation by qualified experts in epidemiology and statistics.
- D. **Make any disparities between data analysis**, done by the government and data analysis done by independent citizens, subject to review by an impartial advisory committee composed of experts in epidemiology and data analysis. This committee should be regularly vetted through public forums to maintain transparency and accountability.

8.5.4. Non-Pharmaceutical Interventions (NPIs)

Recommendations

In line with the “first, do no harm” principle and adhering to best medical practices and sound scientific practices, the following recommendations are proposed:

- A. **Avoid mandatory health measures**, such as lockdowns and universal mask mandates, unless they have been objectively demonstrated through rigorous studies to have a positive benefit-to-risk ratio.
- B. **Prioritize diligent implementation** of the two non-pharmaceutical interventions (NPIs) that have a well-established track record of efficacy in managing respiratory infections: air filtration and isolation of individuals who are both sick and contagious.
- C. **Establish a targeted research and development program** to investigate the adverse effects of ineffective NPIs, with a specific focus on the impacts of masking children and restricting physical and social activities. The goal is to formally assess the extent of physical and mental health damage and propose tailored remediation measures.
- D. **Ensure that scientists and healthcare professionals** working within government agencies have access to the best available scientific evidence, free from conflicts of interest, at both national and international levels. This access will enable them to provide politicians with the highest quality and most up-to-date knowledge for decision-making.
- E. **Instead of prohibiting them, mandate scientific debates** to facilitate the emergence of optimal health measures. Encourage open discussions among experts to foster innovation and evidence-based policy-making.
- F. **Actively promote healthy lifestyles** that can enhance the immune system through epigenetic mechanisms. A strong immune system forms the foundation for protection against infections, cancers, and autoimmune diseases.

8.5.5. Early Treatments

Recommendations

Given the incontestable better outcomes in countries that deployed early treatments using a panoply of generic molecules with an established safety record for the management of the COVID-19 epidemic, our recommendations are to:

- A. **Reinstate positive incentives** to allow physicians to practise medicine according to an ethical, personalized, and evidence-based science and art, according to their Hippocratic oath. Repudiate algorithmic centralized protocols and punitive administrative edicts.
- B. **Investigate alleged corruption** that has interfered with the customary practice of medicine under the fallacious pretext of promoting public health while diverting the health measures to alternative political and commercial interests.
- C. **Promote preventative health measures** grounded in healthy lifestyles and real food, avoiding processed foods and sugar overconsumption and promoting adequate vitamin supplementation, physical exercise, sufficient sleep, stress management, and a vibrant social life.
- D. **Encourage open and evidence-based discussions** among healthcare professionals, researchers, and regulatory bodies regarding the use of generic drugs for early COVID-19 treatment.
- E. **Review and revise treatment guidelines** to include early intervention options that have demonstrated safety and efficacy in large populations. Consider the experience of countries that successfully employed such treatments.
- F. **Address institutional corruption** by investigating cases of corruption and suppression of early treatments within healthcare institutions and regulatory agencies. Implement measures to ensure transparency and ethical conduct in decision-making.
- G. **Support early treatment research** into the efficacy and safety of early treatment options for COVID-19 by allocating resources. Promote collaboration between medical professionals and researchers in this field.
- H. **Ensure patients give Informed Consent** for their chosen treatment by discussing all available treatment options, including early interventions.
- I. **Establish independent medical advisory committees**, free from conflicts of interest, to assess treatment recommendations and provide guidance to regulatory agencies. Enhance transparency in decision-making.
- J. **Promote awareness of vitamin D** and its importance in preventing infectious seasonal diseases, especially during the winter months when vitamin D levels tend to decrease. Encourage further research in this area.

- K. **Hold public health agencies accountable** for conducting systematic analyses of peer-reviewed literature on potential treatments. Ensure that decision-making is evidence-based and prioritizes public health over the public health establishment.

8.5.6. Natural Immunity & Early Treatments Rebuffed to Favour Generalized Vaccination

Recommendations

We recommend the suspension of any further vaccination for COVID-19 until (1) the issues of cGMP production are resolved; (2) the genotoxicity, auto-immunogenicity, and tumorigenicity assays are conducted to the appropriate level for gene therapy products; and (3) rigorous RCTs demonstrate the reduction of morbidity and mortality in a representative population, including the most vulnerable.

Given that there was no efficacy study in the RCT with the mRNA-LNP produced in the commercial manufacturing process and that there were irregularities in the clinical trial process, we recommend that Health Canada require an independent audit of the RCT.

Victims have to be compensated more readily. We also recommend that the government set up a special centre to take care of the vaccine-injured.

Regulatory agencies must revisit the warp-speed-development mindset of the COVID-19 genetic vaccines and rebut the allegation that the mRNA-LNP products have been proven safe and effective and that they can therefore be further used as a vaccine platform for other diseases without proper safety testing.

A Pandora's box has been opened, and promoting any future products based on that mRNA-LNP platform technology for expedited marketing, within one year, without the proper efficacy and safety assessment will only perpetuate bad health outcomes of similar magnitude.

In alignment with the views of numerous medical doctors and scientists worldwide, the following recommendations are made:

- A. **Immediately halt the use of experimental mRNA-LNP** gene therapy injections for COVID-19 prevention.
- B. **Approve any future applications of these injections through** the standard gene therapy product approval process.
- C. **Ensure that the regulatory approval process** and recommendations by vaccine immunization committees are reviewed by independent medical and scientific advisory committees without conflicts of interest.
- D. **Establish clear safety signal thresholds** that would necessitate the automatic removal of any vaccine or therapeutic product from the market, with legal accountability for officials failing to adhere to these pre-established norms.
- E. **Acknowledge, treat, and adequately compensate individuals** who have experienced vaccine-related injuries.

8.5.7. Interim Authorization of COVID-19 Vaccine

Recommendations

- A. **Newly implemented revisions** to the *Food and Drug Regulations* related to the authorization of COVID-19 genetic vaccines must be rescinded as they permanently exempt COVID-19 vaccines from the requirements to objectively prove the safety or efficacy as required under the *Food and Drug Regulations*.
- B. **The current use of COVID-19 genetic vaccines** in Canada that were authorized under the revised provisions of the Interim Order and the newly revised *Food and Drug Regulations* should be stopped immediately.
- C. **A full judicial investigation** of the process under which the COVID-19 vaccinations were authorized in Canada must be carried out. Criminal liability, if discovered, may be dealt with under existing Canadian law.
- D. **All documentation concerning the authorization process** and information provided to the regulatory agencies by the manufacturers should be made publicly available.
- E. **Legislation should be developed**, or amended, to prevent the elimination of the legal requirements to prove that a new drug is objectively safe and that the efficacy of that drug is objectively proven.
- F. **The requirement for the regulatory board** to carry out a risk-benefit analysis for any and all new drugs under consideration for approval should be codified into law. Written minimum requirements for such a review are to be established. The final decisions should be made on the basis of citizen health considerations not political motivations. The results of the risk-benefit must be made public.
- G. **We should review and revise** the current relationship between licensing fees paid by pharmaceutical companies and the total budget allocated to Health Canada for drug-related matters. This is necessary to prevent pharmaceutical companies from exerting undue financial influence on the approval agency.
- H. **Legislation must be included or revised** which re-establishes Canada's approval agency as an independent, fact-based agency without reliance on approval agencies from outside of Canada.
- I. **Investigate any perceived or existing conflicts of interest** that may exist between senior staff of Health Canada and pharmaceutical manufacturers. This may extend to a prescribed time limit prohibition of government agency staff from leaving government service for positions with the pharmaceutical manufacturers.

- J. **All investigations recommended in this section** are to include the power to compel timely production of information and the power to subpoena witnesses.

8.5.8. Canada's Future Approval of New Pharmaceuticals

Recommendations

- A. **Revocation of New COVID-19 Regulations:** The Commission recommends that the new regulatory process be revoked and that Health Canada return to approving all therapeutics on its historical safety requirements.
- B. **Maintain Rigorous Safety Standards:** Prioritize patient safety by maintaining rigorous safety standards for drug approval. The safety of new pharmaceuticals should be thoroughly demonstrated through preclinical and clinical trials before approval.
- C. **Transparency in Regulatory Changes:** Ensure transparency in any regulatory changes related to pharmaceutical approvals. Changes in the approval process should be subject to public consultation and should be clearly communicated to stakeholders, including healthcare professionals and the public.
- D. **Independent Expertise:** Appoint experts with relevant medical and scientific backgrounds to key positions in the regulatory process. Decision-makers, such as the Minister of Health, should have a strong understanding of medical and scientific principles to make informed decisions about drug approvals.
- E. **Balancing Innovation and Safety:** Find a balance between promoting innovation and ensuring safety. While innovation is important for advancing healthcare, it should not come at the expense of patient safety. Consider the potential long-term effects of novel drugs on public health.
- F. **Monitoring and Post-Market Surveillance:** Strengthen post-market surveillance of approved pharmaceuticals. Continuous monitoring of drugs once they are on the market is crucial to detect and address any safety concerns that may arise over time.
- G. **Independent Safety Review:** Establish an independent body or commission responsible for conducting safety reviews of pharmaceuticals, especially novel biologics and gene therapies. This body should be free from industry influence and focused solely on patient safety.
- H. **Public Health Impact Assessment:** Conduct thorough assessments of the potential public health impact of new drugs, particularly in the context of pandemics or health emergencies. Consider both short-term and long-term consequences on public health.
- I. **Ethical Considerations:** Incorporate ethical considerations into the approval process. Ensure that the potential benefits of new pharmaceuticals outweigh the risks and that patient autonomy and Informed Consent are respected.

- J. **Regular Reviews of Regulatory Frameworks:** Periodically review and update regulatory frameworks to adapt to advances in medical science and changing public health needs. Regulatory changes should prioritize safety while facilitating timely access to beneficial treatments.
- K. **International Best Practices:** Benchmark Canada's regulatory processes against international best practices. Learn from the experiences of other countries with strong pharmaceutical regulatory systems.
- L. **Public Awareness and Education:** Enhance public awareness and education about the drug approval process, including the rigorous testing and safety measures in place. Informed patients can make better decisions about their healthcare.
- M. **Monitoring Economic Impact:** While promoting economic development is important, closely monitor the economic impact of regulatory changes. Ensure that economic goals do not compromise patient safety, and make necessary adjustments if conflicts arise.

These recommendations aim to strike a balance between promoting innovation and safeguarding patient safety in Canada's pharmaceutical approval process. It's crucial to prioritize public health and long-term safety while fostering an environment conducive to innovation and economic growth in the pharmaceutical industry.

8.5.9. Medical Practice and Ethics During COVID-19

Recommendations

- A. **A civilian-led detailed investigation** must be carried out to determine who (at all levels) were responsible for these breaches of medical ethics and to recommend criminal investigations as appropriate.
- B. **Existing senior members of healthcare regulatory agencies** responsible for the abandonment of long-held and honoured principles of medical care should, as appropriate, stand criminal investigation.
- C. **Each province and territory**, including the federal government must establish civilian control and oversight to the existing regulatory agencies, including regularly scheduled and publicly available reviews of their activities. These appointments cannot be politically motivated and should be carried out in public with real input from citizens.
- D. **Each Province must Establish an office** of the independent Ombudsmen available to both practitioners and patients.
- E. **Develop laws making it illegal** to deny elderly residents of care facilities from seeing visitors.
- F. **Regulatory Agencies must Enforce existing laws** concerning patient confidentiality, requirement for Informed Consent, and the level of care that is required by each healthcare professional.
- G. **Establish laws ending centralized control** of individual patient care. Patient care is a matter between a patient and their healthcare provider. This relationship cannot be violated through central government planning edicts. The public health service should never be directing patient care, which is a personal matter between the healthcare provider and the patient.
- H. **Ensure that RAW data** is promptly and fully disclosed, eliminating the necessity for *Access to Information Act* (AIA) requests and associated fees, especially when such requests come from patients or researchers.
- I. **Mandatory independent experts** must be added to all panels who are screened for conflict of interest.
- J. **There must be a criminal investigation** of the manufacturers and distributors of any of the vaccines that were administered to the public under false and misleading information. If manufacturers and distributors are found to have acted inappropriately, they should bear the costs of these investigations, as well as any damages assessed. The burden of investigation expenses should be placed on the guilty parties.
- K. **Ensure Protection for healthcare professionals** and journalists acting in good conscience.

- L. **No removal of liability protections** against manufacturers and regulators.
- M. **Strengthen the requirement** for healthcare practitioners to independently review and approve of any treatment or procedure that they are recommending to a patient.
- N. **Establish an annual requirement** for medical ethics training for all healthcare providers; this should be a career long requirement and may be made up of several modules completed through a multi-year process.
- O. **Political figures who are responsible** for the implementation of these mandatory programs must be held accountable in an open and public forum.
- P. **All members of the committees** that implemented the mandates must be exposed to the public, including all records of internal discussions and recommendations. An investigation into these actions needs to be carried out and if criminal, unethical, or incompetent actions are identified, punitive actions must be implemented.
- Q. **Develop and regularly update comprehensive ethical guidelines** and standards that cover a wide range of medical and healthcare practices, including areas such as consent, confidentiality, end-of-life care, resource allocation, and conflicts of interest.
- R. **Ensure that ethical guidelines are widely accessible** to healthcare professionals, patients, and members of the public, fostering transparency and accountability.
- S. **Establish and support institutional ethics committees** in healthcare organizations, consisting of diverse stakeholders, including healthcare professionals, ethicists, legal experts, members of the public, and patient representatives. Empower these committees to provide guidance, consultation, and ethical review of complex cases, research protocols, and policy development.
- T. **Strengthen practices and policies that ensure patients' rights** to make informed decisions about their healthcare, including the right to refuse treatment, access their medical records, and participate in shared decision-making.
- U. **Promote clear communication** between healthcare practitioners and patients to enhance understanding and respect for patient autonomy.
- V. **Safeguard patient confidentiality and privacy** by maintaining strict protocols for the storage, access, and sharing of medical information, in accordance with applicable laws and regulations.
- W. **Provide ongoing education and training** to healthcare professionals on the importance of maintaining patient confidentiality and the potential implications of breaches.
- X. **Ensure rigorous ethical review processes** for research involving human subjects, promoting Informed Consent, minimizing risks, protecting vulnerable populations, and upholding the principles of beneficence and nonmaleficence.

- Y. **Support the work of Research Ethics Boards** (REBs) in reviewing research proposals, monitoring ongoing studies, and ensuring compliance with ethical guidelines.
- Z. **Foster a culture of ethical leadership** and professional conduct in healthcare organizations, emphasizing integrity, honesty, empathy, and accountability at all levels.
- AA. **Establish mechanisms to address and investigate** ethical misconduct or breaches of professional standards, ensuring appropriate consequences and opportunities for remediation.
- BB. **Engage patients and the public in discussions** and decision-making processes related to medical ethics, promoting shared decision-making and incorporating diverse perspectives.

By implementing these recommendations, Canada can maintain and strengthen medical ethics, ensuring the highest standards of patient care, while fostering trust between patients and healthcare professionals and upholding the ethical principles that underpin the healthcare system. Regular review, continuous education, and engagement of stakeholders are vital to address evolving ethical challenges and promote ethical behaviour in the medical field.

8.5.10. Canada's Vaccine Adverse Reactions Reporting System

Recommendations

To improve the vaccine adverse reactions reporting system, several recommendations must be considered:

A. Enhance Healthcare Provider Education and Awareness:

- Provide comprehensive education and training to healthcare providers on the importance of adverse event reporting, including the recognition and reporting of vaccine-related adverse events.
- Streamline the reporting process to make it more user-friendly and efficient.
- Provide mandatory ongoing education of public health officials to provide insights into the risks associated with novel drug implementation so that they understand the difference between traditional vaccine-type medications and new biologic medications.
- Ensure that on the release of any new drug that all parties involved with the administration or monitoring are fully aware of the actual nature of the drugs under consideration. Some of the shortfalls in the system during COVID-19 had to do with a lack of understanding concerning the nature of these injections.
- Provide re-education for colleges of physicians and surgeons across Canada on the principle behind procedures required and the importance of the adverse event monitoring system.

B. Promote Public Awareness and Engagement:

- Launch public awareness campaigns to educate the general public about the importance of reporting vaccine adverse events.
- Provide accessible information on how and where to report adverse events, emphasizing the role individuals play in vaccine safety monitoring.
- Provide a portal through which patients can directly report their alleged vaccine injuries to the system.
- Encourage vaccine recipients and caregivers to report any adverse events they observe following vaccination.

C. Improve Reporting Infrastructure:

- Develop user-friendly online reporting platforms or mobile applications to simplify and streamline the reporting process for healthcare providers and the public.

- Ensure reporting mechanisms are easily accessible, with clear instructions and options for reporting adverse events, including user-friendly interfaces and multilingual support.

D. Implement Active Surveillance Systems:

- Augment passive surveillance systems with active surveillance components to actively identify and monitor adverse events, especially rare or serious events that may be missed through passive reporting alone.
- Augment passive surveillance systems with active surveillance components to actively identify and monitor patient complaints and trends or patterns of patient complaints following a drug rollout.
- Implement proactive strategies, such as automated electronic health record data mining, to identify potential safety signals and conduct targeted investigations.

E. Strengthen Collaboration and Data Sharing:

- Foster collaboration between different stakeholders, including healthcare providers, public health agencies, vaccine manufacturers, and research institutions, to facilitate seamless data sharing and exchange of information.
- Immediately end the practice of public health officials directly contacting patients and advising them to undertake medical procedures contrary to the attending physician's instructions.
- Enhance integration between national and international vaccine safety networks to leverage collective expertise, share best practices, and collaborate on investigations of global vaccine safety concerns.

F. Ensure Timely Analysis and Communication of Findings:

- Prioritize timely analysis of reported adverse events to identify potential safety signals promptly.
- Ensure that those evaluating the data are capable of recognizing and analyzing the data, despite their professional biases.
- Ensure clear and transparent communication of findings to healthcare providers, the public, and other relevant stakeholders, while considering the balance between timely communication and the need for thorough investigation.

G. Continuous Evaluation and Improvement:

- Regularly assess the performance and effectiveness of the reporting system, including feedback from healthcare providers, the public, and other stakeholders, to identify areas for improvement.

- Incorporate advancements in technology and data analytics to enhance the efficiency and accuracy of adverse event reporting and analysis.

By implementing these recommendations, the vaccine adverse reporting system can become more robust, efficient, and responsive, leading to improved vaccine safety monitoring and better protection of public health.

8.5.11. Delivery of Healthcare Services During the Pandemic

Recommendations

Based on the experience of the COVID-19 pandemic in Canada, several recommendations could be made to improve the healthcare system and prevent similar disruptions to normal healthcare services in the future.

These recommendations focus on building resilience, preparedness, and adaptability in the healthcare system. Here are some key suggestions:

- A. **Ensure Proper Emergency Response, Planning, and Implementation:** Public health officials are not trained in the planning and implementing of national integrated emergency response to major public health emergencies. In future, the responsibility for planning and implementing such emergency plans must be undertaken by the emergency measures organizations that already exist for this purpose. Public health must play an active role as technical consultant to the Emergency Measures apparatus but should never be placed in control of it.
- B. **Invest in Healthcare Infrastructure:** Strengthen the healthcare infrastructure by first rationalizing the current inventory and capacity of the system, and then increasing the capacity of hospitals, clinics, and healthcare facilities, if required. This may include investing in more beds, medical equipment, and essential supplies to handle potential surges in patient volumes and designating alternative facilities and mechanisms to share resources across provincial jurisdictions.
- C. **Enhance Telehealth Services:** Expand and promote telehealth services to provide virtual consultations and healthcare support. Telehealth can reduce the burden on physical healthcare facilities, increase accessibility to healthcare services, and ensure continuity of care during emergencies.
- D. **Improve Data Collection and Analysis:** Establish a robust data collection and analysis system to monitor healthcare resources, disease outbreaks, and public health trends. Timely and accurate data can help inform evidence-based decision-making and resource allocation during crises.
- E. **Maintain Strategic Stockpiles:** Create and maintain strategic stockpiles of essential medical supplies, including personal protective equipment (PPE), ventilators, and medications. These stockpiles can help mitigate shortages during emergencies and protect healthcare workers.
- F. **Support Healthcare Workforce:** Ensure the wellbeing and resilience of healthcare workers by providing mental health support, appropriate training for handling emergencies, and fair compensation. A strong and supported workforce is crucial in times of crisis.

- G. **Improve Collaboration and Communication:** Enhance coordination and communication between federal, provincial, and territorial governments, as well as with healthcare providers and public health agencies. Effective communication channels can facilitate rapid response and the dissemination of critical information.
- H. **Pandemic Preparedness Plans:** Develop and regularly update comprehensive pandemic preparedness plans at all levels of the healthcare system. These plans should outline specific strategies and protocols for managing various types of pandemics and health emergencies.
- I. **Training and Dissemination of Emergency Plans:** As seen during the COVID-19 pandemic, existing plans were sidelined and many healthcare workers were not aware of the existence of any plans. Emergency plans must be distributed widely and reviewed with healthcare workers at all levels, and the public should have access to seminars and information sessions. The best plan in the world if unseen and unrehearsed is useless.
- J. **Public Health Education and Awareness:** Strengthen public health education and awareness programs to inform the general population about disease prevention, natural immune system upkeep, and appropriate healthcare-seeking behaviour during outbreaks.
- K. **Supply Chain Resilience:** Diversify and strengthen the supply chain for essential medical equipment and pharmaceuticals to reduce dependence on foreign suppliers and minimize disruptions during global crises.
- L. **Regional Response Capacity:** Establish regional response capacities to handle healthcare crises, allowing for more focused responses in areas heavily affected by outbreaks while maintaining healthcare services in other regions.
- M. **Long-Term Care Facilities:** Implement improved infection control measures in long-term care facilities to protect vulnerable populations during outbreaks and prioritize their healthcare needs.
- N. **Flexible Healthcare Services:** Develop flexible healthcare service models that can quickly adapt to changing circumstances. This could involve creating mobile healthcare units, flexible staffing arrangements, and alternative care facilities during emergencies.

Implementing these recommendations requires a collective effort from governments, healthcare providers, communities, and individuals. By learning from the challenges faced during the COVID-19 pandemic and taking proactive measures, Canada can enhance its healthcare system's resilience and better protect the health and wellbeing of its citizens in the face of future health emergencies.

8.5.12. Public Workplaces and Pandemic Measures

Recommendations

- A. **Employers mandating vaccinations** for all employees in the workplace must provide verifiable data proving vaccine safety and efficacy, outlining the risks and benefits, including any and all adverse effects and provide employees with satisfactory options in the event of vaccine hesitancy and/or refusal.
- B. **Ensure employers' duty** to adequately train staff in workplace health and safety procedures and to inform supervisors and managers of their respective responsibilities includes establishing the importance and applicability of all related legislation, including the *Canada Constitution, 1867*, and specific Acts such as the *Personal Health Information Act*.
- C. **Unions have an obligation** to balance employee protections with arbitrary decisions and compliance orders made by employers. Unions must be required to undertake an exhaustive inquiry of the facts contributing to a grievance particularly when the complaint involves personal choice, bodily autonomy, constitutional protections, and the right to refuse unsafe work conditions.
- D. **When employer-employee conflicts arise** from employer mandates requiring vaccination, the union must intervene with the intention of seeking a satisfactory resolution, inclusive of reviewing employer policies and collective bargaining agreements relating to sick leave and disability benefits to determine eligibility [re: extenuating circumstances].
- E. **Terminated unvaccinated claimants** who were denied EI benefits based on misconduct must have their files re-assessed to determine whether the alleged breach in the employer-employee relationship came about because of employer forced mandates, coercion, and a person's right to choose bodily autonomy; a new decision must be rendered.
- F. **Ensure affirmative defences** are available for all employees working in publicly funded institutions, including transparent appeal processes.
- G. **When non-arm's length publicly funded agencies** enter into a partnership [such as the partnership between CBC and the Public Health Agency of Canada], there should be legislative assurances that the objectives of the newly intertwined relationships are not contradictory.

8.5.13. Alleged Denial of Medical Treatment Due to Pandemic Measures

Recommendations

To prevent situations such as the one faced by Ms. Sheila Lewis from arising in the future, a comprehensive, balanced, and transparent approach needs to be taken. The Commission makes the following recommendations:

- A. **Effective Communication and Education:** Both healthcare providers and patients must be committed to effectively communicating with each other. Given the grave consequences of any decisions made, each side must be committed to educating themselves with ALL SIDES of the discussion, which also requires listening to and understanding alternative opinions, and a mandatory review of the latest information available. This must be combined with a detailed and comprehensive list of objective reasons for any decision being made. Following policy is not a defence.
- B. **Policy Review and Transparency:** Vaccination policies within healthcare institutions should be regularly reviewed and updated based on evolving scientific evidence. The reasoning behind these policies should be transparent and easily accessible to patients. Policies should be implemented in a non-discriminatory manner and should consider unique circumstances and exceptions.
- C. **Ethics Consultations:** Complex decisions involving individual rights and public health should involve consultation with ethics committees. These independent bodies can provide guidance on balancing the competing values at stake, ensuring that any decisions made are fair and respectful of patients' rights.
- D. **Legal Framework:** Legislation should clearly outline the rights and responsibilities of patients and healthcare providers in the context of public health interventions like vaccinations. Clear legal guidelines can help prevent potential abuses and ensure that individuals' rights are respected and protected.
- E. **Patient Advocacy:** Encourage and support the role of patient advocates who can provide a voice for patients, ensuring that they understand their rights and are adequately represented in discussions about their healthcare.
- F. **Psychosocial Support:** Provide support services for patients who may be experiencing distress or facing potential discrimination due to their vaccination status.
- G. **Community Engagement:** Engage with communities to understand their concerns and attitudes towards vaccination. This can inform more effective communication strategies and foster trust.

H. **"Citizen Overview Committee" or "Public Health Review Board":** Establish independent review boards to provide an additional level of oversight and accountability for public health decisions, ensuring that these decisions balance public safety with individual rights. Here's how such a committee might operate:

- **Composition:** The committee should be comprised of diverse representatives from various backgrounds, including but not limited to healthcare, public policy, law, ethics, social work and patient advocacy. Members should include individuals from different age groups, socioeconomic statuses, ethnicities, and professional backgrounds to ensure a broad range of perspectives. Importantly, the committee should include members of the public who can represent the citizens' perspective. Each province should be required to set up these boards.
- **Operation:** The committee should be convened quickly in response to situations that warrant review. This requires a streamlined protocol for initiating reviews and an efficient method of communication among committee members. Given the urgency of public health decisions, the committee should aim to conclude reviews and deliver a decision within 21 days or less, depending on the situation.
- **Authority:** The committee should have a clearly defined mandate, including the power to request documents, to call witnesses, and to access relevant information. The decisions of the committee should be advisory but carry significant weight in policy decisions.
- **Transparency:** The committee's deliberations should be conducted with a high degree of transparency, while respecting necessary privacy laws. Decisions should be publicly accessible, and the reasoning behind each decision should be clearly explained.
- **Training:** Committee members should receive training to equip them with the necessary skills and knowledge to effectively review public health policy decisions. This could include training in healthcare ethics, public health policy, legal aspects of healthcare, and conflict resolution.
- **Review and Accountability:** The operation of the committee should be periodically reviewed to ensure that it is fulfilling its mandate effectively. This could involve surveys of stakeholders, review of decisions, and an analysis of the impact of the committee's recommendations.

The justification for a Citizen Overview Committee for public health decisions hinges upon several key democratic principles: representation, accountability, transparency and promotion of the public good.

- **Representation:** Democracy operates on the principle of "government by the people, for the people." Having decisions that affect public health made by (or under the review of) the very individuals it impacts ensures that a diverse range of perspectives and experiences are considered. This can lead to more balanced and equitable policy outcomes.

- **Accountability:** Public officials, even if unelected, should be accountable to the citizens they serve. A Citizen Overview Committee provides a mechanism for holding these officials accountable for their decisions. This creates a system of checks and balances, ensuring that public health decisions are being made in the best interest of the community.
- **Transparency:** The decision-making process should be transparent to the public. This fosters trust in the system and ensures that policies are implemented fairly and with clear justification. A Citizen Overview Committee, particularly one that makes its findings public, promotes this transparency.
- **Promotion of the Public Good:** Public health decisions should be aimed at promoting the public good. However, the definition of “public good” can vary widely among individuals and communities. A Citizen Overview Committee helps to define the public good in a way that reflects the values and needs of the community.
- **Accessibility and Inclusion:** The committee ensures the voices of marginalized or underrepresented groups are heard in policy-making. This can lead to more inclusive decisions that consider the impacts on all community members.

By basing public health decision-making in democratic principles, a Citizen Overview Committee can ensure that policies are equitable, just, and truly reflective of the community's needs and values. This approach provides a mechanism to challenge and rectify decisions that may be deemed as unduly harmful or unfair, fostering greater trust and cohesion within the community.

This type of committee could help to ensure that public health policy decisions are subject to rigorous and transparent review, thereby increasing public trust and ensuring a more balanced approach to managing public health crises.

Preventing situations like this from arising in the future requires a commitment and concerted effort from healthcare providers, policymakers, and the community. An approach that respects individual rights while protecting public health is essential. It is a vital and delicate balance, but with empathy, transparency, and open dialogue, it is fully achievable.

9. Conclusions

Anyone who participated in the hearings or watched even a small fraction of the more than 300 recorded testimonies will have been changed forever. Many of the testimonies were heartbreaking, shocking, and often terrifying. Over the 24 days of hearings, witness testimonies provided an overall sense of how Canada has been transformed, by the governments' actions to address the pandemic.

The transformation from what was once considered unthinkable -- e.g. sweeping restrictions of Charter rights -- to the acceptance of draconian government lockdowns within a span of just three years is indeed a remarkable phenomenon.

The testimonies objectively demonstrate that an unprecedented attack has been carried out on the citizens of Canada and that not since World War II have so many Canadian lives been lost due to a single aggressive attack on its peoples.

It is important to appreciate that this statement is based on sworn testimony of the events and experiences described by the witnesses and that these testimonies, as incredible as they are, do not fully capture the full breadth of the events that took place over the past three years.

The COVID-19 pandemic, which began in late 2019, presented governments worldwide with an unprecedented opportunity to change the direction of their nations. With the official excuse to contain the spread of the virus and prevent healthcare systems from being overwhelmed, many countries resorted to implementing strict lockdown measures.

These measures, which included widespread business closures, travel restrictions, and stay-at-home orders, were initially introduced as temporary and emergency measures to mitigate the immediate impact of the virus.

In the early stages of the pandemic, there was a widespread sense of urgency and fear surrounding the unknown nature of the virus. Government public health experts, and citizens, were grappling with the need to balance public safety with individual freedoms. The severity of the situation, as described in government propaganda and daily state media broadcasts, led to a general willingness among the population to accept stringent measures as a necessary evil.

During these early stages, the stated primary goal was to flatten the curve and prevent healthcare systems from collapsing under the strain of a sudden surge of COVID-19 cases.

Based on the biased and inaccurate propaganda being presented to the public, the notion of lockdowns seemed logical and justifiable to curb the rapid transmission of the virus. Moreover, because early effective treatments were suppressed in favour of new experimental genetic therapy vaccines, the need for non-pharmaceutical interventions appeared to be necessary.

Testimony from experts confirmed that by late March of 2020, the government already knew the true nature of COVID-19. They knew that it primarily affected the elderly with serious comorbidities, and they knew it was not unusually deadly or virulent.

However, governments persisted in their imposition of emergency measures, and as time went on, the long duration of lockdowns and their impact on daily life began to generate debate and dissent. Economies suffered severe contraction and losses, businesses closed permanently, and livelihoods were disrupted. The societal and psychological toll of prolonged lockdowns became increasingly apparent as people grappled with issues such as mental health, educational challenges, and social isolation.

Governments undertook unprecedented levels of spending, and the impacts of all of this debt will impact generations of Canadians to come.

Thousands of people lost their lives due to fear, loneliness, depression; the postponement or lack of medical care; or from adverse reactions to an experimental biologic injection.

People were so terrified by the government propaganda that they turned on each other; friends, families, and communities were torn apart. The government dehumanized large identifiable groups and, in so doing, encouraged a toxic and dangerous environment. As a result, the incidence of suicide, violence, and despair increased to unprecedented levels.

As the pandemic persisted, there were differences in the approach to lockdowns among various countries. Some nations adopted more targeted and localized measures, while others implemented broad and strict nationwide lockdowns. These varying approaches contributed to a diverse range of experiences and public perceptions.

Citizens began to undertake their own research and come together. They realized that standard practices which had stood the test of time had been discarded and replaced by ill-thought-out, ridiculous, and ineffective mandates.

Although governments had done extensive emergency planning well in advance of 2020, these emergency plans were simply discarded, and those professionals who were trained to implement emergency measures were sidelined.

In summary, the normalcy of once-unthinkable draconian government lockdowns within a relatively short period can be attributed to a focused campaign of propaganda and false information produced by government--and their partners in media and big business--to promote COVID-19 as a terrifying pandemic.

They used this excuse of combatting a novel virus, combined with fears of overwhelming the healthcare systems, to persuade the public to accept these measures.

However, as time progressed, the long-term consequences and societal costs associated with prolonged lockdowns could no longer be hidden from the public.

These are incredible claims to make, and just three years ago they were unthinkable. Once the reader has had the opportunity to thoroughly read this report and watch the video-recorded testimonies, there is no escaping the validity of these assertions.

Accountability for these alleged crimes must be rendered.

10. Commissioners' Statement

10.1. A Message to Canadians

Dear Fellow Canadians,

We, the Commissioners of the National Citizens Inquiry, address Canadians today with a message of empowerment, urging you to recognize the immense power you hold to shape the destiny of our great nation.

It is time to embrace our collective responsibility and take control of our government. Working together, we can create the kind of society that we can be proud to pass on to future generations.

As we collectively awaken to the cold realization of the magnitude of government acts against us, we must ensure that the horror that we all lived through can never happen again.

But it is up to you--not your representatives, not the party, not the other person. It is up to you.

Canada is a land of vast potential, blessed with abundant resources, diverse cultures, and a tradition of compassion and inclusivity. Yet, we find ourselves at a critical juncture where challenges and opportunities abound.

Our collective lips may be bloodied, but we are not defeated. We may be shamed, but we cannot turn away from the horror of the past three years--or it will never be expunged. Worse, it will once again visit itself on our children and grandchildren.

It is a fact of history that the true strength of a nation lies within the determination and resolve of its citizens.

We encourage you to reflect upon the society we desire for our children, one that is characterized by justice, equality, sustainability, and opportunity for all. It is a vision that can only be realized when we actively engage in the democratic processes that govern our land.

The power to effect change rests firmly in our hands.

Now is the time to demand transparency and accountability from our elected officials, to actively participate in public discourse, and to hold our governments to the highest standards.

We must remain vigilant, ensuring that our voices are heard and our concerns are addressed.

Let us not underestimate the influence we possess as engaged and informed citizens.

To create the society we all dream of, we must come together across all divides--geographical, social, and ideological.

We must embrace dialogue, respect diverse perspectives, and find common ground in our shared aspirations.

By fostering unity and understanding, we can overcome the challenges that lie before us and build a brighter future.

We must reject and turn away from the hateful ideologies and propaganda that was used to terrorize and control us. They did control us—neighbour against neighbour, parent against children, brother against brother, us versus them.

However, our responsibility extends beyond governance alone. We must also take a critical look at our individual actions and how we empowered the government to achieve these horrors.

Let us strive to be responsible stewards of our country, vigilantly protecting democratic practices that preserve our God-given rights and freedoms. Let us foster compassion, empathy, and inclusivity, creating a society that celebrates diversity and supports the most vulnerable among us, and protects the rights and freedoms of everyone.

Let the words *Never Again* be heard on every lip.

In the face of adversity, it is our duty as citizens to remain hopeful, resilient, and committed to the principles that define us as Canadians. We have a rich history of progress and innovation, and we can draw upon this legacy to shape a future that reflects our values and aspirations.

Together, let us embrace the responsibility that comes with citizenship. Let us engage in meaningful dialogue, hold our government accountable, and actively participate in the democratic process. Let us be the change we wish to see in our society.

With determination and unity, we can create a Canada that we are truly proud to pass on to our children, a nation that embodies justice, equality, sustainability, and boundless opportunities for all.

It cannot be business as usual. The crimes perpetrated on every single one of us must be addressed—and the perpetrators, at all levels, held to account.

10.2. Final Message of the Commissioners

We, the Commissioners of the National Citizens Inquiry, wish to express our heartfelt gratitude for the tremendous honour and privilege of serving on this distinguished Commission.

As this stage, as the Inquiry draws to a close, we reflect upon the incredible journey we have undertaken together and the significant impact our collective efforts have had on the pursuit of truth, justice, and accountability.

The Commissioners have had a firsthand opportunity to travel Canada from coast-to-coast and meet some of the most extraordinary and courageous citizens of Canada. These witnesses, although aware of the potential consequences of their testimony, bravely stepped forward and set an example for the rest of Canadians.

Throughout this arduous but profoundly important process, we have had the opportunity to work alongside some of the most dedicated professionals, experts, and stakeholders. Their unwavering commitment to the ideals of transparency, fairness, and the pursuit of truth has been an inspiration to us all.

We are grateful for their valuable contributions and for enriching our understanding of the complex issues at hand.

We extend our deepest appreciation to the individuals and organizations who courageously came forward to share their experiences, expertise, and perspectives. Their willingness to engage with the Inquiry has been vital in uncovering the facts, shedding light on critical matters, and shaping the recommendations that will guide positive change.

We also express our gratitude to the wider public for their unwavering support and unwavering confidence in our work. Their expectations, concerns, and aspirations have served as a constant reminder of the significance of our task and the responsibility entrusted to us.

We have endeavoured to honour this trust by conducting a thorough, impartial, and diligent Inquiry.

The collaborative spirit and professionalism exhibited by the Commission members, staff, and all those involved in the Inquiry have been exemplary. Their dedication, expertise, and tireless efforts have been instrumental in our collective pursuit of truth, fairness, and the betterment of our society.

As the Commissioners conclude our mandate, we are acutely aware of the impact our findings and recommendations may have on individuals, communities, and institutions.

We commit to ensuring that our Report reflects the highest standards of integrity, accuracy, and fairness, as we strive to provide a comprehensive account and actionable recommendations that address the core issues at hand.

Finally, we express our profound disappointment to the governments, legislatures, and all those who have not stepped forward to support and facilitate the work of this Public Inquiry. Their abject disregard for accountability, transparency, and the pursuit of justice is an existential threat to a just and democratic society.

Once again, we extend our sincere gratitude to each and every member of this Commission whose dedication, expertise, and unwavering commitment to the pursuit of truth have made this journey possible. It has been an honour and a privilege to serve alongside such exceptional individuals.

Thank you.



Kenneth R. Drysdale



Dr. Bernard Massie



Janice Kaikkonen



Heather DiGregorio



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*These transcripts
serve to preserve
the firsthand accounts,
opinions, experiences,
and perspectives of
those directly impacted by
or involved
in the issues
under investigation.*

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