Special Council Meeting

Monday, September 14, 2020
Conducted Electronically via MS Teams 4:00 PM

Agenda

Public Participation for September 14, 2020 Special Council Meeting

Council will be conducting the September 14, 2020 Special meeting through electronic communications in accordance with the Meeting Procedures (COVID-19 Suppression) Regulation, Order in Council 99/2020.

- Residents can listen to the live audio stream at www.rmwb.ca/Council
- Anyone wishing to participate in the meeting is encouraged to do so by registering to speak as a delegate by way of teleconference or by submitting their delegation comments by email.
- To participate by teleconference:
  - Anyone wishing to speak by teleconference to an item on the September 14, 2020 Council Meeting Agenda must pre-register by 12 noon, Monday, September 14, 2020.
  - To register to speak via teleconference, please email Legislative.Assistants@rmwb.ca or call 780-743-7001 with your name, the phone number that you will be dialing in from and an email address that you can be reached at prior to and during the meeting.
  - You must provide the name of the agenda item that you wish to speak to.
  - All registrants will be emailed the details on how to participate prior to the start of the meeting.
  - Each registrant will be given a maximum of **5 minutes** to address Council.
- To make written submissions as a delegation before or during the live meeting:
  - Please email legislative.assistants@rmwb.ca. You must include your name for the record.
  - You must provide the name of the agenda item that you wish to speak to in the subject line.
  - Please note that email comments for an agenda item must be received prior to the start of that item during the meeting. Emails that are received after the agenda item has been introduced or are not relevant to an agenda item, will not become part of the record of this meeting.
  - All written submissions are public and will be shared with Council verbally on the record during the course of the meeting.
  - Each submission will be shared verbally with Council for a maximum of **5 minutes.**

1. Call to Order

2. Unfinished Business

2.1. The Critical Importance of Keeping Regional Emergency Services' EMS Dispatch within Wood Buffalo

THAT Council publicly demonstrate its commitment to preserving Emergency Medical Services (EMS) Dispatch, operated by Regional Emergency Services (RES) of Wood Buffalo, and advocate, including sending letters to Government of Alberta Officials, in opposition to Alberta Health Services' (AHS) changes to consolidate EMS dispatch provincially; and

THAT Council continue advocacy with Mayors and Operational Leads of the satellite dispatch centres including Red Deer, Calgary, and Lethbridge for the continuance of RES coordinated EMS dispatch services in the region.

2.2. Q2 2020 Financial Performance Report

THAT the Q2 2020 Financial Performance Update be accepted as information.

2.3. Q2 Capital Budget Fiscal Amendments Update

THAT the 2020 Q2 Capital Budget Fiscal Amendments update, as summarized on Attachment 1 (2020 Capital Budget Fiscal Amendments, dated June 30, 2020), be accepted as information.

2.4. Heart of Wood Buffalo Excellence Awards

THAT the recommended recipients of the Heart of Wood Buffalo Excellence Awards, as outlined on Attachment 1 (confidential), be approved and kept confidential until the award recipients are announced by FuseSocial on Monday, October 19, 2020.

2.5. Nomination for the Canadian Federation of Municipalities Board of Directors

WHEREAS the Federation of Canadian Municipalities (FCM) represents the interests of municipalities on policy and program matters that fall within federal jurisdiction;

WHEREAS FCM's Board of Directors is comprised of elected municipal officials from all regions and sizes of communities to form a broad base of support and provide FCM with the prestige required to carry the municipal message to the federal government; and

BE IT RESOLVED that Council of the Regional Municipality of Wood Buffalo endorse Councillor Krista Balsom to stand for election on FCM's Board of Directors for a term expiring June 2021; and

BE IT FURTHER RESOLVED that Council assume all costs associated with Councillor Krista Balsom attending FCM's Board of Directors meetings.

3. New Business

3.1. Bylaw No. 20/024 - Face Covering Bylaw

1. THAT Bylaw No. 20/024, being the Face Covering Bylaw, be read a first time.
2. THAT Bylaw No. 20/024 be read a second time.
3. THAT Bylaw No. 20/024 be considered for third reading.
4. THAT Bylaw No. 20/024 be read a third and final time.

Adjournment

COUNCIL REPORT

Meeting Date: September 14, 2020

REGIONAL MUNICIPALITY OF WOOD BUFFALO

Subject: The Critical Importance of Keeping Regional Emergency Services' EMS Dispatch within Wood Buffalo

APPROVALS:

Jamie Doyle

Director	Chief Administrative Officer

Recommended Motion:

THAT Council publicly demonstrate its commitment to preserving Emergency Medical Services (EMS) Dispatch, operated by Regional Emergency Services (RES) of Wood Buffalo, and advocate, including sending letters to Government of Alberta Officials, in opposition to Alberta Health Services' (AHS) changes to consolidate EMS dispatch provincially; and

THAT Council continue advocacy with Mayors and Operational Leads of the satellite dispatch centres including Red Deer, Calgary, and Lethbridge for the continuance of RES coordinated EMS dispatch services in the region.

Summary:

On August 4, 2020 AHS announced its plan to centralize and consolidate the dispatching of EMS within 180 days for the Regional Municipality of Wood Buffalo, and three other cities including Lethbridge, Red Deer, and Calgary. This cancellation is supported by language in the existing contract that has a *termination without cause* clause, which provides AHS the ability to cancel within 180 days, and in this case, as of January 31, 2021. (Attachment 1)

Wood Buffalo has been opposed to the consolidation of Emergency Medical Dispatch services for many years. In 2009, AHS initiated its province-wide consolidation of EMS and dispatch services. Our region fought for and was granted an exception. Our region has offered an integrated ambulance, fire and dispatch service since the 1970s - this model has stood the test of time. We firmly believe, based on data, that it is the only model that works for our region. Our region is vast, equal to the size of the province of Nova Scotia. Wood Buffalo is home to six First Nations and six Métis communities. There are many rural communities within Wood Buffalo that do not have standard civic addressing. The changes to the EMS dispatch system may prove disastrous for our region based on clear and measurable service markers.

Alberta Health Services is rationalizing this decision based on a recent performance

review conducted by Ernst and Young. (Attachment 2) The report recommended the consolidation of satellite dispatch centres into the existing centralized AHS dispatch centres. The report noted that this would realize a provincial cost savings of approximately $5.0 Million. Recommendation 34 reads: *AHS should rationalize EMS dispatch and air ambulance operations including the relocation and decommissioning of underutilized airbases and a review of service agreements where services can be more efficiently delivered by AHS*.

This decision to remove emergency medical dispatch services from our region will significantly reduce the quality of EMS dispatch service, while creating silos and divisions when our paramedics and firefighters respond to citizen emergency calls. The marginal cost-savings of $660,000 that the Government of Alberta is projecting from the consolidation within our region will be more than offset by significant reductions in the quality of service.

Background:

The Regional Municipality of Wood Buffalo (RMWB) has operated a fully-integrated Fire and EMS service since the 1970's. The integrated dispatch service is a crucial component of coordinated emergency response for our region, in both fire and EMS, between our urban and rural departments and our industrial mutual-aid partners. Changes to the current model would have detrimental impacts on our mutual-aid industry partners, and Indigenous and Métis communities.

In 2016, following the wildfire, RES worked with AHS in good faith to incorporate dispatching technology into the RMWB's 911 Emergency Communication Centre. At this point a significant negative change in the dispatch times was observed. This was attributed largely to the additional steps in the dispatching process to activate emergency crews. We observed a consistent 3-5 minute delay in activating a fire pumper assist in response to a serious medical emergency.

RES found efficiency in the AHS process by leveraging our integrated model and taking advantage of the dispatchers being in the same room for in-person communication - getting the right resources at the fastest possible response time - to an emergency. Statistical analysis demonstrates that our 911 Emergency Communication Centre is outperforming the AHS counterpart by 41% due to the in-person communication within the 911 Emergency Communication Centre

Budget/Financial Implications:

The contract that is being cancelled provided $660,000 in cost recovery funding to the operation of the Regional 911 Emergency Communications Centre. Total cost of service to provide EMS dispatch services to the Wood Buffalo region is allocated to off-set four full-time IAFF employees (approximately $885,000).

Rationale for Recommendation:

The Regional Municipality of Wood Buffalo is the second-largest municipality in Alberta and one of the largest in Canada. It is RES's view that the proposed provincial integration of EMS dispatch services fails to recognize and respect the needs of our unique, vast and remote region. The provincial plan discredits the value of our integrated services delivery and the strong existing partnerships with industry and HERO. The proposed consolidation will likely result in poor patient outcomes, in return for marginal and disputable cost savings. For the above reasons, AHS's approach of a one-size-fits-all provincial model does not work for our region. This decision does not just impact the administration of dispatching in our region - it impacts how resources are deployed as a result, both in timing and in the amount of resources which are sent to a scene.

As part of our commitment to positive patient outcomes and appropriate care, our region has been absorbing the costs of dispatching additional ambulances beyond that within the current provincial funding model. With this change, we may now see under-deployment during critical emergencies. In reviewing the decision to consolidate emergency medical dispatch services, the facts are hard to ignore. (Attachment 3)

In summary, we know that:

- Our local dispatchers dispatch an ambulance 48 seconds faster than AHS, 90 percent of the time.
- Our local dispatchers verify addresses almost 30 seconds faster than AHS.
- Our region is vast, and civic addressing is not always standard or possible in our rural communities.
- Our local knowledge and familiarity with landmarks and hard-to-find places is crucial for the safety of our rural communities.

Impact on Resources

Our local EMS dispatch staff oversee and dispatch the contracted ambulance resources for the region, which includes four ambulances stationed in the urban area. As an integrated Fire/EMS service and dispatch centre, RES can provide higher levels of service to the region through seamless coordination and addition of resources within the region as the situation demands. This means we can go above and beyond AHS's baseline service.

Under the model that AHS is proposing, when a fifth ambulance is required (above the baseline of four), AHS would dispatch an ambulance from Lac La Biche. As a comparison, our current practice is to staff an ambulance with firefighters who are EMS trained and readily available in Fort McMurray. This scenario happens on an almost weekly basis. It's not uncommon to need more ambulances than the four we have -

there are times we concurrently staff up to six. This is especially prevalent when we are dispatched to calls in our southern rural communities, where travel can take up to two hours each way.

Our region's decade of experience as a contract provider to Alberta Health Services allows us to say, with a high degree of confidence, that the consolidation of dispatch by AHS will lead to the end of integrated service delivery and efficient patient-focused EMS services in our region. It is foreseeable that AHS will next wish to completely takeover the ground ambulance service from RES. As a result of the continuing requirements of our AHS contract, it is likely that the RMWB will be out of the "EMS business" and still be delivering EMS services.

Impacted groups in the RMWB:

- RMWB citizens
- RES employees
- First Nation and Métis communities
- Rural communities
- Industrial mutual-aid partners
- Local HERO medevac

Strategic Priorities:

Responsible Government

Attachments:

1. Alberta Health Services - EMS Dispatch Consolidation Notice - 08 04 2020

2. Alberta Health Services Performance Review - Summary Report - Ernst and Young - 12 31 2019

3. Dispatch Benchmarks and Call Volume for June 2020 Northern Communications Centre and Fort McMurray Contract Management

4. Joint Letter to the Minister of Health - 07 24 2020

Impact of AHS EMS Dispatch Consolidation to the Wood Buffalo Region

Written Submission - Chief Mel Grandjamb - Fort McKay First Nation

The Regional Municipality of Wood Buffalo
#2 Tolen Drive
Fort McMurray, Alberta
T9H 1G8

August 4, 2020

Attention: Jody Butz, Regional Fire Chief

Dear Mr. Butz;

Re: Notice of Termination of Services Agreement

We refer to the agreement between Alberta Health Services ("**AHS**") and The Regional Municipality of Wood Buffalo (the "**Operator**") dated May 1, 2016 with contract number CLM202703 (the "**Services Agreement**") with respect to the Provision of Dispatch Services.

Please accept this letter as written notice that pursuant to Section 5.4 of the Services Agreement, the Services Agreement is terminated effective January 31, 2021 (the "**Termination Date**").

We wish to remind the Operator of it ongoing obligations under the Services Agreement in effect between the parties, which are required to continue subsequent to the Termination Date.

Please do not hesitate to contact Rene Lessard at rene.lessard@ahs.ca should you have any questions regarding the foregoing.

Yours truly,

Rene Lessard
Executive Director, Direct Patient Care & General Services Contracting
Contracting, Procurement & Supply Management (CPSM)
Alberta Health Services

Alberta Health Services Performance Review

Summary Report

December 31, 2019

Building a better working world

Contents

1 Executive summary

Alberta's provincial health care model is one that deserves great praise. Through many years of regionalization, restructuring and redesign, Alberta has established the largest integrated provincial health care system across Canada, with more than 125,000 staff and 10,000 physicians serving 4.3 million Albertans.

Alberta's model has driven many successes. Integration has enabled Alberta Health Services (AHS) to streamline governance and accountability, driving standardization through provincially-delivered programs. Organizational leadership and culture have strengthened through consolidation – AHS is one of Canada's top 100 employers and is consistently recognized as a great place to work. AHS also raises more than $250 million annually through its foundations, which are invested in the health care system.

The transition from regional health authorities to AHS has also enabled greater integration, including through the consolidation of administrative systems like payroll, and through the current implementation of Connect Care, the largest province-wide clinical information system across Canada. The shift away from regionalization over the last 20 years has clearly begun to pay off while providing Albertans with a platform from which to continually modernize and improve health services delivery.

However, a significant challenge remains in Alberta. Alberta spends more money on public services than any other Canadian province. Health care, which accounts for approximately 43% of the public spend in Alberta, continues to outpace provinces such as Ontario, BC and Quebec on a per-capita basis. Considering the structural growth pressures that exist in health care, notably negotiated wage increases and population growth, Alberta's spending on health would have to remain flat over the next four years to align with these provinces.

This is a key component of Premier Kenney's Health-Care Guarantee to Albertans, which included a performance review of AHS. In conducting this review, we aimed to provide clear answers on how health care dollars are being spent, what improvement opportunities exist across AHS when considering leading organizations and systems, and to provide recommendations on how long-term sustainability of the health care system can be achieved.

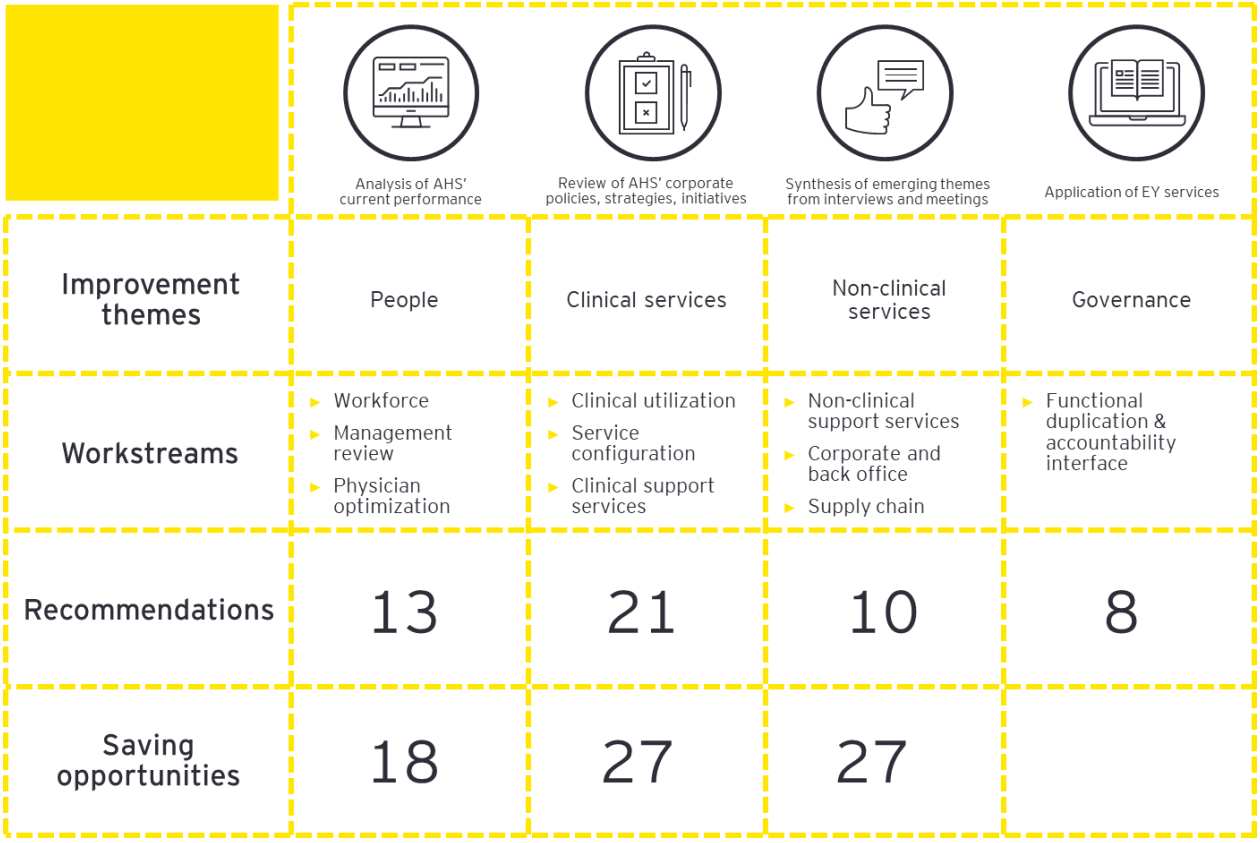
In alignment with the Health-Care Guarantee, core to our review approach was hearing directly from Albertans, including patients, staff and physicians working in AHS. We also heard from key stakeholder groups including patient advocates, regulatory bodies and associations, as well as municipalities and universities. We received an overwhelming response from Albertans, AHS employees and physicians: over 30,000 responses were received through surveys, interviews and focus groups. This signals to us that Albertans recognize that change is needed and want to be part of it.

At the commencement of our work we were given clear direction by the Minister to engage broadly, and to hear directly from Albertans. We have done so and have been guided by the thousands of Albertans – from physicians and care providers to front line staff, managers and the organizations that work alongside AHS - who have shared their perspectives and ideas through this process.

We leveraged the response from across the province to design ten focus areas, or workstreams, that aligned with where the current state analysis and benchmarking of AHS' performance took us. We then took opportunities aligned to these workstreams to staff closer to the front-line to validate and further understand their causes and historical drivers. We also assembled a panel of Global Experts with experience working with health systems like AHS, and who have led significant optimization efforts, to provide an international point of view on potential opportunities, as well as key considerations for implementation and long-term sustainability.

This led to the design of recommendations grouped into 4 key areas of improvement: governance, people, clinical services and non-clinical services. Each area is associated with specific workstreams. The recommendations and opportunities in this report are provided at the workstream level.

Figure 1. Improvement themes and workstreams[1]



The reality is that AHS will need to take actions on a range of opportunities to meet their budget targets, while managing growth pressures and funding provincial strategies such as reducing surgical wait times. We are not suggesting AHS can implement the opportunities we've described in this report all at once. In fact,

[1] In addition to recommendations aligned to the workstreams, 5 recommendations have been put forward aligned to Implementation. These are outlined in Section 7 of this report.

we expect that appropriate validation and phasing of opportunities will be a critical element of the path forward. Our intention is to provide AHS with potential areas of focus, evidence, and opportunities that they can leverage in their future planning efforts to manage operational costs and anticipated pressures.

AHS will need to consider the opportunities presented and, in coordination with Alberta Health, develop an achievable plan for implementation. The values included in this report are presented as gross opportunity amounts and do not represent expected or even achievable savings. The values are presented in this manner to illustrate the breadth of the opportunity that is available to AHS. Achievable savings need to factor in implementation costs, the selection, phasing and sequencing of opportunities, and any potential interdependencies across opportunities. This report provides AHS with a framework from which to begin designing specific initiatives as part of a multi-year implementation strategy. This will inform a savings value that the organization can plan for. The development of this strategy is discussed in greater detail in the final section of this report.

AHS was an active and helpful participant in this exercise. Their executive team led by CEO Dr. Verna Yiu, was highly responsive, providing us with all relevant information and access to key staff within the organization and across the province.

The report that follows summarizes the findings, recommendations, and opportunities identified throughout our review. It is our hope that this will inform Alberta's continued journey of heath system improvement and sustainability.

More detailed discussion of our specific findings and recommendations is available in a full-length companion report.

2 Introduction

The pathway towards a provincial health system

AHS is Canada's largest provincially integrated health system. AHS is the major service delivery arm of Alberta's health system, governed by the AHS Board and accountable to the Minister of Health. AHS provides health services to more than 4.3 million Albertans as well to patients in Saskatchewan, British Columbia and the Northwest Territories for specific health care services.

The formation of AHS is a culmination of several efforts to restructure health services in Alberta. In 1994, more than 200 separate boards and administrations were replaced by 17 new regional health authorities, which were further consolidated in 2004 to 9. In 2008, the Minister of Health and Wellness announced the creation of AHS, as a single, centralized health authority built on an integrated governance model.

The singular governance structure of AHS was intended to streamline access of health care services, drive more effectiveness and efficiency, and create a high quality and innovative system of care.[2] This was to be achieved through a reduction in regional inequalities and competition for health system resources, while centralizing accountability for service delivery across the province.

Early in this period of restructuring, Alberta experienced significant reductions in health care spending across the province – from $1393 per capita in 1993, to $1156 in 1995 – driven largely by reducing the number of hospital beds and the associated health human resources workforce.[3] Since that time, however, Alberta has experienced uninterrupted health spending growth, which has led to Alberta spending significantly more per-capita than its peer provinces.

A national case for change

This review of AHS comes amidst many provinces exploring new and different health care delivery models. Much of this is driven by a growing body of evidence that the level of health system performance does not match how much Canada spends on health, when compared to other international jurisdictions.

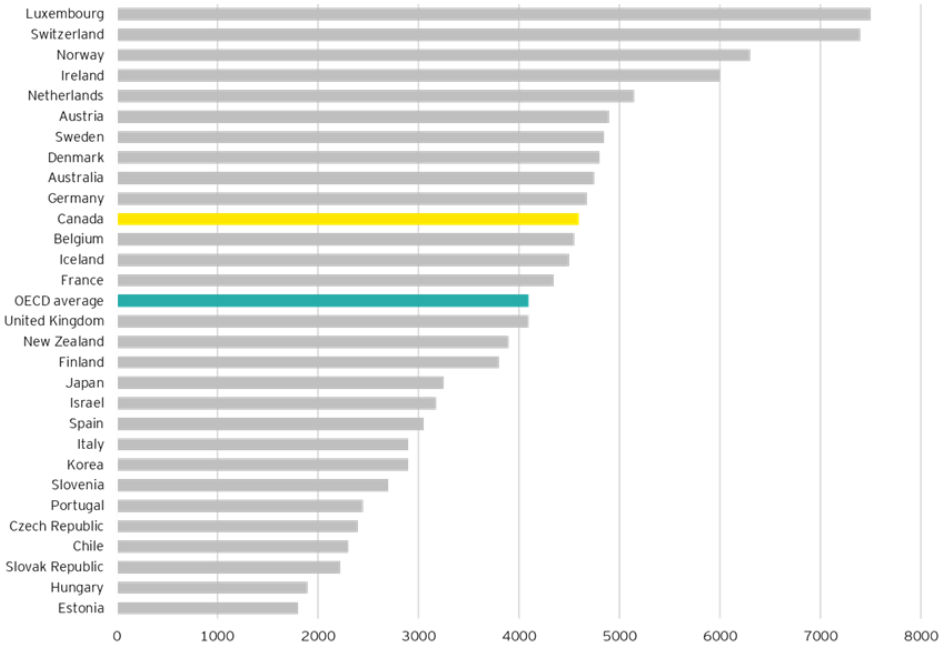
In 2017, the Fraser Institute released a study of Canada's health system performance compared to 29 other countries with similar universal access health care systems. This study used a 'value for money' approach, comparing expenditures with four measures of performance (resource availability, use of resources, access to resources, and quality and clinical performance). The study found that Canada ranks among the most expensive universal access health care systems across the OECD. Resource availability and use of resources

[2]Government of Alberta news release, 2008.
[3] Health Reform in Alberta: The Introduction of Health Regions.

were among the worst and access to resources and quality and clinical performance was mixed. Figures 2 and 3 provide examples of Canada's performance compared to other countries in the study.

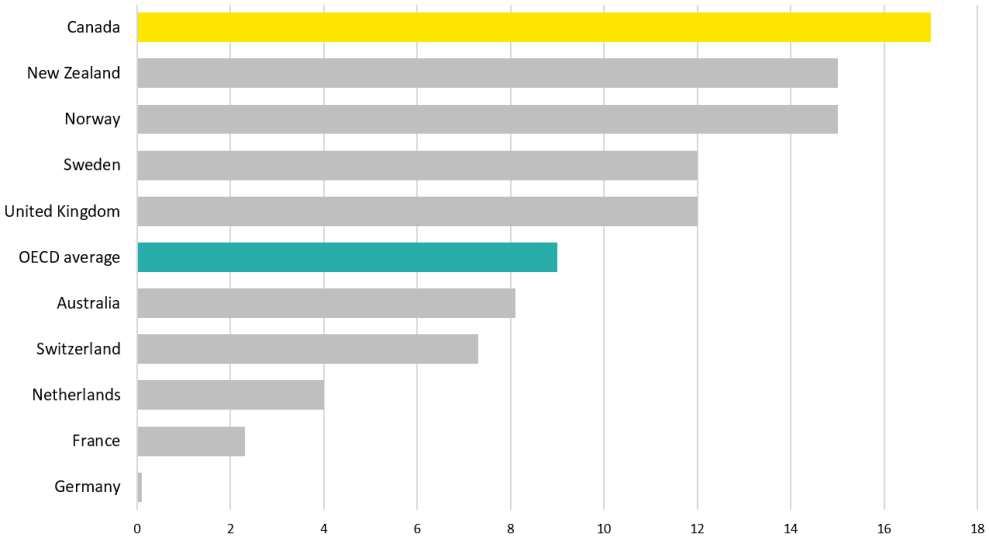
The study concluded that there is an imbalance between the value Canadians receive and the relatively high amount of money spent on care.

Figure 2. Age-adjusted health care spending per capita, 2015



Source: OECD, 2017

Figure 3. Age-adjusted percentage of patients who waited 4+ months for elective surgery, 2015



Sources: Commonwealth Fund, 2017; OECD, 2017

Another study from the Commonwealth Fund also reinforces Canada's higher spend and lower relative performance relationship on the international stage. This study also includes the US health care system and leveraged 72 indicators across the domains of care process, access, administrative efficiency, equity and health care outcomes. Canada ranked 9 out of 11 countries overall, largely driven by lower performance on indicators related to the domains of access, equity and health care outcomes.

The message that these studies create is consistent and clear: Canada's high rate of spending on health does not correlate with higher relative performance on key international measures. This creates questions around how health care dollars are spent, the distribution of these dollars across the health system and how provinces and individual health organizations like health authorities or hospitals use funding as an incentive for achieving high quality patient outcomes.

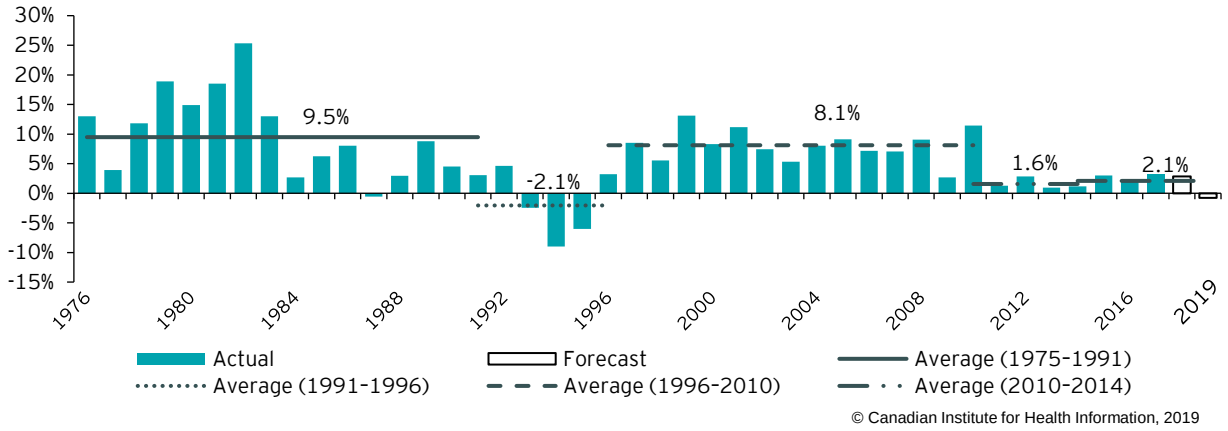
Albertans can be justifiably proud of the provincial health system. It offers world class care to Albertans located across the province, but there is clearly an opportunity to improve the quality and affordability of our health care. Our report, and the direction we have been given by the government, is not about spending less. It is about getting value for what Albertans spend and doing more with the money that exists in the system.

Alberta's health spending and performance

Health spending accounts for the largest proportion of the Government of Alberta's budget – approximately 43%[4]. How dollars are spent on health therefore has a large impact on the fiscal position of government.

Alberta's health spending per capita has generally increased over the last 40 years, with the exception of several years in the 1990s.[5]

Figure 4. Growth in Alberta provincial government health spending per capita



Source: Table B.4.2 (Series B), National Health Expenditure Database, CIHI.

However, Alberta continues to spend more than other Canadian provinces on health.[6] As illustrated in Figure 5, only the territories and Newfoundland spend more than Alberta, per person, on health (this includes

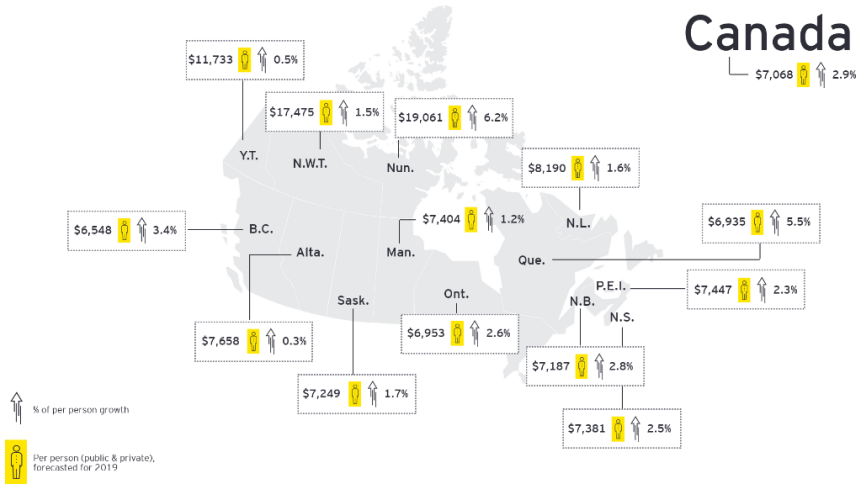
[4] Government of Alberta. *Fiscal Plan: A Plan for Jobs and the Economy 2019-23*. Edmonton, AB.
[5] Canadian Institute for Health Information. *Health Expenditures in the Provinces and Territories – Provincial and Territorial Chartbook, 2019*. Ottawa, ON: CIHI; 2019.
[6] CIHI. National Health Expenditure Trends.

private expenditures such as drug costs), and when compared to provinces with similar patient demographics, such as Ontario and British Columbia, Alberta stands out as the most expensive.

It is also concerning that Alberta's higher level of health spending has not translated into commensurate results and performance levels. Comparatively speaking, Albertans get lower value for their money.

A study from the Fraser Institute found that Alberta ranks 5th on access to physicians, 7th on access to nurses, 6th on hospital beds, 5th on MRIs and 8th on CT Scanners. The study also found that Albertans faced a median wait of 26.1 weeks between GP referral to treatment – far in excess of the national average.[7]

Figure 5. Per capita spending on health across Canada



Similarly, the Conference Board of Canada concluded that Alberta is a "middle-of-the-pack performer" when considering its performance on 10 health indicators against all 29 jurisdictions (all provinces and territories, and 15 peer countries). Alberta scored 12 out of 29 jurisdictions. Of particular concern was Alberta's performance on infant mortality rates, as well as mortality due to heart disease and stroke.[8]

This does not mean that Albertans do not have a high-quality health care system. It should be noted that Alberta does lead the country on several nationally reported indicators. These include the total time spent in the emergency department for admitted patients, repeat hospital stays for mental illness and the potentially inappropriate use of antipsychotics in long-term care. Alberta is also among the top performers nationally on obstetric patients being readmitted to hospital, hospital deaths and the percentage of patients requiring hip fracture surgery within 48 hours.[9]

Additionally, Alberta has made significant investments in innovative clinical care, including the Gamma Knife technology at the University of Alberta Hospital which avoids invasive neurosurgery, and the Alberta Transplant Institute, ranked sixth in the world for transplanting excellence in clinical care and research[10].

Moving forward, Alberta's spending on health services should be balanced by the outcomes generated for patients, as well as affordability and sustainability across the system. Alberta's integrated position provides an excellent starting point to address key areas of system improvement, driving further value for the investments made in the system.

To put it simply, Alberta's high spending on health services does not consistently translate into achieving the highest performance on key measures of system access and patient outcomes.

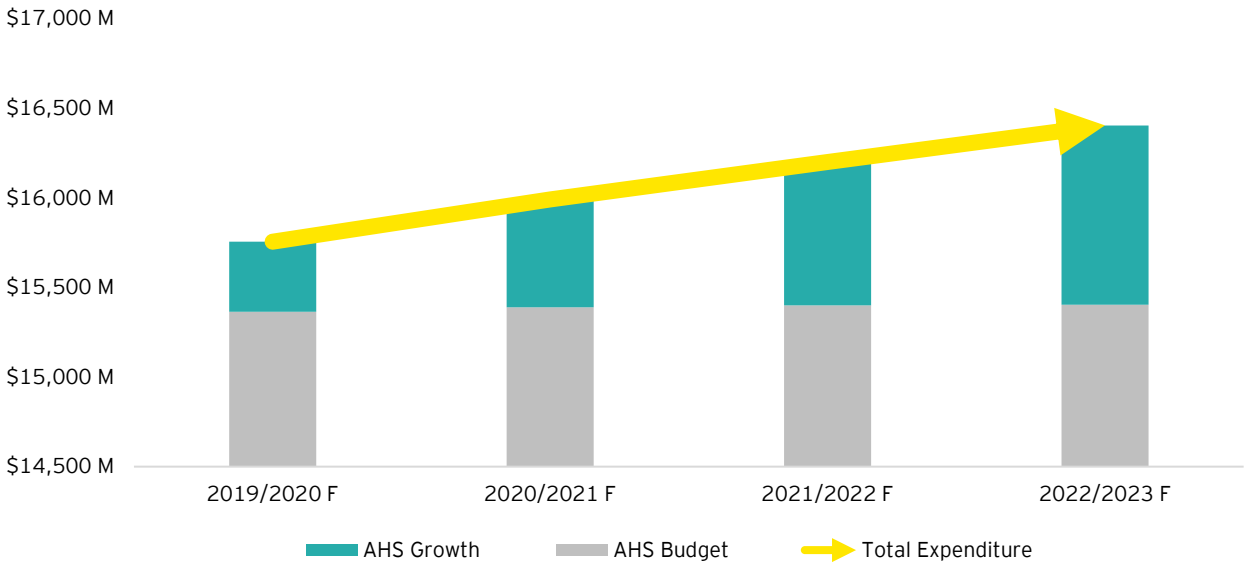
[7] The Fraser Institute. Waiting Your Turn: Wait Times for Health Care in Canada, 2018 Report.
[8] The Conference Board of Canada.
[9] CIHI. Data retrieved from *Your Health System* website.
[10] Centre for World University Rankings. 2017.

The challenge ahead

Alberta's 2019 budget outlines a plan to end the provincial deficit by 2022. Doing so is going to require making hard decisions across all sectors, including health. The government has pledged to not reduce health spending in the province – in fact, the 2019 budget includes an increase in health spending over the next four years.

While AHS isn't seeing its funding reduced, it has unavoidable growth pressures that it will need to address – things like a growing and aging population, new hospitals opening, scheduled collective agreement rate step increases, and commitments to improve services in areas such as surgical wait times. As illustrated below, these pressures represent the equivalent of approximately 1.5% year over year growth. This means that to hold expenditures flat, AHS will have to realize equivalent offsetting efficiencies. This is significant. Managing this challenge will require doing things differently and finding opportunity to use the current health budget more efficiently. The challenge is not to spend less, but to get better value for the dollars that are spent – and it's a challenge we believe that AHS will be able to meet.

Figure 6. Systemic growth pressures to be offset



While the scope of this review focuses on AHS, the scale of the fiscal challenge facing Alberta will require a response across the system. While AHS is accountable for most of the health spend across Alberta, other areas of healthcare spending, notably physician compensation and the provincial drug program, are the responsibility of Alberta Health. Addressing the fiscal challenge will require equally urgent action in these areas, including enhancing government's ability to manage uncontrolled growth in the physician services budget. In parallel to this review of AHS, Alberta Health has begun developing and implementing strategies to address spending on physicians and drugs in the province.

How to read this report

This report consists of the following sections:

- **Review approach and methodology** – restates the review mandate, summarizes the high-level approach to generate key workstreams, findings and opportunities for long-term sustainability;
- **Stakeholder engagement findings** – summarizes the approach, the stakeholders engaged across Alberta, the response received and key takeaways;
- **Workstream findings and recommendations** – outlines the findings, recommendations and opportunities across 10 key workstreams;
- **Opportunity prioritization** – an overview of the prioritization approach undertaken across all opportunities based on complexity and speed to value.
- **Implementation recommendations and the path forward** – a summary of recommendations to provide Alberta Health and AHS with clear direction on what is required to commence the implementation effort.

3 Review approach and methodology

The case for change: a performance review of AHS

On February 20, 2019, then leader of the United Conservative Party Jason Kenney called for a comprehensive performance review of AHS, as part of the Health-Care Guarantee to Albertans.[11] Alberta Health set out the following terms of reference for the review:

1. Examine AHS' management structure, organization and administrative costs, and recommend appropriate consolidation and reorganization reallocating savings to front-line service delivery,
2. Evaluate AHS' programs, services and policies, to identify overlapping functions, including overlap between AHS and Alberta Health, and methods that are out of step with the best practices in other Canadian jurisdictions,
3. Compare AHS to other provinces' health systems and best practices, and identify opportunities to make AHS' operations responsive to the front-line, based on an evaluation of resource distribution, and
4. Gather input from employees, physicians and the public to inform opportunity areas across AHS.

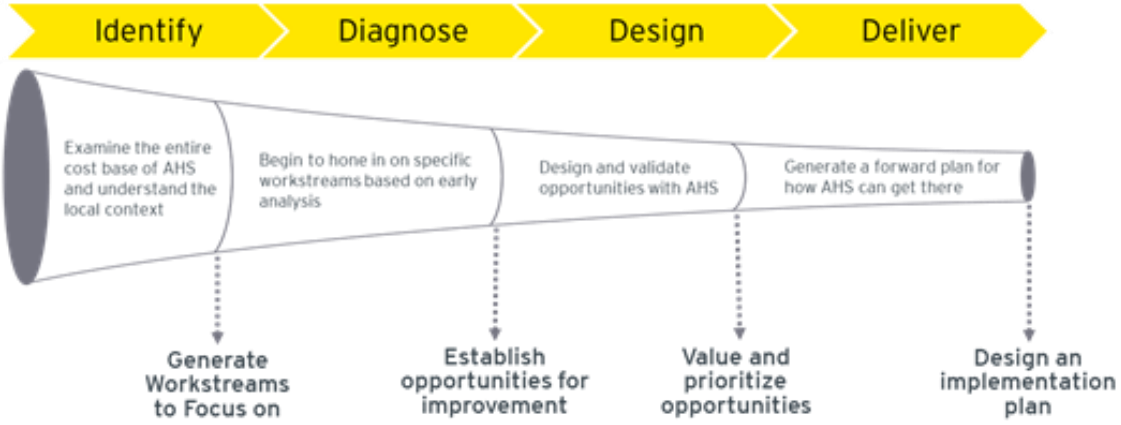
The review commenced in July 2019 with final recommendations to government due by December 31, 2019.

Review approach

To address these objectives, our team designed a four-phase approach. The approach enabled our review team to hone in on specific opportunities through an iterative process, leveraging stakeholder feedback, analysis, benchmarking, testing and validation with staff working within AHS.

[11] United Conservative Party News Release, February 2019.

Figure 7. AHS review approach



Of note, Covenant Health, Lamont Health Care and AHS' wholly-owned subsidiaries were not reviewed individually or separately throughout the review. Where relevant, they were reviewed within each of the workstreams through a consistent review methodology.

Global expert panel

Our approach leveraged the experience and expertise of experts from around the world and across Canada.

We did this by assembling a panel of national and international health system experts to act as advisors to our review team. Members of this global expert panel included former hospital CEOs, health care executives, chairs of government-appointed commissions, former government officials, physician leaders, and experts in key areas such as alternative service delivery for clinical and non-clinical services, IT and Digital Health. We engaged the global expert panel in sessions at four key points in the review.

The recommendations and opportunities summarized in the following sections have been informed and strengthened by the challenge offered up by these experts. We very much appreciated the support they have provided and would recommend establishing a similar advisory group during implementation.

Stakeholder engagement

Engaging Albertans, staff working within AHS, as well as physicians and a variety of health system stakeholders, was a cornerstone of our approach. This is detailed in the following section.

4 Stakeholder engagement findings

Overview

From the onset the guidance we received from Alberta Health and the Minister of Health was clear: make sure that our work is guided and informed by system stakeholders. We took this to heart. Through meetings, roundtables, surveys, and public forums we heard from those who manage our system and, most importantly, those who provide and receive care in it. Our findings reflect what we heard from them and our recommendations have considered the impact proposed change will have on them.

Key stakeholders across the province were segmented into four key groups.

- Albertans
- Health System Stakeholder Groups
- Alberta Health / AHS Executive Leadership
- AHS Front-Line Staff, Management, and Physicians

More than 1,000 responses were received from Albertans. These responses were used to better understand potential areas of opportunity that we then used to test with analysis and more in-depth discussions with AHS.

We also heard from many of Alberta's health system stakeholder groups. These included the regulatory colleges, professional associations as well as the universities and municipalities. Our project team also had the privilege of meeting with the Price Family who bravely shared a story about the untimely and avoidable death of their son and brother Greg. Our time with them profoundly impacted us, and provided us with a compelling, patient-focused perspective on gaps in the health care system. The findings and recommendations in this report address many of the areas they highlighted to us. Their determined efforts to develop proactive strategies to avoid similar incidents from happening in the future can serve as inspiration for Albertans as they embark on the transformation journey that has begun. For more information about the Price family and Greg's story, visit http://gregswings.ca.

> *"To Dream Forward we need to empower people, enable innovation, and reinforce that teamwork is key to maintaining health and providing care. This government can work with that new vision and to take those strong leadership steps."*
>
> *Comment from David Price following a viewing of "Falling through the cracks: Greg's story."*

Senior government officials in Alberta Health, as well as AHS' Executive team, were engaged throughout the review process. This provided our team with the strategic context of Alberta's health system, the structure and function of AHS and its unique structures (e.g. zones, strategic clinical networks, provincial programs), as well as with understanding the interface between Alberta Health and AHS from an accountability and funding perspective. Both leadership teams provided us with feedback on our interim findings and emerging opportunities to drive a level of validity as we designed our final recommendations.

Finally, AHS' front-line staff, management and physicians were engaged in two key ways. First, a survey was distributed to staff and physicians working within AHS, as well as AHS' wholly-owned subsidiaries and Covenant Health. The response we received was significant – more than 30,000 anonymized responses were submitted, with many staff providing ideas around key areas that could be improved across AHS. We leveraged this feedback to identify lines of inquiry, and to validate or discount opportunities that our teams had designed through our own analysis and benchmarking of AHS' costs. This survey relied on respondents to self-identify as front-line staff, management or physicians to help us understand if perspectives varied by group, and to drive more targeted engagement in future phases of work.

We also leveraged AHS staff in a series of zone-based operational leader focus groups. This allowed our team to bring forward key themes to leaders close to the front-lines of service delivery. For example, we invited leaders from HR, professional practice as well as patient care managers to understand major drivers for variation of staffing models, practices for controlling overtime and sick time, and root causes associated with varied levels of skill mix performance.

The sessions were in-person, within each of the zones. This allowed our team to understand any of the unique or local considerations that impact service delivery, which also helped us understand what would be required to implement opportunities effectively across a very diverse health system.

What we heard

Simply put, the response we received from Albertans, those working in AHS and those working with AHS, went beyond our expectations. Over 30,000 responses were received from Albertans, AHS employees and physicians across the various engagement channels guiding our review, representing stakeholder input that far exceeds any of the many other similar projects we have conducted across Canada.

Specific opportunities that came forward from staff and members of the public were assessed within each of the workstreams discussed in the following section. This allowed our team to consider these inputs alongside our analysis of AHS' performance when identifying and validating opportunities. These opportunities were also used to shape conversations with AHS staff, including the operational and clinical leaders, that drove further validation and refinement of potential improvement initiatives.

This report also includes specific quotes from Albertans, as well as AHS employees and physicians from the survey or the operational leader sessions. These quotes represent what was told to us when asked about improvement opportunities or successes across Alberta's health care system but should not be considered as perspectives that have been validated or endorsed by EY.

In addition to the engagement guidance we received in developing opportunities, feedback also led us to some important themes on culture, decision making and organizational readiness which we found very helpful in understanding the context surrounding our findings and in making recommendations for the path forward.

These themes are not a comprehensive representation of everything we heard across each channel. Our team aggregated the findings and what we heard, identified key points of consensus, and designed themes that were the most representative of what was shared with us throughout the review.

These themes are summarized below, alongside selected individual responses from the AHS staff survey, the public engagement process and our many discussions with staff throughout AHS. They provide representative insight into the themes we describe below.

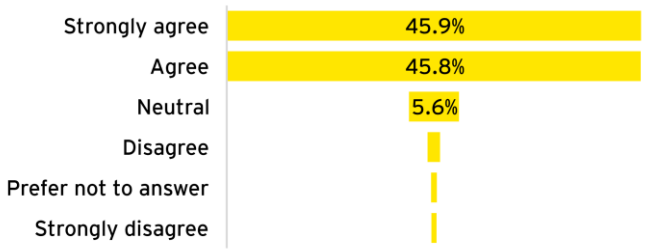
Summary of provincial engagement

1. **75+** Health System stakeholder engagement sessions
2. **5** Zone-based operational leader sessions
3. **1,074** Emails received directly from Albertans
4. **32,519** Staff survey responses, with each zone proportionally represented
   - North – **8.9%**
   - Central – **10.8%**
   - Calgary - **32.5%**
   - Edmonton – **34.9%**
   - South – **7.7%**
5. **28%** Response rate
   - **27,073** – Front-line staff
   - **4,223** – Leadership
   - **1,223** - Physician

Theme 1. *AHS is a change ready organization, with a strong organizational will to drive efficiency while delivering excellent care.*

An overwhelming majority (90%) of respondents to the AHS staff survey agreed that protecting and strengthening the affordability and sustainability of Alberta's health system should be a key priority for AHS.

Figure 8. Overall Response to Survey Question: "Protecting the affordability and sustainability of Alberta's health care system should be an important part of AHS' purpose and vision."



We also heard a clear message from all levels of staff: dedicated, strong and stable leadership is necessary for AHS.

The consolidation process was a tremendous effort and was disruptive and challenging for leaders and staff alike. The first five years of AHS' current existence was marked by changing leadership and significant uncertainty. Any organizational change has the potential to impact the morale of people at all levels. We consistently heard that the appointment of Dr. Yiu as CEO was a turning point for the organization, enabling AHS to move beyond the disruption of its first few years and build momentum towards becoming an integrated, patient-centred provincial health system.

> *"Dr. Yiu and her leadership team have provided the guidance that has been required to stabilize an organization the size and scale of AHS."*
>
> *Comment from AHS Employee Survey*

Finally, there were several perspectives that we heard from Albertans around the high degree of quality experienced when utilizing AHS' services. We heard many success stories – about individual physicians, nurses, clinical staff, speciality clinics or sites, that provided

compassionate, caring, high quality care and support to patients and their families. This is not a minor point and should not be lost in the necessary discussion on improvement opportunities that follows.

This report is in no way an indictment of Alberta's health system. Quite the contrary. It is an evidence-based commentary on a path to improvement. This path should never end. It became clear to us throughout this review that the AHS staff, physicians, leadership and users we heard from acknowledge this imperative. Our work here is focused on providing them with the information and tools they need to act on it.

Theme 2. *The prevailing culture surrounding Alberta's health system is defined by many as being risk averse. The level of transformation envisioned by Alberta's future vision for better and more sustainable health care will require responsible, but bold action.*

A common improvement opportunity raised by staff, as well as many of the health system stakeholder partners we worked with, was the risk averse culture that exists across all levels of staff at AHS.

Many of the examples cited were related to AHS' relationship with its unions. Staff indicated that skill mix opportunities, or new and innovative staffing models, often failed to receive management consideration or endorsement for fear of potential grievance or union opposition. Real change will require discussion and consideration, even if not all ideas are adopted in the end.

We also heard that staff were not able to work to their full scope of practice due to operational decisions that were based on historical ways of working. When we brought this forward to operational leaders across many of the zones, the theme resonated, and additional examples were provided related to better use of licensed practical nurses and nurse practitioners.

Front line staff and operational leaders have clear ideas about how to improve the way they work. We heard from them about topics ranging from the layers of approvals required to drive standard purchasing or hiring decisions to a perceived movement towards a more 'command and control' environment that was in place prior to the establishment of the five zones.

This isn't to say that these are black and white issues that warrant immediate action or reversal. It is more complicated than that. For example, the negative reaction to a perceived move to more "command and control" could be natural uneasiness with more standardization, fiscal restraint and increased efficiency that requires a disruption to more familiar local practices. A dialogue is required in which we can find ways to disrupt the system for the better while understanding and accommodating the impact that it has to the ways in which we are used to working. This dialog isn't without risk. In our experience and based on the engagement that led to this theme, it in our view is a risk worth taking.

Staff also told us that the culture of risk aversity is not contained to the organizational boundaries of AHS. Canada's fully public health care system links operational decisions to the elected governments that fund it. The value that Canadians place in our health system puts intense scrutiny and near-automatic opposition to any change proposed. Alberta is no different in this regard.

> *"People truly want to do the right thing, but we fall short. Sometimes I feel my hands are tied but I don't understand why."*
>
> *Comment from AHS Employee Survey*

When we asked staff and operational leaders for their ideas on long-term sustainability, many brought up opportunities related to hospital configuration – the services provided in hospitals and the number of hospitals that provide them. Many staff indicated that there could be opportunities to reclassify or reconfigure sites that had lower occupancy or under-utilized services, into long-term care homes or urgent care centres that more practically meet the needs of the community they serve. The readers of this report will understand the risk that policy and decision makers face when considering these sorts of proposals.

It is important to point out that we have been directed by the Minister and his Department to identify and report all evidence-based improvement opportunities. The consideration of them by government, AHS and Albertans will likely challenge the culture of risk aversity discussed here. Regardless of which opportunities end up forming the path to improvement and sustainability at AHS, we believe that a culture of consideration and open dialog should be welcomed. To this end, we have made a recommendation regarding Alberta Health's role in actively engaging and informing Albertans on system sustainability and performance that will be discussed later in this report.

Theme 3. *Organizational priorities for achieving health sustainability are not always clear.*

We heard examples from all levels of staff on ways to transform AHS and the broader health system. The staff survey results further recognize the commitment of organization leadership to drive the required transformation. Almost three quarters of staff respondents felt that AHS' leadership is committed to achieving greater health system efficiency. AHS has established solid organizational foundations, commitment and capabilities to drive towards long-term health system sustainability.

While many of these provincial initiatives and priorities are positive, we heard from staff that the volume of these initiatives, as well as the complexity and timescales associated with them, create difficulty in implementing or sustaining the desired benefits. For example, many operational leaders indicated that clinical pathways developed by some strategic clinical networks could not be implemented due to a lack of resources. Others indicated that the coordination of various initiatives could be improved, as guidance or direction that stemmed from different initiatives in the same area were not being coordinated by leaders at the site, zone, or executive level.

> *"From an organizational standpoint we should focus on fewer priorities but getting them done in a timely fashion and getting them done right."*
>
> *Comment from AHS Operational Leader Session*

The staff survey also suggested that grass-roots ideas driven by the front-line often fail to gain traction with leadership, potentially due to a lack of capacity and focus on other priorities. This feedback is important. AHS simply cannot execute everything at once, nor can staff, clinicians and managers be expected to treat every project or initiative as an incremental stand-alone project to their primary role of delivering health care. Phasing, coordination, and integrating the improvement program into the operational and decision-making fabric of the organization is a key topic we will return to in our section on implementation. Getting this right has been the key critical success factor for organizations that have implemented similar sustainability programs.

The feedback we heard from external health system stakeholder groups was consistent with this. Many indicated that AHS' strategy and overarching goals were clear, but how AHS works with government to take the health system forward, based on a clear articulation of priorities, objectives and goals, was not. Many of these stakeholders stated that AHS is an organization that has received many recommendations in the past, including from the Auditor General or the Health Quality Council of Alberta. Yet AHS' ability to prioritize these recommendations, act on them, and demonstrate progress in a transparent way, was voiced as an area where AHS can improve.

We've observed that the highest performing organizations have processes for setting priorities, designing initiatives and implementing them with clear indicators of success. They also have the willingness to stop doing things that are no longer adding value or have transitioned into operations. They have created a new normal where the most important changes are integrated with the most important task – caring for patients.

From what we heard from staff and health system partners, establishing clear priorities, rationalizing what is no longer adding value and creating a clear framework of what needs to get done, by whom and by when, will help to drive realization of benefits, as well as balance the workload on leaders and staff closer to the front-line.

Theme 4. *Alberta has the right foundation in place to maximize the benefits of its position as a provincially integrated system*

The survey also validated a theme that had developed through our analysis and via our many discussions with stakeholders: AHS can and should be achieving a greater level of system performance, based on its consolidation into a single health authority. As we discuss in the back-office section below, AHS' benefits from lower administration costs than its provincial peers and has developed consolidated service models in corporate services that serve as a foundation for further optimization.

However, benefits of AHS' integrated system are as important when it comes to patient care across the province. We heard from operational leaders, physicians and front-line staff that AHS' zonal structure has been useful at maintaining local considerations in care delivery, while at the same time achieving benefits of standardization and focused specialization that come with a truly integrated provincial system. There was support for retaining this structure as the provincial health system continues to transform.

At the same time, we also heard that zones are not always consistently operating as a zone, but more so as a collection of sites that exist in the same geographic area. For example, we were told by operational leaders that policies for repatriation and patient flow were often driven by preferences and historical practices of individual sites. This has apparently created difficulties in moving patients across a zone to the most appropriate setting with the available capacity. Another example was the siting and reclassification of sites based on patient demands and capacity across a zone. Consistently, we heard that these opportunities for consolidation and reconfiguring sites were understood, but not always acted upon.

Stakeholders also forwarded ideas on the opportunity to drive optimization and quality care through implementing more standard practices across the province. Through our engagement across each zone, and by analyzing AHS' performance at a provincial level, we found several examples of delivery models that were variable. The usage of Non-Hospital Surgical Facilities (NHSF) provides helpful insight into this theme: our review of AHS' data indicates that the Calgary zone performs almost all cataracts performed by privately-owned, but publicly-funded NHSFs, while Edmonton performs these services in acute-care hospitals at significantly greater cost.

Our engagement led to the conclusion that Alberta has made strong progress towards achieving an effective and important balance between localized services delivered through zones, and a standardized, system-wide, efficient network of care across the province. Where variation with sites occurs, or when zones seek ways to exempt themselves from the network, the balance is interrupted. Everyone that works in the system should seek out and correct these imbalances. The people we spoke with throughout the engagement demonstrated a sincere willingness to assist in this regard.

We are grateful to the thousands of Albertans that have provided us with their ideas, concerns, perspective and experiences. They have helped us immensely in understanding the full picture of the system as it stands, and the system that can be. We have attempted to integrate their perspective into the findings and recommendations that follow.

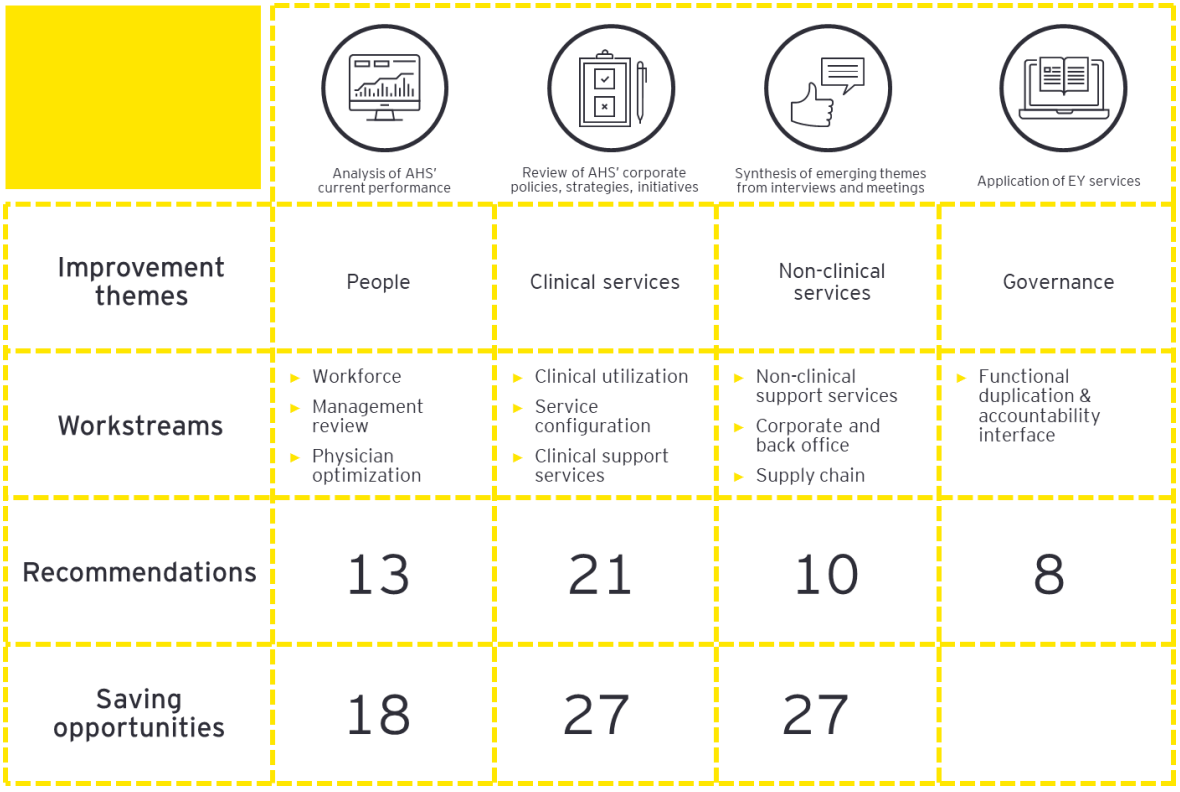
5 Workstream findings and recommendations

Workstreams

After categorizing feedback into major themes and by key functions, we aligned the early engagement outputs with our initial observations of AHS based on an analysis of current performance, a comparison of AHS' performance with other organizations, and our knowledge of improvement areas based on our experience working with other organizations.

This resulted in the creation of 10 workstreams, illustrated below.

Figure 9. Improvement areas and workstreams[12]



This section contains context, findings, recommendations and opportunities across workstreams we have reviewed. The workstreams represent the major cost drivers across AHS. They are also the areas that we feel are associated with the most significant opportunity across the system.

[12] In addition to recommendations aligned to the workstreams, 5 recommendations have been put forward aligned to Implementation. These are outlined in Section 7 of this report.

While AHS is the primary focus of this review, we also conducted interviews and analysis related to Covenant Health and Lamont Health Care Centre. Throughout this report, we have indicated where findings, recommendations, or opportunities include either of these organizations. As AHS' largest service provider, Covenant Health delivers a significant proportion of care services in the province. In specific areas we have explicitly requested data and other information and included Covenant in our analysis.

Gross opportunities – not guaranteed savings

Each of the workstream sections below contains key findings, recommendations and opportunities.

The findings are based on our analysis of AHS' financial and operational data, what we heard from Albertans, staff and physicians at AHS, and our team's experience working with organizations across Canada and globally. Some of the findings are also based on areas that AHS has already identified as being sources of opportunity, and in some instances has begun implementation. The findings inform proposed recommendations for AHS and Alberta Health.

Each section also contains a list of opportunities. Many of them are accompanied by the maximum savings potential or what we call "gross opportunity values". These opportunities provide a high-level indication of the scale of potential gross savings that can be generated. Typically, this is based on the full realization of the opportunity, or the removal of all the potential inefficiency.

Our experience supporting organizations with implementation suggests that the gross savings identified can not be wholly realized. This is because costs need to be factored in, such as new systems or technology, and the significant change management impact that full realization of a gross opportunity may have. Thoughtful planning and the translation of the gross opportunities into discrete, phased initiatives is what's required to understand the scale of savings and when they can be realized.

Example of moving from gross opportunity to realized savings: optimizing OR capacity

EY worked with a large academic health science centre in Ontario to help them identify a potential closure of 343 OR slates, or scheduled days of surgical activity, with a gross opportunity value of $390k. The opportunity was predicated on improvements in turnaround times that would enable surgeons to maintain the same level of activity in a reduced amount of operating time.

During the implementation planning phase, the hospital's Sustainability Program Office refined the valuation to reflect achievable savings based on factors such the specific case mix and needs of various sub-specialties. For example, complex cardiac cases were provided with a longer turn around time than high volume ophthalmology cases. Ultimately, the organization's executive leadership team committed to a reduction of 166 OR slates, valued at $189k.

Improvement Theme: People

Workforce

Context

The workforce section includes findings, recommendations and opportunities related to compensation, workforce management and controls (e.g. human resources policies and procedures, staff scheduling practices) and clinical staffing models.

Overview of the AHS workforce

AHS employs 102,717 people (70,139 FTE) across the province, making it the largest employer in Alberta. The workforce is highly unionized, with 93,804 (61,948 FTE) unionized staff members or 91.3% of the total workforce. Unionized staff include members of five unions, outlined in Table 1. UNA (nursing) and AUPE-GSS employees make up the largest proportion of the workforce making up 27.9% and 27.5% of total AHS headcount respectively. AHS has 8,913 (8,191 FTE) non-union employees making up 8.7% of the workforce. Non-union staff include managers and senior leaders, as well as non-union professional and technical roles. AHS' Executive Leadership Team is made up of 14.0 FTE including the CEO, earning a combined $6.03M in 2018/19 (including salaries and benefits).[13] Employee compensation makes up the largest independent driver of AHS' cost base, with salary and benefit expenses representing approximately 54.3% of AHS' total expenses. When including the employees of AHS' contracted health service providers and other contracted services (including Covenant Health), the percentage would be approximately 70% of total expenses.[14]

Table 1. Summary of AHS' workforce by employee group

Employee Group	Description	Headcount[2,3]	% of AHS Headcount	FTE[3]	Salary & Benefits ($M)[4]
Total AHS[1]		102,717	---	70,139	$7,709.2
Total Union		93,804	91.3%	61,948	$6,682.7
UNA	Provide direct nursing care to patients and deliver health education programs.	28,617	27.9%	18,001	$2,492.7
HSAA	Provide paramedical professional & technical care to patients and deliver health education programs.	19,476	19.0%	14,368	$1,762.5
AUPE-AUX	Provide auxiliary nursing care to patients.	15,804	15.4%	8,725	$782.8
AUPE-GSS	Provide general support and administrative services to patients, those that provide direct patient care and to the organization.	28,209	27.5%	19,055	$1,492.2
PARA	Provide care to patients in outpatient facilities and acute care.	1,698	1.7%	1,698	$152.6
Total Non-Union Employees (Non-Union)		8,913	8.7%	8,191	$1,026.4
All Managers and Senior Leaders		3,296	3.2%	3,197	$451.6
Senior Leaders	Set and align overarching organizational clinical and operational goals and strategies.	68	0.07%	66	$22.8
Managers	Provide leadership and supervision to union and non-union staff who deliver and support the delivery of health services.	3,228	3.1%	3,131	$428.8
Non-Union Professional/ Technical	Provide professional and administrative services to patients and those that provide direct patient care and to the organization.	5,617	5.5%	4,995	$574.9

1. *Totals may not equal the sum of the groups as employees may have jobs in more than one group.*
2. *Does not include vacant positions.*
3. *Source: AHS Payroll System*
4. *Source: AHS Payroll System. Includes salaries earned per fiscal year. Based on assumption of benefits equating to 21% of total salary. .*

[13] AHS 2018/19 Annual Report.
[14] Ibid.

AHS' approach to workforce and sustainability

AHS' Operational Best Practice (OBP) program is an organization-wide initiative that benchmarks AHS with other health care organizations across Canada, with the aim of reducing variation and achieving efficiencies. Using comparative data, AHS has developed OBP specific workforce related targets, first for nursing inpatient units with subsequent roll out across corporate services and clinical support. These targets are designed to achieve more equitable service delivery and reduce cost variation across the province. As part of this process, AHS tracks indicators related to quality, patient experience and performance to monitor and understand any unintended consequences from OBP related changes.

AHS estimates that since late 2015, OBP has achieved annualized savings of $178M and a reduction of 1.6M worked hours across AHS and Covenant Health. OBP benchmarks directly impact the amount of budget that is set for units/departments, and inform organizational decision making. For example, if an area is not achieving its OBP benchmarks it is less likely to be approved to fill vacant positions. AHS is currently in phase 4 of the OBP program and has identified further savings of $101M.

Findings

Compensation

Executive compensation

1. AHS' executives[15] are paid more than their BC counterparts, but less than comparable positions in Ontario.

    - We compared the compensation paid to senior executives at AHS and Covenant Health to their counterparts at the BC regional health authorities, as well as large hospitals in Ontario. When considering the relative size (budget and employees) of AHS compared to its peers, executive compensation does not appear to be excessive.

    - While generally executive-level compensation at AHS is, in our view, appropriate, it should be externally assessed periodically with formal reporting to the board.

    - In general, AHS' executive members make less than twice that of their counterparts at BC's Fraser Health. Fraser Health is one quarter of the size of AHS. CEOs of similar organizations in Ontario make more than the AHS CEO, while leading organizations that are significantly smaller than AHS. Other AHS executive members are compensated generally similarly to their Ontario counterparts.

    - Covenant Health executives are paid comparatively to AHS, despite being a significantly smaller organization. Comparisons of executive leadership compensation per employee across several organizations demonstrates that Covenant health is an outlier compared to AHS, Ontario, and British Columbia. For example, the Covenant Health CEO is paid $51 for every full-time staff member compared to the AHS CEO who is paid $6. While this is only one potential metric for comparison, considering the organizations by size of budget would yield similar results.

[15] Executive in this comparison are those that report to the CEO as per the AHS' organizational chart. We recognize that there are other executive positions that exist within AHS.

Unionized staff compensation

2. AHS' unionized employees are paid more than their peers in other Canadian provinces.

   - Alberta pays higher than the Canadian average across employee groups: 7.2% higher for RNs, 5.5% higher for LPNs, 6.8% higher for HCAs, 11.1% higher for HSAA employees and 6.95% higher for AUPE-GSS employees. [16,17,18 19,20]

   - While AHS has been successful at negotiating a 0% increase to the pay bands in the collective agreements for the past two years, overall costs increased as employees moved up bands.

Non-union exempt employee compensation

3. The high relative pay of nurses in Alberta creates a disincentive to pursue management or advanced practice roles, such as nurse practitioner. These roles are critical to providing consistent and high-quality patient care.

   - The average yearly salary for a unit manager at AHS in 2019 was $109,229[21] with the top 10 highest paid unit managers at AHS earning between $122,000-$127,000.[22] According to publicly disclosed information, 1,851 registered nurses earned more than $127,000 in 2018, with 485 earning over $150,000 and 31 earning over $200,000.

4. Compensation for non-union employees is not linked to the achievement of specific goals, objectives and outcomes.

   - AHS introduced pay-at-risk for health care executives in 2009 but it was ended amid controversy. However, other health care organizations have used this approach successfully to improve accountability and performance.

> *"Front-line unit managers have one of the hardest jobs in health care and they do fantastic work. I would not want to be a unit manager again…there is little incentive to go into management since front-line nurses will easily make as much or more salary with far fewer responsibilities."*
>
> *Comment from AHS Employee Survey*

[16] Source: Provincial Bargaining Coordination Office.
[17] Comparison is based on total compensation.
[18] HSAA union members include Pharmacists, Physical Therapists, Paramedics, Dialysis Technicians, Respiratory Therapists, Psychologists, Public Health Inspectors and others.
[19] AUPE-GSS union members include unit clerks, food services workers, administrative support, carpenters, accounting clerks and others.
[20] While AUPE-GSS employees earn on average 6.95% higher than their peers, compensation ranges by job type with some job types earning below or at market rate.
[21] Estimate based on 1.0 FTE and the average hourly salary.
[22] Based on AHS employee data.

Workforce management and controls

Overtime

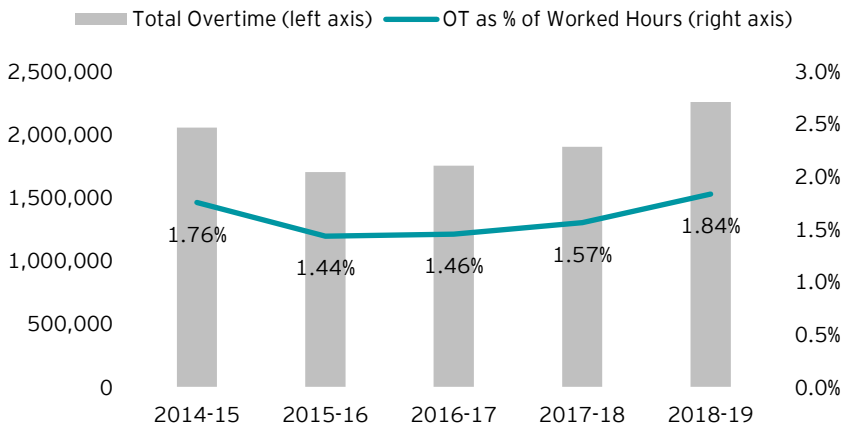
5. Compared to its peers, AHS has been successful overall at managing overtime across the organization, with a low overtime rate of 1.84% of total worked hours across the organization; however, the overtime rate has increased annually beginning in 2015/16, growing from 1.44% to 1.84% in 2018/19.

"More support needs to be given to North zone and rural communities in general. Not enough staff means greater overtime needed and more costs to the system."

Comment from AHS Employee Survey

CIHI data confirms this finding. For 2015-16 and 2016-17, respectively, overtime rates were: 2.60% and 2.86% for Canada as a whole; 2.58% and 2.81% for Ontario and BC; and 1.44%, and 1.46% for Alberta. While Alberta's overtime rate has increased since 2018/19 this rate is still likely lower than peers in Ontario-BC and Canada.

Figure 10. AHS Overtime Hours, 2014/15 to 2018/19



Source: Data provided by AHS.

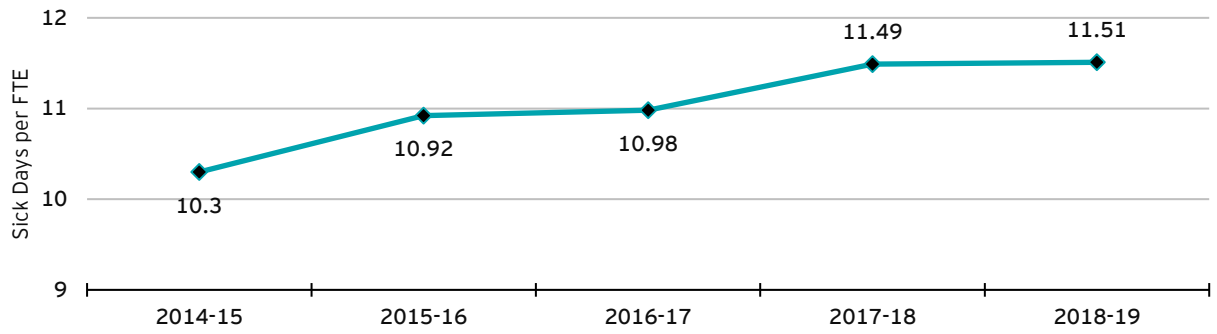
- Despite success with this measure, AHS should assess areas of internal variation across the organization, which may produce opportunities for further incremental reductions.

Sick-time

6. While AHS' sick time rate remains low when compared to peers, the rate has been steadily increasing.

   - AHS' sick rate has increased from 10.3 sick days per FTE in 2014/15 to 11.51 sick days per FTE in 2018/19. This equates to an 11% increase over the past five years.

Figure 11. AHS sick time rate, 2014/15 to 2018/19



Source: Data provided by AHS.

7. AHS has an attendance management policy in place, however it is not consistently enforced, and AHS has had challenges managing inappropriate use of sick time.

Recruitment, retention and vacancy management

8. Provisions contained in the collective agreements can make it challenging for AHS to implement innovative staffing approaches to meet demands, especially in rural areas.

   - The collective agreements contain provisions including restrictions on the use of vacancies that are not common in nursing agreements across Canada.

   - Collective agreements can also inhibit adopting flexible staffing models, such as changing positions to be multi-site positions to help meet demand in rural areas. The UNA collective agreement gives the union the ability to review such positions.

9. AHS' vacancy management program is an effective workforce control that should be strengthened to ensure best use of realized savings.

   - Under AHS' current vacancy management program, each vacancy is reviewed by senior leadership prior to posting to assess necessity to fill.

   - AHS tracks and forecasts future savings generated through enhanced vacancy management, however budget associated with vacant positions is not secured or frozen from Alberta Health budget, resulting in potential redirection rather than actual budget reduction.

Staff scheduling

10. While AHS has followed leading practice in creating a centralized staff scheduling function, there continues to be large parts of the organization that have not transitioned to this model.

    - Decentralized scheduling leads to inconsistent local interpretation of contracts and collective agreements, often relies on resource-intense manual processes, creates challenges with conducting system-wide performance management and reporting, and is less efficient.

    - AHS' centralized Provincial Staffing Services (PSS) provides staffing services to 40% of all employees, while the remaining 60% are supported outside of PSS by decentralized staffing offices and resources that could be consolidated, such as the Rural Hospital Scheduling Office Edmonton.

> *"I have worked in the world of both paper-based and computer-based staff scheduling and can see a huge improvement in terms of less overtime and workload levelling, less sick calls, etc."*
>
> *Comment from AHS Employee Survey*

11. There is an additional opportunity to automate some of the current, highly manual processes involved to collect, evaluate and approve time. This would improve efficiencies and reduce payroll errors, including overpayments.

    - While some degree of automation is enabled in the current state, there are limitations to the current Environment for Scheduling Personnel (ESP) system that inhibit AHS' ability to fully maximize automation opportunities.

    - There are approximately 3,698 employees across the organization who support time entry for decentralized scheduling operations. While time entry typically only makes up a portion of these employees' responsibilities, there is an opportunity to reduce the amount of support required through centralization.

Clinical staffing models

Skill mix and staffing levels: Nursing

12. Clinical staffing decisions are typically based on historical staffing levels and OBP worked hours targets, rather than evidence-based assessments of patient acuity.

    - The optimal staffing model on a unit enables high-quality, safe patient care where patients are being cared for by appropriately qualified and experienced staff.

    - Leading jurisdictions in Canada and internationally have begun to use evidence-based tools to carefully assess patient needs to determine the right number and skill mix of staff on a given unit.

13. Staffing levels within clinical units can vary significantly across similar type of units. When compared with leading practice and other provinces, AHS has higher levels of staffing across all types of units.

- Leading organizations in Canada and internationally use a set of common targets for assessing patient care staffing ratios on different types of acute inpatient units:
  - Medical and surgical units: 4 patients to 1 nurse on days, 5 patients to 1 nurse on nights (equates to 5.33 hours per patient day).
  - Obstetrical units: 5 patients to 1 nurse, days and nights (equates to 4.80 hours per patient day).

Table 2. RN/LPN/HCA worked hours per patient day across AHS and Covenant Health inpatient units

Clinical Area	Degree of variation across AHS (25th and 75th percentiles)	AHS Average (50th Percentile)	Leading practice/ Provincial comparator[23]
Medical Unit	5.17-6.56	5.80	5.33
Surgical Unit	6.24-7.43	6.65	5.33
Medical/Surgical Unit	5.19-6.46	5.69	5.33
Obstetrical	8.33-10.11	9.15	4.80

14. The skill mix of clinical staff at AHS can vary significantly across similar units and can be further optimized.

- While there are some organizations in Canada that are still staffing their inpatient units with only registered nurses, Alberta has worked to introduce staffing models that leverage staff of various skill levels, including registered nurses, licensed practical nurses (LPNs) and health care aids (HCAs).

- Aligning units that use a higher level of RNs to the staffing ratios of their higher performing peers, would reduce staffing costs, and support clinical staff in working to their full scope of practice.

"Our operating room runs with higher than recommended staffing levels and uses almost no ORT/LPN employees."

Comment from AHS Employee Survey

15. AHS and Covenant Health have established staffing models through the OBP program, which will continue to move staffing levels and skill mix towards more effective and sustainable models of care delivery.

[23] Medical/Surgical units was based on 4:1 on days, 5:1 on nights which provides more hours per patient day than UK NHS averages.
Obstetrical units were modelled on 5:1
The remaining areas were benchmarked based on internal variation

Skill mix and staffing levels: Clinical support services

16. AHS has implemented effective strategies to optimize its pharmacy workforce, both in terms of skill mix and overall staffing levels.

    - AHS has also developed an inpatient clinical practice model to ensure limited and costly pharmacist resources are allocated to patients of the highest need, to maximize the impact on clinical outcomes, readmission, and length of stay. To develop the model, bed types were categorized based on the needs of the patient population. Target ratios for 'beds to clinical FTE' were developed, as well as guidance on continuity of care considerations.

17. There is variation in the proportion of laboratory assistants used relative to more expensive laboratory technicians.
    - By standardizing staffing models across the system to optimize the use of laboratory assistants, AHS can have an appropriate and more efficient staffing model.

Full-time/part-time/casual nursing mix

18. AHS' high rate of part-time nurses is not cost effective and poses operational challenges.

    - 33% of AHS' registered nurses (RNs) are full-time, 42% are part-time and 25% are casual.
    - The cost of a 1.0 FTE RN per year is approximately $111,789 as opposed to $118,631 for two 0.5 FTE positions.
    - A part-time workforce can be challenging for management. It can pose challenges in implementing optimal scheduling practices and increases the headcount that managers need to manage, contributing to additional workload.
    - The designated day of rest provision for part time nurses in the UNA Collective Agreement has created challenges in staff scheduling. Part time RNs receive the same number of designated days of rest as full-time employees.[24] Part time nurses who work on designated days of rest are eligible for overtime, regardless of whether they have worked full time hours.

"Previously, nursing was a secondary family income in Alberta, but this isn't the case anymore. We [AHS] have the ability to rethink how we approach part-time nursing."

Comment from AHS Operational Leader Session

"It drives me batty that I have to go in every week for my treatments and I get a new staff member who is casual that doesn't know their way around… this is wasteful and impacts patients."

Comment from AHS Patient and Family Advisory Council

[24] Designated Days of Rest are protected days, and any work on those days triggers payment at 2x the basic hourly rate of pay (or applicable overtime rate).

Patient watch

19. AHS uses highly skilled staff to observe at-risk patients in cases where less costly staff would be more appropriate.

    - Based on available data we estimate that 258 FTE across AHS are providing this service.[25] Of these FTEs, 13% are providing patient watch at overtime or banked overtime rates, increasing the cost of this service.

    - Patient watch is typically provided by Health Care Aides or Mental Health Aides; however, 9% of hours are currently provided by higher levels of nursing care signaling an inefficient use of resources. In addition, there is variability within staffing models across zones.

AHS' approach to workforce sustainability

20. The Operational Best Practice (OBP) program has been successful in raising awareness and instilling a sense of accountability for sustainability across managers and operational leaders.

    - OBP provides managers and leaders with extensive operational data about their areas and supports the organization in setting and achieving savings and quality improvement targets. It should be strengthened by broadening benchmarks, including skill mix targets, as well as further integration with existing organizational budgeting processes.

Recommendations

Recommendation 1: AHS should work with the unions and government to remove or revise collective agreement provisions that impede sustainability without providing any patient benefit.

Recommendation 2: AHS should review its workplace policies and processes to strengthen controls where required to achieve incremental benefits.

Recommendation 3: AHS should expand the use of the Provincial Staffing Services, as well as consider a technology strategy to enable automation and positive time keeping.

Recommendation 4: AHS should optimize staffing levels and skill mix across the organization in both nursing and clinical support services through the use of evidence-based approaches such as acuity-based staffing.

[25] 258 FTE is based on an extrapolation of ESP data on constant care provision.

Opportunities

Table 3. Summary of workforce opportunities

#	Opportunity Name	Opportunity Description & Valuation Approach	Gross Valuation
W1	Removing specific UNA provisions	Removing lump sum payments, designated days of rest for part-time employees and benefits for part-time employees working <15 hours per week. Valuation based on AHS' estimate.	$42M
W2	Overtime reduction	Reduction in overtime usage across all positions. Valuation is based on all areas and positions being at or under a 2.8% rate of overtime. Considers premium costs associated with OT.	$24M
W3	Sick time reduction	Focused attention on attendance management, wellness strategies and sick time protocols to reduce % of sick time across AHS. Valuation is based on a reduction in average sick time from 11.51 sick days per FTE per year to 11 (low estimate) or 10.3 (high estimate). 10.3 sick days per FTE per year was the AHS sick rate in 2014/15 and 11 in 2015/16. Valuation is based on reduction in total sick relief replacement cost of $58.5M, the total cost in 2018/19.	$3M-$7M
W4	Eliminate vacancies >1 year	Eliminate, inactivate and permanently remove budget for positions vacant longer than one year. Valuation is based on elimination, inactivation and permanent removal of budget for vacant position. Low opportunity is based on removal of only exempt positions; high value is based on all positions. Positions identified by AHS as being purposefully held or non-budgeted were removed.	$11M-$103M
W5	Enhanced vacancy management	Implement process to secure budget for vacant positions being held for enhanced vacancy management targets to ensure the underspend is not used to offset other pressures. Valuation is based on AHS' targeted savings from existing enhanced vacancy management program.	$22M
W6	Implement staff scheduling system	Implement staff scheduling system to reduce payroll errors, premium payments and number of timekeeping FTEs. Efficiencies realized through automation including positive time capture are typically in the range of 3-5% annually of the payroll bill for hourly workers; valuation is based on 2-3% to discount for efficiencies already realized. Significant initial investment will be required to realize savings. That investment would offset potential savings.	$82M-$123M
W7	Optimize nurse staffing based on patient demand	Optimize nursing ratio (RN/LPN/HCA) and reduce staffing level in alignment with internal and external leading practice based on patient demand. Includes AHS and Covenant Health sites in nursing units (medical, surgical, obstetrical), operating room, ICU, Emergency department, and long-term care. Valuation is based on both 1) Aligning RN/LPN/HCA ratio (i.e. increasing use of LPNs & HCAs) and 2) reducing staffing levels with either external leading performer or internal median performer.	$231M-$322M

W8	Optimize clinical support staffing based on patient demand	Optimize staffing level for clinical support staff in both AHS and Covenant Health sites for areas including labs, pharmacy, and allied health professionals. Valuation is based on standardizing skill mix (e.g. use of lab techs versus lab assistants) across each functional area using a median target.	$8M
W9	Shift from PT to FT nursing positions	Shifting nursing headcount to move towards more full-time staff. Valuation is based on moving from a 43/57 FT/PT ratio (current ratio, excluding casuals) to a FT/PT ratio of 55/45. Savings are based on estimated $6842 annualized savings and $2848 one time saving; the average difference in cost of employing one FT RN in place of two part-time RNs. Savings are from legislated benefit premiums, AHS' paid health and dental benefit premiums and professional dues reimbursement and wages for attending compulsory training.	$15M
W10	Optimize constant care staffing model	Improve staffing model for "patient watch" patients ensuring the right role is used to perform these duties and technology (e.g. tele-sitting) supports efficiencies. Low valuation is based on reduction in costs for using HCAs for hours of constant care currently provided by LPNs, security or protective services where appropriate. High valuation is based on assumed coverage of 10 patients for tele-sitting and consideration of ongoing operating/technology costs.	$17M-$18M

Management review

This section includes findings, recommendations and opportunities related specifically to the AHS management structure, including the number and types of positions, the number of employees a manager directly supervises and alignment of responsibilities and accountabilities.

Context

Overview

AHS defines managers as positions that have "direct accountability for setting direction, planning, organizing, staffing (hiring/firing), managing performance and outcomes, leading/directing and controlling work and resources." AHS has 3,296 management employees (3,197 FTE), comprising 3.2% of the total AHS workforce.[26]

In addition to management employees, there are 5,617 non-union professional/technical employees (4,995 FTE), making up 5.5% of the total workforce. These employees provide professional and administrative services to patients and staff of AHS. They include positions such as legal counsel, human resource advisors and also include front-line staff such as patient navigators, nurse practitioners and high-level professionals such as researchers and scientists. While some professional/technical positions may provide supervision, AHS does not consider them to exercise managerial responsibility and therefore are not considered to be management.

[26] Based on percentage of total headcount.

Both the management and professional/technical workforce has remained relatively constant over time in terms of size and salary expense.

AHS' human resources team works with operational areas to document the accountabilities of non-union positions and determine position rationale, classification, and the appropriate pay grade. Each role is analyzed and measured against the AHS career framework, which assesses the position along several key dimensions. This framework has specific criteria that must be met to justify classification as a management position.

Findings

Management span of control

1. AHS' percentage of management positions relative to its overall staff base is comparable to industry averages in Canada.

    - The Conference Board of Canada reports that the median management percentage for health care organizations in Canada is 3.4%. Depending the criteria used to determine the management cohort, AHS ranges from 3.2%-3.5%.

2. According to external benchmarking data, several AHS managers have fewer direct reports than managers in peer organizations.

    - A series of benchmarks were compiled from comparator health and public sector organizations. These benchmarks serve as a useful guide for initial assessment of span of control of AHS' management.

    - We compared the number of direct reports of each manager to benchmarks based on our experience working with peer hospital organizations in BC and Ontario, results from other government and public sector organizations, and the Ontario Hospital Association's health human resource planning report. We used both a low and high benchmark to generate a range.

    - It is important to note that these benchmarks are only effective in identifying a cohort of management positions that should be individually assessed against AHS-developed criteria for appropriateness.

"Directors are considered "people managers", however, there are many Directors that have less than five staff in their portfolio…Leaders that have less than twenty staff are not Directors; they are Program Managers, Managers, Team Leads."

Comment from AHS Employee Survey

"Where I work there are three units each with a unit manager. Two of these managers have at least 60 employees under them and the remaining manager has about eight. Most people seem to think that the smaller group could be easily divided and placed into the two larger groups eliminating unnecessary management positions and streamlining communication and workflow."

Comment from AHS Employee Survey

- Our assessment identified 741 positions at AHS with fewer direct reports than the low range of the benchmarks and 1269 with fewer direct reports than the high range of the benchmarks.[27]

- We compared the number of direct reports of each manager at Covenant Health to the same low and high benchmarks used for AHS. We found that 35% up to 59% of management positions are not aligned with benchmarks, which is higher when compared to AHS' 24% to 41%.

- Again, it should be noted that these findings do not account for other factors that drive complexity of the work, which need to be assessed as part of a detailed position-by-position review.

"Managers know their business well and they genuinely want to be efficient with operations."

Comment from AHS Employee Survey

3. There is variability in the number of direct reports for management positions at similar levels, particularly in lower-level management roles, such as supervisors and managers.

- While the median number of direct reports for nursing managers is 57, 25% of nursing managers (approximately 113 positions) have fewer than 31 direct reports and 25% have a very high number of direct reports, more than 84.

- While we recognize that other factors (e.g. budget, location, specialization, and facility size) impacting the complexity of the work may explain some of the variation observed, the degree of variability warrants further investigation to ensure appropriateness.

"Reduce the number of middle managers and empower front-line managers to make decisions and escalate to senior managers if needed."

Comment from AHS Employee Survey

Compensation and classification

4. There is a lack of standardization and consistency in the compensation and classification of management positions that leads to pay inequities and the potential for positions to be paid more than what is appropriate for the role.

- The table below shows examples of management staff job descriptions where there is a significant degree of variation in classification.

- In British Columbia, position classification at the health authorities is tightly controlled by the Health Employers Association of BC (HEABC) to ensure all positions have the commensurate level of responsibilities and accountabilities and ensure standardization across the province's health authorities. In BC, all positions with the same job description are classified to a single salary grade.

[27] The following positions were excluded from the analysis: casual positions, medical leaders, and positions on leave of absence (LOA).

Table 4. Management positions with a high degree of variability in job classification, by job description and number of positions at each salary grade

Salary Grade	M1-2	M1-1	M2-2	M2-1	M3-2	M3-1	M4-2	M4-1	M-5	Total
Executive Director						58	82	23		166
Director				92	111	217				424
Manager		145	776	834						1762
Supervisor	245	110	114							469
Lead				22						32

Legend:

<5 positions

Non-union professional/technical positions

5. While AHS does not consider professional/technical positions to be management and does not expect them to have direct reports, there are a number of non-union professional/technical staff that have job titles implying they should be considered as management.

   - Based on a review of AHS' employee data, we identified 287 positions with position titles that imply they should be managers or directors.

   - The number of positions with management-like titles leads us to believe that there are inappropriate classifications in this category. Review and reclassification of positions would ensure these positions are held to the same expectations in terms of overseeing direct reports as their peers in the management category of staff and allow for an accurate reporting on the true size of management.

   > *"My manager does a lot of the same work I do as the Team Lead, so I wonder why she is my manager and not just a Team Lead and we all report directly to the director."*
   >
   > *Comment from AHS Employee Survey*

   - Additionally, there are approximately 704 team lead/supervisor positions within the professional/technical employee group. While these positions typically don't have staff who report to them, they receive a higher level pay for taking on additional supervisory responsibilities. AHS should review the effectiveness of these positions as there is often a lack of clarity within the role and perceptions that the work can be redundant with middle managers.

Administrative support

6. Most senior-level AHS management employees have non-shared administrative or executive administrative support. In other Canadian health care organizations, management and senior leaders are expected to share administrative support with at least one other position.

   - AHS has 167.6 FTE administrative support for 225.15 FTE director-level position and above[28]; this means there is 1 FTE administrative staff for every 1.3 FTE director-level and above position. With 49 FTE administrative support for 56.95 FTE director-level and above positions, Covenant Health has a similar ratio of 1 FTE administrative staff for every 1.16 leadership FTE.

   - AHS was unable to provide granular data regarding administrative support outside of senior corporate leadership. This leads to challenges with establishing and monitoring consistent and appropriate administrative support ratios throughout the organization.

Recommendations

Recommendation 5: Our initial analysis suggests that there may be opportunities to reduce the number of managers in some areas. AHS should review positions identified as having fewer direct reports than their peers in other organizations with the objective of identifying opportunities to consolidate portfolios and reduce management levels.

Recommendation 6: AHS should review the way it classifies positions and ensure that the organization applies a rigorous and standardized approach moving forward.

Recommendation 7: AHS should look to optimize the use of administrative support by leaders.

Opportunities

Table 5. Management review opportunities

#	Opportunity Name	Opportunity Description & Valuation Approach	Gross Valuation
MR1	Management position review and realignment	Realignment of management positions based on meeting benchmarks for number of direct reports (Covenant Health and AHS).	Unvalued
MR2	Share administrative assistants	Valuation is based on reducing the number of administrative assistants to a 2:1 or 3:1 ratio of director-level positions (M4 and above) to administrative assistants.	$6M-$9M

[28] For the purposes of this analysis, director-level positions and above were considered to be those at the salary grade M4 and above.

Physician optimization

Context

As the largest health care delivery organization in Canada, AHS has more than 8,600 physicians working in its facilities across a range of specialties. While most of the physician activity occurs on a fee for service basis and is paid by Alberta Health based on a provincial Schedule of Medical Benefits (SOMB), AHS does have a considerable operating budget for physician services within its Medical Affairs and Clinical Support Services portfolios.

The scope of this review is focused on the payments to physicians within the control of AHS. It does not comment on compensation to physicians paid directly by Alberta Health.

Table 6. AHS' medical affairs physician-related budgets

Budget category	2016-2017	2017-2018	2018-2019
Medical Leadership	40,682,115	47,325,923	50,324,858
Oncologists	63,365,820	64,705,564	68,239,623
Pathologists	41,288,465	41,571,778	18,279,791
Acute Care	157,552,549	159,513,123	156,681,400
Radiologists	154,936,436	154,936,436	160,494,202
Total	457,825,385	468,052,824	454,019,874

AHS has major physician-related budgets across the following categories:

1. Medical Leadership: Payments to physicians for non-clinical administrative services. This includes positions such as department heads and zone medical leadership positions. Many of these positions operate in "dyad" relationships, in which physician leaders are paired with operational leaders at various levels of the organization to enable joint clinical and operational accountability. These payments total approximately $60 million[29] across 996 distinct individuals.

2. Acute Care: Payments made to physicians as top-ups over and above fee for service billings, including stipends to hospitalist physicians providing general medicine services in acute care units.

3. Oncologists: Cancer physicians paid by AHS, either as salaried employees or as contractors. While most physicians are paid fee-for-service, it is a common model in Canada for oncologists to be paid an annual salary.

4. Pathologists: With the restructuring of Alberta Precision Labs, the costs associated with paying pathologists are being transferred from the AHS medical affairs budget to APL.

5. Radiologists: AHS pays radiologists directly for services completed within AHS facilities, as the Schedule of Medical Benefits does not cover these activities when performed within AHS.

[29] While most of these positions are paid from the medical affairs budget outlined in the table above, some positions are funded via other provincial or zone operational budgets.

Findings

Clinical payments

1. AHS has a large number of legacy contracts in place that provide clinical payments for services that can be billed through the Schedule of Medical Benefits.

   - These programs have a net cost to AHS of approximately $76.1 million. 65% ($50 million) of that cost represents payments for services included in the Schedule of Medical Benefits.

   - Alberta Health has begun a consultation process with physicians on its plans to eliminate $50 million in supplemental payments.

2. Radiologists working at AHS are paid considerably more than in other provinces.

   - In 2014/15, the average radiologist in Alberta billed $1.4 million, versus $872,000 for the average radiologist in Ontario, representing a 59% difference. Alberta pays radiologists 30% more than Ontario and 21% more than BC for X-rays, and 169% more than Ontario and 99% more than BC for ultrasounds.

3. The amount that AHS pays physicians to interpret diagnostic tests is not consistently aligned with what Alberta Health pays for the same services outside of AHS. It is generally less costly for physicians to provide those services in AHS facilities, leading to an opportunity to standardize AHS payments at a lower rate than the Alberta Health Schedule of Medical Benefits.

   - By standardizing the amount that AHS pays physicians for these services to 50% of the comparable amount paid by Alberta Health, approximately $7.5 million would be saved. The lower cost is justified by the fact that by performing these services in an AHS facility, physicians are not incurring the overhead costs that would be associated with performing them in their private offices.

4. AHS does not consistently recover costs for space and other in-kind support provided to physicians operating within its facilities.

   - AHS Medical Affairs is aware of 165 physicians or physician groups that are receiving space or other in-kind support. Of these:
     - AHS recovers some amount of the costs from 86, though the amount and mechanism is inconsistent.
     - 112 do not appear to have an agreement in place establishing the terms of this support.

   - There is no central repository of contracts and it is likely that the 165 physicians/physician groups that medical affairs is aware of is only a small subset of the total number of physicians receiving space or other in-kind support.

Medical leaders' payments

5. AHS' dyad-based medical leadership model aligns with practices in peer organizations, however there are many 'deputy'-level positions that are aligned with lower levels of operational management and are not explicitly required by the medical bylaws.

   - AHS has a dyad-based model of medical leadership, in which physician leaders are paired with operational leaders at various levels of the organization to enable joint clinical and operational accountability. AHS' medical staff bylaws describe the specific medical leadership positions that AHS requires to have in place, at the provincial, zone, regional, and site levels.

   - 45 positions, representing $2.5 million in annual spending, are at the 'deputy' level, which is not a formally required leadership position within the AHS medical staff bylaws.

6. Approximately 359 positions exist that are not explicitly required by the medical bylaws and should be assessed for rationalization or removal, while keeping in mind the critical role that integrated medical leadership plays in delivering quality care and executing on difficult transformational change.

   - Payments to these positions total approximately $17 million and include various administrative and consultative positions, including various knowledge leads, quality and safety positions, and champions. Many of these positions may be delivering value and should be continued, but there is an opportunity to review and rationalize them while considering any potential impacts to patient care.

7. 189 leadership positions are paid to work less than 0.1 FTE (less than four hours per week), which may not enable efficient use of leader's time or delivery of value.

   - Payments to these positions total approximately $2.5 million. These include various positions, including community medical coordinators, physician scheduler, and co-deputy facility section head.

8. AHS pays for increases in salaries to physicians in academic positions, despite being under a salary freeze.

   - 378 faculty positions at the University of Calgary and the University of Alberta are cost-shared between AHS and the respective institutions.

Recommendations

Recommendation 8: Stop paying clinical stipends for services covered by the Alberta Health Schedule of Medical Benefits.

Recommendation 9: In alignment with Alberta Health physician compensation negotiations and budget management initiatives, AHS should address radiology compensation and contracts.

Recommendation 10: Develop a consistent framework for paying physician interpretation fees by aligning payments to 50% of the Schedule of Medical Benefits rate as proposed by AHS.

Recommendation 11: Develop and implement a consistent framework for recovering physician overhead costs.

Recommendation 12: Review 'deputy'-level medical leadership positions, other positions not required by the medical staff bylaws, and positions with less than 0.1 FTE of effort.

Recommendation 13: AHS and AH should work with government and academic institutions with the aim of reducing or eliminating increases in academic salaries, in alignment with AHS and broader government salary freezes.

Opportunities

Table 7. Summary of physician optimization opportunities

#	Opportunity Name	Opportunity Description & Valuation Approach	Gross Valuation
PO1	Physician clinical contracts review	Reduce/remove supplementary payments for clinical services. Savings amount represents the payments made to physicians for service covered by the Schedule of Medical Benefits.	$50M
PO2	Interpretation fees reduction	Rationalize and standardize fees paid by AHS for non-invasive diagnostics tests. Savings amount is based on standardizing diagnostic interpretation fees to 50% of the amount paid by the Schedule of Medical Benefits	$8M
PO3	Medical leaders' stipends and payments review	Review positions not specifically required by the medical bylaws. Savings amount represents full payments to all positions which would be reviewed.	$17M
PO4	Academic funding review	Work with stakeholders to reduce or eliminate increases to academic position salaries and benefits. Savings amount is based on avoiding an annual 3.5% increase over three years.	$5M
PO5	Physician overhead costs recovery	Recover the cost of space and other overhead from physicians using AHS facilities. Savings amount is based on an AHS estimate of potential recoveries	$2M
PO6	Radiologist fee reductions	Further reduce AHS' radiologist billings to bring them in line with other Canadian provincial peers. Savings amount is based on AHS' estimate of difference between radiologist fees in Alberta and Ontario.	$42M

Improvement Theme: Clinical services

Clinical utilization

Context

Clinical Utilization focuses on the efficient and appropriate use of services, procedures and resources. The scope of this workstream includes clinical services provided across AHS' continuum of care, including acute hospital care (inpatient, critical care, surgical and ambulatory), post-acute, long-term care, as well as community-based and home care services. The improvements identified in this workstream are primarily focused on adjusting the resources and costs associated with beds and operating rooms across AHS while allowing patients to be cared for in the right place, at the right time.

Overview of AHS' clinical resources

Clinical care services are a major component of AHS' budget, with acute care representing the largest proportion at 32.9% of total AHS expenses. Over the past few years, AHS has made strategic efforts to curb acute care spending through shifting care to the community and has made investments in upstream services including community, home and continuing care. This has been supported by a 22% increase in spending on continuing and community care since 2014/15, with those areas now making up 7.4% and 9.4% of AHS' budget respectively.[30]

AHS has 38,890 beds across acute care, continuing care and mental health. The acute care bed base has remained relatively stable, with AHS focused on increasing supports in the community. Last year, AHS opened 1,267 new continuing care beds bringing the total increase in continuing care beds to 7,463 since AHS was formed in 2009/10.

Table 8. AHS' beds by category and zone

Bed Category	South	Calgary	Central	Edmonton	North	Provincial
Acute Care (includes ICU, NICU, psychiatric sub acute and palliative in acute)	645	2,791	1,098	3,020	929	8,483
Continuing Care – Long Term Care	968	5,947	2,364	5,085	1,233	15,597
Continuing Care – Designated Supportive Living (DSL3, DSL4, Dementia)	1,892	2,865	1,897	3,677	986	11,317
Continuing Care - Community Palliative and Hospice	20	121	10	85	13	249
Continuing Care – Sub- acute in Auxiliary Hospitals	24	280	0	168	0	472
Addictions and Mental Health	124	913	427	1,185	123	2,722
Total	**3,673**	**12,917**	**5,796**	**13,220**	**3,284**	**38,890**

Source: AHS Annual Report 2018/19.

For the purposes of this report, surgical services encompass main operating rooms and associated processes and flow. Across AHS, there are 252 working operating rooms (ORs) across 55 facilities. For low risk, low acuity surgeries, AHS has 51 contracts in place across 42 facilities to undertake additional surgical activity on its behalf.

[30] AHS Annual Report 2018-19.

AHS' clinical utilization strategies

Enhancing Care in the Community: AHS has strategically focused on providing comprehensive care in the community to help Albertans receive the care they need outside of acute, hospital-based settings. This strategy encompasses a variety of initiatives focused on improving connections between community health care providers and hospital teams, as well as programming and capacity in community, long term care and home care.

Patient Flow and Bed Management: AHS has implemented several initiatives with the aim of improving patient flow throughout the health care system, to facilitate timely and safe discharges, optimize length of stay and support quality patient outcomes. A pillar of this strategy has been the CoACT Program that helps patients, families and care providers communicate and work together and include standard processes across patient intake, daily management and discharges.

The Alberta Surgical Initiative: According to AHS, there are approximately 70,000 people in Alberta waiting for surgery; with 50% of these patients deemed to be waiting longer than clinically recommended targets. AHS and AH have proposed a large-scale business case, requiring $669M of investments, to improve access and the coordination and management of surgery. The cost of this initiative is expected to be absorbed with AHS' current budget.

Findings

Acute care

Emergency department (ED) utilization

1. ED (including urgent care) utilization is higher in Alberta than other provinces, with especially high rates in the North, South and Central zones.

    - Alberta has an average of 514 ED/urgent care visits per 1,000 population compared to 445 in Ontario and 452 in Quebec[31].

    - The average number of ED and urgent care visits per 1,000 population is twice as high in the South, Central and North zones when compared to the Calgary and Edmonton zones.[32] The North zone has on average more than one visit per person per year.

[31] CIHI, *NACRS Emergency Department Visits and Length of Stay*, 2018-2019.
[32] AHS 2018-2019 Annual Report.

2. ED visits in the North, South and Central zones are typically lower acuity levels compared to those in Calgary and Edmonton, suggesting that some of these patients are visiting the ED in place of more appropriate care settings.

   - The South, Central and North Zones have an average 59% of visits associated with lower acuity levels (CTAS 4, 5[33]) compared to 29% for the Calgary and Edmonton Zones.
   - While the percentage of ED/urgent care visits for Family Practice Sensitive Conditions (FPSCs)[34] has decreased by 7.4% over the past ten years, 20% of ED/urgent care visits are still related to FPSCs with particularly high rates seen in the North Zone (32%).

> *"Emergency Departments should be encouraged to dismiss non-emergent conditions back to the GP without fear of "missing something" or the person "being lost in the system."*
>
> *Comment from AHS Employee Survey*

Inpatient admissions

3. Alberta has a higher rate of hospitalizations when compared to other provinces[35]. There are particularly high rates in the North, South and Central zones where the rate is 41% higher than in Calgary and Edmonton zones signalling there is a lack of consistency in terms of how patient pathways are managed.

   - This suggests that there is a lack of consistency in terms of how patient pathways[36] are managed across AHS.

Table 9. Age-standardized inpatient hospitalization rate per 100,000 population, 2017/18

	Rural (North, Central, South)	Urban (Calgary and Edmonton)	Alberta	Rural to Urban Zone Comparison
Inpatient Hospitalization Rate per 100,000	10,343	7,312	8,212	41% ▲

Source: CIHI

[33] CTAS stands for the Canadian Triage and Acuity Scale triages patients based on severity and urgency. On a scale of 1-5 (1 is resuscitation, 2 is emergent, 3 is urgent, 4 is less urgent and 4 is non urgent) typically scores of 1-3 are deemed to be high acuity where scores of 4-5 are low acuity.
[34] Family Practice Sensitive Conditions are specific conditions that could be appropriately cared for in a family physician's office.
[35] CIHI Quick Stats: CIHI Quick Stats: Inpatient Hospitalizations: Volumes, Length of Stay and Standardized Rates, 2017/18
[36] Patient pathways are the route or path a patient will take if they are referred for treatment from the first contact with the health system to the completion of their treatment, including the period the patient is in a hospital or treatment centre, right up until they leave.

4. While the rate of hospitalization for Ambulatory Care Sensitive Conditions (ACSC)[37] has been reduced, Alberta admits 338 patients for ACSC per 100,000 which is above the Canadian average of 321 ACSC admissions per 100,000.

   - High rates in the Central, North and South zones highlight the continued challenges in providing access to primary care, coordinated disease management and support for patients to self-manage their own conditions.

   - It should be noted that AHS has made appreciable efforts to improve care coordination between acute, primary and community providers through the implementation of integrated clinical pathways with the goal of reducing hospital use and avoiding admissions where possible.

5. A review of AHS' top 100 diagnoses admitted through the ED identified 15 specific diagnoses where patients could have been more appropriately managed in an ambulatory setting as per NHS Ambulatory Emergency Care (AEC)[38] guidelines.

   - Ambulatory Emergency Care is predicated on the notion that a significant proportion of adults requiring emergency care can be safely managed on the same day without hospital admission, or through a shortened length of stay. When successfully implemented, AEC becomes the norm for patient care unless otherwise clinically indicated. While originally focused on medical cases, these pathways have expanded across other subspecialties including trauma and orthopedics, general surgery, urology, and obstetrics and gynaecology.

   - During our consultation with operational leads, we were informed of examples in AHS where AEC-like pathways are being implemented. For example, in the Calgary zone, enhanced transitional services were created for specific interventions with a community support team consisting of 24/7 Nurse Practitioners to prevent admissions into the hospital setting. This is an example of leading practice that should be scaled-up across AHS.

[37] ACSC refers to 7 conditions that have are more appropriately managed in ambulatory or community settings as opposed to high cost, acute care. These conditions include: angina, asthma, chronic obstructive pulmonary disease (COPD), diabetes, epilepsy, heart failure and pulmonary edema, and hypertension.

[38] Ambulatory Emergency Care Network, *Directory of Ambulatory Emergency Care for Adults*, NHS Elect, 2018

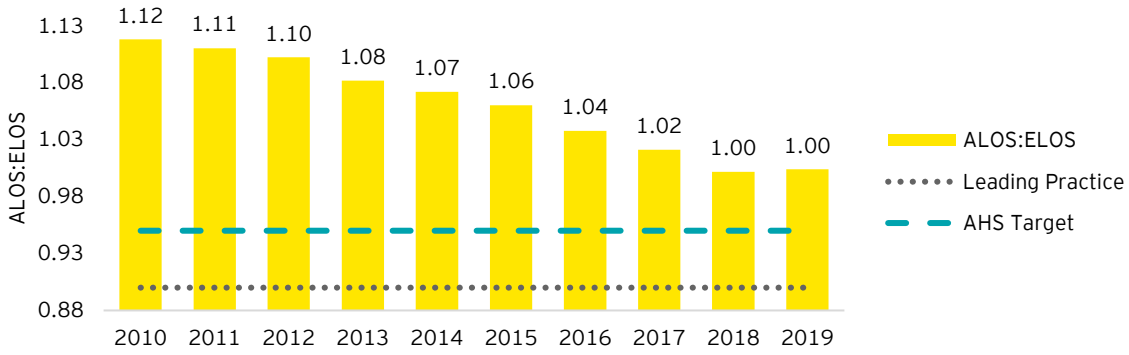
Key terms used in this section

- **Total LOS:** LOS represents a single episode of hospitalization and is calculated by subtracting the day of admission from the day of discharge.
- **Acute LOS**: The number of days a patient is receiving treatment required in the current care setting.
- **Alternative Level of Care (ALC) LOS:** The number of days associated with a patient occupying a bed with a resource intensity or services that are no longer required.
- **Expected LOS (ELOS)**: Estimate of a patient's LOS based on similar clinical groups, age, comorbidities and other intervention factors. Estimates are provided by CIHI and based on national comparisons.
- **ALOS:ELOS Ratio:** For typical patients, the average number of acute days in hospital compared to expected length of stay. A ratio less than one indicates overall efficiency in LOS.
- **Designated Supported Living (DSL):** includes comprehensive services including nursing care for Albertans living in lodges, retirement homes and living centres. There are different levels of DSL including level 3 and 4 for patients requiring 24-hour nursing care and level 4-Dementia DSL for clients living with severe dementia or cognitive impairment.
- **Long Term Care (LTC):** is provided in nursing homes and auxiliary hospitals for patients with unstable, chronic and complex health needs. Health and personal care is provided 24/7 by allied health, RNs or LPNs.
- **Home Care:** provides health and personal care supports for clients to support independent living in their own homes. Depending on patient need, the care team may include a nurse, social worker, occupational therapist, physiotherapist and other professional services.

Inpatient bed utilization and management

6. AHS has improved length of stay (LOS) performance over time which is now in line with expected LOS; however, performance falls short of the AHS target and leading practices with patients in some services staying a greater number of days than expected for their condition.

Figure 12. Typical patient ALOS:ELOS performance trend



Source: CIHI, Discharge Abstract Database (DAD).

7. Mental health patients experience on average a 13% longer than expected length of stay across the province.

    - We heard from operational leaders that particularly in rural areas that improving mental health LOS is hampered by a lack of community supports and resources available for patients outside of hospital.
    - The creation of complex community care centres such as Ambrose Place in Edmonton have supported more timely discharge of patients with mental health and complex needs
    - In the Edmonton zone, a 24/7 access program for mental health and addictions has resulted in less emergency room and acute care utilization, while also improving the wait times for these critical patient services.

8. On average, AHS' elective surgical patients spend 6.3 hours in an inpatient bed before receiving surgery.

    - Leading practice seen in other jurisdictions shows that effective management of elective surgical pathways can eliminate pre-operative length of stay days.
    - Given that most patients proceed straight to surgery, these numbers seem to indicate that a proportion of patients spent several days in hospital prior to elective surgery.

9. Alberta has higher Alternative Level of Care (ALC) rates when compared with other provinces meaning that there are many patients being cared for in a higher-level care setting than what is clinically required. Although AHS has demonstrated recent improvements, ALC rates have continued to climb over the past 10 years.

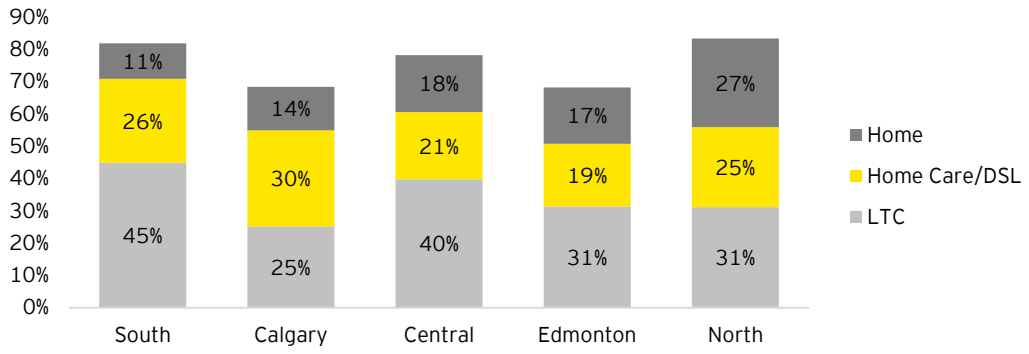
    - AHS had an ALC rate of 16.5% in 2018/19 compared to a target of 13.5% with variability across the zones. The Calgary and North zone have the highest ALC rates at 18.8% and 20.7% respectively.
    - An estimated 1,478 bed equivalents are being occupied by ALC patients across the province. Achieving a 13.5% target would release approximately 315 beds.

Table 10. Average number of ALC beds by zone

South Zone	Calgary Zone	Central Zone	Edmonton Zone	North Zone	Alberta
98	554	162	511	153	**1,478**

10. While many ALC patients are waiting for Long Term Care (LTC), Designated Supported Living (DSL) and home care supports, a significant proportion of patients could have been sent directly home from hospital.

Figure 13. ALC patients waiting for discharge home, home care/DSL or LTC



- Different zones have taken different approaches to address these ALC patients including patients within hospitals or providing specialized services in community settings. For example, Calgary and Edmonton zones have created ALC units in the community by leveraging underutilized LTC beds.

- It is important to note that AHS does not have control over the capital program for construction of continuing care spaces.

11. As part of this review, we conducted a patient appropriateness study at Foothills Medical Centre (FMC) that identified a larger proportion of patients that could be cared for in alternative settings than typically reported in AHS' data, as well as areas for improvement within flow and discharge planning.

Assessing Patient Appropriateness at FMC

The Study: EY partnered with *Vitalhub*, who applied their *The Making Care Appropriate for Patients (MCAP)* tool to assess 341 medical and psychiatric patients in October 2019. MCAP is an evidence-based tool that determines the medical necessity for patients to receive a given level of care.

What We Found: While patients were appropriately admitted to FMC, one third of medical and one quarter of psychiatric patient's stay post admission, could have been provided in an alternative level of care. Discharge planning issues were cited as a major challenge with many patients able to go home with supports, or directly home. Only one third of the patients reviewed had a discharge plan created on or after admission. Psychiatric patients generally did not have discharge planning information included in their chart. Of reviewed charts, 77% of medical and only 14% of psychiatric patients had an anticipated date of discharge.

What This Means: The MCAP builds on our ALC related findings identifying a larger patient cohort of patients that could be cared for in a more appropriate setting. Although FMC is one of many hospitals within AHS, we believe insights from this review can be translated across the system to support an action plan that improves flow and allows patients to be cared for in the most appropriate setting.

12. AHS has several clinical pathways, patient flow and LOS initiatives underway however, many initiatives are zone specific and the uptake and implementation of provincial initiatives varies.

    - While tailoring initiatives within the local context can make sense, we have heard that this has also created large differences across various sites in terms of care delivery processes, strategies and resource deployment.

13. On average, critical care patients wait 29 hours after their discharge decision is made before being sent to the ward or home.

    - This delay equates to 85 bed equivalents out of 285 adult ICU beds. Reducing this delay would allow for the more efficient use of one of the systems most costly resources.

> *"A lot of the time people will be sitting in the ICU ready for transfer for days or even weeks with no beds available on general wards or in the community. This creates a huge back up of patients in the ICU, it's expensive for patients to take up an ICU bed."*
>
> *Comment from AHS Employee Survey*

Surgical services

14. Across AHS, surgical services are locally owned and managed at a site level. Individual physicians have significant control over operating room (OR) scheduling, leading to variations in operational management.

    - ORs are allocated to physicians in the form of OR timeslots, called "slates", which are in most zones, based on historical trends rather than actual utilization or changes in demand. While this practice is not unique to AHS, it creates significant challenges in OR resource management.

    - In larger zones such as Calgary and Edmonton, they are developing new policies to regulate booking and are establishing Committees to review utilization and allocations across sites.

15. In 2018/19 AHS performed 50,050 cases across 44 different elective procedures that matched the NHS criteria of limited clinical value.[39][40]

    - To determine the clinical appropriateness of procedures performed in the OR, we reviewed all 2018/19 elective procedures across AHS using the NHS Clinical Commissioning Group list of "procedures of limited clinical value", defined as procedures where the evidence of clinical effectiveness is deemed to be weak or absent.

16. Among physicians performing the same procedures, there is variability in delivery as day surgery versus inpatient overnight cases.

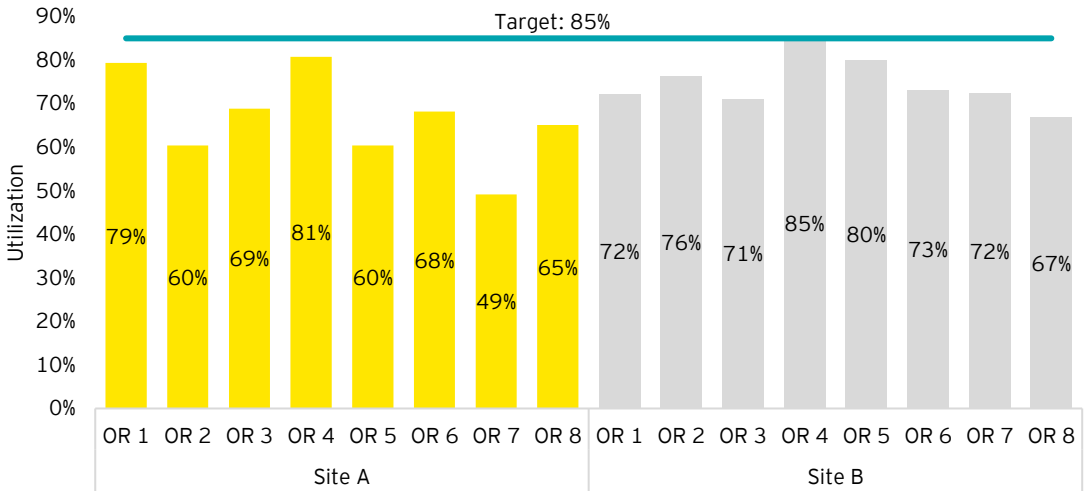
    - Supported by further clinical review, a conversion of select inpatient cases to day surgery would eliminate the accompanying LOS, releasing 71 beds of capacity across the system.

[39] NHS Milton Keynes Clinical Commissioning Group, https://www.miltonkeynesccg.nhs.uk/referrals-and-priorities-policies/
[40] This represents approximately 40,156 outpatient, and 9,894 inpatient cases.

17. Opportunities exist to improve utilization within existing OR infrastructure and staffing.

- While AHS reports that its ORs are approximately 90% utilized, there are variations in the local definitions for utilization resulting in a lack of clarity on true overall OR performance.
- Our assessment indicates that operational OR capacity was utilized 71% of the time across AHS in 2018/19, indicating an additional 18,713 potential OR slates to be undertaken.
- We assessed utilization, using a common leading practice definition[41], at two sites in AHS. As can be seen from the chart below, there is significant variation in overall utilization across each of the ORs.

Figure 14: OR utilization



18. AHS and AH have developed the Alberta Surgical Initiative (ASI) to reduce wait times that is predicated on building net new capacity, including staffing and capital infrastructure.

- In total, AHS identified 79,511 additional procedures to be undertaken over the next four years to achieve waiting time targets.
- Our analysis suggests that surgical wait times can be reduced, in part, by maximizing existing capacity (as discussed above), moving some procedures out of hospitals to independent providers and reducing procedures of limited clinical value.
- There are also examples of leading practice where clinical services such as Oncology and Hip and Knee Replacements have already moved to a centralized intake model which allows for better wait list management, triage for surgery and movement of patients along the surgical pathway.

[41] *For this review, we looked at capped utilization, the percentage of surgical time used within a defined period of staffed resourced time*

Ambulatory care

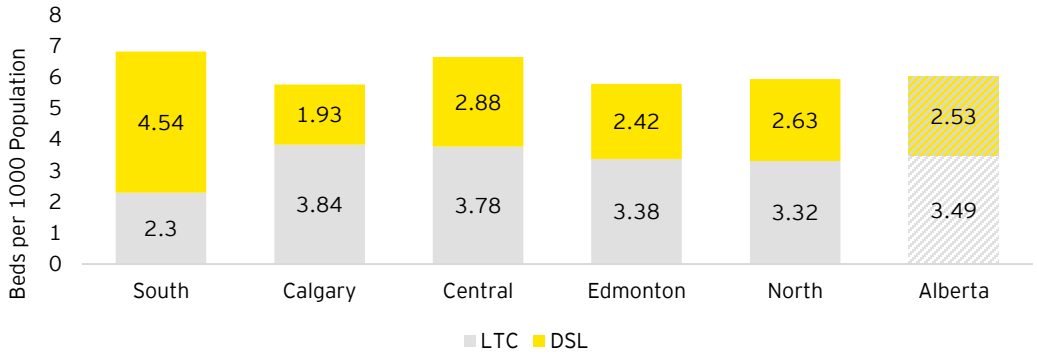
19. In newer AHS ambulatory clinics, policies and procedures have been put in place to manage the number and types of patients being seen. However, several historical AHS clinics, as well as several community providers remain outside of this framework with unclear definition and purpose.

20. While AHS has made recent progress with standardizing some clinic processes, key processes related to booking, scheduling, and referrals remain highly variable from clinic to clinic, resulting in underutilization of space and resources and limited coordination for patients.

Long term care (LTC)/ Designated supportive living (DSL)

21. Across AHS, there is variation in the mix and the number of LTC/DSL beds across zones, contributing to AHS' high ALC rates and challenges in moving patients through the system.

Figure 15. LTC and DSL bed capacity per 1,000 population across AHS



22. A detailed review conducted by AHS revealed that a significant proportion of patients admitted to LTC would have been more appropriately cared for in DSL.

    - An AHS study of LTC patients between April 2014-October 2017 found only 30% of patients assessed for placement into Continuing Care were assessed as needing LTC. However, 62% of all assessed patients were placed into LTC. Some of these patients were placed in LTC due to geographical, financial or living constraints that impeded the appropriate placement into a DSL setting.

23. AHS has a shortage of DSL beds to meet the current patient need and a potential surplus of acute and LTC beds. A realignment of this bed base would support a reduction in wait times, ALC rates and improve quality of patient care.

    - There are 506 patients waiting at home for DSL, 296 patients in acute care and 1,300 patients in long-term care that could be in DSL beds.

> *If the need is more for Designated Supportive Living and less LTC, conversion should be allowed (i.e. communities with 2 LTC and no DSL)."*
>
> *Comment from AHS Employee Survey*

24. There is a mixed ownership model of LTC and DSL beds in Alberta where facilities are either AHS owned and operated, AHS subsidiaries, non-profits or contracted private third-party providers. AHS' dual role in oversight of services from providers as well as a service provider itself has created confusion regarding its role within the system.

    - Across AHS and its wholly owned subsidiaries (Carewest and CapitalCare), AHS owns a total of 4,604 LTC beds which is 30% of the total LTC spaces. AHS' ownership, particularly of Carewest and CapitalCare represent an opportunity to harness this large financial asset to improve its financial position.

    - AHS conducts audits on providers, including those that it directly operates. Alberta Health is also involved in audits of continuing care creating potential role duplication, and mixed messages within the system.

25. Long-Term Care providers are funded using a Patient Care Based Funding Model (PCBF) that aligns funding per resident with clinical, physical and psychosocial needs. The design and implementation of this funding model is a significant accomplishment. For AHS to continue to maximize the benefits from this model, there are several key improvements that could be made.

    - When AHS shifted to PCBF, a no loss provision was implemented to support providers. This temporary measure should now be removed, and providers required to comply with the PCBF funding parameters.

    - The current tool used to assess residents clinical, physical and psychosocial needs is challenged to accurately measure dementia and behavioural problems that are increasing in the complex LTC population. AHS is working to improve its methodology to better reflect the nuances of patient acuity.

26. In LTC, the funding each organization receives is the same based on PCBF, however, the cost per resident day varies across the different ownership models. This requires further investigation to understand patient acuity and other drivers of cost differences.

    - AHS is not able to currently delineate exactly how much it spends per resident day. This is in part, due to resource sharing across co-located hospitals and LTC facilities, and how these resources are financially reported. AHS is in the process of conducting a detailed costing exercise to better understand the true cost of its owned LTC facilities.

27. AHS has made a significant effort to standardize LTC contracts by bringing providers under a single Master Service Agreement with a variety of performance tracking mechanisms such as KPIs and quality measures. However, there is opportunity for improvement to ensure that AHS is exercising its full rights with each contract.

Home care

28. There is a lack of standardization and consistency in terms of the delivery and availability of home care services. Operational leaders told us that there are challenges in the distribution of home care services and that comprehensive home care services are not readily available in all parts of the province.

    - Approximately one third of home care services are contracted out to third-party providers. AHS has an oversight role, as well as professional care and case management. In some cases, particularly in rural areas, AHS directly provides home care services.

29. Outcomes-based performance monitoring is not a consistent component of the management of third-party home care providers by AHS.

    - There are currently 48 homecare contracts, 67% of which are managed through a standard Master Service Agreement (MSA). All contracts are monitored by AHS procurement and requires providers to report performance data, however 16.5% of contracted providers do not regularly provide the required information.

    - AHS tracks system-level indicators for home care performance (e.g. readmissions, ALC, ED visits), volumes and financials, however these indicators and targets are not consistently focused on assessing quality and optimal patient outcomes for those directly served. While this may incentivize operators to provide cost effective care, it does not hold them to account to provide the best quality for clients.

"Current home care vendor contracts are not benefiting patients. Patients are not receiving needed care as assessed by AHS professional staff due to a business model that relies on a casual workforce (double booking and missed visits) and not being held accountable for the care provided"

Comment from AHS Employee Survey

Recommendations

Recommendation 14: AHS should prioritize the further provincial standardization of clinical care pathways and protocols to ensure all Albertans have access to evidence-based, outcomes focused and cost-effective care.

Recommendation 15: AHS should continue to strengthen its integration with primary care through the expansion of community-based and home care programs to care for patients in the most appropriate setting.

Recommendation 16: AHS should expand a bed flow program, such as the CoACT Collaborative Care Framework, to standardize and manage beds effectively across the province, improve LOS and allow for the patient care in the right place, at the right time.

Recommendation 17: AHS should internally establish a province wide performance monitoring and management framework for the governance, accountability and reporting of surgical services.

Recommendation 18: Within a provincialized surgical framework, AHS should reassess the level of investment needed to achieve the Alberta Surgical Initiative volumes based on utilization improvements and potential for alternate treatment pathways for patients.

Recommendation 19: AHS should create a fit for purpose operating model for ambulatory care and outpatient clinics and develop a strategic vision and governance model to support AHS' objectives both in the hospital and the community.

Recommendation 20: AHS should consider realigning bed resources within acute, LTC, designated supportive living (DSL) and community care, to support an immediate reduction in ALC, ensuring that patients are cared for in the most appropriate setting.

Recommendation 21: AHS should reconsider LTC facility ownership in cases where private delivery may be more efficient and appropriate.

Recommendation 22: Transition from volume based and transactional home care oversight model to one where providers are held to account for patient outcomes and quality of care for those that they serve.

Opportunities

Table 11. Summary of clinical utilization opportunities

#	Opportunity Name	Opportunity Description & Valuation Approach	Gross Valuation
CU1	Reduce avoidable admissions for ambulatory care sensitive conditions	Maximize existing "Ambulatory Care Sensitive Conditions" guidelines and expand to include additional pathways that can be treated through ambulatory emergency care setting vs. being admitted. Valuation based on reducing inpatient admissions as per the NHS Ambulatory Emergency Care (AEC) guideline's target range multiplied by bed days reduced.	$1M-$14M
CU2	Acute LOS improvement	Bed reductions based on driving down length of stay for typical and long stay patients through improved clinical pathways and supporting flow processes. Valuation based on reducing the LOS of typical patients to an ALOS: ELOS target of 0.9 and reducing LOS of long stay patients by 10% based on external leading practice.	$71M
CU3	Reduction of ALC in acute setting	Reduction of ALC to meet the AHS 13.5% target by improving out of hospital assessment and managing patients in the community. Savings based on acute bed reductions. Valuation based on reducing the inpatient ALC LOS associated with reducing the ALC rate down to AHS' internal target of 13.5% for each site.	$34M
CU4	ALC cohorting	Shift 554 acute level of care beds to different care model (i.e. LTC) to provide the optimal care to patient needs. Valuation based on reduction of cost associated with providing lower level of care for those beds. Valuation assumes each site meets the 13.5% ALC rate target.	$29M
CU5	ICU discharge delay	Reduce and eliminate the delay in patient discharge for ICU units across hospital sites based on time between transfer decision made and patient discharge. Valuation based on the delayed ICU LOS multiplied by the cost differential between an ICU unit and ward unit, assuming all delays can be eliminated for all ICU units (excludes NICU).	$20M

CU6	Day case conversion	Increase the number of procedures done in day case as opposed to inpatient, where appropriate, to reduce overall reliance on acute beds. Valuation based on a reduction in cost of inpatient beds associated with inpatient procedures being converted to a day case procedure. Target number of procedures has been set at the internal median rate for day case for each procedure.	$13M
CU7	Reduce procedures of limited clinical value	Targeted reduction of the number of procedures with limited clinical value being undertaken across AHS. Valuation based on reducing the cost associated with not undertaking procedure identified within the UK NHS Commissioning Group guidelines. Range of valuation based on reducing only ambulatory procedures through to all procedures.	$47M-$100M
CU8	Surgical wait time	Reassess level of operational and capital investment required as part of Alberta Surgical Initiative based on utilization improvements, wait times strategy and alternative patient pathways (i.e. NHSF).	
CU9	OR suite & procedure room Utilization	Maximize the utilization of OR capacity by reducing turnaround times, enhancing on-time starts and finishes and structuring days aligned to case lengths.	
CU10	LTC to DSL reconfiguration	Convert LTC beds to DSL beds. Staff converted beds as DSL, e.g. with a less intense staffing level. Valuation based on the reduction of cost from the change in care model associated with transitioning the 1,300 patients that AHS has identified to the most optimal level of care.	$32M
CU11	Rightsizing LTC care models to Patient Care Based Funding Model	Remove funding floor protections put in place in FY2010/11 to enable LTC facilities to right size their model of care with Patient Based Funding model. Valuation based on AHS' estimate of the funding floor removal impact.	$21M
CU12	Sale of Capital Care and Carewest LTC	Divest and sell Capital Care and Carewest to third party provider. This represents one-time revenue for AHS. There are no operational savings.	Estimated in hundreds of millions of dollars
CU13	Optimize home care contracts	Improve the current home care contract terms through performance/ quality measures-based contracts and potential further outsourcing opportunity.	

Service configuration

Context

Service configuration refers to how and where care is delivered in the province, with the goal of organizing resources so that patients receive the most appropriate care in the right place and at the right time.

> *"Why does Alberta have so many more hospitals than every other province?"*
>
> *Comment from AHS Employee Survey*

The demand for care in Alberta will only continue to increase as its population grows and ages over time. Leading jurisdictions are responding to these trends by 'shifting care left' – focusing on maximizing out of hospital care and ensuring the hospital system is truly for the most unwell. Alberta's single provincial system facilitates the provision of care in the optimum locations across a single integrated system.

The configuration of clinical services in Alberta is influenced by its unique geography and population distribution. Achieving a sustainable provincial health care system will require:

a) Delivering services in areas of low population density in a way that balances patient access with the critical mass of patient volumes needed to provide safe patient care.
b) Appropriately allocating services between regional hospitals that can care for less acute patients and larger hospitals in urban centres that can deliver tertiary and quaternary care.
c) Creating centres of excellence for complex specialty care to enable deep specialization and avoid costly duplication.
d) Expanding the use of efficient, high-volume independent facilities that can best deliver common surgeries and clinical procedures.

For the purposes of this review we have predominately considered acute service configuration. Long term care (LTC) and Designated Supported Living (DSL) have been included with the Clinical utilization section.

Service configuration outside main population centres

Alberta has a total of 100 acute care facilities, 85 of which are classified as small/medium community hospitals (with 24/7 emergency departments). Many of the sites are run by general practitioners (GPs) or family practitioners (FPs) and the acute services are co-located with outpatient centres, long-term care, and designated supportive living facilities, with staff often being shared across each of these areas. These facilities serve approximately 830,000 Albertans and cost approximately $880 million per year.

Determining the configuration of services that meets the needs of smaller more remote communities generally involves balancing enabling timely access to care against the need to ensure appropriate quality. These communities expect to have reasonable access to emergency departments, acute inpatient beds, and obstetrical care to support delivery of babies in the surrounding areas. At the same time, servicing a community with a small, low-volume facility can lead to both quality and cost effectiveness challenges. Physicians and other care providers require ongoing exposure and experience with certain types of procedures, such as complex births, to maintain proficiency. Likewise, underutilized hospitals lead to inefficient use of staff and facilities.

AHS has developed frameworks for defining the clinical configuration of services relating specifically to the remote locations of EDs, acute beds, and maternity. In conjunction with the configuration framework, access guidelines exist to help inform an assessment of their clinical viability. For ED, Acute care and Maternity the

frameworks can help to determine if a facility could be reclassified as a daytime-only unit or be consolidated with another hospital nearby.

Service configuration in metro and urban areas

Approximately 81% of Alberta's population resides within an urban area, with the notable majority living along the Calgary-Edmonton corridor. There are 16 facilities in Alberta which are classified as "metro/urban" hospitals with 6,323 acute beds. Making up over 74% of the province's beds, these hospitals serve both the local population of 3.5M in local catchment areas, as well as provincial patients for defined specialties. AHS has developed a structured and evidenced system for classifying these facilities, depending on the level of care that they provide.

Since its formation, AHS has focused on establishing and enhancing integrated 'corridors of care' that connect smaller populations, regional and tertiary/provincial centres together and support the flow of patients across the system.

Configuration of specialty tertiary and quaternary services

Beyond the broad configuration of core services at the local, metro, and urban levels, it is important for the health system to consider how it provides effective and appropriate specialized tertiary and quaternary care. Leading practices from the UK and other jurisdictions suggest that driving towards consolidated centres of excellence for specialist services enables a critical mass of expertise and resources, which in turn leads to improved patient care[42]. Integrated health systems such as Alberta are better positioned to be able to adopt this model. AHS has consolidated many specialty services into regional centres with most tertiary/quaternary services provided in Calgary or Edmonton. As part of this review, we have considered the standard basket of specialized services, this listing is provided in the full report.

Non-hospital surgical facilities

In addition to providing services in AHS operated hospitals, Alberta currently allows several procedures to be delivered in non-hospital surgical facilities (NHSF). NHSFs are publicly funded, independently operated facilities that perform scheduled surgeries (i.e. not emergent care cases) in a specialized surgical centre with its own clinical and support staff. The types of cases performed in NHSFs vary from province to province, but in most circumstances are for stable and low-risk patients not requiring advanced levels of care that is usually provided by hospital operating rooms. A recent jurisdictional scan shows that Alberta is one of the leading adopters of NHSFs across Canada.

The province has undertaken substantial work in developing processes and accreditation standards for out-of-hospital surgical cases. AHS currently has 51 contracts across 42 of these facilities to conduct approximately 40,000 surgical procedures annually (this represents 15% of all AHS surgical procedures – 293,000 total cases), for a combined spend of $24M. Alberta Health and AHS plan to expand the use of NHSFs over the next four years, both in terms of the volume and types of cases.

[42] https://www.kingsfund.org.uk/publications/reconfiguration-clinical-services

Findings

Small/medium hospital configuration framework

1. AHS has established a transparent classification framework for defining hospital levels of service and access guidelines that indicate where these services may be located.
    - The framework has been applied to all acute hospital facilities, EDs and Maternity services across AHS, and enables AHS to ascertain what levels of service provision it has across all zones.
    - Alongside the classification framework, AHS has developed clinical access guidelines for EDs, acute care and elective care relating to small/medium community hospitals.
    - AHS has done a good job of assessing its hospital configuration against these access guidelines, however these guidelines have not yet been used to implement any provincial configuration strategies.
2. Of the 83 small/medium facilities outside the main population centres, 77 emergency departments within small/medium community facilities in Alberta meet the criteria to be considered for reclassification or consolidation.
    - These sites are characterized by very low overnight visit volumes (average three per night) and high proportions of patients with minor emergency care needs, that could be better treated by their GP or in the community.
    - For the 73 sites our assessment found that the cases would be better served through an urgent care model or ambulatory clinic setting with reduced hours of operation (typically around 16 hours per day).
    - Alongside the under-utilization of the existing resources it was found that more than 50% of the small/medium facility EDs had higher 30-day ED readmission rates compared to the provincial average. This could be an indication of clinical quality and safety challenges.
3. 36 acute sites do not meet the criteria for clinical viability in their current configuration.
    - These sites would be potential candidates for reconfiguration or reduction of the inpatient beds. There are 5 facilities where occupancy and patient acuity is sufficiently low that they would be considered for closure
    - When reviewing the configuration, access times to services have been considered, and in these cases the populations served would reside within 45 minutes travel time window specified.
4. AHS is making notable progress in establishing virtual care, telehealth and other technology enabled solutions to support care to remote populations.
    - There are 51 local, zone, or provincial initiatives related to community-based virtual care, technology-enabled care, and telehealth programs currently in progress across AHS. In many cases the projects are highly innovative, and AHS is potentially leading when compared to its peers.

- Most of these projects are in pilot phases and while local outcomes are being assessed, it is important to further understand the potential to scale across broader geographies and on a more permanent basis.

- Virtual care and other technologies should be at the centre of any configuration activities. This is consistent with many other jurisdictions with similar rurality, and the need to continue to provide access to consultation and care in a timely manner.

5. Small/Medium sites which provide 24/7 access to maternity surgical services deliver an average of 201 cases per year per site, which may not be high enough volume to ensure appropriate quality and patient safety.

   - A total of 28 of AHS' small/medium sites have full or specialist obstetrical services that are available 24hrs a day. On average there are 201 births annually in these facilities.

   - Clinical evidence indicated that less than 250 births annually would be deemed sub-optimal and may result in clinical quality concerns for the facility. AHS' Maternal Newborn Child & Youth strategic clinical network has suggested that a minimum of 300 obstetrics patients per year per site would reduce clinical risk through increased clinical competency.

   - Furthermore, when assessing access times for these patient populations it would be possible to consolidate maternity services while maintaining the 45 mins access time goal.

Service configuration

6. AHS has a largely well-consolidated tertiary and quaternary service portfolio that supports patients across the province.

   - When compared to other jurisdictions and standardized for population, the number of service centres for specific tertiary and quaternary specialties are in line with expectations. Furthermore, AHS has broadly allocated these services evenly across Edmonton and Calgary, to ensure appropriate coverage for the north and south of the province respectively.

   - Based on the current allocation of services, there are some relevant areas where AHS could consider further consolidation. This would include plastic surgery, neonatal-perinatal medicine and the configuration of Neurosciences across Edmonton.

Provincial trauma program

7. Edmonton has two adult major trauma centres (level I and level II), while receiving similar case volumes of major trauma as Calgary, which has one level I centre.

   - Clinical guidance would suggest that one Level I or Level II adult trauma centre and one Level I or Level II paediatric trauma centre will be required in a trauma system serving population of up to 2 million within an anticipated caseload in the order of 500 to 1,000 major trauma cases[43]. In 2018/19, 991 adult major trauma cases were treated in Edmonton across two sites, while 851 cases were seen in Calgary through the single level I centre.

   - Experience from other jurisdictions highlights that running two separate trauma sites in close proximity can lead to duplication of the tertiary and quaternary services needed to support a trauma program. In assessing the current state in Edmonton, this appears to be the case, with a number of tertiary services provided across both centres. Associated on-call rotas are also independently provided on each site for select tertiary services through which major trauma coverage is provided.

8. 15% of patients seen at the level I and II trauma centres are minor/intermediate trauma patients from out of zone. These cases could be treated at local level III and IV trauma centres.

   - 15% of the cases from outside of the Edmonton and Calgary zones that are treated at the level I and II sites are below the ISS > 12 threshold for major trauma. While this pathway does not result in suboptimal care, there is the potential for cases to be treated in local regional trauma units rather than the provincial trauma centres.

   - While both EMS (local) and Referral, Access, Advice, Placement, Information & Destination (RAAPID) (out of zone) triage trauma cases to be allocated to a relevant and available trauma centre (with RAAPID also coordinating repatriation and capacity management of the ICU and trauma beds), a notable volume of patients bypass regional centres equipped to receive minor/intermediate trauma and are treated at the level I or II in Calgary or Edmonton.

Non-hospital surgical facilities

9. NHSFs in Alberta and in other Canadian jurisdictions are conducting procedures at lower cost than in acute settings.

   - There is a significant cost efficiency reported for the defined basket of procedures that are currently performed through NHSFs. This ranges between 13% and 55%. This level of savings is significant given the volume of cases undertaken across AHS.

   - Experiences of other Canadian jurisdictions indicate cost efficiencies of up to 70% by performing appropriate cases in private surgical environments.

[43] Trauma Association of Canada, Trauma Accreditation Guidelines (2011)

10. There is significant geographic variation in the use of non-hospital surgical facilities across zones in AHS, particularly for cataract procedures.

    - 96% of cataract procedures in the Calgary zone are done in NHSFs, compared to only 18% of procedures in the Edmonton zone.

    - As some NHSF contracts have been in place since prior to AHS' consolidation, there is an additional opportunity to review existing contracts and procure new rates based on market availability.

Recommendations

Recommendation 23: Alberta Health and AHS should establish provincial clinical access guidelines and further develop clinical standards to enable an affordable and safe configuration of acute care facilities across the province.

Recommendation 24: AHS should consider reconfiguration of small/medium community sites based on the validated and agreed access guidelines.

Recommendation 25: Review existing virtual health initiatives and consider development of a provincial plan to leverage virtual health technology to provide care across remote populations.

Recommendation 26: Ensure trauma is managed as a provincial service, with stronger adherence to trauma triage and referral protocols to avoid bypass of regional centres where not clinically appropriate.

Recommendation 27: Consider consolidating Edmonton's two major trauma centres to a single site.

Recommendation 28: AHS and Alberta Health should assess opportunities to expand the use of non-hospital surgical facilities (NHSFs) across the province.

Opportunities

Table 12. Summary of service configuration opportunities

#	Proposed Opportunity Name	Opportunity Description & Valuation Approach	Gross Valuation
SeC1	Small/medium ED configuration	Reconfigure current in-scope small/medium hospital EDs based on visit volumes and appropriateness, this includes options for ED hours modification and reclassification or closure. Valuation based on a reduction of 1/3 of ED operating costs and associated on-call costs for DI and labs considering where services may run reduce hours of operation.	$32M
SeC2	Small/medium hospital configuration	Consolidate/ repurpose in-scope small/medium hospitals based on defined access and hospital classifications as a function of underutilization or occupancy. Valuation based on cost of either reclassifying or reducing inpatient beds across sites.	$29M
SeC3	Maternity service consolidation	Consolidate maternity services in rural areas to support maintenance of clinical competency and appropriate level of care, where appropriate. Valuation assumed to be part of small/medium hospital configuration.	
SeC4	Urban area service configuration	Reconfigure and reduce duplications of services across quaternary service sites. Optimize tertiary and quaternary services through consolidation and reduction of duplication of services between neighbouring sites.	
SeC5	Provincial trauma program optimization	Optimize the Trauma provincial program through better utilization of specialty services in tertiary and quaternary hospital sites. Valuation based on potential rationalization and standardization of Trauma program staff only; it does not include any potential savings related to consolidation of clinical trauma services.	$0.4M-$1M
SeC6	Non-hospital surgical facilities (NHSF) procedure expansion across zones	Expand the usage of NHSF procedures across each zone. Implement new procedures in NHSFs based on jurisdictional comparators (ON, BC, SK, QC). Valuation based on providing AHS day surgery cases at 10-20% lower support costs.	$32M-$65M

Clinical support services

Context

The section includes findings, recommendations and opportunities that focus on the provision of laboratory, diagnostic imaging, pharmacy, and emergency medical services across AHS. These clinical support services are an essential part of the health care system and critical to delivering safe, efficient and effective patient care. Structurally, these functions are organized into provincial programs that provide overarching strategy, clinical and operational oversight and set standards across AHS. The provincial leadership teams from each function work closely with AHS zone leadership to support locally based operations and initiatives. This section will highlight opportunities within clinical support services related to clinical appropriateness, utilization, service delivery models and cost effectiveness.

"Provincial Services under the Clinical Support Services areas have seen numerous successes & strengths. Standardization of education, training, best practice have been implemented across the province in all of these areas"

Comment from Operational Leader Session

Table 13: Clinical Support Overview

Clinical Support Area	# Locations	Activity	FTE	Expense
Laboratory Services	210	81M tests	3,819	$800M
Diagnostic Imaging	299	2.9M exams	1,137	$457M
Pharmacy	146	N/A	1,837	$507M drug $210M department
Emergency Medical Services	204	560k events	3,600	$506M

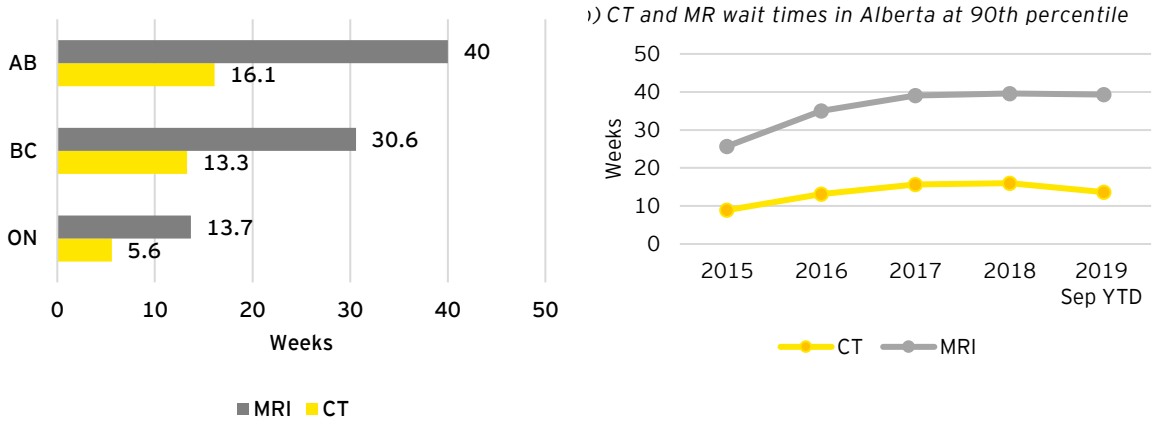
Labs

Lab services are predominantly focused on hospital and community-based lab tests, but also include mobile collections, specimen transportation, and specialized and public health laboratories. Over the past several years, laboratory services in Alberta have been the focus of several significant re-structuring and integration efforts, marked by multiple reviews and attempts to transform the laboratory services business model. These transformation agendas have been shaped by government strategy and direction and have been impacted substantially by electoral changes in 2015 and 2019.

Alberta Precision Labs (APL), created as Alberta Public Labs in 2018 and renamed in 2019, is a wholly owned subsidiary of AHS. APL is led by a Chief Operating Officer and a Chief Medical Laboratory Officer. This public organization represents the consolidation of laboratory services previously provided by AHS, Calgary Lab Services, Covenant Health, and Lamont Health Care Centre. APL has two distinct operating models: the North sector is a hybrid of private and public providers whereas the South sector is fully public. Overall, APL outsources 23% of its tests to private providers.

Diagnostic Imaging

The program delivers over 2.9M exams per year across multiple modalities including CT, X-Ray, Radiography, Nuclear Medicine, Ultrasound, and Lithotripsy. Provincially, Alberta's CT and MRI wait times are significantly higher than other provinces creating challenges related to quality and accessibility to healthcare for Albertans. One in every ten patients in Alberta waits more than 40 weeks for an MRI which is months longer than the wait times experienced by residents of BC or Ontario. It is important to note that compared to Ontario and BC, Alberta has a similar amount of equipment per capita signalling that challenges lie in how this equipment is utilized[44].



Source: CIHI

Pharmacy

The pharmacy provincial portfolio is responsible for drug production, distribution and direct patient care in hospitals and other AHS facilities. Drug expenses represent a significant cost pressure, and since 2017/18 AHS' spend on drugs and gases has increased by 8.5%; largely due to the advent of new biologics and the approval of new cancer drugs. In Alberta, medications are paid for by different parties depending on how and where the medications are administered. Medications provided in hospitals and long-term care are provided to patients at no cost and are funded by AHS, or in the case of specialty cancer drugs, by Alberta Health. In the community many Albertans rely on insurance coverage provided through supplementary plans, often sponsored by their employer or sponsored by the Government of Alberta through various programs (e.g. Seniors Benefit Program).

Emergency Medical Services

AHS' Emergency Medical Services (EMS) provides out-of-hospital response, treatment and transport to patients requiring urgent and immediate care. EMS also performs inter-facility transfers and non-emergent patient transport across AHS (this will be discussed in the non-clinical support services section). This past year, EMS responded to 560,434 events, which has increased by 9% over the last three years. AHS' EMS also provides community paramedic services as part of a Mobile Integrated Health Program that trains community paramedics to provide short-term treatment for low-acuity illnesses.

[44] https://www.cadth.ca/canadian-medical-imaging-inventory-2017

Findings

Clinical appropriateness

1. AHS has begun to adopt and implement recommendations from the national "Choosing Wisely" appropriateness program. While appreciable progress has been made, targeted reductions are often lower than Choosing Wisely guidelines.

Choosing Wisely

Evidence has found that up to 30% of tests, treatments and procedures in Canada are potentially unnecessary. While reducing these inappropriate services can save money, most importantly, it will decrease wait times, improve patient safety and the overall patient experience.

Choosing Wisely Canada is the national voice for reducing inappropriate tests, working with health systems, providers and patients to create recommendations, tools and clinical guidance for implementation.

Source: Choosing Wisely Canada

- Currently, there are 53 initiatives in-flight across AHS, of which 28 are led by the clinical support services and 25 are led by the strategic clinical network teams.
    - Approximately half of these initiatives have quantified savings or efficiencies totaling $42M-$62M. Further quantification of initiatives could provide additional savings opportunities for AHS.
- In some cases, targets are not fully aligned with Choosing Wisely recommendations or could potentially be pushed more aggressively.
- AHS established the Improving Health Outcomes Together team, a provincial governing body to oversee the delivery, spread, engagement and monitoring of clinical appropriateness initiatives.
    - Even with this team in place, many initiatives remain localized to sites or departments, and initiative owners have varied approaches to target setting, return on investment assumptions and overall implementation.
- Most of the savings identified have been deemed cost avoidance by AHS, rather than budget savings.

"My family doctor declined my request for an MRI when I had a herniated disc in my back. I needed physio to get better and his diagnosis of the problem was 100% correct. I did not need an expensive MRI. More education for doctors around using knowledge and experience without adding to already lengthy waits for imaging that are costly to the system is needed.

Comment from AHS Employee Survey

Laboratory services

2. Alberta Precision Laboratories (APL) deploys a mixed service delivery model for lab services in Alberta, delivering laboratory services in the South, while managing an outsourced delivery model in the North. When comparing similar tests within this hybrid model, there is a cost differential of $1.29 per test between APL ($9.61/test) and the private provider ($8.32/test)[45].

Diagnostic imaging

3. Diagnostic imaging utilization (e.g. exams/hour) can vary greatly within the same modality and can be further optimized to increase capacity and reduce wait times where appropriate.

   - There is significant variability across all modalities with large differences between low and high performing sites. AHS is achieving its internal target for MRI utilization, but CT utilization is falling behind internal targets. However, wait times for these exams are significantly higher than other provinces.

Table 14. Diagnostic Imaging exam volume per hour

DI Modality	Average Exams/Hour	Low Exams/Hour	High Exams/Hour	AHS Target
CT	1.69	0.85	5.56	3.80
MRI	1.85	1.00	2.5	1.60
Ultrasound	1.05	0.44	2.36	N/A
Radiography	1.72	0.65	3.20	N/A
Nuclear Medicine	0.54	0.30	0.73	N/A

   - Currently, AHS is responsible for all costs associated with DI activity, including radiologist compensation. As a result, an increase in volumes may lead to an increase in radiologist fees that needs to be considered. As discussed in the physician optimization section of this report, radiologists are paid significantly more in Alberta than in other provinces.

4. AHS has identified 6 radiography sites that could be consolidated or closed based on AHS developed DI utilization and access guidelines.

   - There could be further opportunity to consolidate an additional 5 radiography and 1 ultrasound site if the DI guidelines, specifically travel time, were adjusted from 20 minutes to 45 minutes to align with broader AHS acute care access guidelines.[46][47]

[45] APL Cost and Volume Analysis Sept 2018 – Aug 2019
[46] AHS Rural Service Access Guidelines for Emergency Department & Acute Medical Inpatient Service Planning (2013)
[47] The two consolidation scenarios above are separate from DI consolidations associated with site closures as part of the *Service Configuration Workstream*.

5. Diagnostic imaging at AHS is challenged by aging equipment, 32% of which is past its recommended replacement year. The majority of DI equipment is due for replacement in the next 5-10 years.

   - With no allocated capital funding in 2019/20 and significant expenses related to service/maintenance costs, AHS could consider alternative models such as a Managed Equipment Service (MES) arrangements, which are being adopted in other Canadian hospitals.
   - Managed Equipment Service would provide AHS with timely replacement of the equipment as part a long-term contract (typically 10-15 years). In addition, vendors would provide services related equipment purchasing, installation, maintenance, and staff training.
   - Many vendors have invested heavily in the development of AI technology that improves automation, productivity and standardization within DI. Moreover, vendors are using advanced data analytics to support the interpretation and analysis of images. Leveraging a MES model could provide AHS with expedited access to these types of new innovations.

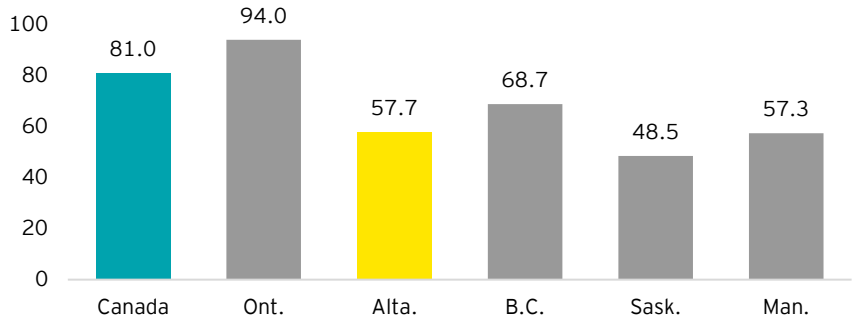
Pharmacy

6. Alberta spends less per-capita on hospital drugs than many other provinces.

   - Alberta has a province-wide formulary, which has allowed AHS to drive down drug costs through controls on what can be prescribed and the use of generic medications
   - As part of the formulary process, AHS reviews new drugs for approval against what is provided on formularies across Canada enabling cost effective, and evidence-based access to medications.

> *"Provincial pharmacy has saved millions by streamlining provincial formulary and drug optimization initiatives."*
>
> *Comment from AHS Employee Survey*

Figure 17. AHS hospital drug spend per capita by province 2017/18[48]



[48] Canadian Institute of Health Information - Canadian MIS Database (CMDB). *Hospital Expenditure by Type of Expense*, 2018

7. AHS has controls in place for the approval and ordering of drugs that are not on the provincial formulary. As evidenced by a relatively small non-formulary spend, AHS performs well in this area

   - AHS' spend on non-formulary drugs in 2018/19 was $2M across the most commonly used drugs. While this is a small spend, it has doubled from the previous year, with AHS actively reviewing these variances to reinforce its controls and processes where necessary.

8. AHS conducts quarterly reviews of its drug spending across the top 25 drugs to address increases in spend as well as to investigate variations across zones. AHS is working to be able to provide provider level feedback by improving its drug database and partnering with the University of Alberta to apply more advanced analytics.

9. AHS has a variable approach to retail pharmacy in its facilities across the province and has not fully leveraged its size and scale to maximize existing retail pharmacy arrangements.

   - There is a mix of outsourced arrangements including leasing and profit-sharing agreements. Pharmacies in rural areas are mostly AHS owned and operated.

10. The Calgary zone has consolidated pharmaceutical services for long-term care with three private providers, saving $670,000 per year. Adopting this model in other parts of the province could allow for similar benefits to be achieved.

11. In Alberta, there is no co-pay for drugs for LTC clients and many non-prescription medications are 100% covered by AHS. AHS can explore alternative options for drug payments that align with similar patient populations within AHS, and provinces such as Ontario[49].

Emergency medical services and air ambulance

12. Four of the province's air ambulance bases are significantly underutilized.

Table 15. Air ambulance base volumes

Community	Air Ambulance Volume	Volume from Base Community	Volume from Other Communities	Percent Pick-up away from Base
1. Lac La Biche	761	74	687	90%
2. Peace River	1439	259	1180	82%
3. Slave Lake	799	152	649	81%
4. Fort Vermilion	537	206	331	62%
5. High Level	583	253	330	57%

   - In these facilities, most transports do not originate in the aircraft's community base location. An assessment of volumes, transport routes, and costs suggests that some of these bases could be consolidated with higher utilized bases. These communities would continue to have air ambulance services to maintain service delivery, with aircrafts relocated to nearby locations.

13. AHS has identified an opportunity to consolidate four contracted EMS dispatch centres into EMS managed communications centers to reduce costs.

[49] Ontario Drug Benefit Program. https://www.ontario.ca/page/get-coverage-prescription-drugs

- The workload currently handled through service agreements with the City of Calgary, City of Lethbridge, City of Red Deer and the Regional Municipality of Wood Buffalo Dispatch Services is duplicative of what AHS' EMS communications centers currently provide and can be consolidated and managed by AHS.

Recommendations

Recommendation 29: AHS should expand and scale clinical appropriateness initiatives to reduce unnecessary tests to improve patient safety, experience and access across Alberta.

Recommendation 30: AHS should further leverage private contracts for the provision of laboratories services across Alberta. While an initial focus should be on community-based testing, subsequent consideration should be given to expanding to specialty test options.

Recommendation 31: AHS should optimize capacity across DI services by consolidating underutilized radiography facilities and increasing throughput of CT and MRI modalities to help manage wait lists where appropriate.

Recommendation 32: AHS should consider and assess options related to a Managed Equipment Service (MES) approach to major DI equipment to provide more timely equipment replacement and access to innovations that can drive further efficiencies.

Recommendation 33: AHS should review and optimize its commercial business models for pharmacy including retail pharmacy options (e.g. owned, lease, profit share) and LTC delivery models. Consideration should be given to co-pay options and expanding the Calgary private LTC model.

Recommendation 34: AHS should rationalize EMS dispatch and air ambulance operations including the relocation and decommissioning of underutilized airbases and a review of service agreements where services can be more efficiently delivered by AHS.

Opportunities

Table 16. Summary of clinical support services opportunities

#	Opportunity Name	Opportunity Description & Valuation Approach	Gross Valuation
CSS1	Improve adherence to test appropriateness	Reduce redundant/ unnecessary tests based on clinical appropriateness. Savings identified by AHS clinical appropriateness initiative leaders. Valuation challenged to incorporate province-wide scale or maximum target informed by leading practice, where possible.	$43M-$62M
CSS2	Improve DI utilization	Improve efficiency and productivity across DI modalities, driving higher utilization and potential rationalization. Valuation based on reduction in cost through increased utilization to targets set by either AHS or median performer.	$7M-$15M
CSS3	Closure of underutilized DI sites	Rationalize DI sites where volume is low (<1500 per year) and is close (Within 45 min) to another hospital that offers the same service. Valuation based on removal of DI function for underutilized sites as per the budgeted costs.	$2M
CSS4	Outsourcing lab activities	Maximize current outsourcing model across remaining laboratory services. Valuation based on the cost differential between current insource vs. outsource cost per test (excluding genetics and public Health) multiplied by current in-house AHS volumes.	$102M
CSS5	Managed Equipment Service - private partnership model	Explore a private partnership model for Managed Equipment Service (MES) to improve overall cost effectiveness and maximize additional technology to drive productivity. Valuation based on industry benchmarks with reductions to capital and service costs. This would be applied to all identified DI equipment.	Unvalued
CSS6	Outpatient and private LTC pharmacy business model	Assess options to determine best approach to deliver retail and private LTC pharmacy services. Assess options for clients to pay for non-prescription drugs and co-pay for other drugs.	Unvalued
CSS7	Underutilized air ambulance bases closure	Decommission underutilized air ambulance bases and consolidate aircrafts to existing bases. Valuation based on AHS estimate of decommissioning air ambulance base operational costs.	$2M
CSS8	Consolidate regional dispatch operations into EMS communications centers	Confirm and validate two separate EMS dispatch savings initiatives to terminate City of Calgary, Lethbridge, Red Deer and Wood Buffalo Dispatch Services. Valuation based on AHS estimates.	$5M

Improvement Theme: Non-clinical services

Non-clinical support services

Context

AHS' non-clinical support services are discussed in this section. These refer to services that are essential to enabling the wellbeing of patients when they experience the health system, such as food and protective services. Our analysis first reviews the delivery model of these services (in-house, hybrid or outsourced) then assesses the viability of moving to an alternative service delivery (ASD), or outsourced model based on jurisdictional comparators, EY's experience and market intelligence.

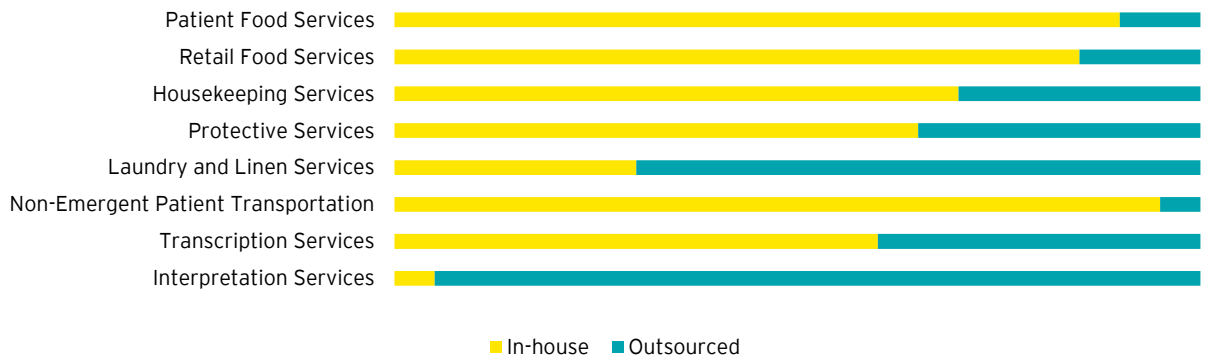
The following non-clinical support services were included in this assessment.

Table 17. Non-clinical support services: breakdown of AHS spend and FTEs

Service	# FTE	Size of Budget
Patient Food Services	1,330	$205,618,488
Retail Food Services	172	$26,301,430
Housekeeping Services	2,355	$198,560,379
Protective Services	418	$71,324,855
Laundry and Linen Services	235	$60,138,385
Interfacility transfers and non-emergent patient transportation (part of EMS operations)	3,600[50]	$506,000,000
Health information management	1,999	$159,994,275
Interpretation and translation services	2.4	$1,561,091
Facilities management and real estate	1,190	$412,086,168

Across various non-clinical support services, AHS uses a mixed model of in-house and outsourced service delivery. This breakdown is described in the figure below.

Figure 18. Summary of in-house versus outsourced model for non-clinical support services



[50] Non-emergent patient transport FTE and budget is integrated within EMS total operations.

Findings

Review of Non-Clinical Support Services

Patient food services

1. AHS' average cost per day for patient food across several sites benchmarks higher than industry comparators with outsourced delivery models. The table below indicates food and total costs per inpatient day. Food costs are only food and raw materials, while total costs are inclusive of food, supplies and labour costs.

Table 18. Cost per day for patient food across 13 sites

Facility Type	Facility Name	Net Food / IP Day	Site Net Costs / IP Day
Acute	Alberta Children's Hospital	$11.91	$41.11
Acute	Chinook Regional Hospital	$13.81	$37.63
Acute	Medicine Hat Regional Hospital	$13.11	$41.44
Acute	Queen Elizabeth II Hospital	$13.23	$36.62
Acute	Red Deer Regional Hospital	$11.54	$39.85
Acute	South Health Campus	$10.42	$34.39
Acute	Sturgeon Community Hospital	$13.37	$39.97
Acute	Peter Lougheed Centre	$10.78	$29.60
Acute	Rockyview General Hospital	$10.46	$27.97
Acute	Royal Alexandra Hospital	$11.30	$36.25
Acute	U of Alberta and Stollery Hospital	$10.61	$31.18
Acute	Foothills Medical Centre	$11.50	$28.36
Mixed	Northern Lights Regional Health Centre	$16.60	$54.17
Outsourced Benchmark 1	*Site in Ontario*	*$7.90*	*$27.80*
Outsourced Benchmark 2	*Site in Ontario*	*$8.33*	*$30.68*
Outsourced Benchmark 3	*Site in British Columbia*	-	*$28.00*

2. Other jurisdictions such as Ontario and British Columbia have outsourced their patient food operations to third party vendors. These organizations have achieved an increase of patient satisfaction by 5-15% while reducing food costs per patient day of 5-20%.

Retail food services

3. Retail food services, largely delivered through in-house delivery models, are not profitable across AHS.

   - Retail food sales generate an operating deficit of $1.3m. The Regional Health Authorities Regulations do not allow ancillary services like retail food sales to be subsidized by operational dollars. AHS therefore relies on vending, leasing and catering revenues to address the shortfall created by retail food sales.

Table 19. Retail food services revenue and expenses (FY 2017/18)

AHS Retail Food Services Revenue and Expenses (FY 2017/18)			
	Expenses ($)	Revenues ($)	Net Income/ (Loss) ($)
Retail Food Services	26,690,801	25,346,882	(1,343,919)

- AHS has identified a hesitancy by the private sector to provide retail food operations in lower volume, non-urban sites. Other jurisdictions have addressed this hesitancy by pushing vendors to bundle these under-serviced locations into large procurements that involve more profitable, urban areas, or inpatient food services.

Housekeeping services

4. The sites in which AHS has outsourced housekeeping services, such as Chinook Regional Hospital, are less expensive and are of same or better quality when compared to AHS sites with in-house delivery models.

    - There is a cost differential of $24.74 per cleanable square metre between AHS' outsourced service provider and the average cost of the 12 largest insourced sites.

Protective services

5. AHS' protective services model, leveraging the unique role of Community Peace Officers, is a higher cost model compared to other jurisdictions.

    - AHS' Protective Services Community Peace Officer Training Program is the first program outside the Government of Alberta to be an accredited program by Justice & Solicitor General.

    - The average cost of a CPO at AHS is approximately $18K higher than a contracted security guard (not inclusive of training).

6. Other jurisdictions such as Ontario, Nova Scotia and British Columbia have a mixed model between in-house and outsourced security and protective services staff where they effectively utilize an 80:20 or 90:10 model of contracted security guards to higher trained or skilled protective service resources.

   - In-house resources used by other jurisdictions include security staff, Commissionaires, Special Constables or a combination of all.

   - AHS is supporting and collaborating with representatives from various BC Health Authorities, Saskatchewan Health Authority, Newfoundland Regional Health Authority and the Nova Scotia Health Authority in work that could lead to a national health care protective services benchmark.

Laundry and linen services

7. AHS has a mixed model for laundry and linen services with approximately 68% of services outsourced across the province. The current outsourced arrangements generate several benefits to AHS.

   - Laundry outside Calgary and Edmonton is provided through six AHS operated regional processing plants and 44 dedicated on-site facilities. AHS incurs all costs associated with these sites, including utilities, maintenance, facility and plant repair, and site-to-site transport. These costs are not incurred when AHS outsources this function.

   - The equipment and plant infrastructure at several AHS-run facilities is nearing or past end of life and would require an investment estimated at over $200M to maintain operations.

8. While the same vendor serves both the Calgary and Edmonton regions, two contracts exist with a difference in unit cost.

   - The difference in unit cost between the Calgary and Edmonton contract is $0.34 per cleanable kilogram.

   - Moving to a fully provincial delivery model for laundry and linen may enable AHS to drive price standardization across the two current contracts, enabling additional savings.

Non-emergent patient transportation

9. Interfacility transfers (IFT) across AHS sites are largely provided by AHS Emergency Medical Services (EMS). This has been a historical trend where patient transfers (medically required or not) have been provided by EMS using a mix of high cost ambulance vehicles with medically trained staff and a much smaller fleet of non-ambulance transport (NAT) units.

   - There is currently one existing contract in Red Deer that provides AHS non-ambulance transport resources to support interfacility transports. This contract supports approximately 1,500 transfers.

   - However, as the volumes below indicate, over 30,000 annual trips could be provided through a dedicated NAT service through an ASD arrangement. Such an agreement has resulted in a significant cost reduction across BC's lower mainland health authorities. This would also result in capital cost avoidance as the burden on the more expensive ambulance fleet is reduced.

Table 20. Resource level required at booking (transport count), January to December 2018

Resource Level Required at booking (Transport Count) From January 2018 to December 2018				
Pick Up Location Municipality	Advanced Life Support (ALS)	Basic Life Support (BLS)	NAT	Total
Calgary	6,627	17,937	12,896	37,460
Edmonton	5,161	16,825	17,253	39,239
Red Deer	1,261	2,659	1,954	5,874
Total	13,049	37,421	32,103	82,573

   - AHS is unable to provide the current cost per trip of IFTs carried out by EMS across the province. It is therefore difficult to understand the cost-differential and magnitude of savings that could be achieved by transitioning to a lower cost provider that fully services all non-ambulance transportation calls in the three cities.

10. Other jurisdictions such as British Columbia and Ontario have outsourced their interfacility patient transports to third party providers to reduce costs and infrastructure requirements.

   - In British Columbia, studies showed that approximately 30% or 130K ambulance events in the Lower Mainland were interfacility transfers, and approximately 75% did not require a paramedic in attendance. The Lower Mainland saved over $50M from 2014 – 2017 using non-emergent patient transport providers.

   - Over a 5-year period, the number of BC interfacility transfers provided by ambulances (as deemed medically necessary) declined from 65% to 29%. 911 response times were improved by allowing emergency medical services groups to devote their limited and costly resources to be a first responder role.

   - Benefits realized by other jurisdictions include avoidance of patients missing or being late for essential treatments or diagnosis, as well as improved patient flow with timely and reliable discharges.

11. AHS EMS services are sometimes not used for intended purposes or in lieu of community transportation.

    - For example, patients needing transfer to long term care homes to and from appointments are going by ambulance when families/friends or community transportation would be more efficient.

Health information management

12. AHS has achieved significant savings through a contracted service provider for transcription services and could realize additional savings through expansion of ASD in this area.

    - Covenant Health and Lamont Health Care Centre operate their own transcription services using AHS' dictation platform and should be included in any consolidation or ASD assessments.

Interpretation and translation services

13. AHS has transitioned a significant amount of face-to-face interpretation services to a contracted over-the-phone provider for a lower cost. Further transition would result in additional savings.

Real estate and facilities management

14. AHS has recently initiated sustainability measures related to their facilities and their operations including exploring the consolidation of leases and a corporate utilities management plan, which have the potential to reduce costs across the organization.

Alternative service delivery (ASD)

15. There are significant opportunities to achieve greater system sustainability through an expansion of ASD at AHS.

    - Alberta can take a "fast follower" approach to other jurisdictions that have achieved significant savings and enhanced services in commonly outsourced areas.

    - The benefits of ASD are not limited to reduced cost and include capital avoidance, technology refresh, modernization, risk transfer and a reduced burden on management and corporate support.

    - Additional efficiencies have been gained through strategic procurement, enhanced vendor performance management, and jointly managed utilization reduction programs.

16. AHS does not have any integrated support models across its current outsourced arrangements.

    - Hospitals in British Columbia and Ontario, for example utilize an integrated support services model where there is end-to-end third-party service provision of services that lower overall administration costs and share common support platforms such as help desk and service management tools.

17. AHS does not have a central structure managing existing ASD relationships or future service delivery partnerships. The management of AHS' current ASD arrangements falls under the same division and executive leader but is part of an extensive operational portfolio that includes provincial laboratories and the province's cancer program.

- The Business Initiatives and Support Services (BISS) office in BC has overseen a portfolio of ASD initiatives that have achieved industry leading results in efficient, high-quality services throughout the province.
- The centre of excellence has established key performance metrics and benchmarks across contracted services, introduced innovative public sector procurement approaches that allow for outcomes-based solutions, and provides independent challenge and deal support from within to ensure that health authorities gets the best contracts possible.

"Current contracts don't support innovation or quality incentives."

"Previously have had poor experiences with outsourcing in terms of quality outcomes."

Comments from AHS Operational Leader Session

Recommendations

Recommendation 35: A dedicated function should be established within AHS to support the qualification, service design, procurement, negotiation and management of alternative service delivery partnerships.

Recommendation 36: AHS should develop an enterprise-wide alternative service delivery strategy, and actively pursue opportunities to reduce costs, and improve services through outsourcing non-clinical support services.

Recommendation 37: As part of, or in parallel to, the ASD strategy AHS should fully assess opportunities to optimize and strengthen existing non-clinical support services.

Opportunities

Table 21. Summary of non-clinical support services opportunities

#	Opportunity Name	Opportunity Description & Valuation Approach	Gross Valuation
NCSS1	Inpatient food services outsourcing	Outsourcing patient food services operations to third-party. Valuation based on market intelligence and jurisdictional comparators. Investment will be required.	$100M-$146M
NCSS2	Housekeeping services outsourcing	Outsourcing housekeeping services operations to third-party. Valuation based on market intelligence and jurisdictional comparators. Investment will be required.	
NCSS3	Protective services outsourcing and resource rationalization	Transition protective services model to an 80% contracted and 20% in-house model (using CPOs). Valuation determined by scaling in-house and contracted provider costs to 80:20 model (low range) and 90:10 model (high range).	
NCSS4	Transcription services outsourcing	Transition remaining in-house minutes to existing contracted service. Valuation based on calculating difference of in-house transcription minutes to contracted provider rate.	
NCSS5	Laundry and linen services outsourcing	Transition remaining laundry and linen services to existing contracted provider. Valuation based on AHS estimate and market intelligence. Investment will be required.	
NCSS6	Interpretation services outsourcing	Transition remining face-to-face interpretation services to contracted telephone provider. Valuation based on calculating difference between face-to-face operational cost to telephone provider rate.	
NCSS7	Non-emergent patient transportation outsourcing	Transition interfacility transfers and non-emergent patient transportation to contracted provider.	
NCSS8	Implement comprehensive retail strategy	Outsource retail operations to third party vendor to assume all retail operational costs. Revenue from lease and profit share model to AHS.	
NCSS9	Implement AHS-wide sustainability management program	Program to reduce utility and energy costs in electricity, natural gas and water, based on external plan. Valuation based on AHS estimates received. Investment will be required.	$25-$28M

Corporate and back office services

Context

The corporate and back-office workstream is comprised of corporate programs, tactical measures and automation. Corporate programs include human resources, finance, information technology, and other support functions, which are delivered across each zone but report through a central provincial structure. Tactical measures refer to a broad category of activities that AHS can take in the short term to reduce costs and increase revenue in non-patient facing or discretionary categories. During the review we also assessed the extent to which key back-office processes could be automated, through workshops with AHS operational staff.

Findings

Corporate support programs

Finance

1. AHS' finance function benchmarks favourably, with a lower cost proportional to the overall operating budget, compared to peer organizations.

2. The total cost to perform the finance function per finance function FTE is higher than comparative organizations. This suggests that there could be internal opportunities to streamline services within the function. For example, AHS' accounts receivable function utilizes more than 12 Accounts Receivable (AR) systems.

Information technology

3. AHS' centralized IT function performs better than benchmark medians, and in some cases better than 25th percentile, which should be expected in a large consolidated organization that benefits from economies of scale and integrated services.

    - Rationalizing IT applications could drive further improvements in performance. AHS has more than 1000 applications, which could be reviewed for potential rationalization based on business requirements and cost reduction.

    - AHS has also identified 28 groups (167 FTEs) of "shadow IT" that sit outside of the centralized IT function.

4. AHS has a predominantly in-house model for IT services and infrastructure such as data centers, networks, mobility services, and desk side support

Human resources

5. Like finance and IT, AHS' consolidated human resources function performs well against benchmarks, considering the number of HR FTE and the scope of the organization they support.

   - Some HR portfolios could potentially be consolidated based on service scope to improve organizational productivity and achieve some cost efficiency. Examples include consolidating Abilities Management with Workplace Health and Safety, and consolidating Workforce Strategies, Talent Management and Employee Relations into a combined portfolio.

Legal and privacy

6. With an annual budget of $13 million, 38 lawyers and 15 paralegals, AHS' legal services operation is significantly larger than similar support functions in peer organizations and offers specialized legal services that are not provided by other health provider organizations.

   - Given the relative size differential between AHS and peer organizations, and AHS' predominantly in-house staffing model, it is difficult to assess whether the cost of these services is disproportionately high without deeper analysis. AHS does have unique services related to system responsibilities not common amongst its peers that must also be considered in any assessment.

   - The staffing model should be reviewed and adjusted if necessary.

Learning and education

7. Learning and education at AHS benchmarks higher than peer organizations, considering the costs of this function relative to the size of the overall operating budget.

   - AHS spends more than $170 million and has more than 1,000 FTEs dedicated to learning and education across multiple parts of the organization. Of those employees, approximately 650 are clinical nurse educators, with the remaining responsible for a variety of knowledge management activities.

   - AHS also has 10 learning-related IT systems, providing duplicative functionality. For example, there are multiple licenses for different versions of Adobe Connect (an e-learning program) held by teams across AHS. This lack of coordination has resulted in a variety of similar software products in use, different versions of the same software, and in some cases, different pricing from the same vendor.

Analytics

8. AHS has 80 analytics functions embedded within provincial programs and sites, in addition to a centrally delivered analytics program.

   - AHS estimates approximately 300-350 data analyst roles operate independently of the centralized analytics function, in areas such as mental health and cancer, whereas other programs make greater use of the centralized function.

Other

9. AHS' wholly-owned subsidiary Alberta Precision Laboratories (APL) has a number of corporate back-office functions, as well as management that have not been reviewed or consolidated during the integration of APL into AHS. In total, there are approximately 88 FTE that fall into this category.

   - These back-office functions and management positions should be reviewed and right-sized to reflect service levels provided to other clinical support programs, such as Diagnostic Imaging and Pharmacy.

Tactical measures

Revenue generation

10. Alberta captures less potential revenue for private and semi-private rooms in acute-care hospitals than other provinces.

    - AHS is only capturing 2.3% of potential preferred accommodation revenue, whereas in Ontario we have observed large academic hospitals achieve a capture rate of more than 25% with similar clinical and operational structures as AHS.

11. The rates that Alberta charges for private and semi-private rooms in acute-care hospitals are on par with the Canadian average. However, there are several other Canadian health care providers that charge significantly higher rates in comparison to AHS.

Table 22. Comparison of preferred accommodation rates

Hospital / Health Authority	Province	Semi-Private Accommodation Rate	Private Accommodation Rate
AHS	Alberta	$150	$187
Vancouver General Hospital	British Columbia	$165	$195
Eagle Ridge and Peace Arch Hospitals	British Columbia	$165	$195
Grand River Hospital	Ontario	$247	$290
Strathroy Middlesex General Hospital	Ontario	$210	$250
North Bay Regional Health Centre	Ontario	$220	$245
Joseph Brant Memorial Hospital	Ontario	$250	$290
Mount Sinai Hospital	Ontario	$310	$410
Cape Breton Healthcare Complex	Nova Scotia	$160	$180
South Shore Health	Nova Scotia	$160	$180

12. Alberta's legislated co-pay rates for long term care (LTC), designated supportive living (DSL) and alternate level of care (ALC) beds are lower than those in Ontario.

- Updating the legislation to bring long-term care rates in-line with other provinces could offset the costs of providing these beds.

> *"I feel that there should be a system in place when a patient is placed in an AHS Continuing Care Facility to have payments set up and ready to go. Currently we have upwards of 20 residents who do not pay their AHS monthly rent, so AHS is losing $30,000 every month ($360 000 per year). This money doesn't seem to be recouped with accounts going to collections either."*
>
> *Comment from AHS Employee Survey*

Table 23. Monthly accommodation LTC and DSL rates, 2018

Monthly Accommodation LTC and DSL rates for 2019[51]			
Province	Standard Room	Semi-Private Room	Private Room
Alberta	$1,705	$1,795	$2,074
Ontario	$1,891	$2,150	$2,474
Quebec	$1,189	$1,596	$1,910
BC	$3,377		
Saskatchewan	$2,829		

- AHS also has an Alternate Level of Care (ALC) accommodation charge for patients occupying hospital beds while awaiting admission into an LTC/DSL facility. As with most provinces, the Alberta's ALC rate is equivalent to its LTC. If Alberta increased its LTC rate, its ALC revenue would increase correspondingly.

13. AHS has optimized its collection of parking revenue, with over $40m collected annually and rates that are set in a 5-year strategy in alignment with market comparators.

14. The fees that AHS collects through enforcement of the Public Health Act offset only a small proportion of the cost of performing enforcement activities.

- AHS spends approximately $39.58 million per year on its Safe, Healthy Environments program, which is responsible for monitoring and enforcing *Public Health Act* and supporting regulations in a variety of settings, including restaurants, rental accommodations, pools, etc.

- The Public Health Act and supporting regulations could be modernized. Consideration should be given to allowing for alternative enforcement techniques such as those used in other provinces. Furthermore, the amount of the fines prescribed for violating the Act and supporting regulations should be increased to bring the Act in line with other similar legislative schemes, and to ensure an appropriate deterrent.

[51] Alberta Health, Continuing Care Accommodation Rate, 2019.

Discretionary spending

15. AHS has put in place effective policies and processes to reduce or control discretionary spending in several areas, including staff travel, minor equipment purchasing, telecommunications, mailroom and the central management of technology subscriptions.

16. AHS can further implement discretionary spending controls, including through the use of a bring-your-own-device policy, leveraging a provincial courier contract and actively managing the 'spike' of discretionary spending we have observed at AHS towards the end of the fiscal year.

Strengthening the budgeting process

17. AHS' current practices for budget management and accountability impact the ability to identify and address cost pressures, to understand root causes of budget variances and to drive enhanced capture of revenue.

- Budgets are typically rolled over from prior year with select adjustments made for strategic investments and corporate saving initiatives (such as OBP targets).

- Currently, AHS is running an overall budgetary deficit with a large negative "savings target" being held corporately to balance out the deficit. This negative variance is addressed through in-year underspends. Strengthening budgetary process and aligning budgets according to actual spending will allow AHS to more effectively identify and address cost pressures.

- AHS' Business Advisory Services team works closely with budget owners to identify and document explanations of budget variances for financial reporting. However, these explanations are often a blend of approved/justified and unjustified and are not always translated into a clear mitigation strategy with a documented action plan.

Automation

18. Through joint workshops with AHS, 47 manual processes across HR, Finance and Supply Chain, accounting for 172 FTE, were identified as candidates for potential automation. These include the staff onboarding process, balance sheet reconciliation and data management processes.

- To the extent that AHS has explored automation, it has been done through local initiatives. Healthcare organizations across Canada are moving towards a centre of excellence model for identifying, implementing and sustaining automation opportunities across the organization, which allows them to maximize benefits and target organization-wide processes.

Recommendations

Recommendation 38: AHS should explore opportunities to optimize corporate programs to achieve or exceed performance levels of comparative organizations.

Recommendation 39: AHS should develop a corporate automation program and pursue automation opportunities across HR, Finance, CPSM, IT, and others.

Recommendation 40: AHS should aggressively pursue revenue generation initiatives in non-clinical, auxiliary categories, in alignment with peer organizations.

Recommendation 41: AHS should look to refine its overall budgetary process to ensure departmental budgets are aligned with the actual operating model of each department, along with instituting an immediate review of discretionary spending controls to drive immediate savings.

Opportunities

Table 24. Summary of corporate and back office services opportunities

#	Opportunity Name	Opportunity Description & Valuation Approach	Gross Valuation
CBO1	AHS-wide budget review	Review and challenge spending patterns against budgets to identify tactical opportunities and true cost pressures. Savings based on 0.5% of total operating budget based on EY experience conducting these reviews.	$70M
CBO2	Preferred accommodation rate and capture increase	Increasing preferred accommodation rates based on jurisdictional comparators and increasing capture. Valuation based on increasing private and semi-private accommodation rates to provincial comparators, increasing capture rate to 10-20%, and removing 60% legislative requirement for standard accommodation.	$40M-$83M
CBO3	Robotic process automation - back office services	Automation of repetitive, high transactional processes in HR, Finance, CPSM, and IT. Valuation based on reducing FTEs currently associated with executing the processes that were identified for potential automation.	$16M
CBO4	LTC/DSL accommodation fee Increase	Alberta's LTC/DSL accommodations fee is lower than other provinces. Opportunity to increase fees to align with what Ontario is charging and reduce the LTC/DSL funding by the same amount. Valuation based on revenue increase associated with aligning with Ontario's rate based on the current occupancy rate with the assumption that 42% of the clients will require income support.	$57M
CBO5	Stop / limit discretionary spending	Strengthen controls and reduce discretionary spend across AHS.	
CBO6	Reduce redundancies between AHS and APL	Reduce duplicative management and corporate functions between AHS and APL. Savings amount determined by calculating total cost of APL corporate support and management functions.	$3M-$8M
CBO7	Application rationalization	Over thousand applications currently housed within AHS - opportunity to rationalize based on total users and active licensing agreements.	
CBO8	Data centres/hosting, help desks, networks outsourcing	Consider outsourcing for data centres / hosting, service help desks, and networks based on similar models in other jurisdictions.	

Supply chain

This section focuses on findings, recommendations and opportunities related to supply chain operations at AHS. The AHS supply chain, managed by the Contracting, Procurement and Supply Management (CPSM) program, refers to the way that products and services are procured, managed and distributed to clinical and non-clinical customers across AHS.

Context

CPSM employs approximately 1,000 FTEs distributed across the province. In 2018/19, CPSM procured more than $5.9B in products and services across AHS, its wholly-owned subsidiaries and Covenant Health. CPSM also manages a significant physical distribution network with two large distribution centres (DCs) in Edmonton (EDC) and Calgary (CDC) and eight smaller regional warehouses.

Findings

Strategic sourcing

1. CPSM has many suppliers in several product and service sourcing categories. The sourcing categories that account for a large proportion of provincial spend include on average, 15 suppliers. A larger number of suppliers can drive increased workload and impact the ability to get the best pricing.

Table 25. Number of vendors by sourcing category

Sourcing Categories	Annualized Spend	Annualized Addressable Spend	# of Suppliers making up 80% of Total Category Spend
LAB.REAGENTS	$ 72,804,967	$ 43,359,301	26
LAB.SUPPLIES	$ 41,231,900	$ 41,231,900	20
MED SURG.MEDICAL FACILITY	$ 38,287,128	$ 38,287,128	21
LAB.EQUIPMENT & INSTRUMENTS	$ 21,102,576	$ 21,102,576	17
MED SURG.CARDIOLOGY	$ 68,053,048	$ 21,005,409	11
MED SURG.CARE & TREATMENT	$ 23,156,912	$ 19,457,900	16
DIAGNOSTIC IMAGING	$ 48,625,439	$ 19,450,176	11
MED SURG.SURGICAL	$ 31,120,609	$ 15,000,000	23
EQUIPMENT MAINTENANCE.NON-BIOMEDICAL	$ 12,741,586	$ 12,741,586	36
MED SURG.SURGICAL EQUIPMENT	$ 11,493,493	$ 11,493,493	8
MED SURG.EXAM & MONITORING	$ 10,612,535	$ 10,612,535	18

- Note: the large number of contracts identified across lab sourcing categories are based on the recent transition of these contracts from Calgary Laboratory Services to CPSM. CPSM has begun the work to consolidate these contracts.

2. Based on a comparison of similar items purchased by AHS and a group of shared service organizations (SSOs), we identified 1,381 items where AHS pays more than the SSOs. For these items, the price differential averaged 16%.

   Note: This analysis also identified approximately 845 items that AHS pays less than the price benchmark, suggesting that in many cases, AHS is performing better than its peers.

   - With appropriate approvals and sharing agreements with other SSOs, CPSM could leverage this information to enhance sourcing event negotiations. Understanding what other similar jurisdictions are paying for the same items will enable CPSM to negotiate from a more informed position, potentially resulting in cost savings from reduced prices. Additionally, CPSM could partner with these other jurisdictions (provincially or nationally) to aggregate their volumes and drive further unit price savings.

Non-contract spend

3. Of the $5.9B of spend CPSM manages, approximately $422m is not on a contract. Of this non-contract spend, $156m is not associated with a purchase order.

   - Spend that is not on contract can result in:
     - Increased cost due to higher item/service pricing;
     - Increased and/or duplication of effort from having to negotiate with suppliers on an individual or ad hoc basis; and
     - Potential risk from non-standard or unfavourable terms and conditions.
   - Additionally, non-PO spend suffers from a lack of detailed purchasing information, which hampers detailed analysis and thus efforts to identify, audit, and remedy non-compliant activity as well as limiting the ability to look for cost reduction opportunities.
   - Adjusted for non-addressable spend, AHS' total off-contract spend is estimated at $230-$422M. This represents 3.8%-7.1% of AHS' total purchasing spending, which exceeds industry peer performance.
   - CPSM has many agreements with numerous major suppliers. Our analysis identified 55 suppliers with six or more contracts each. Together, these 55 suppliers represent $981M (or 17%) of the total annual spend across 1,994 contracts. $345M of this spend is considered addressable and excluded from opportunity calculations.

- AHS can achieve cost savings by better leveraging its bargaining position with selected suppliers by reducing the number of contracts and negotiating optimized terms and conditions, total supplier spend and earned volume rebates (EVRs), and pricing using an MSA framework.

Inventory management

4. The current process for determining the minimum and maximum quantities of stock to be held within distribution centres is based on historical use and order patterns. While this process is generally effective at the organization level, it does not provide forward-looking or predictive forecasting.

    - Other organizations have begun to leverage more predictive tools such as machine learning to enable better forecasting of supplies required. These technologies leverage historical usage data, but also enable inventory levels to be set based on surgical schedules, shortages vendors have reported on social media, or even the weather.

5. Reducing slow moving and obsolete inventory (SLOB) avoids incurring holding costs for items that will effectively never be used. These items can be transferred to other locations where they are still in demand, sold off to generate revenue, or transferred back to suppliers for credit.

    - CPSM has at least $4.7M of slow moving and obsolete inventory:
        - $1.2M is slow moving with over 360 days of inventory
        - $3.5M is obsolete and has not had demand in the last 720 days (2 years)

Warehousing and logistics

6. CPSM has made several positive physical distribution network and personnel changes in the past years but their network is not yet optimized.

    - Satellite sites are used to serve one or more health service providers in the geographical region of the site. Each site has its own inventory, transportation (if applicable), and staff. Some of these smaller satellite DCs are integrated directly into existing hospitals.

    - CPSM management has been working to improve the productivity at the Calgary DC, as it is not as efficient as the distribution centre in Edmonton. Implementing best practices from Edmonton will optimize and reduce inventory levels. Doing so will also improve working capital and reduce stockouts, will also result in improved productivity and free up new capacity. EDC has doubled its picking productivity in the past two years.

    - There is also an opportunity standardize products to a greater degree across CPSM's distribution centres as currently there is only a 60% match between the Calgary and Edmonton sites.

Supply chain activities outside of CPSM

7. Procurement of capital equipment is currently being done in a disparate and uncoordinated manner by both the equipment planning group as well as 23 other decentralized groups outside of direct control by CPSM.

    - The capital equipment procurement process allows clinical programs and zone operations leaders to create their own equipment priorities independently of each other. This results in an allocation of provincial capital equipment spending that is not always reflective of the true needs.

    - There is no single asset inventory for the province and no AHS policy for life cycle management.

        - There is no single provincial inventory of capital equipment assets resulting in situations where inventory on books is far less than actual inventory value.

        - Individual departments (e.g. Biomedical Engineering, Diagnostic Imaging, Labs, etc.) hold their own lists of the equipment they maintain and service while outsourced equipment servicing is not well-tracked.

        - Teams sometimes rely on vendors to provide information on the quantity and location of equipment purchased by AHS to plan equipment maintenance and upgrade cycles.

8. Construction contracting is currently not subject to the same governance, policies and controls as products and services purchasing through CPSM, leading to the potential for both procurement and execution costs to be higher than necessary, with lower quality than could be achieved via the application of the governance, policies, and processes used within CPSM.

9. There are staff with supply chain titles that do not report to CPSM.

    - 52.0 FTE (24.0 FTE Supply Coordinators and 28.0 FTE Stores personnel) work outside of CPSM and in AHS facilities. These staff do not follow processes and policies established by CPSM in key areas such as how goods are sourced, how vendors are engaged or how inventory is managed. While the number of these staff is relatively small, the decisions made by such staff could have significant financial implications and contribute to variable clinical practice.

Recommendations

Recommendation 42: AHS should improve strategic sourcing to realize cost savings, including reducing the number of suppliers per category and converting purchases currently not made on contract to contract.

Recommendation 43: AHS should continue to drive improvements to the provincial planning and materials management functions and should integrate supply chain functions across AHS that are not currently within CPSM.

Recommendation 44: AHS should consider integrating the contracting and management of capital equipment and capital construction into the CPSM function.

Opportunities

Table 26. Summary of supply chain opportunities

#	Opportunity Name	Opportunity Description & Valuation Approach	Gross Valuation
SuC1	Reduce supplier fragmentation in selected procurement categories	Reduce the number of suppliers per category where appropriate, increasing purchase volumes per supplier to drive reductions in unit pricing and improvements in terms and conditions. Valuation based on reduction of the number of suppliers per category, resulting in a cost savings of 3-6% on total spend (per selected category).	$9M-$18M
SuC2	Benchmark item purchase prices against other jurisdictions, identifying opportunities for joint cost savings	Utilize price benchmarking against other jurisdictions to ensure that CPSM achieves the supplier "best price" that leverages AHS' buying power. Valuation based on a comparison between AHS and Canadian health care item price database. Savings were calculated for matched items only.	$4M-$8M
SuC3	Migrate non-contract spend to contract. Capture additional transaction data for non-Purchase Order purchases	Convert purchases currently not made on contract to contract which will result in lower prices and better terms and conditions. Ensure that more detailed information is available for purchase transactions (especially non-PO). Valuation based on a 5-10% reduction in pricing for items that were previously not on contract being migrated to contract.	$9M-$34M
SuC4	Consolidate agreements with selected major suppliers	Sign Master Services Agreements (MSAs) with larger, strategic suppliers, to strengthen supplier relationships, take advantage of Earned Volume Rebates and secure mutual benefits. Valuation based on a 0.5-1.0% reduction in total spend for top selected suppliers with more than 5 contracts.	$3M-$7M
SuC5	Build a more proactive demand planning/forecasting process	Implement a predictive demand planning process (leveraging machine learning) to improve inventory performance, reduce inventory costs and improve service while supporting ongoing growth. Valuation based on inventory holding cost savings resulting from a 10-20% reduction in CPSM and in-hospital supplies inventory.	$1M
SuC6	Reduce slow moving and/or obsolete inventory	Address slow moving and/or obsolete inventory to free up space and recover resources. Valuation based on a 25% cost recovery for obsolete items at the CPSM DCs.	$0.2M
SuC7	Optimize CPSM's physical distribution network, improve Calgary DC and optimize distribution channels	Continue to optimize CPSM physical distribution network through warehouse consolidation, distribution channel adjustments, and further performance improvement initiatives. Valuation based on a 20% operating cost savings from consolidated sites and 15-20% savings from continuous improvement initiatives at CDC.	$2M
SuC8	Integrate non-CPSM in-hospital supply chain team into CPSM	Non-CPSM in-hospital supply chain functions can be done by more consistently and efficiently if integrated into CPSM. Valuation based on operating cost savings from identified in-hospital supply chain personnel.	$0.5M

SuC9	Integrate and improve the capital equipment procurement process into CPSM	CPSM should be charged with managing and coordinating capital equipment purchasing in a single consistent process, province-wide, to fully benefit from larger, bulk capital buys and timelier replacement of equipment at the end of its economic life. Valuation based on a 5-10% savings on identified capital spend.	$8M-$16M
SuC10	Improve construction contracting procurement, management and control	Leverage CPSM's governance, policies, processes, and templates for construction contracting. Valuation based on a 7.5-10% savings on identified construction contracting spend.	$8M-$15M

Improvement Theme: Governance

Functional duplication and accountability

Context

In many ways, Alberta's care delivery model is ahead of its provincial peers – Alberta has done significant and challenging work to build a consolidated health care system with a single major provider of acute care services. Across Canada, jurisdictions are struggling to manage fragmented systems that are making increasingly expensive and duplicative investments in new technologies, clinical protocols, facilities, and equipment. As care becomes more complex and dependent on technology, this fragmentation is accelerating, leading health systems across Canada to move towards consolidation in response. For example:

- Saskatchewan and Nova Scotia have followed Alberta in the creation of single health authorities.
- British Columbia is centralizing major pillars of service delivery, including IT and digital health, laboratory services, and diagnostic imaging into its Provincial Health Services Authority (PHSA).
- Manitoba has created a new provincial organization, Shared Health, to serve a similar purpose as PHSA in BC.
- Ontario has recently introduced Ontario Health Teams and has created a "super agency", Ontario Health, to begin coordinating the activities of the more than 150 independent hospitals and hospital networks in the province.

AHS has a $15.4 billion annual budget and more than 102,000 employees. AHS' massive size relative to Alberta Health creates the opportunity for a power imbalance between the two organizations. The structure of Alberta's system also impacts Alberta Health, as it does not need to play the role of broker, funder, and coordinator across multiple regional organizations. To address the potential imbalance and the unique relationship, the roles and expectations of Alberta Health, AHS, and other players in our complex system need to be clearly defined.

In a system such as Alberta's, the role of Alberta Health should generally be focused on three high-level functions:

- **Mandate:** Articulating a clear strategic vision for the system, developing enabling policies, and defining expected outcomes.
- **Funding:** Allocating the provincial health budget in such a way that it effectively and efficiently enables the achievement of outcomes.
- **Governance:** Commissioning the achievement of desired policy and outcomes to the most appropriate service provider, defining expected service levels, and managing delivery against clearly understood performance expectations.

Conversely, the role of service providers is to operationalize the achievement of Alberta Health's strategy and policy. They do this through:

- **Accountability:** Developing an operational plan to achieve Alberta Health's expected outcomes and providing Alberta Health with the data and analysis necessary to measure progress.
- **Service delivery:** Executing on the operational plan and providing services to Albertans.

The accountability interface that connects Alberta Health's governance responsibilities with AHS' service delivery responsibilities is critical to this model succeeding.

With the current fiscal situation and the significant transformation that is planned for the health system, Alberta Health's need to have a highly effective relationship with AHS and other service providers will only become more important. The remainder of this section:

1. Provides findings related to the effectiveness of the accountability interfaces in Alberta's health system, as well as a number of specific areas of functional duplication identified throughout the review; and
2. Provides recommendations for strengthening the interfaces and resolving some areas of duplication.

Findings

Accountability interface

1. Alberta's governance model has not fully evolved to align to a single provider/administrator model.

   - Within Alberta Health, policy portfolios are not always clearly aligned with significant areas of AHS operations. While efforts have been made to more clearly define the roles and responsibilities between the two organizations, they have not resulted in lasting clarity or consistent understanding, particularly as it relates to operational oversight and policy development.

   - Alberta Health and AHS do not consistently work in partnership to develop and operationalize provincial policies through a formalized approach. In a single-provider system where the government does not need to coordinate across multiple health authorities or hospitals, Alberta Health should be focused on system-wide strategy and priority setting.

2. In FY 18/19, Alberta Health provided AHS with a $13.9 billion financial transfer, most of which it expects AHS to manage within a small number of high-level funding envelopes. This system appears to strike a reasonable balance between providing operational flexibility to AHS while enabling accountability.

3. AHS receives an annual accountability letter outlining Alberta Health's expectations for the year, however there is an opportunity for increased coordination and collaboration in the development of the annual plan and ongoing performance management approach.

   - Stakeholders from both Alberta Health and AHS suggested that the letters reflect specific priorities and requirements, rather than an integrated provincial health system strategy.

   - Given the significant challenges ahead for AHS and the health system, it will be critical for an effective and streamlined approach to be in place to enable joint planning between Alberta Health and AHS.

4. Achieving the government mandate of increased use of non-hospital surgical facilities will require enhanced and sophisticated health care services planning and contracting capabilities.

   - To effectively qualify, contract, and manage private providers, the province will need to develop capabilities in service planning, strategic procurement, financial and commercial management, and contract performance management. These are skillsets that are not always consistently available in the public or health sectors, necessitating the building of capability and capacity.

5. The agreement and relationship between AHS and Covenant Health does not allow AHS to exercise effective oversight over Covenant Health as a part of an integrated health system.

   - The relationship between the two organizations is governed by a Cooperation and Services Agreement. The Agreement makes Covenant Health accountable to AHS for the provision of services, but also asserts the independence of Covenant Health. The agreement necessitates negotiation for changes in contracted services, restricting AHS' ability to manage the province as an integrated system.

   - This issue becomes particularly challenging in relation to matters such as integrated system planning that involve Covenant Health facilities. For example, AHS has identified an opportunity to achieve ICU operational efficiencies in the Edmonton zone, but is challenged with implementing it as it would impact ICU facilities at Covenant-run hospitals.

6. Alberta's consolidated system has enabled it to reduce the duplication seen in other jurisdictions; however, some specific areas have been identified.

   - Relative to other provincial systems, Alberta does not have significant functional duplication, however several specific areas were identified throughout the review and are considered later in this section.

7. Having achieved an impressive level of consolidation, zone-based siloes are beginning to re-emerge.

   - While AHS is a consolidated organization, there continue to be variations in practices, policies, and service delivery across the zones. This was a consistent theme throughout our stakeholder consultations.

Areas of identified duplication

Throughout our report, specific areas of potential duplication between Alberta Health and AHS were identified to us for consideration. Based on a rapid assessment of the potential impact and materiality of those areas, we considered the following areas:

- Analytics
- Public Health
- Primary Care
- Strategic Clinical Networks
- Infrastructure
- Information Technology

Analytics

1. It is reasonable for both organizations to have dedicated analytics functions to support their mandates.

    - AHS leverages analytics for supporting operations and internal planning, including clinical decision support, clinical performance management, capacity management, operational performance management, and human resource management. Alberta Health requires analytics to support health system planning, health system performance management, resource allocation, health economics, population health analytics.

2. Both Alberta Health and AHS have mature analytics functions that work collaboratively together.

    - The leaders of the Alberta Health and AHS analytics functions are working to develop and implement a modern, federated provincial health data system and framework that would enable effective sharing and use of data across both organizations, as well as with researchers and other third parties, as appropriate.

Public Health

3. Public health was identified as an area of potential duplication, in part due to the presence of provincial public health medical officers in both Alberta Health and AHS.

    - The Alberta model is comparable to public health systems in other Canadian Jurisdictions, as there is necessity to separate the development of provincial public health policy from the operationalization of that policy.

Primary Care

4. Alberta has invested heavily in the creation of a system of Primary Care Networks (PCNs), intended to improve access and quality of care, and to facilitate more coordinated transitions along the continuum of care.

   - Alberta Health provides approximately $238 million in funding to PCNs annually, exclusive of associated physician billing.

   - Each PCN is governed jointly between the physician leadership of the PCN and AHS. AHS has 88 staff supporting primary care-related planning, strategy, and coordination, with a large focus on providing support to the PCNs.

5. In response to a 2015 review of the PCN program by Alberta Health, the province has put in place a new provincial governance model. This governance model articulates a reasonable delineation of roles and responsibilities between Alberta Health and AHS.

   - If implemented properly, this new model should help to address concerns that AHS is developing primary care policy that is more appropriately within the scope of Alberta Health.

6. While AHS plays an important role in managing the PCNs, focused on the integration and delivery of care across community and the acute care sectors, ultimate responsibility for the primary care system falls with Alberta Health. Alberta Health's primary role in funding PCNs and physicians, as well as developing system policy, desired outcomes and broader provincial strategies is important and appropriate.

   - AHS has a significant number of resources dedicated to primary care strategy and coordination. AHS and AH will need to ensure that those resources are working in alignment with AHS' areas of primary care responsibility. In cases where they may not be, their activities should support AH in developing broader primary care policy and strategy.

Strategic Clinical Networks

7. AHS has 16 Strategic Clinical Networks, each with a specific area of clinical focus:
   - Addiction and mental health
   - Bone and joint health
   - Cancer
   - Cardiovascular health and stroke
   - Diabetes, obesity, and nutrition
   - Seniors health
   - Critical care
   - Emergency
   - Surgery
   - Respiratory health
   - Maternal, newborn, child, and youth
   - Digestive health
   - Kidney health
   - Population, public, and Indigenous health
   - Primary health care integration
   - Neurosciences, rehabilitation, and vision

8. Since 2012, AHS has spent $116.26 million on strategic clinical network operations. The strategic clinical networks have spent a further $124 million of grant funding on specific projects, $65.8 million of which has come from outside of Alberta.

9. AHS senior leadership is strongly committed to the strategic clinical network model and highlight the significant value they have brought to the health system. Examples include:

   - Reducing the time between suspicious breast imaging and surgical consult by 60%.
   - Reducing the 'door to needle' time for stroke victims from 70 to 39 minutes in Edmonton and Calgary.
   - Reduced bed-days for diabetes-related foot amputations by half and implemented new pathways with limb-preserving approaches.
   - Based on evidence, discontinued fetal fibronectin testing for preterm labour. AHS estimates this has saved $5 million per year.

10. While the strategic clinical networks have demonstrated valuable outputs, they represent a complex and costly model to do so, which may warrant reconsideration given the sector's fiscal challenges.

    - Each strategic clinical network has a medical leader and an operational director, along with supporting staff and overhead costs.
    - Having 16 subject-matter specific networks may result in sub-optimal use of funding:
        - Each strategic clinical network will be actively looking to conduct research within their specific domain, regardless of if that domain is a provincial priority.
        - There is no flexible structure for conducting similar activities in other priority areas, short of creating a new strategic clinical network.

11. Strategic clinical networks have wide latitude to determine their own priorities, and do not generally align to provincial priorities set by Alberta Health.

    - The process for setting SCN priorities is largely bottom up, with SCNs generating ideas and then bringing them to AHS leadership for approval. A more top-down priority setting process could allow for closer alignment of SCN activity to Alberta Health and AHS' priorities.
    - Alberta Health would likely benefit from the significant expertise of strategic clinical networks in the development of provincial health strategy and policy.

Information Technology

12. AHS and Alberta Health both have extensive IT responsibilities, however system governance, planning, and delivery is not always optimally coordinated.

    - Alberta Health mandates and funds AHS to develop and implement some of the largest IT systems in the country. These complex, multi-year implementations have high delivery and cost risk associated with them. While AHS is often best suited to deliver them, it is essential that Alberta Health have the ability to provide prudent oversight on behalf of the Government of Alberta.
    - Along with AHS, they have established gated grant processes for large projects, which require fulfillment of project deliverables to unlock further funding. While this approach is effective for large projects, Alberta Health has less visibility into how grant funds are used in other projects.
    - Alberta Health plays a system coordination role to ensure that there is an integrated technology strategy that connects all parts of the health care system and manages competing priorities and funding needs.

Infrastructure

13. For capital investments over $5 million, Alberta Infrastructure takes the lead role on project management and delivery, working with Alberta Health and AHS.

    - This model can create some additional complexity; however, it enables Alberta Health and AHS to draw on existing government major capital project expertise, rather than maintaining that expertise in-house or building it up each time a new capital project is initiated.

Recommendations

Recommendation 45: Strengthen the accountability interface between Alberta Health and AHS to clarify responsibilities, put in place a coordinated annual planning process, and develop an effective performance management framework.

Recommendation 46: Consider assigning a senior leader within Alberta Health with primary responsibility for strengthening and managing the accountability interface between Alberta Health and AHS.

Recommendation 47: Create a dedicated independent providers secretariat.

Recommendation 48: Alberta Health should develop a funding model that separates system funding into three categories: global budgets, targeted grants for priority areas, and funds for independent provider services.

Recommendation 49: End the current Covenant Health Cooperation and Services Agreement and develop a new agreement that enables more effective system coordination by AHS.

Recommendation 50: Develop and formalize clear operational accountability frameworks for Primary Care and Information Technology.

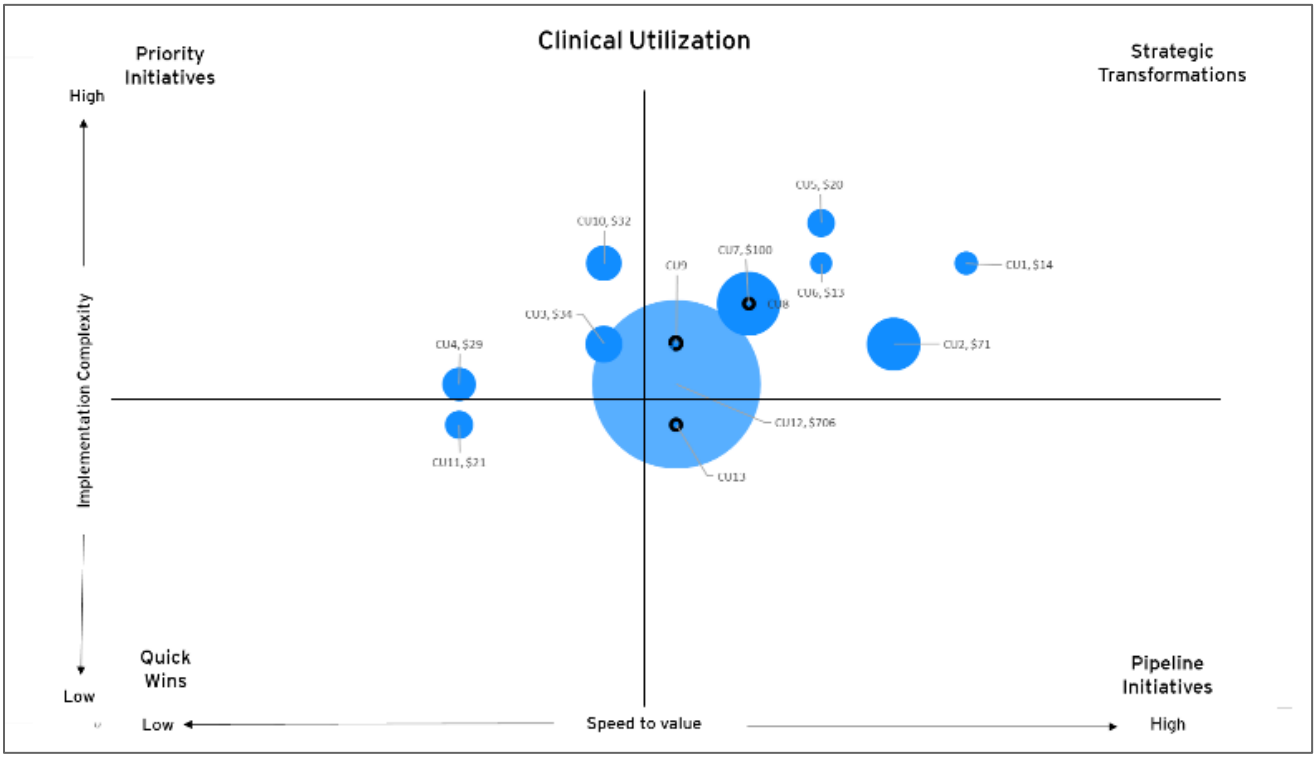
Recommendation 51: Reconsider the number, mandate, and governance of strategic clinical networks to more efficiently leverage them to achieve health system priorities.

Recommendation 52: AHS should be diligent in completing the consolidation of the provincial health system and should actively seek to avoid retrenchment to unnecessary local variation in care delivery.

6 Opportunity prioritization

The opportunities put forward in the previous section suggest that significant fiscal improvement can be driven across Alberta's health system. Unfortunately, the task is not as simple as saying "go." Each opportunity requires thoughtful planning and strategic support from the Executive, ownership from operational leaders and physicians, project management support to ensure key performance metrics are achieved, consultation with health system stakeholders including unions, and for certain opportunities, dedicated investment to fully realize the degree of benefits set out. Simply put, opportunities cannot be implemented without a clear plan of attack.

Sample workstream prioritization. Prioritization details for each workstream are available in the companion document.



EY conducted a prioritization process. The outputs of this process can be found in the detailed companion document. This prioritization should inform AHS' implementation planning process, based on a clear articulation of strategic and financial goals from Alberta Health. This is further described in the next section of this report.

7 Implementation recommendations and the path forward

The scale of the challenge facing the Alberta health system is significant. Albertans pay more for their health care than other comparable provinces and bringing costs into line will not happen overnight – nor will it happen easily. But despite the challenge, making these financial improvements are necessary for the long-term viability and wellbeing of the health system. Responding to the challenge will require new thinking, new capabilities and new ways of working for Alberta Health and AHS. Simply put, it will require creating a "new normal" where sustainability is at the core of the provincial health system.

To establish this new normal, AHS needs to understand the change, be ready for the change, and have the right leaders to take the change forward. As part of the set-up of the Sustainability Program Office discussed in recommendation 55, a maturity and change readiness assessment should be undertaken. This should include key dimensions required for success, such as AHS' vision, culture, sustainability mindset, benefit tracking processes, and governance. As part of this assessment, it will also be important to ensure that AHS' leadership has the capabilities and commitment to deliver the level of change anticipated.

Lessons from other provinces and global jurisdictions have shown that making changes of this scale comes down to building momentum and maintaining a relentless focus on successful execution. As stated, AHS needs to act on a range of opportunities to meet their budget targets, or to keep expenditures flat. The opportunities we've put forward offer a starting point for an actual plan to be formed that begins the process of designing savings and targets that are clear and reasonable. The remainder of this section provides recommendations related to implementation.

Recommendation 53: AHS should complete a formal leadership review of the executive leadership team, including its structure, capabilities, and readiness to deliver a large transformation program. The review should be actioned expeditiously so that the results can inform the development of the implementation plan.

Recommendation 54: AHS should develop an implementation plan, based on the fiscal targets and strategic priorities set by Alberta Health. AHS should lead the development of this plan in coordination with Alberta Health within the first 100 days of implementation.

Given the pressing fiscal reality, AHS should continue to execute any in-progress savings initiatives and rapidly commence any "quick win" opportunities that have been identified, in parallel to the development of the longer-term implementation plan.

Recommendation 55: Establish an AHS Sustainability Program Office to drive the plan forward, with clearly defined resources, reporting processes and executive accountabilities.

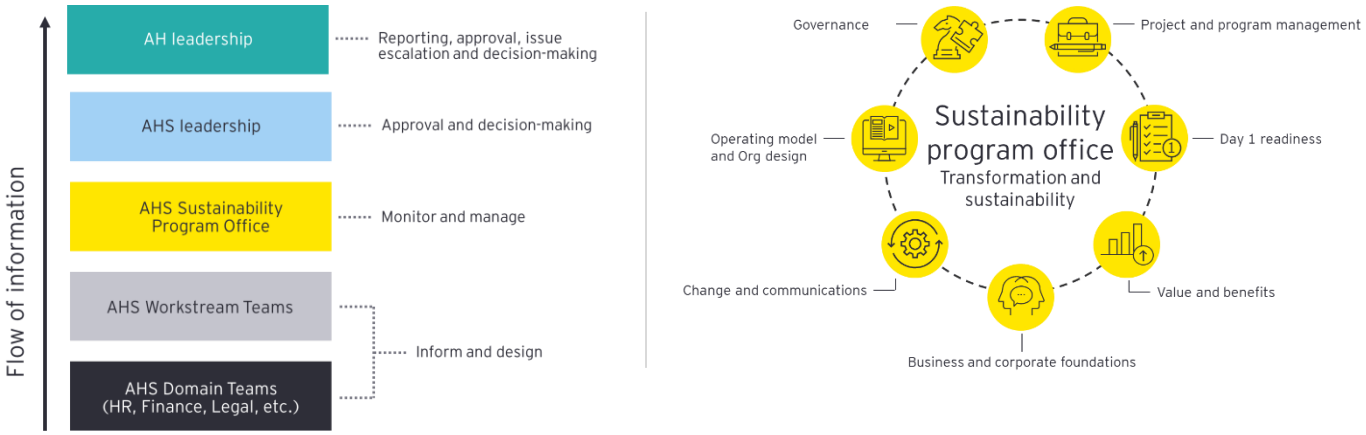


Figure 19. Sustainability program office model

Recommendation 56: Develop an integrated change and communications strategy that will enable appropriate clinical and operational ownership of initiatives.

Recommendation 57: Alberta Health should educate and regularly update Albertans, providing ongoing reporting to taxpayers to build increased awareness and understanding of the cost and performance of Alberta's health system establishing an important accountability interface with citizens for achieving value for money.

"A public education campaign should be developed, focused on the cost of health services delivery, the realities of making difficult decisions (e.g. service configuration) and their role in a public system (e.g. secure access to a family doctor)"

Comment from Operation Leader Sessi

With the right enablers in place, as well as the right implementation plan, Albertans should feel optimistic that the level of health system transformation needed for long-term sustainability can be achieved.

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EMS Dispatch Communications and Deployment

Medical Dispatch Review Committee

NCC

14 July 2020

Alberta Health Services

Emergency Services

Agenda

1) Introductions
2) Agenda
3) Minutes
4) Dispatch Benchmarks
5) Call Review #1
6) Call Review #2
7) Call Review #3
8) Next Meeting: 11 August 2020, 1100 hrs

Dispatch Benchmark / MDPS Definitions / Calculations

Medical Priority Dispatch System Compliance Calculation

Standards for Accreditation

	ACE
High Compliance	
Compliant	
Partial Compliance	10%
Low Compliance	10%
Non-Compliant	7%

Percentage of Deviations Accepted	Critical	Major	Moderate	Minor
	3%	3%	3%	3%

Dispatch Benchmarks Definitions:

- Address Interval - The time interval from when the event is received in EMS dispatch center to the time that the address is verified and call is accepted into CAD. Standard reporting is at the 50th and 90th percentile
- Dispatch Interval - The time interval from time call is accepted into CAD and sent to the dispatcher to when the first unit is activated at either Pre-Alert or Dispatch. Standard reporting is at the 50th and 90th percentile
- Activation Interval - The time interval from time call is received in EMS dispatch to time that the first unit is activated. Standard reporting at the 50th and 90th percentile.

Dispatch Benchmarks & Call Volume: NCC & FMCM

Call Volume: June 2020	
NCC	FMCM
5,182	354

	Address Verification		Dispatch Interval		Activation Interval	
	P50	P90	P50	P90	P50	90
NCC	00:00:32	00:01:26	00:00:12	00:00:24	00:00:46	00:01:54
FMCM	00:00:31	00:00:57	00:00:05	00:00:10	00:00:36	00:01:06

ACE Performance Standard

Selected Discipline: EMD

Agency: Alberta Health Services

Date Range: 6/1/2020 ... 6/30/202(

	Percent	Number of Cases
High Compliance	45%	196
Compliant	35%	153
Partial Compliance	8%	34
Low Compliance	4%	18
Non-Compliant	7%	32
Totals	100%	433

Percentage of Deviations	Critical	Major	Moderate	Minor
Total Accreditation Acceptance	0.38%	0.54%	1.01%	2.24%

These accreditation standards relate to the following:

ED-Q Performance Standards – Edition 10

ACE Performance Standard

Selected Discipline: EMD

Agency: Regional Municipality of Wood Buffalo SDC

Date Range: 06/01/2020 ... 06/30/2020

	Percent	Number of Cases
High Compliance	78%	51
Compliant	14%	9
Partial Compliance	2%	1
Low Compliance	0%	0
Non-Compliant	6%	4
Totals	100%	65

Percentage of Deviations	Critical	Major	Moderate	Minor
Total Accreditation Acceptance	0.33%	0.16%	0.22%	0.88%

These accreditation standards relate to the following:

ED-Q Performance Standards – Edition 10

Event Overview #1

Date of Event:
22 June 2020

Event Location:
Edmonton

Call Taker Location:
NCC

Dispatch CAD Code:
19D03(HOT)

Code Description:
Heart Problems / A.I.C.D

Chief Complaint / Problem:
On the stairs and his defibrillator has gone off

MPDS Card Set – case entry protocol

ENTRY QUESTIONS

1. What's the **address** of the emergency?
   House/Apartment/Business/Intersection/Landmark/Jurisdiction/GPS
2. What's the **phone number** you're calling from?
3. Okay, tell me **exactly** what happened.
   - Obviously NOT BREATHING and Unconscious (non-traumatic) — 9-E-1
   - Hanging, Strangulation (no assailant involved), Suffocation — 9-E-3,4,5
   - Underwater (DOMESTIC rescue) — 14-E-2
   - Underwater (SPECIALIZED rescue) — 14
   - Person on fire — 7-E-1

   a. **(Not obvious)** Are you **with** the patient **now**?

   b. **(Not obvious)** How **many** (other) people are **hurt/sick**?
      - Multiple victims — CC
      - Traffic/Transportation incident (3rd or 4th pty caller) — 29

   c. **(Choking)** Is s/he **breathing** or **coughing** at all? (You go check and tell me what you find.)
      - No — 11-E-1

      i. **Do not slap** her/him on the back.
4. How **old** is s/he?

   a. **(Unsure)** Tell me **approximately**, then.
5. Is s/he **awake** (conscious)?
   - Yes
   - No
   - Unknown
6. Is s/he **breathing**? ?

   a. **(Hasn't checked – 2nd party caller)** You go check and tell me what you find.
      - Yes
      - No/NOT BREATHING — ?-E-?
      - UNCERTAIN/INEFFECTIVE/AGONAL BREATHING (1st or 2nd pty caller) — ?-E-?
      - Unknown (3rd or 4th pty caller)

THE INTERNATIONAL ACADEMY™
EMD PROTOCOL™
Medical Priority Dispatch System™

POST-DISPATCH INSTRUCTIONS

a. **(ECHO)** I'm sending the **paramedics** (ambulan to help you now. **Stay on the line.**

b. **(Hanging and not OBVIOUS DEATH)** **(Cut** her/him **down** immediately,) **loosen** the noose, then tell me if s/he's **breathing.**

c. **(Underwater) Do not go in the water** unless it's **safe** to do so.

d. **(Strangulation and not OBVIOUS DEATH)** **Loosen** anything around the **neck**, then tell m if s/he's **breathing.**

e. **(Suffocation) Remove** anything **covering** the **face** or **in** the **mouth**, then tell me if s/he's **breathing.**

f. **(Person on fire)** Tell her/him to **stop** running, **drop** to the **ground, cover** her/his **face**, and **ro** around. If water is available, **douse** her/him w it **immediately** until the fire is completely out **(Water not available)** Get a **blanket, rug**, or **large jacket** and **use it to wrap her/his body** and **smother** the flames.

g. **(Critical Caller Danger)** **(If it's too dangerous to stay** where you are, and you think you can leave safely,) **get away** and **call us** from somewhere **safe.**

DLS * **Link to CC unless:**

- Suspected MEDICAL Arrest — NAB
- Hanging/Strangulation/Suffocation (INEFFECTIVE BREATHING and Not OBVIOUS DEATH) — NAB

AMPDS™ v13.0, NAE-std, 1

MPDS Card Set – case entry protocol

NOT BREATHING Situations

The following, when **offered** in response to "Tell me exactly what happened" or any listed Entry Question:

- **Not breathing** at all — **9-E-1**
- **UNCERTAIN BREATHING** — **9-E-2**
- **Hanging** — **9-E-3**
- **Strangulation** — **9-E-4**
- **Suffocation** — **9-E-5**
- **COMPLETE obstruction** — **11-E-1**
- **Drowning arrest** (out of water) — **14-E-1**
- **Underwater** (**DOMESTIC** rescue) — **14-E-2**

INEFFECTIVE BREATHING

The following, or reasonable equivalents, when **volunteered** at any point during Case Entry (code as **ECHO** on 2, 6, 9, 11, 15, 31):

- "Barely breathing"
- "Can't breathe (at all)"
- "Fighting for air"
- "Gasping for air" (**AGONAL BREATHING**)
- "Just a little" (**AGONAL BREATHING**)
- "Making funny noises" (**AGONAL BREATHING**)
- "Not breathing"
- "Turning blue" or "Turning purple"

Determining AGONAL BREATHING

Use when the patient is **unconscious** and breathing reported by the caller is **questionable**, or when **mandated by the protocol** ?. A **time between** breaths of **8 seconds or more** is considered **INEFFECTIVE BREATHING**. Check a maximum of **four breaths** (three intervals tested).

(Read verbatim) Okay, I want you to say "**now**" every **single** time s/he **takes** a breath **in**, starting **immediately**.

- **≥ 8 sec. interval = AGONAL**

AGONAL BREATHING

An **ineffective, deteriorating** breathing pattern that lingers after the heart has essentially **stopped pumping blood to the brain**.

UNCERTAIN BREATHING

A situation where a **2nd party** caller is **uncertain, unsure, indefinite, or ambiguous** when asked if an unconscious patient is breathing.

ECHO Determinant Practice

The **ECHO** level allows **early recognition** and **closer response initiation** based on **extreme conditions of breathing** and **other dire circumstances as defined**, such as a **person on fire**.

Such coding is separated from **DELTA** to encourage **local** assignment of the **absolute closest** response of **any trained crew** (i.e., police with AEDs, fire ladder or snorkel crews, **HAZMAT**, or other specialty teams).

Rules

1. If the complaint description includes **scene safety** issues, choose the Chief Complaint Protocol that **best addresses** those issues.
2. If the complaint description involves **TRAUMA**, choose the Chief Complaint Protocol that best addresses the **mechanism of injury**.
3. Use of the **AGONAL BREATHING Detector** is **not necessary** when **UNCERTAIN BREATHING** or **INEFFECTIVE BREATHING** is **associated with unconsciousness**.
4. When **cardiac arrest** appears to be **TRAUMATIC** in nature, choose the Chief Complaint Protocol that best fits **scene safety** concerns and the **mechanism of injury**.
5. If the complaint description appears to be **MEDICAL** in nature, choose the Chief Complaint Protocol that best fits the patient's **foremost symptom**, with **priority symptoms** taking precedence.
6. If the complaint description involves **hazardous materials** (toxic substances) that **pose a threat** to bystanders or responders, go to **Protocol 8**.
7. When the complaint description is **seizure, go to Protocol 12** regardless of consciousness and breathing status.
8. If the Chief Complaint and status of **consciousness and breathing are unknown** initially (3rd party caller), go to Protocol 32.
9. When the complaint description involves **both NON-TRAUMATIC chest pain/heart attack symptoms and breathing problems**, choose the Chief Complaint Protocol that best fits the patient's **foremost symptom**, with **ECHO-level conditions** taking precedence. **(≥ 16, alert, no reported STROKE symptoms)** Use the **Aspirin Diagnostic & Instruction Tool** on either protocol as appropriate.
10. When the complaint description is **breathing-related tracheostomy** (trach or stoma) **problems in the conscious patient**, go to Protocol 6.
11. Some **critical** patient care instructions may be **necessary prior** to the "**send**" **point**. Any significant **scene safety concerns** take precedence and **must be addressed before** the provision of instructions.
12. Case Entry Questioning **must always be completed** after PDIs **when directed** by (hanging, strangulation, suffocation, underwater, choking, person on fire).

Axioms

1. **UNCERTAIN BREATHING** status indicates a **2nd party** caller who has seen the patient and is still unsure. **This is considered NOT BREATHING until proven otherwise**.
2. **Unknown breathing** status indicates a **3rd or 4th party** caller who cannot personally verify the patient's status.
3. After an **ECHO** response, **completing all Case Entry and Chief Complaint** Key Questions ensures that the proper knowledge regarding **safety** issues and the appropriate warnings and/or advice are immediately and always **passed on** to the responders and potential scene helpers.
4. **Prompt recognition of AGONAL BREATHING** is critical to the treatment of cardiac arrest because it **reduces time to compressions and defibrillation**. **MEDICAL** Arrest PAIs should be **instituted immediately** after **ECHO** coding and associated PDIs when an unconscious patient's **breathing status is INEFFECTIVE or UNCERTAIN** (**AGONAL BREATHING** Detector use is **not** necessary).

0 CASE ENTRY PROTOCOL

MPDS Card Set – 19-D-03

19 Heart Problems / A.I.C.D.

KEY QUESTIONS

1. Is s/he **completely alert** (responding appropriately)?
2. Is s/he **breathing normally**?
   a. **(No and Alert)** Does s/he have **difficulty** speaking/crying **between** breaths?
3. **(Not 1st party)** Is s/he **changing color**?
   a. **(Yes)** **Describe** the color change.
4. Is s/he **clammy** or having **cold sweats**?
5. Does s/he have a **history** of **heart problems**?
   a. **(A.I.C.D.)** Did it **fire** (go off) in the **last 30 minutes**?
6. Does s/he have **chest pain** or **chest discomfort**?
7. Did s/he take any **drugs** or **medications** in the **past 12 hours**?
   Cocaine (or derivative)
   Medications

* DELTA or CHARLIE codes 1–5

8. I'm going to tell you how to **check** her/his **pulse** (heart rate).

POST-DISPATCH INSTRUCTIONS

a. I'm sending the **paramedics** (ambulance) to help you now. **Stay on the line** and I'll tell you **exactly** what to do next.

b. **(≥ 1 + Not alert)** If there is a **defibrillator** (AED) available, **send** someone to get it **now** in case we need it later.

c. **(Patient medication requested and Alert)** Remind her/him to do what her/his **doctor has instructed** for these situations.

* Utilize the **Aspirin Diagnostic & Instruction Tool** – if authorized by local **Medical Control** and the **chest pain/discomfort** (Heart Attack Symptoms) patient is **alert**, **≥ 16 years old**, and has **no** reported **STROKE symptoms**.

DLS * Link to ☎ X-1 unless:

Unconscious	NABC-1
INEFFECTIVE BREATHING and Not alert	NABC-1

LEVELS	#	DETERMINANT DESCRIPTORS	CODES	RESPONSES	MODES
D	1	**Not** alert	19-D-1		
	2	**DIFFICULTY SPEAKING BETWEEN BREATHS**	19-D-2		
	3	**CHANGING COLOR**	19-D-3		
	4	**Clammy** or **cold sweats**	19-D-4		
	5	Just **resuscitated** and/or **defibrillated** (external)	19-D-5		
C	1	**Firing** of **A.I.C.D.**	19-C-1		
	2	**Abnormal** breathing	19-C-2		
	3	**Chest pain/discomfort** ≥ 35	19-C-3		
	4	**Cardiac** history	19-C-4		
	5	**Cocaine**	19-C-5		
	6	**Heart rate** < **50** bpm or ≥ **130** bpm (**without** priority symptoms)	19-C-6		
	7	**Unknown** status/**Other** codes **not** applicable	19-C-7		
A	1	**Heart rate** ≥ **50** bpm and < **130** bpm (**without** priority symptoms)	19-A-1		
	2	**Chest pain/discomfort** < 35 (**without** priority symptoms)	19-A-2		

NOT LICENSED FOR USE IN ANY ON-LINE CALLTAKING POSITION

AMPDS™ v13.0, NAE-std, 150529

Chronology

Event Comment Datetime	Event Comment	Event Comment Terminal	System Generated Flag
2020/06/22 03:05:37	AZ - 00020 ^Cell Loc Info: LL(-113:29:38.5373,53:33:47.0340): EST [redacted] NW EDMONTON Conf:90% Uncert:10 m	emsn77372	No
2020/06/22 03:05:37	** LOI search completed at 2020-06-22 03:05:37	wsemscadint03	Yes
2020/06/22 03:05:37	OLMC: CCC TAC 8 Interoperability for AFRRCS Equipped Partner Agencies Police: Contact dispatch for Talkgroup OTHER: Helicopter EMS LZ : AFRRCS Simplex 1 	AFRRCS	No
2020/06/22 03:05:49	[redacted]ALTERNATE NUMBER	emsn77372	No
2020/06/22 03:05:57	^** Recommended unit EDMO-2P9 for requirement PRU (3.9 min) ^** Recommended unit EDMO-2A37 for requirement ALS (4.2 min) ^** Recommended unit EDMO-2A33 for requirement ALS (7.4 min) ^** Recommended unit EDMO-2A32 for requirement ALS (7.5 min)	emsc74065	Yes
2020/06/22 03:06:01	^AFRRCS sent to 4110903 : 10.174.27.127 : EDMO-2P9	wsemsef01	No
2020/06/22 03:06:04	^AFRRCS sent to 4111719 : 10.174.31.189 : EDMO-2P9	wsemsef01	No
2020/06/22 03:06:07	^AFRRCS sent to 4113529 : 10.174.165.139 : EDMO-2A32	wsemsef01	No
2020/06/22 03:06:09	^AFRRCS Read on 4113529 : 10.174.165.139 : EDMO-2A32	wsemsef01	No
2020/06/22 03:06:09	^AFRRCS Received on 4113529 : 10.174.165.139 : EDMO-2A32	wsemsef01	No
2020/06/22 03:06:10	^AFRRCS sent to 4113001 : 10.174.162.31 : EDMO-2A32	wsemsef01	No
2020/06/22 03:06:12	^AFRRCS Received on 4113001 : 10.174.162.31 : EDMO-2A32	wsemsef01	No
2020/06/22 03:06:15	^AFRRCS Received on 4110903 : 10.174.27.127 : EDMO-2P9	wsemsef01	No
2020/06/22 03:06:17	^AFRRCS Read on 4113001 : 10.174.162.31 : EDMO-2A32	wsemsef01	No
2020/06/22 03:07:09	Problem: ON THE STAIRS AND HIS DEFIBULATOR HAS GONE OFF Caller Relationship: 2nd party Chief Complaint: Implanted Defibrillator (A.I.C.D.) 40-year-old, Male, Conscious, Breathing.	emsn77372	No
2020/06/22 03:08:12	Dispatch CAD Code: 19D03 Determinant Level: CHANGING COLOR ----KQ: His color change is purple. ----KQ: He has an implanted defibrillator. ----KQ: He is completely alert (responding appropriately). ----KQ: It's not known if he is breathing normally. ----KQ: He is changing color. ----KQ: It's not known if he is clammy.	emsn77372	No

Chronology

Event Comment Datetime	Event Comment	Event Comment Terminal	System Generated Flag
2020/06/22 03:08:19	** Event Priority changed from 5 to 2 at: 2020-06-22 03:08:19 ** >>>> by terminal: emsn77372	emsn77372	Yes
2020/06/22 03:08:19	** Event Type changed from 00A01(COLD) to 19D03(HOT) at: 2020-06-22 03:08:19 ** >>>> by terminal: emsn77372	emsn77372	Yes
2020/06/22 03:08:21	** Event Type changed from 00A01(COLD) to 19D03(HOT) at: 2020-06-22 03:08:19	wsemscadweb01	Yes
2020/06/22 03:08:21	** MEDICAL - CHANNEL W1 ASSIGNED	wsemscadweb01	Yes
2020/06/22 03:08:23	^***SELECT AND RECOMMEND INITIATED***	emsc74064	No
2020/06/22 03:08:29	|2ND RECOMMEND COMPLETE|	emsc74064	No
2020/06/22 03:08:45	DEVICE HAS GONE OF 5 TIMES	emsn77372	No
2020/06/22 03:11:11	----KQ: It has fired in the last 30 minutes. ----KQ: He has other heart attack symptoms: DEVICE HAS GONE OF 6 TOMES ----KQ: He did not take any drugs (medications) in the past 12hrs. ----KQ: His pulse is less than 50 beats per minute. Beats Per Minute 44 Rate < 50	emsn77372	No
2020/06/22 03:11:35	GO TO THE FRONT DOOR NOT THE BACK	emsn77372	No
2020/06/22 03:12:08	HAS GONE OFF FOR THE 7TH TIME	emsn77372	No
2020/06/22 03:13:01	8 TIMES	emsn77372	No
2020/06/22 03:16:57	EDMO-2A32 -- CREW INITIATED - CODE15	emsc74064	No
2020/06/22 03:17:01	EDMO-2P9 -- CREW INITIATED - CODE15	emsc74064	No
2020/06/22 03:22:38	EDMO-2A32 -- CREW INITIATED - CODE15	emsc74061	No
2020/06/22 03:23:15	EDMO-2P9 -- CREW INITIATED - CODE15	emsc74061	No
2020/06/22 03:23:29	RAH CTAS 2	emsc74061	No
2020/06/22 03:47:55	EDMO-2P9 -- CREW INITIATED - CODE15	emsc74064	No

Call Audit

Caller party: 2nd | Call Date: 6/22/2020 3:06:06 AM | Code Selected: 19 - D - 3
How Obtained: | Code Reviewed: 19 - D - 3
Complaint Description: ON THE STAIRS AND HIS DEFIBULATOR HAS GONE OFF

	Case Entry
■	Address
■	Callback number
■	Primary discipline choice
■	Tell me exactly what happened.
■	Choking question
■	ECHO/Fast Track used
■	With the patient now
■	With the patient now subquestion
■	Patient count question
■	Age question
■	Age subquestion
■	Gender
■	Awake question
■	Breathing question
■	Breathing subquestion
■	Questions asked in order
■	Chief Complaint selection
■	Freelance questions
■	Freelance instructions
■	All questions/instructions given in the appropriate area
■	Obvious questions
■	Clarifiers
■	Calming techniques

	Key Questions	KQ Type
■	Sub-Chief Complaint	
■	Key Questions asked in order	
■	Freelance questions	
■	Freelance instructions	
■	All questions/instructions given in the appropriate area	
■	Obvious questions	

Comment: "Does he have chest pain or chest discomfort?". The caller had expressed that the patients A.I.C.D. was going off and he was in pain.
In the future, when answers are obvious you do not need to ask them. This practice assures callers that the calltaker is listening to them, and this is consistent with good customer service practices. If you ask the question as written without explaining to the caller why the question is being asked, it can set up a frustrating or hostile conversation with the caller.

■	Clarifiers

Call Audit

Caller party: 2nd | Call Date: 6/22/2020 3:06:06 AM | Code Selected: 19 - D - 3
How Obtained: | Code Reviewed: 19 - D
Complaint Description: ON THE STAIRS AND HIS DEFIBULATOR HAS GONE OFF

	Calltaker Initiated Shunt	
	Shunted appropriately (new or updated information)	
	Followed appropriate protocol links	
	Calming techniques	
	Is he completely alert (responding appropriately)?	7
	Is he breathing normally?	7
	Is he breathing normally?	7
	Is he changing color?	7
	Describe the color change.	7
	Is he clammy or having cold sweats?	0
	Did it fire (go off) in the last 30 minutes?	0
	Does he have chest pain or chest discomfort?	7
	Did he take any drugs or medications in the past 12 hours?	0
	I'm going to tell you how to check his pulse (heart rate). Get right next to him.	0
	Ø Accept the heart rate calculated.	0

Comment: "Does he have chest pain or chest discomfort?" recorded as 'Other HEART ATTACK symptoms'. The caller said "Yes, he has a device in his chest it's gone off five times, he has chest pain!" Moving forward, this should be recorded as 'Chest pain'. Answers improperly recorded into ProQA can start a cascade of errors that stem from one mistake.

Final Coding

- Determinant Code
- Determinant Level
- Determinant Descriptor
- Determinant Suffix
- Did not use Malicious Final Code

Dispatch Life Support

- PAIs
- PDIs

Comment: "From now on, don't let him have anything to eat or drink. It might make him sick or cause further problems." Was not given.
"Just let him rest in the most comfortable position and wait for help to arrive." Was not given.
Going forward, all PDIs should be given when possible and appropriate.

- Freelance questions
- Freelance instructions
- All questions/instructions given in the appropriate area
- Obvious questions
- Clarifiers

Call Audit

Caller party: 2nd | Call Date: 6/22/2020 3:06:06 AM | Code Selected: 19 - D - 3

How Obtained: | Code Reviewed: 19 - D - 3

Complaint Description: ON THE STAIRS AND HIS DEFIBULATOR HAS GONE OFF

Followed appropriate DLS Links	Comment: Case Exit pathway was not completed. X3 & Arrival Interface instructions were not given. In the future, it is best practice to provide all Case Exit PDIs when possible and appropriate.
Met the minimum Standards of Practice	
Followed appropriate protocol links	
Calming techniques	
Breathing Verification Diagnostic	
Pulse Diagnostic	
Stroke Diagnostic	
Aspirin Diagnostic	Comment: In the future, the Aspirin Diagnostic should be used for a chest pain/discomfort patient who is alert, > or equal to 16, not pregnant, and has no reported STROKE symptoms.
Compressions Diagnostic	
Contractions Diagnostic	
Chemical Suicide Diagnostic	
Coronavirus (COVID-19)	

Customer Service

Calltaker attitude	
Use correct volume, tone, and rate	
Display compassion	
Avoid gaps	
Explain actions	
Provided reassurance	
Did not create uncontrollable expectations	
Avoided prohibited behaviors	

Overall Performance: Non-Compliant

Comments: The caller was clearly distraught and concerned for his brother. You maintained a calm, even tone throughout the call evaluation. When the caller got excited and started yelling you used repetitive persistence and reassuring statements to maintain control of the call. Good job [redacted]

Legend:

50	Correct	0	Not As Scripted
3	Not Correct	1	Not Read
5	Obvious	18	N/A
		1	Input Error

e-PCR / Patient Outcome

COMMENTS

40 y/o male Rapid HR w/ Cocaine use.
EMS arrive on scene and are taken to patient by family. Patient is lying on the floor in his living room. He is obese at approx. 280-300lbs. He is yelling in pain and his internal defibrillator is actively going off on arrival. Patient is agitated, cooperative, answers appropriately, 0 shortness of breath, and patient is c/o weakness and pain when shocked. He tells EMS he has been shocked 6 times prior to EMS arrival.
HXCC:
•At approx. 0300 patient was in an argument with his brother that resulted in increased stress and his (ICD) internal cardiac defibrillator fired.
•Prior to the event patient admits to cocaine and alcohol use.
•His defibrillator continued to fire several times after and family called 911.
•Patient has had his ICD go off in the past, however never more than once.
•Patient says ICD went off 6x prior to EMS arrival.
•ICD went off 10x total.

Assessment:
•GCS x 15, PEARL @ 3mm, 0 neural deficits, agitation, cooperative, and answers appropriately.
•Respiratory rate is 24BPM, SPO2 95%+ on room air, 0 c/o shortness of breath, 0 cyanosis.
•Radials are strong, irregular, and rapid, patient feels weakness in the ambulance. Skin is warm and flushed. Patient does not have chest pain outsi of when his ICD goes off.
•Abdomen is unremarkable. 0 nausea or vomiting.
•0 trauma.
•12 lead attached shows a SVT w/ runs of ventricular tachycardia. PVCs are non-perfusing. After Versed administration HR decreases and ICD dc not fire again with EMS.

TX:
•Versed 5mg IM as per OLMC consultation (Dr. Hanrahan)
•18g IV right AC saline locked.
•Extraction via mega mover by EDMO-FIRE.
•Transport to Royal Alex ER-T6.
note: EMS drew up 100mcg of fentanyl in anticipation of possible pain managment for ICD shock, however after Versed administration, patient w not shocked and no pain managment was required.

Questions / Discussion

Event Overview #2

Date of Event:
21 June 2020

Event Location:
FMCM

Call Taker Location:
FMCM

Dispatch CAD Code:
29B02(HOT)

Code Description:
Traffic / Transportation Incidents

Chief Complaint / Problem:
Motorcycle accident

MPDS Card Set – case entry protocol

ENTRY QUESTIONS

1. What's the **address** of the emergency?
   House/Apartment/Business/Intersection/Landmark/Jurisdiction/GPS ✔
2. What's the **phone number** you're calling from? ✔
3. Okay, tell me **exactly** what happened.
   - Obviously NOT BREATHING and Unconscious (non-traumatic) — 9-E-1
   - Hanging, Strangulation (no assailant involved), Suffocation — 9-E-3,4,5
   - Underwater (DOMESTIC rescue) — 14-E-2
   - Underwater (SPECIALIZED rescue) — 14
   - Person on fire — 7-E-1

   a. **(Not obvious)** Are you **with** the patient **now**?

   b. **(Not obvious)** How **many** (other) people are **hurt/sick**?
      - Multiple victims — CC
      - Traffic/Transportation incident (3rd or 4th pty caller) — 29

   c. **(Choking)** Is s/he **breathing** or **coughing** at all? (You go check and tell me what you find.)
      - No — 11-E-1

      i. **Do not slap** her/him on the back.
4. How **old** is s/he?

   a. **(Unsure)** Tell me **approximately**, then.
5. Is s/he **awake** (conscious)?
   - Yes
   - No
   - Unknown
6. Is s/he **breathing**? ?

   a. **(Hasn't checked – 2nd party caller)** You go check and tell me what you find. ✔
      - Yes
      - No/NOT BREATHING — ?-E-?
      - UNCERTAIN/INEFFECTIVE/AGONAL BREATHING (1st or 2nd pty caller) — ?-E-?
      - Unknown (3rd or 4th pty caller)

THE INTERNATIONAL ACADEMY™
EMD PROTOCOL™
Medical Priority Dispatch System™

POST-DISPATCH INSTRUCTIONS

a. **(ECHO)** I'm sending the **paramedics** (ambulan to help you now. **Stay on the line.**

b. **(Hanging and not OBVIOUS DEATH)** **(Cut** her/him **down** immediately,) **loosen** the noose, then tell me if s/he's **breathing.**

c. **(Underwater)** **Do not go in the water** unless it's **safe** to do so.

d. **(Strangulation and not OBVIOUS DEATH)** **Loosen** anything around the **neck**, then tell m if s/he's **breathing.**

e. **(Suffocation)** **Remove** anything **covering** the **face** or **in** the **mouth**, then tell me if s/he's **breathing.**

f. **(Person on fire)** Tell her/him to **stop** running, **drop** to the **ground, cover** her/his **face**, and **ro** around. If water is available, **douse** her/him w it **immediately** until the fire is completely out **(Water not available)** Get a **blanket, rug**, or **large jacket** and **use it to wrap her/his body** and **smother** the flames.

g. **(Critical Caller Danger)** **(If it's too dangerous to stay** where you are, and you think you can leave safely,) **get away** and **call us** from somewhere **safe.**

DLS ✱ **Link to CC unless:**
- Suspected MEDICAL Arrest — NAB
- Hanging/Strangulation/Suffocation (INEFFECTIVE BREATHING and Not OBVIOUS DEATH) — NAB

AMPDS™ v13.0, NAE-std, 1

MPDS Card Set – case entry protocol

NOT BREATHING Situations

The following, when **offered** in response to "Tell me exactly what happened" or any listed Entry Question:

- **Not breathing** at all — 9-E-1
- **UNCERTAIN BREATHING** — 9-E-2
- **Hanging** — 9-E-3
- **Strangulation** — 9-E-4
- **Suffocation** — 9-E-5
- **COMPLETE obstruction** — 11-E-1
- **Drowning arrest** (out of water) — 14-E-1
- **Underwater** (**DOMESTIC** rescue) — 14-E-2

INEFFECTIVE BREATHING

The following, or reasonable equivalents, when **volunteered** at any point during Case Entry (code as **ECHO** on 2, 6, 9, 11, 15, 31):

- "Barely breathing"
- "Can't breathe (at all)"
- "Fighting for air"
- "Gasping for air" (**AGONAL BREATHING**)
- "Just a little" (**AGONAL BREATHING**)
- "Making funny noises" (**AGONAL BREATHING**)
- "Not breathing"
- "Turning blue" or "Turning purple"

Determining AGONAL BREATHING

Use when the patient is **unconscious** and breathing reported by the caller is **questionable**, or when **mandated by the protocol** ?. A **time between** breaths of **8 seconds or more** is considered **INEFFECTIVE BREATHING**. Check a maximum of **four breaths** (three intervals tested).

(Read verbatim) Okay, I want you to say "**now**" every **single** time s/he **takes** a breath **in**, starting **immediately**.

- **≥ 8 sec. interval = AGONAL**

AGONAL BREATHING

An **ineffective, deteriorating** breathing pattern that lingers after the heart has essentially **stopped pumping blood to the brain**.

UNCERTAIN BREATHING

A situation where a **2nd party** caller is **uncertain, unsure, indefinite, or ambiguous** when asked if an unconscious patient is breathing.

ECHO Determinant Practice

The **ECHO** level allows **early recognition** and **closer response initiation** based on **extreme conditions of breathing** and **other dire circumstances as defined**, such as a **person on fire**.

Such coding is separated from **DELTA** to encourage **local** assignment of the **absolute closest** response of **any trained crew** (i.e., police with AEDs, fire ladder or snorkel crews, **HAZMAT**, or other specialty teams).

Rules

1. If the complaint description includes **scene safety** issues, choose the Chief Complaint Protocol that **best addresses** those issues.
2. If the complaint description involves **TRAUMA**, choose the Chief Complaint Protocol that best addresses the **mechanism of injury**.
3. Use of the **AGONAL BREATHING Detector** is **not necessary** when **UNCERTAIN BREATHING** or **INEFFECTIVE BREATHING** is **associated with unconsciousness**.
4. When **cardiac arrest** appears to be **TRAUMATIC** in nature, choose the Chief Complaint Protocol that best fits **scene safety** concerns and the **mechanism of injury**.
5. If the complaint description appears to be **MEDICAL** in nature, choose the Chief Complaint Protocol that best fits the patient's **foremost symptom**, with **priority symptoms** taking precedence.
6. If the complaint description involves **hazardous materials** (toxic substances) that **pose a threat** to bystanders or responders, go to **Protocol 8**.
7. When the complaint description is **seizure, go to Protocol 12** regardless of consciousness and breathing status.
8. If the Chief Complaint and status of **consciousness and breathing are unknown** initially (3rd party caller), go to Protocol 32.
9. When the complaint description involves **both NON-TRAUMATIC chest pain/heart attack symptoms and breathing problems**, choose the Chief Complaint Protocol that best fits the patient's **foremost symptom**, with **ECHO-level conditions** taking precedence. (**≥ 16, alert, no reported STROKE symptoms**) Use the **Aspirin Diagnostic & Instruction Tool** on either protocol as appropriate.
10. When the complaint description is **breathing-related tracheostomy** (trach or stoma) **problems in the conscious patient**, go to Protocol 6.
11. Some **critical** patient care instructions may be **necessary prior** to the "**send**" **point**. Any significant **scene safety concerns** take precedence and **must be addressed before** the provision of instructions.
12. Case Entry Questioning **must always be completed** after PDIs **when directed** by (hanging, strangulation, suffocation, underwater, choking, person on fire).

Axioms

1. **UNCERTAIN BREATHING** status indicates a **2nd party** caller who has seen the patient and is still unsure. **This is considered NOT BREATHING until proven otherwise**.
2. **Unknown breathing** status indicates a **3rd or 4th party** caller who cannot personally verify the patient's status.
3. After an **ECHO** response, **completing all Case Entry and Chief Complaint** Key Questions ensures that the proper knowledge regarding **safety** issues and the appropriate warnings and/or advice are immediately and always **passed on** to the responders and potential scene helpers.
4. **Prompt recognition of AGONAL BREATHING** is critical to the treatment of cardiac arrest because it **reduces time to compressions and defibrillation**. **MEDICAL** Arrest PAIs should be **instituted immediately** after **ECHO** coding and associated PDIs when an unconscious patient's **breathing status is INEFFECTIVE or UNCERTAIN** (**AGONAL BREATHING** Detector use is **not** necessary).

0 CASE ENTRY PROTOCOL

MPDS Card Set – 29-B-02

29 Traffic / Transportation Incidents

KEY QUESTIONS

*** Sinking Vehicle / Vehicle in Floodwater** — 29-D-2s

1. **(Suspected)** Are there **chemicals** or other **hazards** involved?
   a. **(HAZMAT)** Do you know the warning **placard numbers** (chemical ID)?
2. Is anyone **pinned** (trapped)?
3. **(Vehicle only)** Was anyone **thrown** from the vehicle?
4. Does everyone appear to be **completely awake** (alert)?
   a. **(No)** Okay, is s/he **breathing right now**?
      i. **(Yes)** Is her/his breathing **noisy** (not normal)?
5. Are there any obvious **injuries**?
   a. **(Yes)** Is there any **SERIOUS bleeding** (spurting or pouring)?

POST-DISPATCH INSTRUCTIONS

a. I'm sending the **paramedics** (ambulance) to help you now. **Stay on the line** and I'll tell you **exactly** what to do next.
b. **Do not splint** any injuries.
c. **Do not move** her/him unless s/he is in **danger**.
d. **(Water) Do not go in the water** unless it's **safe** to do so.
e. For **everyone's safety**, (tell any bystanders to) **stand** well **clear** of approaching **traffic**. If it's **safe** to do so, **turn on** flashing **hazard lights**.

DLS — * Link to ☎ X-1 unless:

Danger or Contamination	X-7
Arrest	NABC-1
INEFFECTIVE BREATHING and Not alert	NABC-1
Unconscious and Effective breathing ?	X-3
Sinking Vehicle (1st party)	L-1 pullout →
Vehicle in Floodwater (1st party)	L-2 pullout →
Control Bleeding	X-5
Nosebleed Control	X-5a
Amputation (no significant bleeding)	X-6
Avulsed Tooth (no significant bleeding)	X-6a

LEVELS	#	DETERMINANT DESCRIPTORS ✚ V U Y X AND SEE ADDITIONAL INFO	CODES	RESPONSES	MODES
D	1	**MAJOR INCIDENT** (**a** through **h**)	29-D-1		
	2	**HIGH MECHANISM** (**k** through **t**)	29-D-2		
	3	**HIGH VELOCITY** impact	29-D-3		
	4	**HAZMAT**	29-D-4		
	5	**Pinned** (trapped) victim	29-D-5		
	6	**Arrest**	29-D-6		
	7	**Unconscious**	29-D-7		
	8	**Not** alert with **noisy** breathing (abnormal)	29-D-8		
	9	**Not** alert with **normal** breathing	29-D-9		
B	1	**Injuries**	29-B-1		
	2	**SERIOUS** hemorrhage	29-B-2		
	3	**Other** hazards	29-B-3		
	4	**LOW MECHANISM** (1st or 2nd party caller)	29-B-4		
	5	**Unknown** status/**Other** codes **not** applicable	29-B-5		
A	1	**1st party** caller with injury to **NOT DANGEROUS** body area	29-A-1		
	2	No injuries **reported** (**unconfirmed** or ≥ **5** persons involved)	29-A-2		
Ω	1	**No** injuries (**confirmed** for **all** persons **up to 4**)	29-Ω-1		

Chronology

Event Comment Datetime	Event Comment	Event Comment Terminal	System Generated Flag
2020/06/21 17:20:41	AZ 150 00811 SOUTH OF ANZAC BETWEEN ANZAC AND ENGSTROM LAKE	emsf00035	No
2020/06/21 17:20:41	Interoperability for AFRRCS Equipped Partner Agencies MutualAid: FMCM Mutual Aid 11 OLMC: FMCM TAC 8 OTHER: Helicopter EMS LZ : AFRRCS Simplex 1 Police: Contact dispatch for Talkgroup 	AFRRCS	No
2020/06/21 17:20:42	** LOI search completed at 2020-06-21 17:20:42	wsemscadint03	Yes
2020/06/21 17:20:44	^***SELECT AND RECOMMEND INITIATED***	emsf00035	No
2020/06/21 17:20:46	^** Recommended unit FMCM-1B5 for requirement BLS (34.0 min) ^** Recommended unit FMCM-1A1 for requirement ALS (37.3 min) ^** Recommended unit FMCM-1A3 for requirement ALS (44.3 min) ^** Recommended unit FMCM-1A4 for requirement ALS (49.7 min)	emsf00035	Yes
2020/06/21 17:20:48	^AFRRCS sent to 4110190 : 10.174.24.134 : FMCM-1B5	wsemsef01	No
2020/06/21 17:20:49	^***SELECT AND RECOMMEND INITIATED***	emsn77378	No
2020/06/21 17:20:51	^AFRRCS sent to 4111151 : 10.174.29.5 : FMCM-1B5	wsemsef01	No
2020/06/21 17:20:56	^AFRRCS Received on 4111151 : 10.174.29.5 : FMCM-1B5	wsemsef01	No
2020/06/21 17:21:16	^AFRRCS Read on 4111151 : 10.174.29.5 : FMCM-1B5	wsemsef01	No
2020/06/21 17:21:47	** Event Priority changed from 5 to 6 at: 2020-06-21 17:21:47 ** >>>> by terminal: emsf00035	emsf00035	Yes
2020/06/21 17:21:47	** Event Type changed from 00A01(COLD) to 29(COLD) at: 2020-06-21 17:21:47 ** >>>> by terminal: emsf00035	emsf00035	Yes
2020/06/21 17:21:47	Problem: MOTORCYCLE ACCIDENT Caller Relationship: 3rd party Chief Complaint: Traffic Collision / Transportation Incident 30-year-old, Male, Conscious, Breathing.	emsf00035	No
2020/06/21 17:21:49	~FMCM(FIRE) has created event N20018270	wsemsef01	No
2020/06/21 17:21:50	~FMCM(FIRE): Dispatcher evaluating call.	wsemsef01	No
2020/06/21 17:22:15	~FMCM(FIRE): Dispatcher committed call. Incident open.	wsemsef01	No

Chronology

Event Comment Datetime	Event Comment	Event Comment Terminal	System Generated Flag
2020/06/21 17:22:29	Dispatch CAD Code: 29B02 Determinant Level: SERIOUS hemorrhage ----KQ: The incident involves a single motorcycle. ----KQ: There is SERIOUS bleeding. ----KQ: Chemicals or other hazards are not involved. ----KQ: There is no one pinned. ----KQ: Everyone appears to be completely awake (alert). ----KQ: His injuries are described as other than to a NOT DANGEROUS area.	emsf00035	No
2020/06/21 17:22:29	** Event Type changed from 29(COLD) to 29B02(HOT) at: 2020-06-21 17:22:29 ** >>>> by terminal: emsf00035	emsf00035	Yes
2020/06/21 17:22:30	** Event Priority changed from 6 to 4 at: 2020-06-21 17:22:30 ** >>>> by terminal: emsf00035	emsf00035	Yes
2020/06/21 17:23:10	Unit FMCM-1B5 status changed to EN (Enroute).	wsemsef02	No
2020/06/21 17:23:26	~FMCM(FIRE): Anzac Paged	wsemsef01	No
2020/06/21 17:24:41	~FMCM(FIRE): SOUTH OF ANZAC BETWEEN ANZ. AND ENGSTROM	wsemsef01	No
2020/06/21 17:24:57	~FMCM(FIRE): BTWN APPX KM 273-272	wsemsef01	No
2020/06/21 17:26:54	SOUTHBOUND LANE	emsf00035	No
2020/06/21 17:27:50	~FMCM(FIRE): ANZAC EN ROUTE	wsemsef01	No
2020/06/21 17:29:56	ANZAC RESPONDING WITH 7 MEMBERS	emsf00035	No
2020/06/21 17:31:13	PATIENT IS FULLY ALERT, HE HAS SOME ROAD RASH ON HIS LEGS, ARMS AND HIP	emsf00035	No
2020/06/21 17:32:28	|POLICE NOTIFIED|	emsf00035	No
2020/06/21 17:35:11	** Event Type changed from 29B02(HOT) to 29B01(HOT) at: 2020-06-21 17:35:11 ** >>>> by terminal: emsf00035	emsf00035	Yes
2020/06/21 17:36:45	~FMCM(FIRE): IncidentType changed from 'Pre-Alert - Event Pending: Pre-Alert - Event Pending' to '29B1: Injuries'	wsemsef01	No
2020/06/21 17:42:04	DISREGARD NOTE ABOUT SERIOUS BLEEDING; SPOKE TO PATIENT AT THE END AND NO BLEEDING CONTROL INSTRUCTIONS NEEDED, HE IS BLEEDING BUT IT IS SCRAPES AND ROAD RASH	emsf00035	No
2020/06/21 17:50:23	Unit FMCM-1B5 status changed to AR (Arrived).	wsemsef02	No
2020/06/21 18:01:36	FMCM-1B5 -- NO RESPONSE UNIT CONTACT. Timer Extended: 5	emsf00035	No
2020/06/21 18:04:29	~FMCM(FIRE): ETA FOR RCMP 10 MIN	wsemsef01	No
2020/06/21 18:05:59	Unit FMCM-1B5 status changed to TR (Transport).	wsemsef02	No
2020/06/21 18:16:45	~FMCM(FIRE): Dispatcher closed incident.	wsemsef01	No
2020/06/21 18:45:23	Unit FMCM-1B5 status changed to TA (Transport Arrive).	wsemsef02	No

Call Audit

Caller party: 3rd | Call Date: 06/21/2020 17:20:56 | Code Selected: 29 - B - 2
How Obtained: | Code Reviewed: 29 - B - 2
Complaint Description: MOTORCYCLE ACCIDENT

2.1.c

Case Entry

- Address
- Callback number
- Primary discipline choice
- Tell me exactly what happened.
  Comment: "So, there was about 4 motorcycles and they passed us and I guess he lost control of...started doing that wobble and basically....it wasn't a collision with another vehicle.".
- Choking question
- ECHO/Fast Track used
- With the patient now
  Comment: The caller reported he was on hands free, to get the best assessment possible it could be recommended for the caller to go patient side. This will also help with the delivery of PDIs later on in the assessment.
- With the patient now subquestion
- Patient count question
  Comment: As there was no clear descriptor of how many occupants were on the motorcycle asking the patient count was required.
- Age question
- Age subquestion
- Gender
- Awake question
  Comment: The awake question was asked then without letting the caller answer the breathing question was also asked. The caller then stated yes. As there was not enough time for the caller to answer the awake question we can not be sure which question the answer "yes"was for. Please remember to ask each question separately and obtain an answer for each.
- Breathing question
  Comment: The awake question was asked then without letting the caller answer the breathing question was also asked. The caller then stated yes. As there was not enough time for the caller to answer the awake question we can not be sure which question the answer "yes"was for. Please remember to ask each question separately and obtain an answer for each.
- Breathing subquestion
- Questions asked in order
- Chief Complaint selection
- Freelance questions
- Freelance instructions
- All questions/instructions given in the appropriate area
- Obvious questions
- Clarifiers
- Calming techniques

Key Questions KQ T

- Sub-Chief Complaint

Call Audit

Caller party: 3rd | Call Date: 06/21/2020 17:20:56 | Code Selected: 29 - B - 2

How Obtained: | Code Reviewed: 29 - B - 2

Complaint Description: MOTORCYCLE ACCIDENT

	Key Questions asked in order	
	Freelance questions	
	Freelance instructions	
	All questions/instructions given in the appropriate area	
	Obvious questions	
	Clarifiers	
	Calltaker Initiated Shunt	
	Shunted appropriately (new or updated information)	
	Followed appropriate protocol links	
	Calming techniques	
	Ø Type of incident?	3
	Are there chemicals or other hazards involved?	1
	Is anyone pinned (trapped)?	0
	Does everyone appear to be completely awake (alert)?	7
	Are there any obvious injuries?	0
	Is there any SERIOUS bleeding (spurting or pouring)?	7

Comment: Are there any chemicals or other hazards involved?'

The caller stated the motorcycle did "that wobble thing then went into the ditch", in KQ the selection of solitary MC is not incorrect but the description of the event suggests that High Velocity Incident may have been more appropriate to capture a higher level response.

'And does he appear to be completely awake?'. This changes the intent of the question as the original question asks, 'Does everyone...'. Since we don't know if there is more than one patient, this needs to be read as scripted to capture all possible patients.

The phone was passed to the rider of the MC. The bleeding was confirmed as not serious. This needs to be updated in KQ as bleeding not serious. This also captures a more accurate response of the situation.

Final Coding

	Determinant Code
	Determinant Level
	Determinant Descriptor
	Determinant Suffix
	Did not use Malicious Final Code

Dispatch Life Support

	PAIs
	PDIs
	Freelance questions
	Freelance instructions
	All questions/instructions given in the appropriate area

Call Audit

Caller party: 3rd | Call Date: 06/21/2020 17:20:56 | Code Selected: 29 - B - 2

How Obtained: | Code Reviewed: 29 - B - 2

Complaint Description: MOTORCYCLE ACCIDENT

	Obvious questions
2	Clarifiers
	Comment: You're bleeding there, sir, are you?',
	"Nothing that we need to control the bleeding with, sir?'.
	Followed appropriate DLS Links
	Met the minimum Standards of Practice
	Followed appropriate protocol links
	Calming techniques
	Breathing Verification Diagnostic
	Pulse Diagnostic
	Stroke Diagnostic
	Aspirin Diagnostic
	Compressions Diagnostic
	Contractions Diagnostic
	Chemical Suicide Diagnostic
	Coronavirus (COVID-19)
	Customer Service
	Calltaker attitude
	Use correct volume, tone, and rate
	Display compassion
	Avoid gaps
	Explain actions
	Provided reassurance
	Did not create uncontrollable expectations
	Avoided prohibited behaviors

Overall Performance: Non-Compliant

Comments: Well done working with multiple callers to make sure you understood exactly what had happened. In order to get the best assessment possible it is a good practice to see if the caller would be willing to go patient side. Once into your PDIs the caller then was willing to go relay bleeding control instructions.

e-PCR / Patient Outcome

COMMENTS

responded to 53y/o male who was riding at highway speeds on his motorcycle. P/t states he hit a gust of wind and went into an uncontrolable speed wobble that threw him off his bike. p/t did not loose conciousness and denies having any neck or spinal pain. P/t A/Ox4 and ambulatory. had significant road rash to both lower and bother upper limbs. as well as buttocks and hip. minimal blood lose. >100ml. P/t was given entonox but had little effect on pain relief. 20g iv in left AC and 500ml of N/S given.
I did not attempt to clean the wounds as P/T was already in significant pain and with out adequate pain control i did not want to cause further pain.
P/t transported in semi fowlers position. No issues during transport, other than not being able to relieve pain with entonox.
P/T care transfered to northern lights emerg staff.

Questions / Discussion

Event Overview #3

Date of Event:
09 June 2020

Event Location:
Edmonton

Call Taker Location:
NCC

Dispatch CAD Code:
36A03S(COLD)

Code Description:
Pandemic / Epidemic / Outbreak (surveillance or triage

Chief Complaint / Problem:
Stuck in a roasting pan on the floor, can’t get her up, can’t move

MPDS Card Set – case entry protocol

ENTRY QUESTIONS

1. What's the **address** of the emergency?
   House/Apartment/Business/Intersection/Landmark/Jurisdiction/GPS ✔
2. What's the **phone number** you're calling from? ✔
3. Okay, tell me **exactly** what happened.
   - Obviously NOT BREATHING and Unconscious (non-traumatic) — 9-E-1
   - Hanging, Strangulation (no assailant involved), Suffocation — 9-E-3,4,5
   - Underwater (DOMESTIC rescue) — 14-E-2
   - Underwater (SPECIALIZED rescue) — 14
   - Person on fire — 7-E-1

   a. **(Not obvious)** Are you **with** the patient **now**?

   b. **(Not obvious)** How **many** (other) people are **hurt/sick**?
   - Multiple victims — CC
   - Traffic/Transportation incident (3rd or 4th pty caller) — 29

   c. **(Choking)** Is s/he **breathing** or **coughing** at all? (You go check and tell me what you find.)
   - No — 11-E-1

   i. **Do not slap** her/him on the back.
4. How **old** is s/he?

   a. **(Unsure)** Tell me **approximately**, then.
5. Is s/he **awake** (conscious)?
   - Yes
   - No
   - Unknown
6. Is s/he **breathing**? ?

   a. **(Hasn't checked – 2nd party caller)** You go check and tell me what you find. ✔
   - Yes
   - No/NOT BREATHING — ?-E-?
   - UNCERTAIN/INEFFECTIVE/AGONAL BREATHING (1st or 2nd pty caller) — ?-E-?
   - Unknown (3rd or 4th pty caller)

THE INTERNATIONAL ACADEMY EMD PROTOCOL

Medical Priority Dispatch System

POST-DISPATCH INSTRUCTIONS

a. **(ECHO)** I'm sending the **paramedics** (ambulan to help you now. **Stay on the line.**

b. **(Hanging and not OBVIOUS DEATH)** **(Cut** her/him **down** immediately,) **loosen** the noose, then tell me if s/he's **breathing.**

c. **(Underwater)** **Do not go in the water** unless it's **safe** to do so.

d. **(Strangulation and not OBVIOUS DEATH)** **Loosen** anything around the **neck**, then tell m if s/he's **breathing.**

e. **(Suffocation)** **Remove** anything **covering** the **face** or **in** the **mouth**, then tell me if s/he's **breathing.**

f. **(Person on fire)** Tell her/him to **stop** running, **drop** to the **ground, cover** her/his **face**, and **ro** around. If water is available, **douse** her/him w it **immediately** until the fire is completely out **(Water not available)** Get a **blanket, rug**, or **large jacket** and **use it to wrap her/his body** and **smother** the flames.

g. **(Critical Caller Danger)** **(If it's too dangerous to stay** where you are, and you think you can leave safely,) **get away** and **call us** from somewhere **safe.**

DLS ✱ Link to CC unless:

- Suspected MEDICAL Arrest — NAB
- Hanging/Strangulation/Suffocation (INEFFECTIVE BREATHING and Not OBVIOUS DEATH) — NAB

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MPDS Card Set – case entry protocol

NOT BREATHING Situations

The following, when **offered** in response to "Tell me exactly what happened" or any listed Entry Question:

- **Not breathing** at all — 9-E-1
- **UNCERTAIN BREATHING** — 9-E-2
- **Hanging** — 9-E-3
- **Strangulation** — 9-E-4
- **Suffocation** — 9-E-5
- **COMPLETE obstruction** — 11-E-1
- **Drowning arrest** (out of water) — 14-E-1
- **Underwater** (**DOMESTIC** rescue) — 14-E-2

INEFFECTIVE BREATHING

The following, or reasonable equivalents, when **volunteered** at any point during Case Entry (code as **ECHO** on 2, 6, 9, 11, 15, 31):

- "Barely breathing"
- "Can't breathe (at all)"
- "Fighting for air"
- "Gasping for air" (**AGONAL BREATHING**)
- "Just a little" (**AGONAL BREATHING**)
- "Making funny noises" (**AGONAL BREATHING**)
- "Not breathing"
- "Turning blue" or "Turning purple"

? Determining AGONAL BREATHING

Use when the patient is **unconscious** and breathing reported by the caller is **questionable**, or when **mandated by the protocol** ?. A **time between** breaths of **8 seconds or more** is considered **INEFFECTIVE BREATHING**. Check a maximum of **four breaths** (three intervals tested).

(Read verbatim) Okay, I want you to say "**now**" every **single** time s/he **takes** a breath **in**, starting **immediately**.

- **≥ 8 sec. interval = AGONAL**

AGONAL BREATHING

An **ineffective, deteriorating** breathing pattern that lingers after the heart has essentially **stopped pumping blood to the brain**.

UNCERTAIN BREATHING

A situation where a **2nd party** caller is **uncertain, unsure, indefinite, or ambiguous** when asked if an unconscious patient is breathing.

ECHO Determinant Practice

The **ECHO** level allows **early recognition** and **closer response initiation** based on **extreme conditions of breathing** and **other dire circumstances as defined**, such as a **person on fire**.

Such coding is separated from **DELTA** to encourage **local** assignment of the **absolute closest** response of **any trained crew** (i.e., police with AEDs, fire ladder or snorkel crews, **HAZMAT**, or other specialty teams).

Rules

1. If the complaint description includes **scene safety** issues, choose the Chief Complaint Protocol that **best addresses** those issues.
2. If the complaint description involves **TRAUMA**, choose the Chief Complaint Protocol that best addresses the **mechanism of injury**.
3. Use of the **AGONAL BREATHING Detector** is **not necessary** when **UNCERTAIN BREATHING** or **INEFFECTIVE BREATHING** is **associated with unconsciousness**.
4. When **cardiac arrest** appears to be **TRAUMATIC** in nature, choose the Chief Complaint Protocol that best fits **scene safety** concerns and the **mechanism of injury**.
5. If the complaint description appears to be **MEDICAL** in nature, choose the Chief Complaint Protocol that best fits the patient's **foremost symptom**, with **priority symptoms** taking precedence.
6. If the complaint description involves **hazardous materials** (toxic substances) that **pose a threat** to bystanders or responders, go to **Protocol 8**.
7. When the complaint description is **seizure, go to Protocol 12** regardless of consciousness and breathing status.
8. If the Chief Complaint and status of **consciousness and breathing are unknown** initially (3rd party caller), go to Protocol 32.
9. When the complaint description involves **both NON-TRAUMATIC chest pain/heart attack symptoms and breathing problems**, choose the Chief Complaint Protocol that best fits the patient's **foremost symptom**, with **ECHO-level conditions** taking precedence. (**≥ 16, alert, no reported STROKE symptoms**) Use the **Aspirin Diagnostic & Instruction Tool** on either protocol as appropriate.
10. When the complaint description is **breathing-related tracheostomy** (trach or stoma) **problems in the conscious patient**, go to Protocol 6.
11. Some **critical** patient care instructions may be **necessary prior** to the "**send**" **point**. Any significant **scene safety concerns** take precedence and **must be addressed before** the provision of instructions.
12. Case Entry Questioning **must always be completed** after PDIs **when directed** by (hanging, strangulation, suffocation, underwater, choking, person on fire).

Axioms

1. **UNCERTAIN BREATHING** status indicates a **2nd party** caller who has seen the patient and is still unsure. **This is considered NOT BREATHING until proven otherwise**.
2. **Unknown breathing** status indicates a **3rd or 4th party** caller who cannot personally verify the patient's status.
3. After an **ECHO** response, **completing all Case Entry and Chief Complaint** Key Questions ensures that the proper knowledge regarding **safety** issues and the appropriate warnings and/or advice are immediately and always **passed on** to the responders and potential scene helpers.
4. **Prompt recognition of AGONAL BREATHING** is critical to the treatment of cardiac arrest because it **reduces time to compressions and defibrillation**. **MEDICAL** Arrest PAIs should be **instituted immediately** after **ECHO** coding and associated PDIs when an unconscious patient's **breathing status is INEFFECTIVE or UNCERTAIN** (**AGONAL BREATHING** Detector use is **not** necessary).

0 CASE ENTRY PROTOCOL

MPDS Card Set – 36-A-03S

36 Pandemic / Epidemic / Outbreak (Surveillance or Triage)

KEY QUESTIONS

1. What is the most **prominent complaint?**
(Difficulty breathing)
   a. Does s/he have **difficulty** speaking **between** breaths?
      i. **(No) Describe** to me what her/his **breathing** is like.
   b. **(INEFFECTIVE or DSBB)** Did s/he have **any flu-like symptoms** prior to this?
      Yes & INEFFECTIVE — 36-D-1
      Yes & DSBB — 36-D-2
      No — 6

(Chest pain ≥ 35)
   a. Has s/he ever had a **heart attack** or **angina** (heart pains)?
      Yes — 10
2. Is s/he **completely alert** (responding appropriately)?
3. **(Not 1st party)** Is s/he **changing color?**
   a. **(Yes) Describe** the color change.
4. Is s/he having **chills** or **sweats?**
   Yes & chest pain/discomfort ≥ 35 — 10
5. **(Not COVID-19)** Is s/he **vomiting?**
   Yes & chest pain/discomfort ≥ 35 — 10
6. Does s/he have a **new cough** that **recently** started?
7. Does s/he have a **sore throat?**
8. Does s/he have **muscle** or **body aches?**
9. Does s/he have a **fever** (**hot to touch** in room temperature)?
10. Does s/he have a **runny** or **stuffy nose?**
11. **(Not COVID-19)** Does s/he have **diarrhea?** ✱ see Rule 2
12. Does s/he have **fatigue** or **weakness?**
13. **(Not COVID-19)** Does s/he have a **headache?**
   a. **(Yes & no other flu-like symptoms)** Was there a **sudden** onset of **severe** pain?
      Yes — 18

KEY QUESTIONS (continued)

14. Does s/he have any **HIGH RISK** conditions?
    No flu-like symptoms in KQ 4–13 — CC

POST-DISPATCH INSTRUCTIONS

a. **(If regular dispatch)** I'm sending the **paramedics** (ambulance) to help you now. **Stay on the line** and I'll tell you **exactly** what to do next.
b. **(If reduced/limited dispatch)** I'm **arranging care** for you now. An ambulance (or Care Van) will come to check you **when they are available**. This might take (several hours).
c. **(No EMS response/Home quarantine instructions)** Due to the **extent** of the epidemic, your condition **requires** that you **remain at home** and **avoid close contact** with others. A **healthcare professional/specialist** will (contact you soon to) **give** you **further instructions**. **(Connect to a specialist if available.)**
d. **(No EMS response and alternative treatment site available)** Since the **hospitals** are currently **full** and only accepting **critically ill** patients, I'm going to **give** you the **address/location** of the **nearest** treatment center. **(Follow local instructions.)** Do you have **transportation** to get there? **(If no, follow local instructions.)**
e. **(Patient medication requested and Alert)** Remind her/him to do what her/his **doctor has instructed** for these situations.
f. **(≥ 1 + DELTA)** If there is a **defibrillator** (AED) available, **send** someone to get it **now** in case we need it later.

DLS ✱ Link to ☎ X-1 unless:
INEFFECTIVE BREATHING and Unconscious — ABC-1

LEVELS	#	DETERMINANT DESCRIPTORS ➔ S A B C X L M H	CODES: LEVEL 0 (S,X)	LEVEL 1 (A,L)	LEVEL 2 (B,M)	LEVEL 3 (C,H)
D	1	**INEFFECTIVE BREATHING** with **flu-like symptoms**	36-D-1			
	2	**DIFFICULTY SPEAKING BETWEEN BREATHS** with **flu-like symptoms**	36-D-2			
	3	**Not alert** with **flu-like symptoms**	36-D-3			
	4	**CHANGING COLOR** with **flu-like symptoms**	36-D-4			
C	1	**Abnormal breathing** with **single** flu-like symptom or **Asthma/COPD**	36-C-1			
	2	**Abnormal breathing** with **multiple** flu-like symptoms	36-C-2			
	3	**Chest pain/discomfort** ≥ 35 with **single** flu-like symptom	36-C-3			
	4	**Chest pain/discomfort** ≥ 35 with **multiple** flu-like symptoms	36-C-4			
	5	**HIGH RISK**	36-C-5			
A	1	**Chest pain/discomfort** < 35 with **single** flu-like symptom	36-A-1			
	2	**Chest pain/discomfort** < 35 with **multiple** flu-like symptoms	36-A-2			
	3	Flu-like symptoms **only** (cough, fever, chills, sweats, sore throat, vomiting, diarrhea, muscle/body aches, fatigue/weakness, headache, etc.)	36-A-3			

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Chronology

Event Comment Datetime	Event Comment	Event Comment Terminal	System Generated Flag
2020/06/09 18:04:44	[redacted]	emsn77380	No
2020/06/09 18:04:45	** LOI search completed at 2020-06-09 18:04:45	wsemscadint03	Yes
2020/06/09 18:04:45	OTHER: Helicopter EMS LZ : AFRRCS Simplex 1 Police: Contact dispatch for Talkgroup OLMC: CCC TAC 8 Interoperability for AFRRCS Equipped Partner Agencies 	AFRRCS	No
2020/06/09 18:04:53	^** Recommended unit EDMO-1A14 for requirement ALS (1.5 min) ^** Recommended unit EDMO-2A25 for requirement ALS (3.5 min) ^** Recommended unit EDMO-6P8 for requirement PRU (3.8 min) ^** Recommended unit EDMO-1A13 for requirement ALS (9.3 min)	emsc74065	Yes
2020/06/09 18:04:55	^AFRRCS sent to 4111083 : 10.174.28.193 : EDMO-2A25	wsemsef01	No
2020/06/09 18:04:58	^AFRRCS sent to 4112284 : 10.174.34.185 : EDMO-2A25	wsemsef01	No
2020/06/09 18:05:01	BUZZER IS CALLERS PHONE NBR	emsn77380	No
2020/06/09 18:05:03	^AFRRCS Received on 4112284 : 10.174.34.185 : EDMO-2A25	wsemsef01	No
2020/06/09 18:05:04	^AFRRCS Received on 4111083 : 10.174.28.193 : EDMO-2A25	wsemsef01	No
2020/06/09 18:05:17	MAP ZONE 24, CC 07	emsc74064	No
2020/06/09 18:05:52	PT 250 LBS	emsn77380	No
2020/06/09 18:06:54	PT HAS BEEN PULLED OUT OF THE ROASTING PAN	emsn77380	No
2020/06/09 18:07:35	Problem: STUCK IN A ROASTING PAN ON THE FLOOR, CANT GET HER UP, CANT MOVE Caller Relationship: 2nd party Chief Complaint: Pandemic / Epidemic / Outbreak (Surveillance or Triage) 58-year-old, Female, Conscious, Breathing.	emsn77380	No
2020/06/09 18:07:36	** Event Priority changed from 5 to 6 at: 2020-06-09 18:07:36 ** >>>> by terminal: emsn77380	emsn77380	Yes
2020/06/09 18:07:36	** Event Type changed from 00A01(COLD) to 36(COLD) at: 2020-06-09 18:07:36 ** >>>> by terminal: emsn77380	emsn77380	Yes

Chronology

Event Comment Datetime	Event Comment	Event Comment Terminal	System Generated Flag
2020/06/09 18:09:33	Dispatch CAD Code: 36A03S Determinant Level: Flu-like symptoms only (cough, fever, chills, sweats, sore throat, vomiting, diarrhea, muscle/body aches, fatigue/ weakness, headache, etc.) Suffix Text: Level 0 (COVID-19 surveillance only) ----KQ: This is a coronavirus (COVID-19) outbreak. ----KQ: The locally designated Triage Level is 0 (surveillance only). ----KQ: The most prominent complaint is having general illness/sickness (other symptoms): CANT MOVE ----KQ: She does not have chills or sweats. ----KQ: She does not have a fever. ----KQ: She does not have a runny or stuffy nose. ----KQ: She has fatigue or weakness. ----KQ: She is not a HIGH RISK patient. ----KQ: She is completely alert (responding appropriately). ----KQ: She does not have a new cough that recently started. ----KQ: She does not have a sore throat. ----KQ: She does not have muscle or body aches.	emsn77380	No
2020/06/09 18:09:33	** Event Type changed from 36(COLD) to 36A03S(COLD) at: 2020-06-09 18:09:33 ** >>>> by terminal: emsn77380	emsn77380	Yes
2020/06/09 18:09:34	** Event Priority changed from 6 to 5 at: 2020-06-09 18:09:34 ** >>>> by terminal: emsn77380	emsn77380	Yes
2020/06/09 18:10:34	^AFRRCS Read on 4111083 : 10.174.28.193 : EDMO-2A25	wsemsef01	No
2020/06/09 18:13:26	EDMO-2A25 -- CREW INITIATED - CODE15	emsc74064	No
2020/06/09 18:34:54	EDMO-2A25 -- NO RESPONSE UNIT CONTACT. Timer Extended: 5	emsc74058	No
2020/06/09 18:35:40	DISREGARD LAST	emsc74058	No
2020/06/09 18:42:44	EDMO-2A25 -- CREW INITIATED - CODE15	emsc74064	No
2020/06/09 18:42:51	CODE 15 VIA DISP 4	emsc74064	No
2020/06/09 18:47:11	PT REFUSED TRANSPORT. WILL BE DOCUMENTING AND MOVING OFF SCENE.	emsc74064	No
2020/06/09 18:47:15	EDMO-2A25 -- CREW INITIATED - CODE15	emsc74064	No

Caller party: 2nd | Call Date: 6/9/2020 6:04:54 PM | Code Selected: 36 - A - 3 - S

How Obtained: | Code Reviewed: 36 - A - 3 - S

Complaint Description: STUCK IN A ROASTING PAN ON THE FLOOR, CANT GET HER UP, CANT MOVE

Case Entry

- Address
  - Comment: "C Block buiding?"
- Callback number
- Primary discipline choice
- Tell me exactly what happened.
- Choking question
- ECHO/Fast Track used
- With the patient now
- With the patient now subquestion
- Patient count question
- Age question
- Age subquestion
- Gender
- Awake question
- Breathing question
- Breathing subquestion
- Questions asked in order
- Chief Complaint selection
- Freelance questions
  - Comment: "You said she's overweight, how much does she weigh?"
  - Moving forward, avoid asking freelance questions that do not provide an appropriate clarification or enhancement to a question in the protocol.
- Freelance instructions
- All questions/instructions given in the appropriate area
- Obvious questions
- 3 Clarifiers
  - Comment: "She's stuck in a pan?"
  - "So she's stuck in a roasting pan on the floor?"
  - "Pardon me, 68?"
  - "Now that she's out of the roasting pan, what injuries does she have?"
  - In the future, it is best practice to ask all clarifying questions in an objective manner.
- Calming techniques

Key Questions | KQ Type

- Sub-Chief Complaint
- Key Questions asked in order
- Freelance questions
- Freelance instructions
- All questions/instructions given in the appropriate area

Call Audit

Caller party: 2nd | Call Date: 6/9/2020 6:04:54 PM | Code Selected: 36 - A - 3 - S

How Obtained: | Code Reviewed: 36 - A - 3 - S

Complaint Description: STUCK IN A ROASTING PAN ON THE FLOOR, CANT GET HER UP, CANT MOVE

Obvious questions	
Clarifiers	
Comment: "Does she have fatigue or weakness? Yes or No."	
Calltaker Initiated Shunt	
Shunted appropriately (new or updated information)	
Followed appropriate protocol links	
Calming techniques	
Ø Select the disease outbreak.	3
Ø Enter the locally designated Triage Level:	0
Ø Select the most prominent complaint:	3
Is she completely alert (responding appropriately)?	7
Is she changing color?	7
Is she having chills or sweats?	0
Does she have a new cough that recently started?	0
Does she have a sore throat?	0
Does she have muscle or body aches?	0
Does she have a fever (hot to touch in room temperature)?	0
Does she have a runny or stuffy nose?	0
Does she have fatigue or weakness?	0
Ø Is this a HIGH RISK patient?	7

Final Coding

Determinant Code	
Determinant Level	
Determinant Descriptor	
Determinant Suffix	
Did not use Malicious Final Code	

Dispatch Life Support

PAIs	
PDIs	
Comment: EMS arrived before the last PDI could be given.	
Freelance questions	
Freelance instructions	
All questions/instructions given in the appropriate area	
Obvious questions	
Clarifiers	
Followed appropriate DLS Links	
Met the minimum Standards of Practice	

Call Audit

Caller party: 2nd | Call Date: 6/9/2020 6:04:54 PM | Code Selected: 36 - A - 3 - S

How Obtained: | Code Reviewed: 36 - A - 3 - S

Complaint Description: STUCK IN A ROASTING PAN ON THE FLOOR, CANT GET HER UP, CANT MOVE

- Followed appropriate protocol links
- Calming techniques
- Breathing Verification Diagnostic
- Pulse Diagnostic
- Stroke Diagnostic
- Aspirin Diagnostic
- Compressions Diagnostic
- Contractions Diagnostic
- Chemical Suicide Diagnostic
- Coronavirus (COVID-19)

Customer Service

- Calltaker attitude
- Use correct volume, tone, and rate
- Display compassion
- Avoid gaps
- Explain actions
- Provided reassurance
- Did not create uncontrollable expectations
- Avoided prohibited behaviors

Overall Performance: Partial Compliance

Comments: This call was for a 58 year female that was stuck in a roasting pan on the floor. You remained polite and professional throughout the whole call evaluation. You made sure to reassure the caller that help was on the way and that she was doing a great job. Well done [redacted]

Legend:

51	Correct	0	Not As Scripted
5	Not Correct	0	Not Read
6	Obvious	19	N/A
		0	Input Error

e-PCR / Patient Outcome

COMMENTS

EDMO-2A25 is dispatched to a 59 y/o F pt for ETOH intoxication
O/A – EMS is greeted by niece at door – niece is visibly upset – stating that her aunt cant stay here, pt is found kneeling over cooking pot full o urine, not distress noted, no abnormal breathing noted, eyes open and tracking, skin pwd, no trauma noted, untidy environment, ETOH noted on scene, no bleeding noted, pt is obese
HxCC – pt states that she is having difficulty standing after kneeling down to urinate in pot, pt states she does not want to go to hospital, pt wou like a ambulance ride home as she has no money for a cab
Tx – assessment, vitals, 4/12 lead – sinus tach, assisted pt to standing, pt refuses EMS care and transport, niece states she will pay for cab ride home, pt left in care of niece – will contact EMS is medical intervention is required

Questions / Discussion

Questions / Discussion

Round Table

OFFICE OF THE MAYOR

CITY OF Lethbridge

Calgary
Office of the Mayor

REGIONAL MUNICIPALITY OF WOOD BUFFALO

July 24, 2020

The Honourable Tyler Shandro
Minister of Health
423 Legislature Building
10800 – 97 Avenue
Edmonton, AB T5K 2B6

Dear Minister Shandro,

Thank you for meeting with us on July 15, 2020 to discuss the potential changes to Emergency Medical Services (EMS) dispatching resulting from the AHS review of the Ernst and Young (EY) report on potential cost savings and performance improvement and to hear why Lethbridge, Red Deer, Wood Buffalo and Calgary all support maintaining the current integrated emergency dispatch model. We do not support the consolidation of dispatch in the north and south zone and the dismantling of the regional dispatch system. All four municipalities strongly urge you to simply rule out the proposed EMS dispatch consolidation prior to receiving AHS's proposed implementation plan for the EY report.

Any expected savings, which we do not accept will necessarily materialize, would be offset by significant reductions in the quality of the service. Avoiding a siloed approach in emergencies is critical to ensuring that EMS, fire and police first responders can address complex, risky or dangerous situations more effectively. These clear benefits significantly outweigh the relatively small expected savings, particularly considering the admission that changes to the dispatch model will result in longer response times to medical emergencies which is likely to drastically impact patient outcomes in certain emergencies.

All four of our municipalities have enjoyed a collaborative relationship with AHS since its inception and our citizens have experienced the benefits of this intergovernmental cooperation. Creating further coordination issues and red tape by splitting off the dispatch of EMS is not in the public interest. The capability to simultaneously coordinate dispatch for police, fire and EMS is critical to achieving the best response in the shortest time. When a citizen phones 9-1-1, they are often in the midst of one of the most stressful, difficult situations they have ever experienced. Our integrated emergency dispatch model ensures that callers do not have to repeat their story multiple times to receive help from multiple agencies, which would be the case under the new dispatch model that the EY report is proposing.

In 2019, the Red Deer Fire Department had 3,505 medical co-responses. In 40 percent (1,398) the fire engine arrived first. In Red Deer, the de-integration of services would mean that fire resources would no long be able to respond to medical incidents. In Calgary, the Calgary Fire Department's Medical First Responders are rapidly dispatched as part of the current model and attend almost 25,000 calls each year and are on scene first in almost half of all critical events. In Lethbridge in 2019, of the 16,901 Medical Incidents and Motor Vehicle Collisions, a fire apparatus responded first 4,703 times. Municipal fire departments attending to citizens in medical emergencies alongside EMS saves lives.

Calgary 9-1-1 has been dispatching EMS since its inception. A centralized dispatch system would be the first time that the Calgary tri-services model has ever been fractured. This integrated tri-service dispatch model reflects the industry best practice – a model that many agencies are trying to replicate. Indeed, the recent hailstorm Calgarians experienced on June 13 reinforced the value of the all-hands-on-deck, integrated dispatch model as significant damage and flooding occurred extremely quickly. Responding to emergencies in the midst of this COVID-19 pandemic is becoming more complex.

As was stated on our call, there is an opportunity to address the related issue of the patient transfer system. In principle, we support the red tape reduction, and the cost-efficiency of changes to inter-facility transfer. However, the need to maintain our emergency response capabilities as we confront an increasingly uncertain and unpredictable world is critical.

Thank you for your consideration of this issue.

Sincerely,

Naheed K. Nenshi
Mayor, City of Calgary

Tara Veer
Mayor, City of Red Deer

Chris Spearman
Mayor, City of Lethbridge

Don Scott
Mayor, Regional Municipality of Wood Buffalo

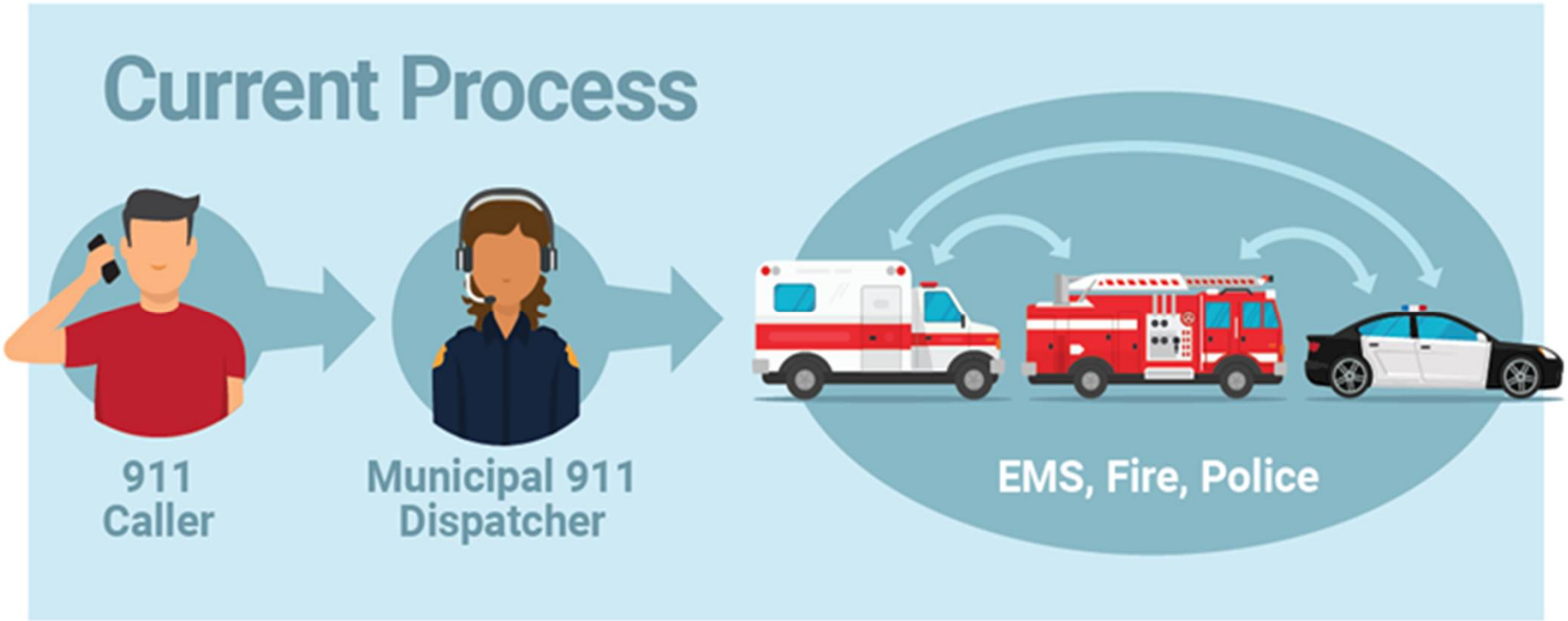
cc: The Honourable Jason Kenney, Premier

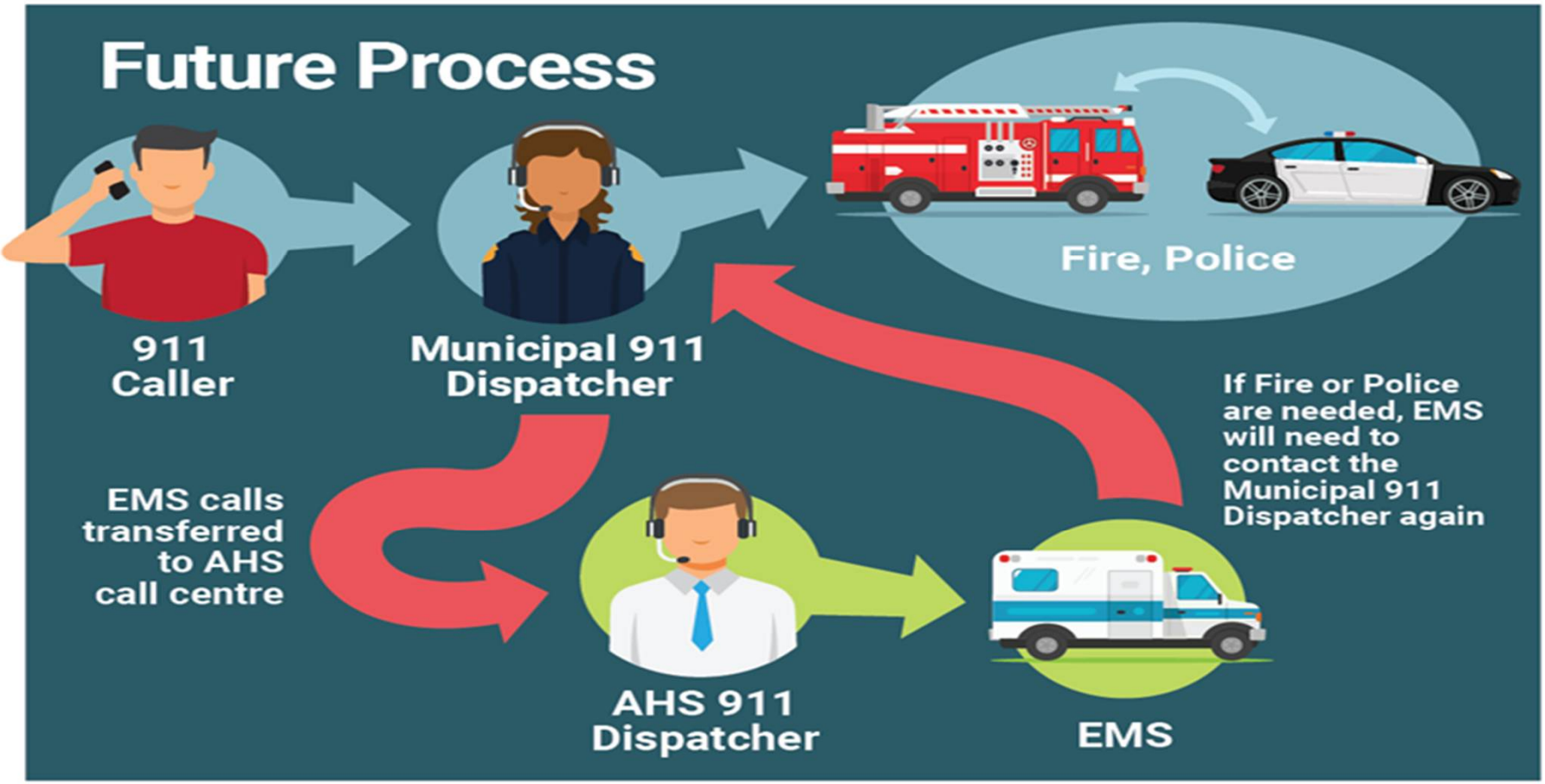
Impact of AHS EMS Dispatch Consolidation to the Wood Buffalo Region

Presenter: Regional Fire Chief Jody Butz, Deputy Chief Kelly Roberts

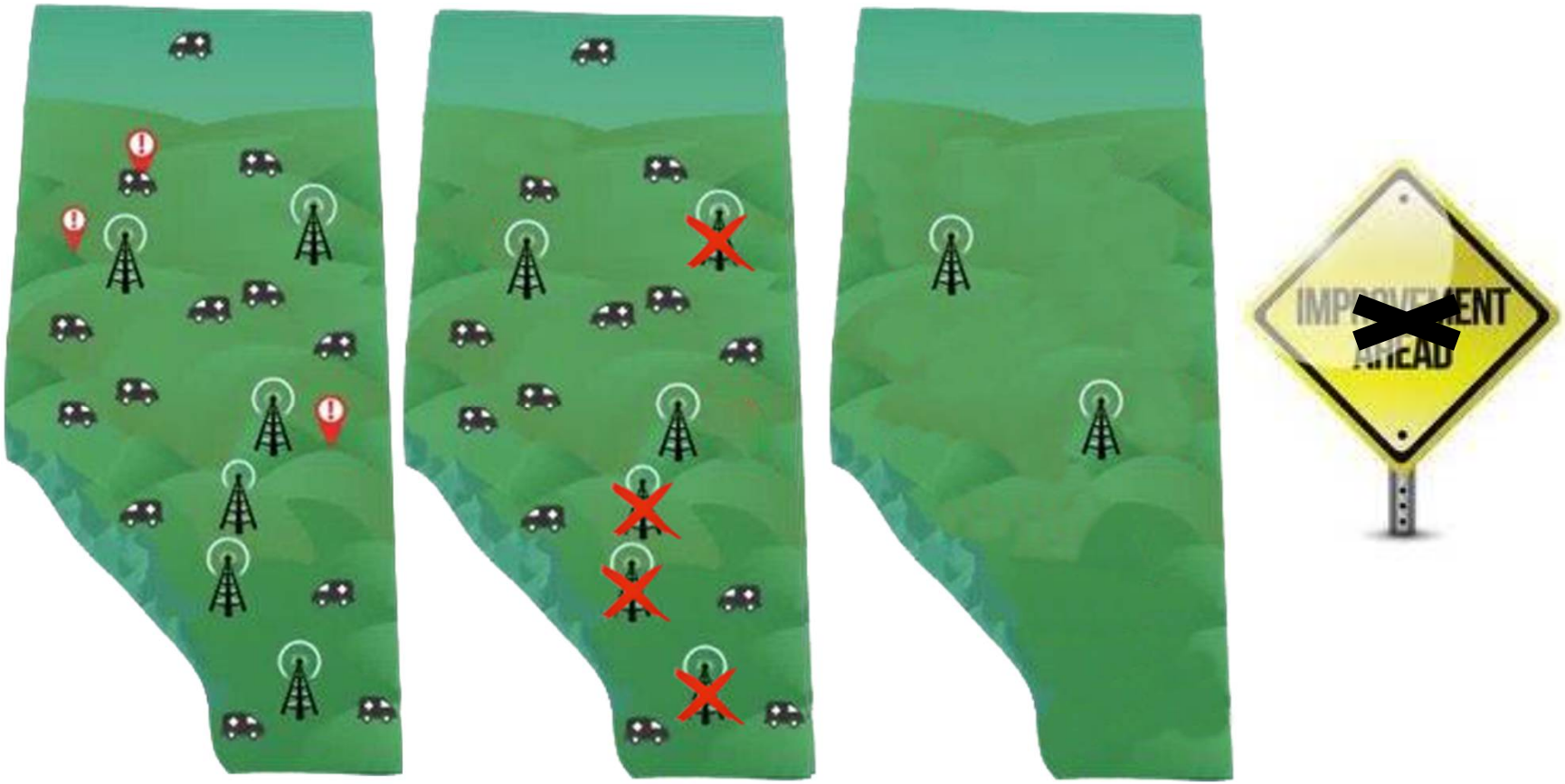
Department: Regional Emergency Services

Meeting Date: September 8, 2020


Current Process
911
Caller
Municipal 911
Dispatcher
EMS, Fire, Police

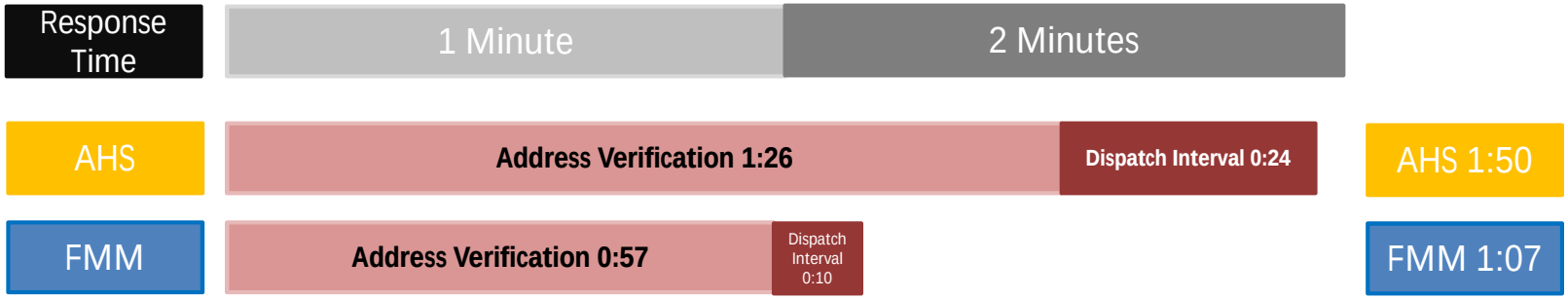

Future Process
911 Caller
Municipal 911 Dispatcher
Fire, Police
If Fire or Police are needed, EMS will need to contact the Municipal 911 Dispatcher again
EMS calls transferred to AHS call centre
AHS 911 Dispatcher
EMS

Provincial EMS Dispatch System

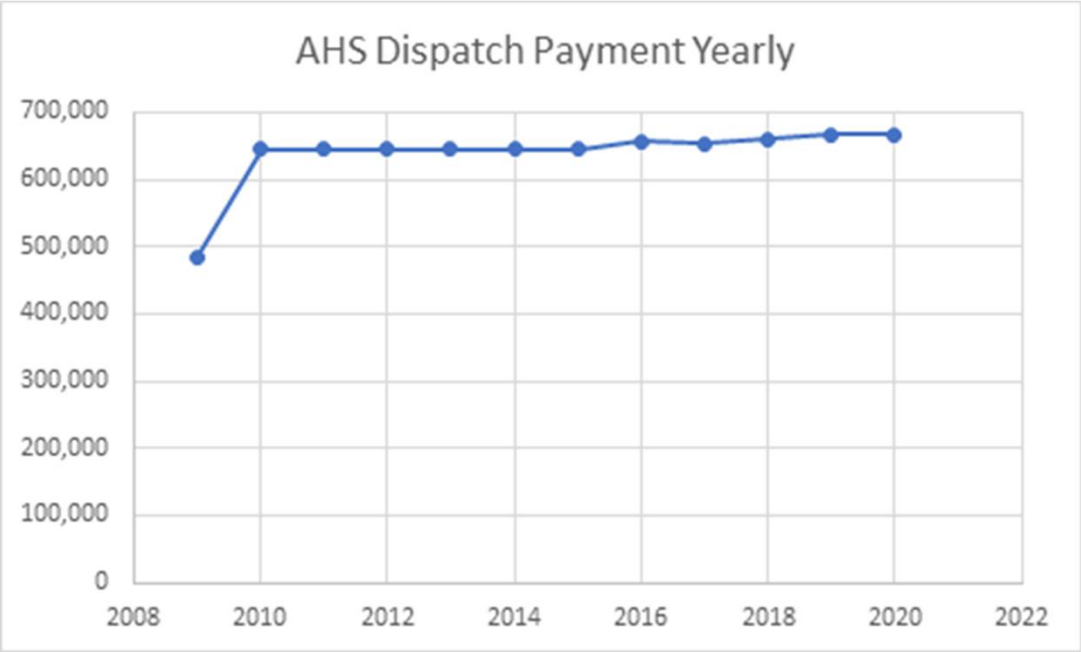


Response Time Comparison – June 2020

- 90% of the time, FMM can go from call answered, through address verification and dispatch in 1 minute and 7 seconds.
- By the same measurement, AHS takes 1 minute and 50 seconds. That extra 43 seconds is significant when your loved one is waiting for help.



Financials



- In the last 10 years, annual Dispatch revenue received from AHS have remained static.

Case Study:
FRESC Experiences after Divesting from EMS Dispatch

More Taxes
- The Alberta taxpayer paying twice for infrastructure and service delivery for Ambulance Dispatch

Fractured Approach
- A fractured approach to providing emergency service response to emergencies

Less Coordination
- Lack of service response coordination (Fire, rescue, hazmat and EMS)

Time Delays
- Time delays in responding to medical first response in rural communities

Poor Rural Location Familiarity
- Poor rural area familiarization and ongoing issues determining the location of the emergency

Public Transparency
- No measuring or reporting of service performance by AHS SCC to the public or municipalities

Internal Fear
- AHS Employees fear reprimand if anything gets out about poor service levels

Negative Impacts
- Since 2009, our municipalities and ultimately our residents have experienced the negative impacts of the decision to remove EMS dispatch from our center

Source: Foothills Regional Emergency Services Commission (FRESC)

Impact:

Regional Municipality of Wood Buffalo

Regional Municipality of Wood Buffalo Emergency Services

Fort McMurray Local 2494 Fire Fighters Association

IAFF Alberta Fire Fighters Association

First Nations and Metis Nations

Mutual-Aid Partners & Industry Partners

Rural Communities

Local HERO Foundation

Phoenix Heli-Flight

Actions

Oppose Alberta Health Services' (AHS) changes to consolidate EMS dispatch provincially.

Educate impacted stakeholders and indigenous communities throughout the region.

Continue to advocate with Mayors and Operational Leads of the satellite dispatch centers throughout the province.

Written Submission

2.1 The Critical Importance of Keeping Regional Emergency Services' EMS Dispatch within Wood Buffalo

- Chief Mel Grandjamb
  Fort McKay First Nation

FORT McKAY
FIRST NATION

September 10, 2020

Honourable Tyler Shandro
Minister of Health
423 Legislature Building
10800 - 97 Avenue
Edmonton, AB T5K 2B6

Sent via e-mail to: health.minister@gov.ab.ca

Re: Centralizing of EMS dispatch

Dear Minister Shandro:

I write to oppose Alberta Health Services (AHS) intention to consolidate the emergency medical service dispatch announced August 4, 2020 that would terminate the independent, integrated emergency response dispatch of the Regional Municipality of Wood Buffalo (RMWB) in favour of a centralized service out of Peace River and, possibly, Edmonton.

When this consolidation measure was first proposed in 2009 and again in 2013, the principle argument was that it would enhance patient care, specifically as concerned the treatment and movement of patients between municipal jurisdictions and health authorities. The argument suggested that, in some circumstances, it might be preferable to have an ambulance based in one jurisdiction respond to an emergency in another because it is physically closer—thereby enabling a rapid response—even if the patient is transported to a hospital in another jurisdiction. An example cited then was to ensure services between Edmonton and Strathcona County were complementary. However, there are no neighbouring jurisdictions with which the RMWB must coordinate its services. The next nearest hospital in Lac La Biche, separated by an entire county, is 290 kilometres away. This argument does not follow.

Of more immediate concern to my Council and our members is the numerous mutual aid agreements that the RMWB has with oil sands operators, who maintain on-site medical and emergency services personnel, across the region. It is a 30 to 40 minute trip by Highway 63 from Fort McMurray north to Fort McKay on a day in which traffic

and weather do not further impede movement. Accordingly, emergency medical service to my community is actually provided by Syncrude, the nearest operator, who can put an ambulance in my community in ten minutes. More rapid response and treatment within the medical "golden hour" has a significant impact on health outcomes. Discontinuation of the ambulance service provided through mutual aid agreements, which would not pass into AHS's consolidated dispatch service, means that AHS will have chosen to put the health and welfare of our members at risk for the potential saving of $660,000 a year. This is not an acceptable exchange.

A further reason the RMWB has resisted the AHS overture has to do with the unique nature of emergency services in Canada's most northerly urban centre with a population that exceeds 100,000 people, including workers in camp accommodations. Fort McMurray's remoteness relative to other urban centres can pose significant recruitment challenges across many disciplines and career paths, demonstrated by the fact the RMWB's 2018 census reveals a "shadow population" (non-permanent residents typically housed in work camps) of 36,000 people. RMWB's Regional Emergency Services is a fully integrated unit that combines emergency medical personnel and equipment with fire response personnel and equipment. This unique arrangement, in which some personnel are cross-employed and training in both disciplines is available to everyone, has proven a significant recruitment advantage. Consolidating emergency medical dispatch will functionally dis-integrate Regional Emergency Services and make it more difficult to recruit new personnel to address attrition. An unintended consequence of consolidated dispatch may well be to weaken emergency services in Wood Buffalo across the board, another unacceptable exchange.

The RMWB has highlighted this next point in its correspondence both with your office and AHS. Much of this very large region—at 66,000 square kilometres the RMWB is bigger than Nova Scotia—retains a fierce rural character and the transportation network is as often defined by landmark as it is by name or number. In other words, if a dispatcher based in Peace River or Edmonton is not familiar with the region, he or she may well be ineffective in helping a caller in distress to pinpoint the location to which an ambulance must be dispatched. These delays, too, as one or possibly two people who don't know the region try to determine where help is required will introduce further delays that negatively affect patient outcomes. Much of the emergency response in the region is related to traffic accidents on highways 63 and 881. Again, the shadow population of nearly 40,000 people travels to and from Fort McMurray on a regular basis. During the COVID pandemic when air travel is not recommended, an even larger proportion of that commuter workforce is traveling by road than it used to do.

FORT McKAY
FIRST NATION

In fact, Wood Buffalo is so large that in real emergencies it is not serviced by the STARS air ambulance, which flies only single engine aircraft. Rotary service in Wood Buffalo is provided by contract with the RMWB and federal regulations require that the emergency helicopter landing pad to be constructed at the Fort McMurray Regional Hospital be used only by two-engined rotary aircraft. This service is a successful component of the emergency dispatch system RMWB has operated for decades and would be compromised by AHS consolidation.

I wish to be abundantly clear: the RMWB has twice persuaded provincial officials that absorbing its dispatch system into the provincial system would negatively affect patient outcomes and twice the Province has reversed its decision. This third attempt is not a matter of three times is the charm; it should be a matter of three strikes, you're out. The arguments that might apply in more densely populated areas do not apply in Wood Buffalo and they do not apply to the Fort McKay First Nation. Insisting upon this change to save less than a million dollars in this region—where ambulance dispatch services are already quantifiably faster than the provincial average—is not an acceptable exchange.

My members' lives and the welfare of their families cannot be valued so cheaply by government or its agents. At minimum, we expect to be consulted on this matter. We will be watching carefully and exploring all options available to ensure that the delivery of emergency medical services to our community is not reduced to an accountancy exercise.

Sincerely,

Mel Grandjamb
Chief
FORT McKAY FIRST NATION

cc: Minister Rick Wilson, Indigenous Relations
Dr. Verna Yiu, President and CEO, Alberta Health Services
Mayor Don Scott, Regional Municipality of Wood Buffalo
Chris Johnson, CEO, Fort McKay First Nation
Jody Butz, Regional Fire Chief, Regional Municipality of Wood Buffalo

COUNCIL REPORT

Meeting Date: September 14, 2020

Regional Municipality of Wood Buffalo

Subject: Q2 2020 Financial Performance Report

APPROVALS:

Jamie Doyle

_____	_____
Director	Chief Administrative Officer

Recommended Motion:

THAT the Q2 2020 Financial Performance Update be accepted as information.

Summary:

The first quarter financial results are showing an annual projected surplus of $9.7 million which is the result of an increase in operating revenue of $12.4 million and an increase in operating expenses of $2.7 million.

Background:

The Quarterly Financial Report provides a more comprehensive quarterly financial update that includes municipal operating revenues and expenses with comparatives to budget and projections, capital project spending and information regarding investment, as well as information regarding grants that the Municipality has applied for and or received during the quarter.

Operating revenues to June 30, 2020 are $309.2 million. On an annual basis, the revenue projection is $593.6 million which reflects an increase of $12.4 million to the annual revenues. Higher investment income is the main reason for the projected increase in revenues.

Operating expenses to June 30, 2020 are $211.6 million. On an annual basis, the expense projection is $433.9 million which reflects a projection increase of $2.7 million. There has been decreases in some of the operating expenses such as lower fuel prices, less road materials due to a milder winter and no community events due to COVID - 19. These decreases are offset by a higher allowance being put in place for property tax accounts.

The approved 2020 Capital Budget is $154.1 million; by the second quarter, the capital budget was amended to $146.1 million, a decrease of $8.0 million. As of June 30, 2020, $38.0 million has been spent on the continued delivery of capital projects. Two projects Rural Water/Sewer Servicing and the Snow Disposal Site construction make up 42% of

this spend.

The cash position at the end of June is $1.15 billion. This amount is comprised of $305.3 million in the bank and $842.4 million in investments. Of this amount, $984.8 million is committed to budgeted services/programs, capital projects and funds for financial stability. The uncommitted balance equals $162.9 million.

As of June 30, 2020, there is no drawn debt owing and no committed undrawn debt.

The Municipality received approval for $35.8 million in capital grants and $3.3 million in operating grants in 2020. Included in this amount is $6.4 million in funding for the Federal Gas Tax fund and $25.8 million for the Municipal Sustainability Initiative (MSI). Continuous research into grant opportunities is ongoing.

The Municipality has spent $259.4 million in recoverable wildfire costs since May 2016. To date, the Province has advanced $216.3 million for reimbursable expenses; Red Cross has advanced $9.0 million and our insurance provider has paid $29.6 million.

The Municipality has spent $8.3 million in recoverable flooding costs during the quarter. To date, the Province has advanced $20.0 million for reimbursable expenses.

In addition, the municipality has spent approximately $1.2 million on COVID - 19 related expenses.

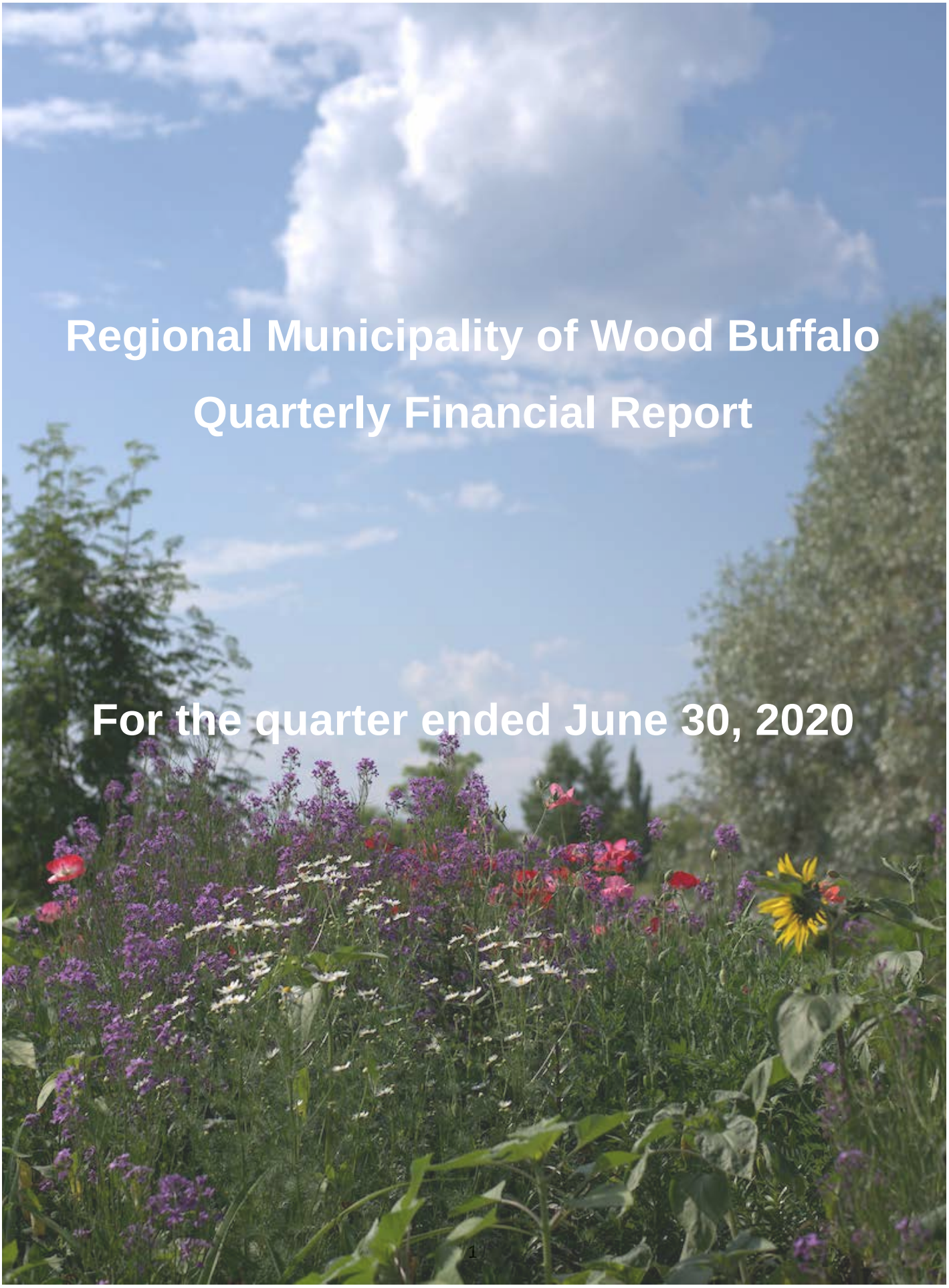
In summary, the Municipality continues to look for cost efficiencies while providing the services and programs to the residents.

Strategic Priorities:

Responsible Government

Attachments:

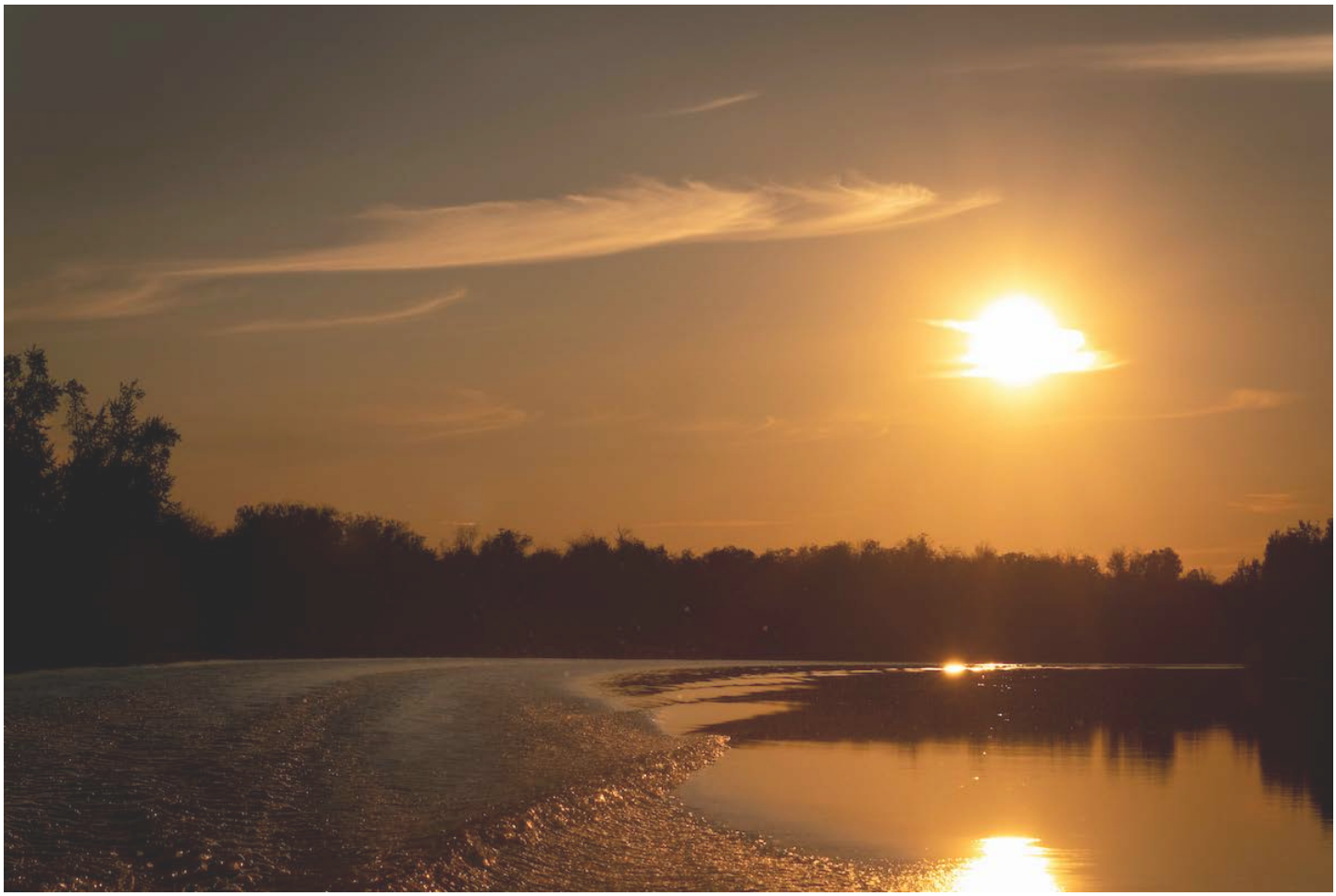
2020 Q2 Financial Performance Report



Regional Municipality of Wood Buffalo

Quarterly Financial Report

For the quarter ended June 30, 2020



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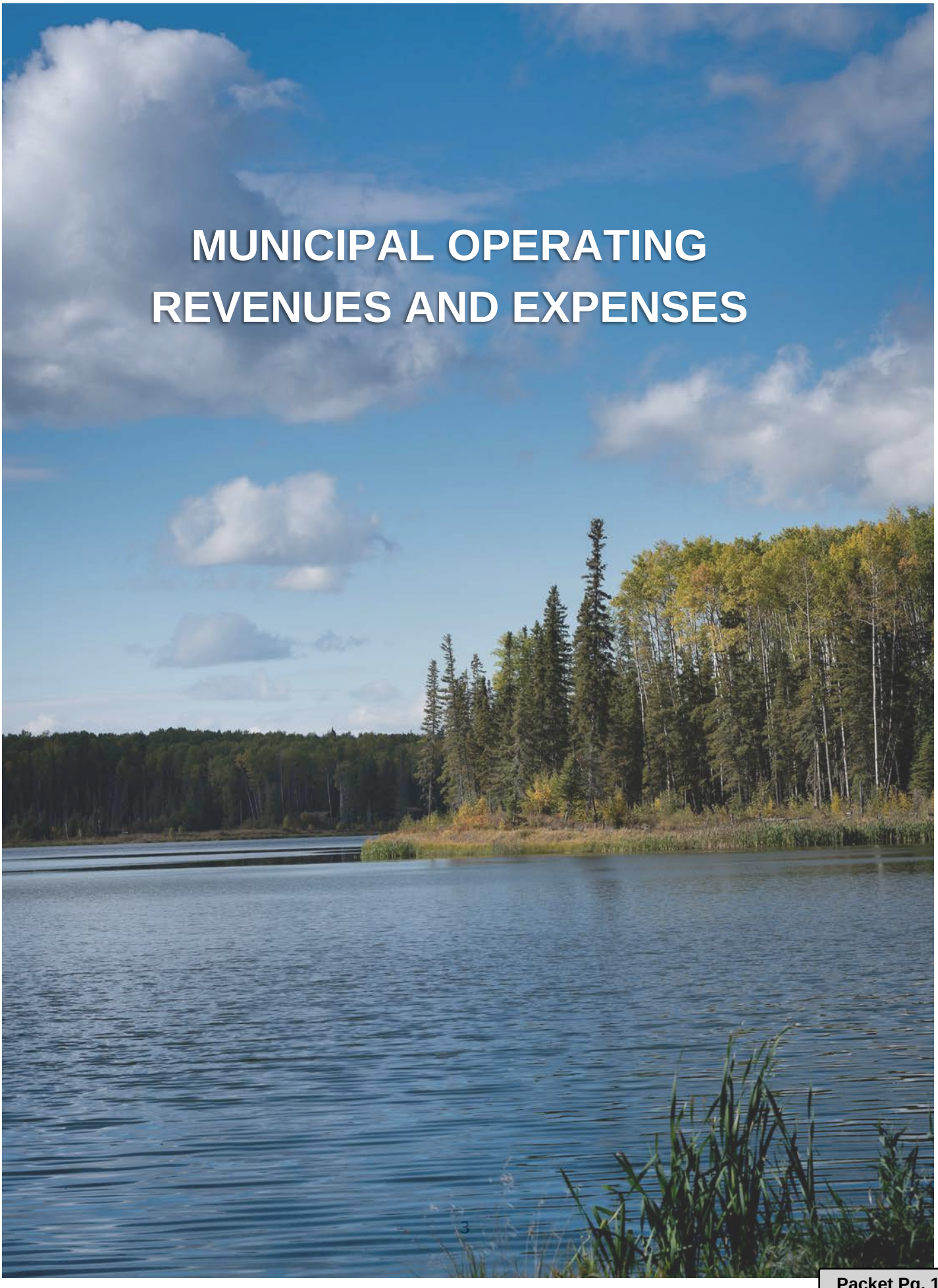


MUNICIPAL OPERATING REVENUES AND EXPENSES

Municipal Operating Revenues and Expenses

For the Period Ending June 30, 2020

	June Actual YTD	June Budget YTD	Budget YTD Variance Increase (Decrease)	Annual Budget	Annual Projections	Annual Budget Variance Increase (Decrease)
Revenues:						
Net taxes available for municipal purposes	$ 246,353,904	$ 246,477,900	$ (123,996)	$ 492,955,800	$ 493,104,539	$ 148,739
Government transfers	7,769,930	7,190,720	579,210	15,603,760	15,835,760	232,000
Sales and user charges	19,669,075	19,572,803	96,272	34,202,685	34,938,405	735,720
Sales to other governments	1,059,660	1,199,240	(139,580)	2,703,400	2,703,400	-
Penalties and costs on taxes	2,355,771	1,571,500	784,271	2,269,000	2,941,000	672,000
Licenses and permits	958,928	769,700	189,228	943,000	1,346,000	403,000
Fines	711,053	843,000	(131,947)	1,323,000	1,323,000	-
Franchise and concession contracts	4,468,927	4,415,000	53,927	8,175,000	8,175,000	-
Return on investments	24,797,245	10,473,200	14,324,045	21,510,000	31,510,000	10,000,000
Rentals	747,305	639,850	107,455	1,152,500	1,348,000	195,500
Other	345,724	205,000	140,724	382,200	417,600	35,400
	309,237,522	293,357,913	15,879,609	581,220,345	593,642,704	12,422,359
Expenses:						
Salaries, wages and benefits	113,214,489	112,866,799	347,690	222,195,412	222,195,412	-
Contracted and general services	23,197,453	34,157,199	(10,959,746)	69,746,860	68,326,332	(1,420,528)
Purchases from other governments	11,520,290	12,289,056	(768,766)	24,587,720	25,937,720	1,350,000
Materials, goods, supplies and utilities	15,741,774	18,735,703	(2,993,929)	35,621,254	34,076,774	(1,544,480)
Provision for allowances	4,400,564	290,000	4,110,564	1,226,000	4,826,000	3,600,000
Transfers to local boards and agencies	190,000	256,740	(66,740)	513,480	513,480	-
Transfers to individuals and organizations	43,224,391	59,061,414	(15,837,023)	77,097,599	77,842,599	745,000
Bank charges and short-term interest	92,641	108,230	(15,589)	215,120	187,320	(27,800)
Other	14,900	8,530	6,370	16,900	16,900	-
	211,596,502	237,773,671	(26,177,169)	431,220,345	433,922,537	2,702,192
Reserves:						
Transfers to reserves/operations	75,377,147	75,332,693	44,454	150,000,000	150,000,000	-
	75,377,147	75,332,693	44,454	150,000,000	150,000,000	-
Operating surplus (deficit)	$ 22,263,873	$ (19,748,451)	$ 42,012,324	$ -	$ 9,720,167	$ 9,720,167

Municipal Operating Revenues and Expenses (continued)

As of June 30, 2020, the Municipality is projecting an annual surplus of $9.7 million. The annual projected surplus consists of an operating revenue increase of $12.4 million and an operating expense decrease of $2.7 million.

Operating Revenues

Year to date operating revenues to June 30, 2020 are $309.2 million. The annual revenue projection is $593.6 million which reflects a projected increase of $12.4 million. This projection increase is shown primarily in:

- Sales and User Charges increased by $0.7 million mainly due to lifting of the Boil Water Advisory earlier than expected.
- Penalties and costs on taxes increased by $0.7 million based on penalties charged in the first quarter based on outstanding prior year property tax accounts.
- Return on Investments increased by $10.0 million due to increased yields and continued investment strategic administration.

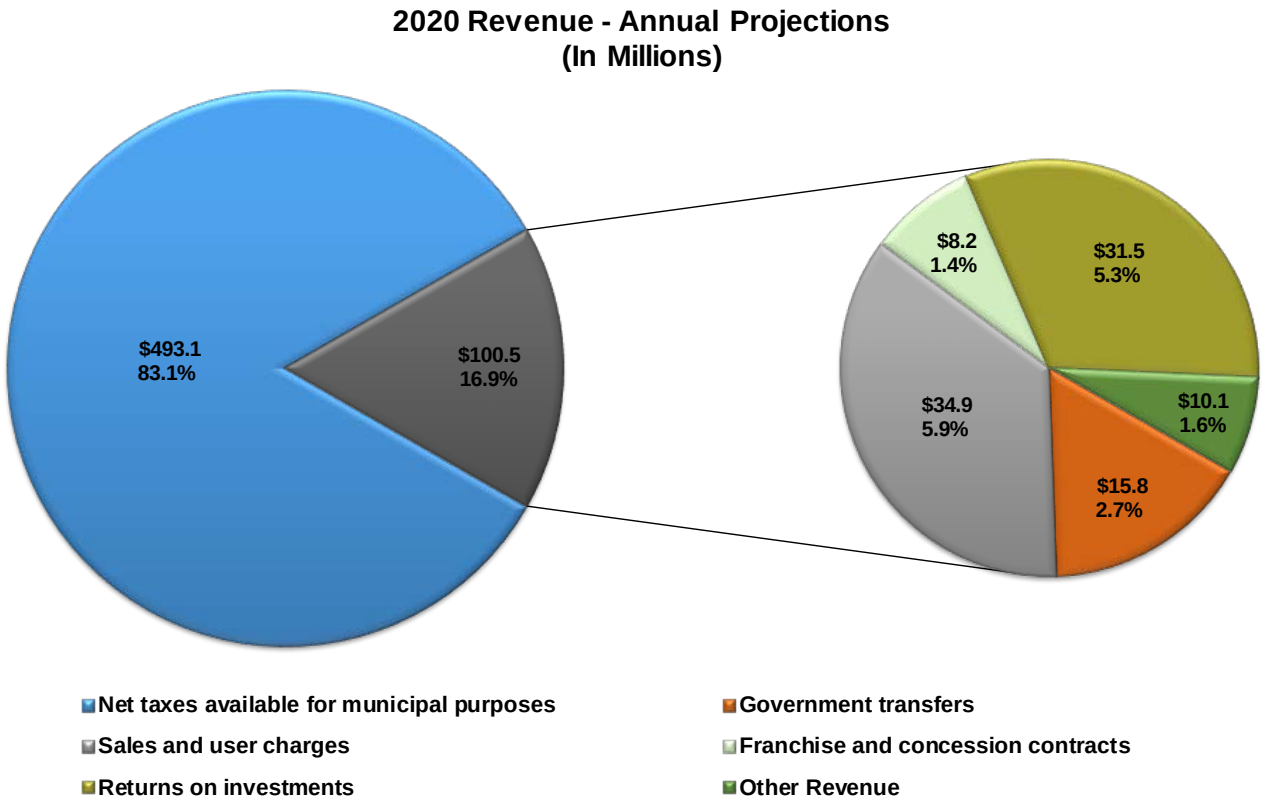
Operating Expenses

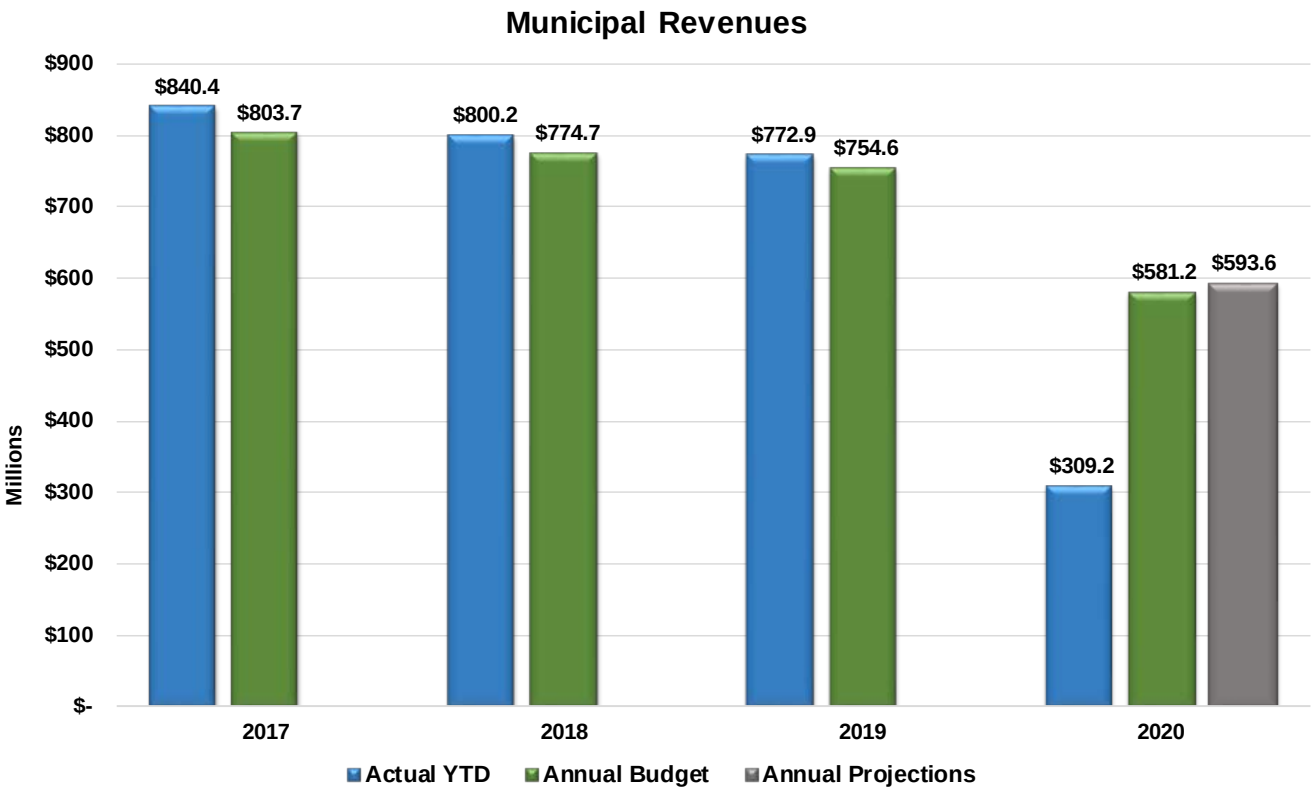
Year to date operating expenses to June 30, 2020 are $211.6 million. On an annual basis the expense projection is $433.9 million which reflects a projection increase of $2.7 million. This projection increase is shown primarily in:

- Contracted and General Services decreased by $1.4 million mainly as a result of operational work being delayed due to external factors.
- Purchases From Other Governments increased by $1.4 million to cover the additional costs of Rural Policing.
- Materials, Goods, Supplies and Utilities decreased by $1.5 million; this decrease includes $0.6 million from lower fuel prices, $0.2 million decrease as a result of a milder winter (road materials) and $0.4 million decrease from expected changes to community events (due to COVID-19).
- Provision for Allowances increased by $3.6 million, as a result of an lower budget for prior year property tax accounts.

Municipal Operating Revenues and Expenses (continued)

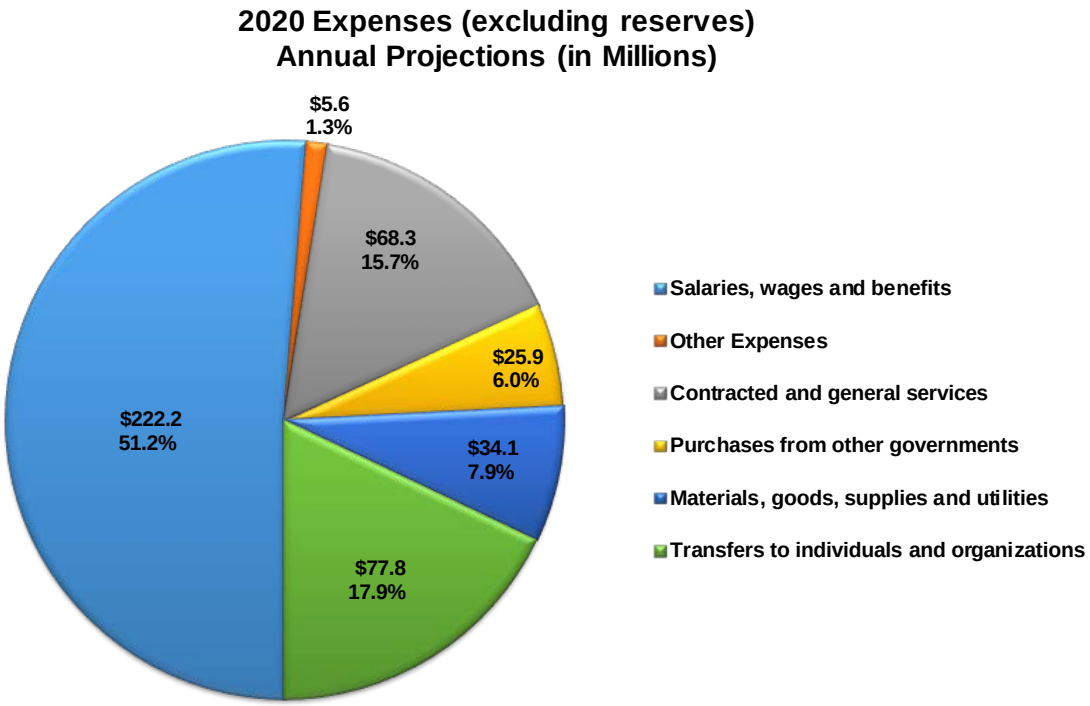
Operating Revenues

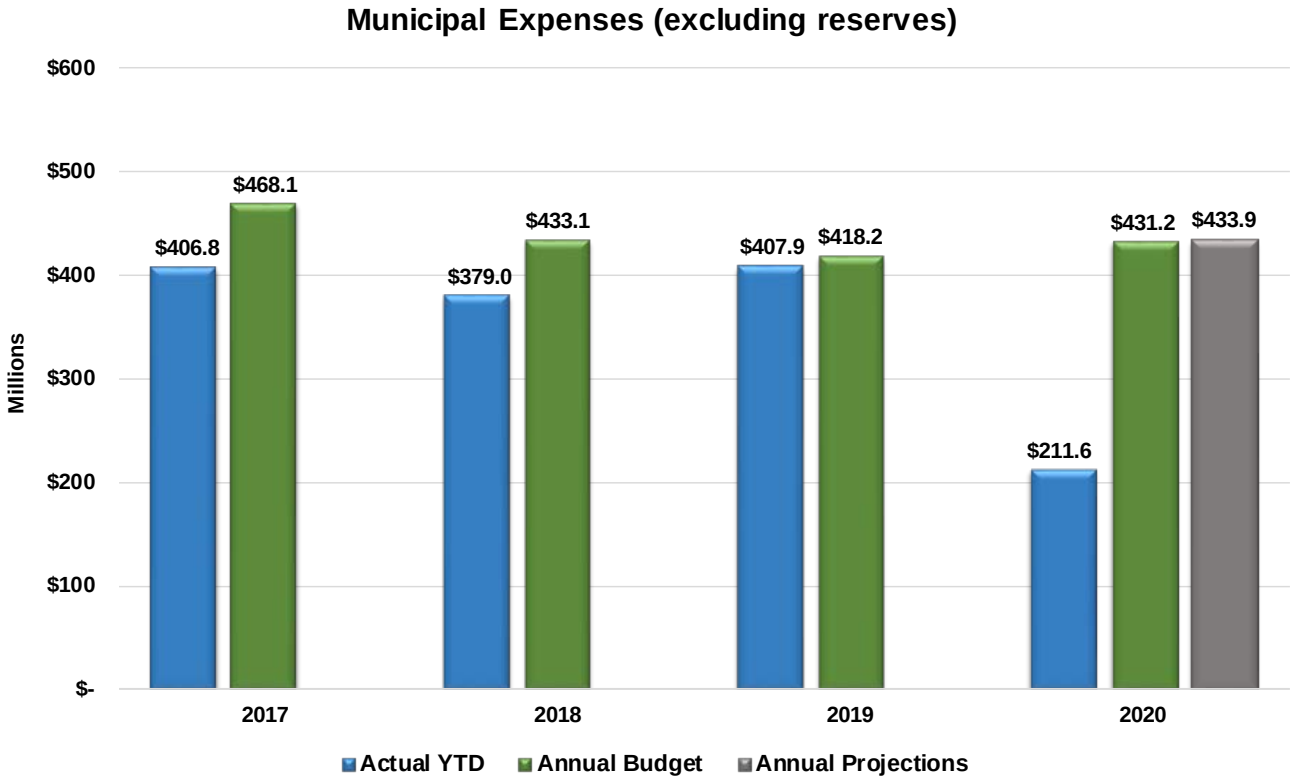




Municipal Operating Revenues and Expenses (continued)

Operating Expenses





FINANCIAL POSITION

Capital

Capital Project Spending

For the Period Ending June 30, 2020

Project Name		2020 Actual YTD $
Top 20		
Rural Water/Sewer Servicing Construction		11,774,818
2019 Snow Disposal Site - Construction		4,079,010
Urban Infrastructure Rehab Construction 2019		2,000,397
Fort McMurray WTP PACL Tank Design/Build		1,743,832
Transit Facility (Green Trip) - Construction		1,126,580
Saline Creek Parkway Phase 2 Design (F)		1,110,884
Fort McMurray WWTP Process Improvement - Construction		884,087
Fort Chipewyan WTP Expansion Construction		827,615
Urban Infrastructure Rehab Street Improvement 2019		749,816
Fort McKay Pavilion		715,248
Rural Infrastructure Rehab 2015-2017 - Construction		706,042
IT Infrastructure Upgrades 2019		528,572
Urban Infrastructure Rehab Design 2019-2022		504,659
911 Emergency Communication Centre Relocation		502,431
Ambulance Replacement (2)		459,369
Clearwater Drive (Prairie Loop Blvd)		353,888
2019 Refuse Truck - Solid Waste 1		350,000
Urban Infrastructure Rehab 2018 - Construction		337,334
Conklin Multiplex - Pre Design & Design		309,864
Fort McMurray Animal Control Centre		303,814
All Other Project Costs	$	8,612,533
Total Capital Spending	**$**	**37,980,791**

**Spending equals total Settlement for the month driven by Service Entry Sheet entries on capital internal*

WTP = Water Treatment Plant
PACL = Poly Aluminum Chloride
TRIP = Transit Incentives Program
WWTP = Waste Water Treatment Plant

The Municipality approved the 2020 capital budget of $154.1 million which includes $0.7 million for Public Art. As of June 30, 2020, the capital budget has been revised to $146.1 million stemming from 2020 capital amendment net decreases of $8.0 million. As of June 30, 2020, $38.0 million has been spent on the delivery of capital projects. The Rural Water/Sewer Servicing and Snow Disposal Site projects combined are 42% of the total spend.

Bank and Investments

Bank
As of June 30, 2020
(in millions)

Cash		
Operating - Bank Balance	$	305.3
Investments		842.4
Total Cash		**1,147.7**
Committed Funds		
Operating Requirements		168.6
Deferred Revenue		
Grants		49.7
Developer Agreements		3.3
Offsite Levies		2.7
		55.7
Reserves		
Committed Funds		
Capital		585.8
Emerging Issues		123.8
Operating		50.9
		760.5
Total Committed Funds		984.8
Remaining	**$**	**162.9**

The current amount of cash in the bank plus investments total $1.1 billion as of June 30, 2020. The commitments against this balance include $168.6 million for operating requirements, $55.7 million in deferred revenues, which is money the Municipality has received in advance but is committed to spend in the future and $760.5 million in committed reserve funds.

Bank and Investments (continued)

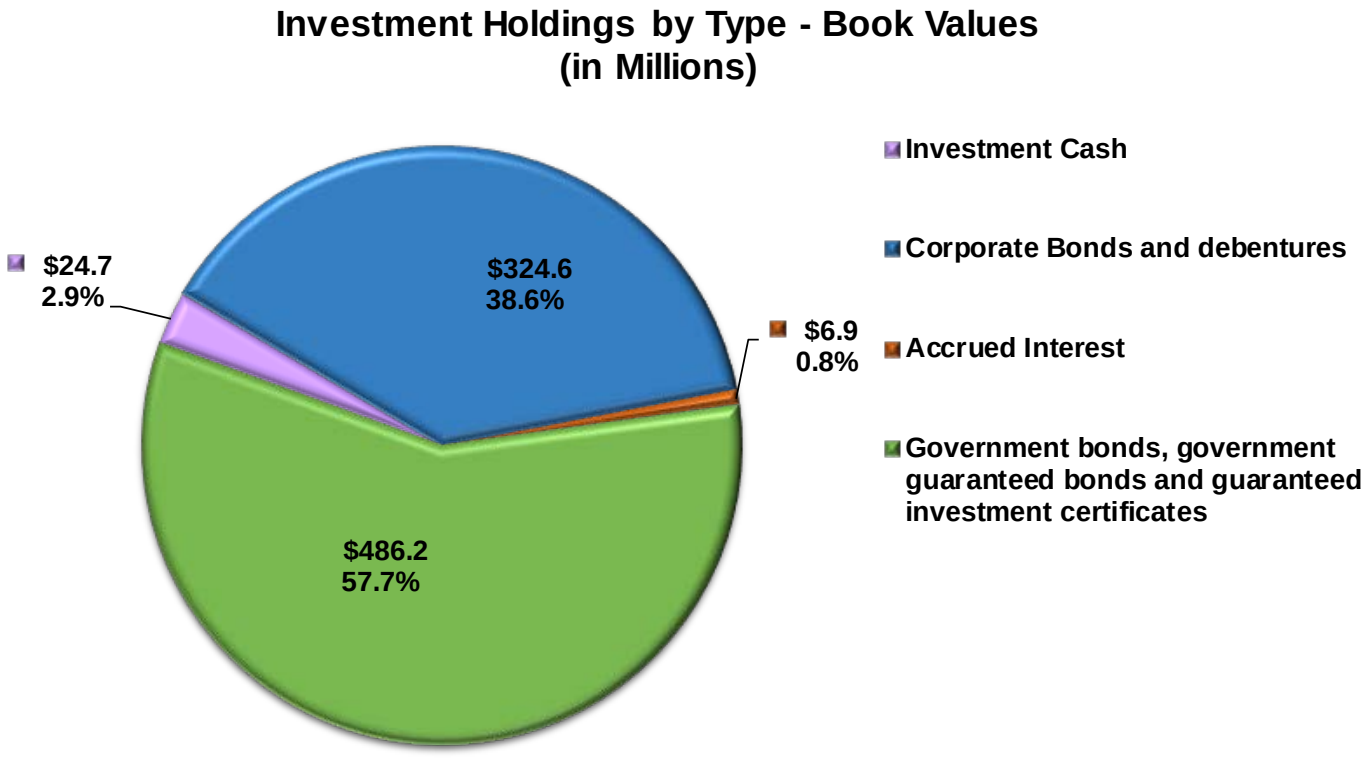
Investments

The Municipality has $842.4 million in investment holdings as of June 30, 2020, of which $140.1 million are short-term investments with maturity dates under one year. Returns on investments to June 30, 2020 total $24.8 million with $22.6 million from investment income and $2.2 million from interest income.

Investment Holdings

(In Millions)

Type:	Cost Value @ December 31, 2019	Cost Value @ June 30, 2020	Market Value @ June 30, 2020
Corporate bonds and debentures	$ 294.1	$ 324.6	$ 330.0
Government bonds, government guaranteed bonds and guaranteed investment certificates	516.7	486.2	505.1
Investment cash	2.4	24.7	24.7
Accrued interest	4.6	6.9	6.9
Total	**$ 817.8**	**$ 842.4**	**$ 866.7**



Grants

To date the Municipality has received approval for $35.8 million in capital grants and $3.3 million in operating grants.

There are five capital grant applications totaling $85.7 million that have been submitted for consideration with the government. The capital grant applications include:

- Alberta Municipal Water/Wastewater Program (AMWWP) for $49.9 million,
- Airports Capital Assistance Program (ACAP) for $14.5 million for the Pavement Overlay project,
- GreenTRIP Grant – Round 2 for $3.4 million,
- Investing in Canada Infrastructure Program – Public Transit for $17.9 million and
- Recreation Energy Conservation Program - $26K for an energy conservation implementation project

Research into grant opportunities is an on-going process.

Grants (continued)

Summary of Capital and Operating Grants Awarded
As At June 30, 2020

Past & Current Capital Grants	2020	2019	2016-2018	Information
Provincial and Federal Allocations				
Federal Gas Tax Fund (FGTF)	$ 6,388,689	$ 6,499,011	$ 19,837,563	2020 amount is preliminary allocation
Federal Gas Tax Fund (FGTF) - one-time top-up 2019		6,121,681	-	In 2019, there was a one-time payment from Canada to Alberta, in addition to the 2019 funding transfer. The top-up is intended to be directed towards municipal infrastructure needs.
Municipal Sustainability Initiative (MSI)	25,832,442	16,910,000	79,749,741	2020 amount is preliminary allocation
MSI Additional			23,571,422	
Engineering				
Alberta Community Resilience Program (ACRP)		6,590,000	-	2019 - Funding awarded for Flood Mitigation Projects - Reaches 7,8,9 (Lower Townsite)
Alberta Municipal Water/Wastewater Partnership (AMWWP) - Conklin WTP Phase 1 Expansion			4,286,347	Original approval in 2004 was for a $922,500 contribution under the AMWWP program. A cost revision funding request was submitted in 2016 which resulted in additional AMWWP contribution of $4,286,347 under AMWWP. Total grant $5,208,847.25.
Alberta Municipal Water/Wastewater Partnership (AMWWP) - Conklin WTP Phase 2 Upgrades - Construction			764,354	Application submitted Nov 2015. Revised November 2016. Approved for $764,354 representing 27% of eligible costs.
Alberta Municipal Water/Wastewater Partnership (AMWWP) - Fort Chipewyan WTP Expansion			19,756,092	Application submitted Nov 2015. Revised January 21, 2016. Approved for $19,756,092 representing 69.64% of eligible costs.
Canada 150 Program - Administered by Western Economic Diversification Canada			200,000	2017 - Anzac Community Centre Upgrades
Community Facility Enhancement Program (CFEP)			123,500	The Ptarmigan Nordic Ski Club with the support of the Regional Municipality of Wood Buffalo has secured a grant to offset 50% of the cost of the Furniture, Fixtures and Equipment required for the Doug Barnes Cabin Expansion - Construction project.
First Nations Water Tie-In Program	4,474	44,742	-	Funding was approved to conduct a Regional Water Transmission Line Extension Feasibility study. The study will look at a regional system from the Hamlet of Fort Chipewyan that will provide service to the Mikisew Cree First Nations in the Allison Bay area. An additional 10% was approved in 2020.
Strategic Transportation Infrastructure Program (STIP)			574,035	Fort Chipewyan Winter Road Culvert Replacement ($765,380 total cost) 75% approved
Investing in Canada Infrastructure Program (ICIP)	3,451,996			Green Infrastructure funding for the Lower Townsite Flood Mitigation Project Reaches 7 and 8.
Public Works				
Airport Capital Assistance Program (ACAP) Funding			1,588,208	Airfield Lighting Rehabilitation Project at Fort Chipewyan Airport
GreenTRIP Round 3			6,459,000	Bus Bay Turn-out project
GreenTRIP Round 3			842,560	Airporter/Paratransit
GreenTRIP Round 3			1,276,667	Shelter Additions.
GreenTRIP Round 3			21,570,614	Intelligent Transportation System.
Public Transit Infrastructure Program (PTIF)			3,451,000	Bus Bay Turn-out project
Fort McMurray Fire Relief Fund Rotary District 5370 Charitable Foundation			75,000	Fort McMurray Port of Entry Rebuild Project
Lions Club International Foundation		147,000	-	A donation/grant in the amount of $147,000 has been approved for upgrades to the Lion's Park.
Adventurer Foundation and Fraserway RV			310,000	A donation towards the cost of construction of the Christina Gordon Playground was provided by the Adventurer Foundation, a donor advised fund at The Foundation Office.ca, is the official giving foundation of Fraserway RV LP and the Adventurer Group of Companies.
Regional Emergency Services				
9-1-1 Grant	123,352	496,125	70,628	The grant runs from July 1st to June 30th annually. 9-1-1 Grants are calculated quarterly based on 9-1-1 revenue and population served by the Public Safety Answering Point (PSAP).
Total Capital Grants	**$ 35,800,953**	**$ 36,808,559**	**$ 184,506,731**	

Grants (continued)

Operating Grants	2020	2019	2016-2018	Information
Community Services				
Coalitions Creating Equity Program (CCE)		$ 10,000	$ 123,000	2018 - Community Services has developed an application for funding to the Alberta Human Rights and Multiculturalism Grant Program for the Wood Buffalo Equity Coalition Program which will be delivered by the Regional Advisory Committee on Inclusion, Diversity and Equality (RACIDE). 2019 - Community-based Response Model to Acts of Discrimination, Racism and Hate Project Funded
Community Inclusion Grant			30,000	Alberta Justice and Solicitor General - Human Rights, Education and Multicultural Fund 2016 - Diversity Plan 2016 and Beyond 2018 - Diversity and Inclusion Business Recognition Program 2018 - Diversity & Inclusion Employee Census 2019
Conoco Phillips			5,000	$5,000 for Green Teen Program in 2016.
Covid-19 Community Response Fund for Vulnerable Population Fund	40,000			Provided by the Canadian Medical Association Foundation.
Family & Community Support Services	1,924,513	1,924,513	5,773,539	Provincial level program through Alberta Human Services. Payment is based on population.
Family and Community Safety Program (Children and Youth Service Grant)			150,000	Funded by Minister of Human Services to provide advocacy services in the community.
Labour Market Partnerships (LMP) Grant - Inclusive Business Project			51,000	Funding is being provided through the Labour Market Partnerships (LMP) Grant by the Alberta Department of Labour. The project will address the evidenced need for increased workplace education and awareness about inclusion and diversity, develop inclusive workplace evaluation, consultation policies and feedback practices. The overall cost of the project, including in-kind contributions, will be $84,500.
Municipal Cannabis Transition Program (MCTP)		88,472	134,292	The MCTP is a program that will support eligible Alberta municipalities with increased enforcement and other implementation costs related to the legalization of cannabis.
Municipal Policing Assistance Grant (MPAG)		1,209,840	3,712,384	Current funding agreement is for two (2) years from April 1, 2018 and ending March 31, 2020. Payment is based on per capita calculation.
Point in Time Count			50,000	Community Services was successful securing funding from Employment and Social Development Canada (ESDC) for the "Everyone Counts: the 2018 Coordinated Point-in-Time Count.
Police Officer Grant (POG)		300,000	900,000	Current agreement is for two (2) years from April 1, 2018 and ending March 31, 2020.
Reaching Home: Canada's Homelessness Strategy Indigenous Homelessness (Federal)	401,134	401,134		2019/2020 - $401,134 2020/2021 - $401,134
Reaching Home: Canada's Homelessness Strategy Designated Communities (Federal)		1,688,760		2019/2020 - $321,219 2020/2021 - $321,219 2021/2022 - $348,774 2022/2023 - $348,774 2023/2024 - $348,774
Reaching Home: Canada's Homelessness Strategy Designated Communities (Federal) Community Capacity and Innovation Fund		306,900		2019/2020 - $71,180 2020/2021 - $61,180 2021/2022 - $61,180 2022/2023 - $56,580 2023/2024 - $56,580
Reaching Home: Canada's Homelessness Strategy Indigenous Homelessness (Federal) Covid-19 Supplement	413,708			2020/2021 - $413,708 Covid-19 Supplement
Reaching Home: Canada's Homelessness Strategy Designated Communities (Federal) Covid-19 Supplement	331,289			2020/2021 - $331,289 Covid-19 Supplement
Victims and Survivors of Crime Week 2019	7,500	6,000		RCMP and Bylaw Support Services received grants towards their Victims and Survivors of Crime Week project in 2019 and 2020.
Victims of Crime Fund - Grant to Victims Services		69,360	942,602	Grant to provide services that benefit victims or a class or classes of victims during their involvement with the criminal justice process. 2017 - 3 year grant for Victims Services for 2018-2020. 2019 - Additional Funding to 2018-2020 agreement (2019 - $35,788, 2020 - 33,572)
Victims of Crime Fund - Indigenous Victims Outreach Specialist (IVOS)		300,000		2019 - 3 Year grant for Indigenous Victims Outreach Specialist for 2019-2021

Grants (continued)

Operating Grants (continued)	2020	2019	2016-2018	Information
Communications, Stakeholder, Indigenous and Rural Relations				
Alberta Indigenous Relations		$ -	$ 50,000	Grant to assist with the Urban Aboriginal Connection Initiative project - Wood Buffalo Pan Aboriginal Connection project.
Local Food Week Grant		2,442		Recreation and Culture applied for a Local Food Week grant to assist with costs of a special event to highlight local food week 2019 at the August 14th, 2019 Urban Market.
Human Resources				
Canada Summer Jobs			92,938	2017 - 17 students 2016 - 29 Students.
Careers - The Next Generation			4,500	A grant to offset the costs of summer students employed at the Water Treatment Plant. $15 per hour x 100 hours x 3 students.
Green Job Initiative - Summer Work Experience		11,424	11,424	2019 - 2 students 2018 - 2 students
Summer Temporary Employment Program (STEP) Program			56,100	2017 - 10 Students - $4,200 per student - $42,000 total. 2016 - 5 Labourer Positions.
Public Works				
Alberta Recycling Municipal Demonstration Grant			30,000	Grant awarded for $30,000 towards a pour-in-place recycled tire project at the Syncrude Athletic Park.
Alberta Recycling Municipal Electronics and Paint Round-up Grant		13,000	72,952	Alberta Recycling Grant to offset cost to advertise and run the round-up activities. 2019 - Awarded grant of up to $13,000 (actual payment will be based on expenses incurred) towards the June 1, 2019 round-up event
Alberta Recycling Tire Marshalling Area (TMA)			90,000	Awarded funding of $30,000 each for Tire Marshalling Areas in Conklin, Janvier and Fort Chipewyan.
Celebrate Canada Grant	32,000	10,548	27,000	Canadian Heritage provides financial support for Canada Day activities.
FCM's Municipal Asset Management Program (MAMP)			50,000	Funding has been awarded from the FCM's Municipal Asset Management Program (MAMP) to offset the cost of conducting condition assessments of (50) municipal building facilities.
Forest Resource Improvement Association of Alberta (FRIAA) FireSmart Program			750,000	The FRIAA FireSmart Program is separate and independent from the Government of Alberta's FireSmart Community Grant Program. Maximum amount of funding for a single project will be $400,000 over the life of the project. The RMWW applied for funding for the following Hazard Reduction activities. $400,000 Birchwood/Conn Creek, $400,000 Anzac, $125,000 Mitigation strategy, $40,000 public education. Applications totaled $965,000. Actual funding awarded $750,000.
Recreation Energy Conservation (REC) Program		10,000	-	The Recreation Energy Conservation (REC) program will be providing funding towards Scoping Audits of two municipal recreation facilities. Future applications will be considered for Engineering Studies or Implementation Projects. REC helps municipally-owned recreation facilities reduce energy use and GHG emissions by providing financial incentives to help identify energy-saving opportunities and implement energy-saving projects. A single municipality is capped at $750,000 over the program lifespan.
TD Friends of the Environment			22,019	Eligible projects include Community Gardens, Environmental Education Projects, Outdoor Classrooms, Protection of Endangered Species/Wildlife, Recycling/Composting Programs, Tree Planting and Urban Naturalization Projects, Energy Conservation/Renewable Energy, Research Projects, Habitat restoration. 2017 - Pacific Park Community Garden (Timberlea), 2016 - 20 trees for Dr. Clark School.

Grants (continued)

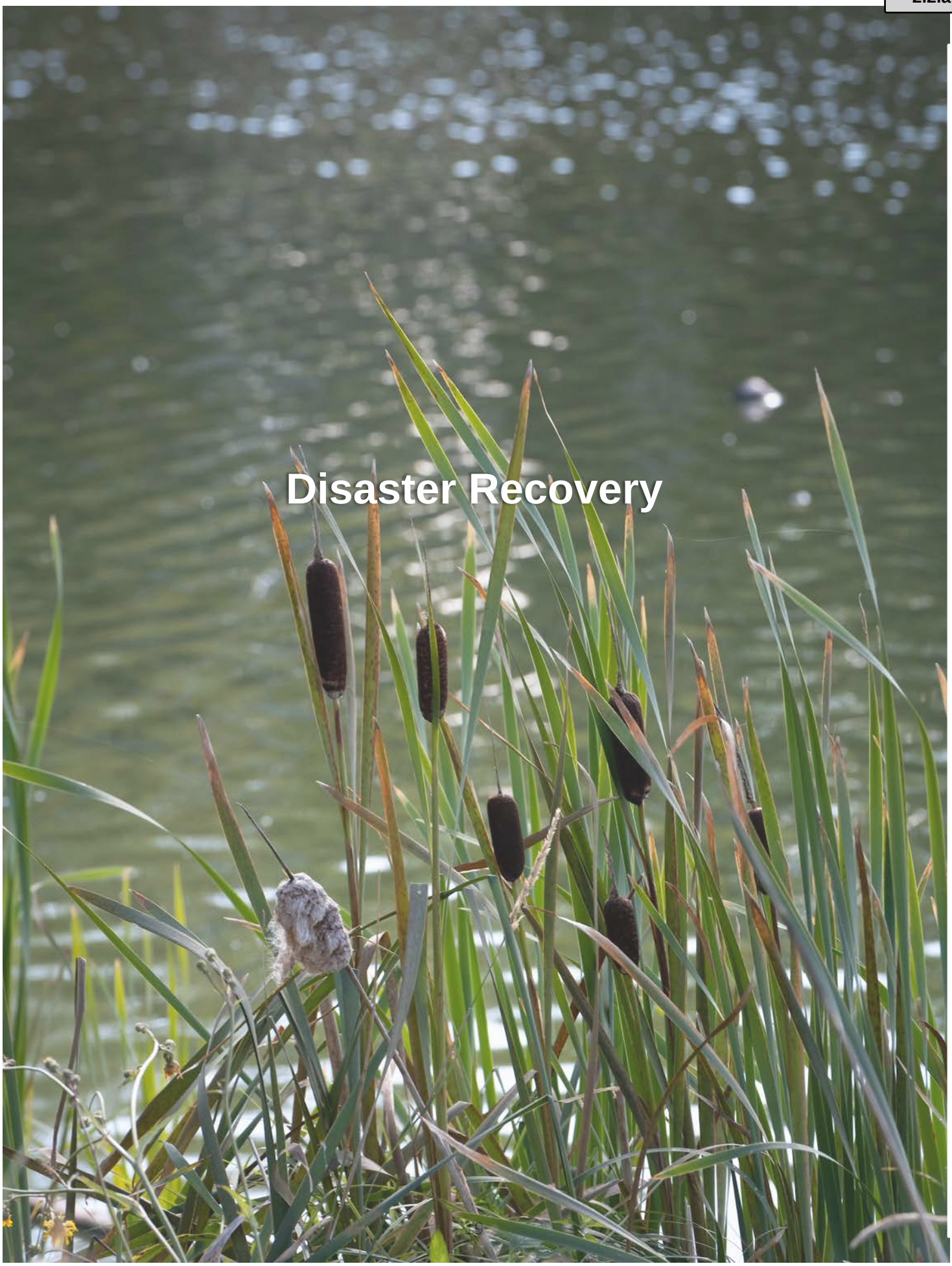
Operating Grants (continued)	2020	2019	2016-2018	Information
Public Works (continued)				
TD Tree Days		$ -	$ 10,200	2017 - Planting of approximately 150 potted trees and shrubs at Vista Ridge on September 24, 2017. 2018 - Planting of approximately 300 trees and shrubs at Beaconhill Lookout in September 16, 2018.
Tree Canada	$ 7,000			2020 - Awarded $3,500 under Tree Canada's Edible Tree program and $3,500 awarded under Greening Canada School Grounds Program
Regional Emergency Services				
911 Grant	$ 123,970		1,422,916	The objective of the 911 Grant Program is to strengthen and support local delivery of 911. This is being done using funding generated from a monthly 911 levy on cellphones, and by developing provincial standards for 911. All of this is being done in close collaboration with Alberta's 911 centres. A portion of the 2016 grant was transferred from Capital.
Enbridge Safe Community Grant		7,500		The funds will be used to purchase an extrication tool for the Janvier Fire Department.
Emergency Management Preparedness Program (EMPP)			11,525	The objective of the Emergency Management Preparedness Program (EMPP) is to provide an effective and cost-efficient grant program for increased emergency management capacity that resulted in an increased number of trained emergency management practitioners. 2016/2017 grant - $11,525.
Fire Services Training Program (FSTP) (Formerly Fire Services and Emergency Preparedness Program)			5,800	This program supports the expansion and enhancement of regional fire service training. The objective is to provide an effective and cost-efficient mechanism for increased training capacity that results in a greater number of trained fire service personnel.
RMWB FireSmart Grant Budget includes approximately $2.5 M for capital projects			10,500,000	The Minister of Agriculture and Forestry has recently committed $10.5M to the FireSmart program in the RMWB over the next 3 years. This funding will be provided in the form of an Agriculture and Forestry Development Grants and the Regional FireSmart Committee will have oversight over its spending. An application has been completed with input from the RMWB, the Regional FireSmart Committee and Agriculture and Forestry. Funding was approved August 2017.
Wood Buffalo Recovery Committee				
Canadian Red Cross - Recovery Gift (Includes $3.8 M for FireSmart activities)			10,000,000	The Canadian Red Cross Society will provide these funds to further the Alberta Wildfire relief and recovery. Included in the $10M is $3.8 M for FireSmart activities.
Wildfire Community Preparedness Day		3,000	2,200	Wildfire Community Preparedness Day is held annually in May. FireSmart Canada offers up to $500 funding awards to implement neighborhood projects. 2019 - The RMWB received 6 awards of $500 each for events held in Gregoire Lake, Saprae, Ft. Chipewyan, Conklin, Anzac and Janvier 2018 - The RMWB received 4 awards of $500 each plus $200 towards the cost of refreshments for events held in Gregoire Lake, Saprae, Ft. Chipewyan and Conklin.
Wood Buffalo Economic Development Corp				
Canadian Red Cross -Disaster Response Services Agreement Small Business Program (Phase 3B)			992,472	For Support to Small Business Program (Phase 3B) programming for small businesses impacted by the May 2016 Horse River Wildfire disaster in the Regional Municipality of Wood Buffalo
Community and Regional Economic Support (CARES) Program			845,000	2016 - To support the Back to Business Resource Centre and Business Recovery Expositions. 2018 - To support the development of a five-year Economic Development Strategic Plan
Invest Canada - Community Initiatives (ICCI)			5,500	An application submitted by the Economic Development Department for funding for Foreign Direct Investment Tools and Material Development has received approval for $5,500.
Total Operating Grants	**$ 3,281,114**	**$ 6,362,893**	**$ 36,924,363**	

Grants (continued)

Capital Grant Applications in Progress	Amount	Information
Engineering		
Alberta Municipal Water/Wastewater Program (AMWWP)	$ 49,923,797	The application for funding of the Rural Water and Sewer Servicing (RWSS) Project was originally submitted in 2015 and was updated for the 2018/2019 AMWWP program. Estimated eligible costs are $55.3M. If successful, the program could fund up to 75% of these costs. Also, additional grant funds of $11,031,017 have been requested for the Fort Chipewyan Water Treatment Expansion Project. This project was awarded a grant in 2016 of approximately $19.7M based on estimates. The projects actual costs are higher than originally estimated so additional grant funding has been requested. In 2018, an application was submitted for the Fort Chipewyan Lift Station #1. Estimated eligible cost is $6.9M. If successful, the grant may fund approximately 69% of the eligible costs.
Public Works		
Airports Capital Assistance Program (ACAP) Fort Chipewyan Pavement Overlay Project	14,460,100	An updated application was submitted to Transport Canada for 100% funding of the Fort Chipewyan Pavement Overlay Project. The RMWB is in the process of updating this application for 2020.
GreenTRIP Grant - Round 2	3,401,870	Application submitted in GreenTRIP Grant Round 2 for 66 2/3 % of project costs. Funding requested - Transit Terminal - $3,401,870. Consideration of application is on hold until location of transit terminal has been determined.
Investing in Canada Infrastructure Program - Public Transit	17,905,869	Under the Investing in Canada Infrastructure Program (ICIP), the Regional Municipality of Wood Buffalo has been advised of an allocation of $17.9M over the next 10 years. On May 3rd, an application was submitted to utilize $185,440 of the $17.9M allocation for the Transit Operator Security Door Installation Project (40% of total project costs $463,600). Applications will need to be submitted for approval to utilize this allocation.
Recreation Energy Conservation Program	26,152	The RMWB has submitted an application for up to $75% of project costs for an energy conservation implementation project.
Total Capital Grant in Progress	**$ 85,717,788**	

Grants (continued)

Operating Grant Applications in Progress	Amount	Information
Community Services		
Measuring Municipal Inclusion Grant (MMIG)	$ 10,000	The Alberta Urban Municipalities Association (AUMA) is currently offering funding to support Alberta municipalities to use AUMA's Measuring Inclusion Tool for Municipal Governments to evaluate the inclusiveness of their organization and to advance strategies that will propel the municipal government to be a more inclusive employer, service provider, and community leader. This application of $10,000 is for phase 1 of the project. An additional $40,000 may be available for subsequent phases depending on the outcome from Phase 1.
Financial Services		
Connect to Innovate	3,041,055	The Connect to Innovate program will invest up to $500 million by 2021, to bring high-speed Internet to rural and remote communities in Canada. This program will support new "backbone" infrastructure to connect institutions like schools and hospitals with a portion of funding for upgrades and "last-mile" infrastructure to households and businesses. Application was submitted by IT April 2017. Estimated project costs $6,486,432. Funding requested $3,041,055.
Regional Emergency Services		
AgriSpirit Fund	25,000	Regional Emergency Services submitted two applications for funding: ▪$12,000 request - Janvier Dire Department Protection Sprinkler Kits ▪ $13,000 request - Fort McKay Fire Department Extrication Tool
Public Works		
Municipal Asset Management Program (MAMP) Grant	50,000	Round 2 of the MAMP program has been announced and an application is being developed requesting $50,000 from the program. Additional details will follow.
Total Operating Grant in Progress	**$ 3,126,055**	



Disaster Recovery

2016 Wildfire

The Municipality has spent $259.4 million in recoverable wildfire costs since May 2016 out of which $15.4 million was incurred in the normal operations of the municipality. To date the Province has advanced $209.3 million for reimbursable expenses under the Disaster Recovery Program, Red Cross has advanced $9.0 million, FireSmart has advanced $7.0 million and our insurance provider has paid $29.6 million and closed the file as all claims are complete.

Administration is continuing to work with the Province to quantify claims. The Disaster Recovery Program (DRP) project summary estimate is $250.3 million. As of June 30, 2020, $216.9 million has been submitted to DRP or is a submission in progress.

The Red Cross has entered into an agreement with the Municipality to cover $10.0 million of certain wildfire related costs and has advanced $9.0 million, of which $3.5 million has been spent on operating expenses, $2.2 million has been received for permits not charged to residents and $1.5 million has been spent on capital expenses towards this initiative.

The Municipality has an agreement with Government of Alberta Agriculture and Forestry to cover $8.5 million of certain FireSmart wildfire related costs and has advanced $7.0 million, of which $4.6 million has been spent on operating expenses and $1.1 million has been spent on capital expenses for this agreement.

2016 Wildfire Recoverable Costs
May 1, 2016 to June 30, 2020

	DRP	FireSmart	Insurance	Red Cross	Total
Approved Submissions	175,508,067	3,049,360	21,469,614	5,715,044	205,742,085
Submitted - Not Yet Approved	8,035,778	-	-	-	8,035,778
In Preparations	33,310,777	1,550,352	-	52,693	34,913,822
Total 2016 Wildfire Operating Recoverable	**216,854,622**	**4,599,712**	**21,469,614**	**5,767,737**	**248,691,685**
Capital Spending	-	1,087,507	8,160,401	1,463,927	10,711,835
Total 2016 Wildfire Recoverable	**216,854,622**	**5,687,219**	**29,630,015**	**7,231,664**	**259,403,520**
Advances Received and Interest	(209,282,632)	(7,019,070)	(29,630,015)	(9,000,000)	(254,931,717)
Total 2016 Wildfire Costs Unrecovered (Advanced)	**$ 7,571,990**	**$ (1,331,851)**	**$ -**	**$ (1,768,336)**	**$ 4,471,803**

2016 Wildfire Project Summary
May 1, 2016 to June 30, 2020

	RMWB Project Estimate	Actuals To Date *	Remaining
DRP Response (Operations and Infrastructure)	$ 152,447,615	$ 136,980,727	$ 15,466,888
DRP Recovery (Operations and Infrastructure)	97,891,355	79,267,632	18,623,723
Insurance	29,630,015	29,630,015	-
Red Cross	10,000,000	7,231,664	2,768,336
FireSmart	10,500,000	5,687,219	4,812,781
Miscellaneous funding	606,263	606,263	-
Total 2016 Wildfire Project Summary	**$ 301,075,248**	**$ 259,403,520**	**$ 41,671,728**

**** Actuals to date reflect submissions and costs being reviewed for submission.***

2020 River Break Up

The Municipality has spent $8.3 million in recoverable River Break Up costs since April 2020. To date, the Province has advanced $20.0 million for reimbursable expenses under the Disaster Recovery Program.

Administration is working with the Province to quantify claims. The Disaster Recovery Program (DRP) project summary estimate is $77.0 million. As of June 30, 2020, submissions in progress total $8.3 million.

2020 River Break Up Recoverable Costs
April 24, 2020 to June 30, 2020

	DRP
Approved Submissions	-
Submitted - Not Yet Approved	-
In Preparations	8,331,751
Total 2016 Wildfire Operating Recoverable	**8,331,751**
Advances Received and Interest	(20,000,000)
Unrecovered (Advanced)	**$ (11,668,249)**

2020 River Break Up Recoverable Costs
April 24, 2020 to June 30, 2020

	RMWB Project Estimate	Actuals To Date *	Remaining
DRP Response (Operations and Infrastructure)	$ 10,000,000	$ 5,628,259	$ 4,371,741
DRP Recovery (Operations and Infrastructure)	67,000,000	2,703,492	64,296,508
Total 2020 River Break Up Project Summary	**$ 77,000,000**	**$ 8,331,751**	**$ 68,668,249**

**** Actuals to date reflect costs being reviewed for submission.***

COUNCIL REPORT

Meeting Date: September 14, 2020

Regional Municipality of Wood Buffalo

Subject: Q2 Capital Budget Fiscal Amendments Update

APPROVALS:

Jamie Doyle

_____	_____
Director	Chief Administrative Officer

Recommended Motion:

THAT the 2020 Q2 Capital Budget Fiscal Amendments update, as summarized on Attachment 1 (2020 Capital Budget Fiscal Amendments, dated June 30, 2020), be accepted as information.

Summary:

This report provides a summary of capital budget amendments implemented by Administration within the provisions of the Fiscal Responsibility Policy (FIN-160) for the second quarter ending June 30, 2020.

There were 23 capital projects amended in this quarter as listed on Attachment #1, resulting in a net increase of $11,815,293 to the capital budget. None of these amendments are due to scope changes, and therefore the nature and typer of capital projects are not altered.

These amendments were reviewed and recommended by the Capital Projects Steering Committee.

Background:

Of the 23 capital project amendments, there are nine (9) cash flow adjustments, eight (8) requests for additional funding, five (5) funding changes and one (1) request to release funds:

Cash Flow Adjustment

- Anzac Lagoon Expansion - Design and Construction
- Building Lifecycle 2017-2021
- Casman Centre Rink Boards Structural Steel Replacement
- Fort Chipewyan 6 Bay Garage and Animal Shelter

- Fort Chipewyan Lift Station Upgrades - Construction
- Fort McMurray Landfill Closure Cells 1,2,3 Lateral Expansion and Old Landfill
- Janvier School Site Upgrades
- Jubilee Major Maintenance 2020
- Public Works North Facilities

Additional Funding

- Confederation Sanitary Sewer Phase II - Construction
- Fire Training Area and Site Preparation
- Fort Chipewyan New Cemetery Design Build
- 1A Lift Station Hoist Systems
- Pedestrian Actuated Crosswalk 2020
- Rural Broadband
- Timberlea PRV Station #2 - Design and Construction
- Transit Bus Operator Security Doors

Funding Change

- 911 Call Handling System
- Flood Mitigation - Design/Build
- Rural Water and Sewer Servicing - Construction
- Thickwood Perimeter Sewer - Construction

Funding Release

- 2020 RES Light Fleet Replacements (3)

Within the Fiscal Responsibility Policy (FIN-160), Administration is authorized to re-allocate capital budget funds provided that:

- The change will result in efficient administrative and project delivery process;
- The change will not result in addition or cancellation of the capital project;
- There are no scope changes, and therefore the nature and type of capital

projects are not altered; where additional funding is required, funds available from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects will be utilized, and

- Council set debt and debt service limits are not exceeded.

Budget/Financial Implications:

Attachment 1 shows the net budget impact of these amendments. The original approved budget and the revised budget are presented with the net budget impact by project and funding source.

Attachment 2 summarizes the impact of cash flows and the source of funding from the proposed amendments by years.

Rationale for Recommendation:

The second quarter 2020 Capital Budget Fiscal Amendments satisfy all the above conditions as stated in the Fiscal Responsibility Policy (FIN-160) with a net increase of $11,815,293 to the 2020 approved capital budget and prior capital budgets approved by Council.

Strategic Priorities:

Responsible Government

Attachments:

1. Q2 2020 Capital Budget Fiscal Amendments

2. Q2 2020 Cash Flow by Year

3-25. Q2 2020 Fiscal Amendment Forms

Regional Municipality of Wood Buffalo
2020 Capital Budget Fiscal Amendments July 31

Attachment 1

	Project Description	Nature of Amendments	Total Project Cost	Federal Grants	Provincial Grants	Reserves (CIR)	Other Sources	Debenture	Att.
	Original Project Budget								
1	2020 RES Light Fleet Replacements (3)	Original Budget	210,000	-	-	210,000	-	-	3
2	911 Call Handling System	Original Budget	450,000	-	-	450,000	-	-	4
3	Anzac Lagoon Expansion - Design & Construction	Original Budget	6,000,000	-	-	6,000,000	-	-	5
4	Building Lifecycle 2017 - 2021	Original Budget	14,510,880	-	-	14,510,880	-	-	6
5	Casman Centre Rink Boards Structural Steel Replacement	Original Budget	205,000	-	-	205,000	-	-	7
6	Confederation Sanitary Sewer Phase II - Construction	Original Budget	37,229,702	-	-	37,229,702	-	-	8
7	Fire Training Area and Site Preparation	Original Budget	3,000,000	-	-	3,000,000	-	-	9
8	Flood Mitigation - Design/Build	Original Budget	143,000,000	-	-	143,000,000	-	-	10
9	Fort Chipewyan 6 Bay Garage and Animal Shelter	Original Budget	7,100,000	-	-	7,100,000	-	-	11
10	Fort Chipewyan Lift Station Upgrades - Construction	Original Budget	30,000,000	-	-	30,000,000	-	-	12
11	Fort Chipewyan New Cemetery Design Build	Original Budget	2,813,000	-	-	2,813,000	-	-	13
12	Fort McMurray Landfill Closure Cells 1,2,3, Lateral Expansion and Old Landfill	Original Budget	6,500,000	-	-	6,500,000	-	-	14
13	Janvier School Site Upgrades	Original Budget	535,000	-	-	535,000	-	-	15
14	Jubilee Major Maintenance 2020	Original Budget	2,309,000	-	-	2,309,000	-	-	16
15	Overhead Crane Modifications 1A Lift Station	Original Budget	500,000	-	-	500,000	-	-	17
16	Pedestrian Actuated Crosswalk 2020	Original Budget	60,000	-	-	60,000	-	-	18
17	Public Works North Facilities	Original Budget	16,600,000	-	-	16,600,000	-	-	19
18	Rural Broadband - Southern Hamlets	Original Budget	7,760,000	-	-	7,760,000	-	-	20
19	Rural Water and Sewer Servicing - Construction	Original Budget	220,000,000	250,000	31,184,286	188,565,714	-	-	21
20	Thickwood Perimeter Sewer - Construction	Original Budget	61,966,939	12,315,516	-	49,651,423	-	-	22
21	Thickwood Perimeter Sewer - Construction	Original Budget	61,966,939	18,936,208	-	43,030,731	-	-	23
22	Timberlea PRV Station #2 - Design and Construction	Original Budget	330,000	-	-	330,000			24
23	Transit Bus Operator Security Doors	Original Budget	463,600	-	-	463,600			25
	Total Original Project Budget		**$ 623,510,060**	**$ 31,501,724**	**31,184,286**	**$ 560,824,050**	**$ -**	**$ -**	
	Revised Project Budget								
1	2020 RES Light Fleet Replacements (3)	Funds Release	136,811	-	-	136,811	-	-	3
2	911 Call Handling System	Fund Swap	450,000	-	300,000	150,000	-	-	4
3	Anzac Lagoon Expansion - Design & Construction	Cash Flow	6,000,000	-	-	6,000,000	-	-	5
4	Building Lifecycle 2017 - 2021	Cash Flow	14,510,880	-	-	14,510,880	-	-	6
5	Casman Centre Rink Boards Structural Steel Replacement	Cash Flow	205,000	-	-	205,000	-	-	7
6	Confederation Sanitary Sewer Phase II - Construction	Additional Funding	44,000,000	-	-	44,000,000	-	-	8
7	Fire Training Area and Site Preparation	Additional Funding	4,000,000	-	-	4,000,000	-	-	9
8	Flood Mitigation - Design/Build	Fund Swap	143,000,000	-	6,590,000	136,410,000	-	-	10
9	Fort Chipewyan 6 Bay Garage and Animal Shelter	Cash Flow	7,100,000	-	-	7,100,000	-	-	11
10	Fort Chipewyan Lift Station Upgrades - Construction	Cash Flow	30,000,000	-	-	30,000,000	-	-	12
11	Fort Chipewyan New Cemetery Design Build	Additional Funding	2,889,941	-	-	2,889,941	-	-	13
12	Fort McMurray Landfill Closure Cells 1,2,3, Lateral Expansion and Old Landfill	Cash Flow	6,500,000	-	-	6,500,000	-	-	14
13	Janvier School Site Upgrades	Cash Flow	535,000	-	-	535,000	-	-	15
14	Jubilee Major Maintenance 2020	Cash Flow	2,309,000	-	-	2,309,000	-	-	16
15	1A Lift Station Hoist Systems	Additional Funding	1,245,343	-	-	1,245,343	-	-	17
16	Pedestrian Actuated Crosswalk 2020	Additional Funding	91,500	-	-	91,500	-	-	18
17	Public Works North Facilities	Cash Flow	16,600,000	-	-	16,600,000	-	-	19
18	Rural Broadband	Additional Funding	10,500,000	-	-	10,500,000	-	-	20
19	Rural Water and Sewer Servicing - Construction	Fund Swap	220,000,000	250,000	32,094,293	187,655,707	-	-	21
20	Thickwood Perimeter Sewer - Construction	Fund Swap	61,966,939	18,936,208	-	43,030,731	-	-	22
21	Thickwood Perimeter Sewer - Construction	Fund Swap	61,966,939	20,832,232	-	41,134,707	-	-	23
22	Timberlea PRV Station #2 - Design and Construction	Additional Funding	830,000	-	-	830,000			24
23	Transit Bus Operator Security Doors	Additional Funding	488,000	-		488,000			25
	Total Revised Projects		**$ 635,325,353**	**$ 40,018,440**	**$ 38,984,293**	**$ 556,322,620**	**$ -**	**$ -**	
	NET INCREASE/(DECREASE) IN CAPITAL FUNDING REQUIRED		**$ 11,815,293**	**$ 8,516,716**	**$ 7,800,007**	**$ (4,501,430)**	**$ -**	**$ -**	

Regional Municipality of Wood Buffalo
2020 Cash Flow by Year - July 29th

Attachment 2

	Total Project Cost (Accumulative)	Funding Sources: Federal Grants	Provincial Grants	Reserves (CIR)	Other Sources	Debenture
Original Funding Sources						
2019 and prior	**232,431,540**	24,881,032	31,184,286	176,366,222	-	-
2020	**84,046,560**	6,620,692	-	77,425,868	-	-
2021 and thereafter	**313,031,960**	-	-	313,031,960	-	-
Original Funding Sources Total (a)	**$ 629,510,060**	**$ 31,501,724**	**31,184,286**	**$ 566,824,050**	**$ -**	**$ -**
Revised Funding Sources						
2019 and prior	**232,931,540**	24,881,032	32,774,286	175,276,222	-	-
2020	**78,758,893**	15,137,408	6,210,007	57,411,478	-	-
2021 and thereafter	**329,634,920**	-	-	329,634,920	-	-
Revised Funding Sources Total (b)	**$ 641,325,353**	**$ 40,018,440**	**38,984,293**	**$ 562,322,620**	**$ -**	**$ -**
Revision / Difference (b) - (a)	**$ 11,815,293**	**$ 8,516,716**	**$ 7,800,007**	**$ (4,501,430)**	**$ -**	**$ -**

Attachment 3

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: 2020 Light Fleet Replacements
AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	
ORDER CODES (if assigned):	0042020	701161	601988	Funds Release

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	210,000	-	-	210,000	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 210,000	$ -	$ -	$ 210,000	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/30/2020	$ 210,000	$ -	$ 136,811	$ 73,189

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This amendment is to release unused funds from the current budget.

During the 2020 budget presentation there was an error in the business case. Council gave approval for 2 Light Fleet replacement vehicles but the business case reflected 3. This amendment is to release the unused funds back into the CIR.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	136,811	-	-	136,811	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 136,811	$ -	$ -	$ 136,811	$ -	$ -

Budget Change

TOTAL	$ (73,189)	$ -	$ -	$ (73,189)	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	No
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment 4

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: 911 Call Handling System

AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0432020	701200	602027	

CURRENT PROJECT BUDGET

Year	*Annual Cost*	*Fed Grants*	*Prov Grants*	*Reserves*	*Other Sources*	*Debenture Financed*
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	450,000	-	-	450,000	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 450,000	$ -	$ -	$ 450,000	$ -	$ -

CURRENT COST AND COMMITMENT

As at	*Current Budget*	*Actual to Date*	*Commitments*	*Available*
4/8/2020	$ 450,000	$ -	$ 426,171	$ 23,829

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This amendment is to adjust the funding sources for the 911 Call Handling System budget. The 911 grant funds of $300,000 will be allocated to this budget in exchange for the CIR funds that are currently allocated, thereby reducing the overall CIR funding source.

AMENDED PROJECT BUDGET

Year	*Annual Cost*	*Fed Grants*	*Prov Grants*	*Reserves*	*Other Sources*	*Debenture Financed*
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	450,000	-	300,000	150,000	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 450,000	$ -	$ 300,000	$ 150,000	$ -	$ -

Budget Change

TOTAL	$ -	$ -	$ 300,000	$ (300,000)	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	No
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment: 3-25. Q2 2020 Fiscal Amendment Forms (Q2 2020 Capital Budget Fiscal Amendments Update)

Attachment 5

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Anzac Lagoon Expansion - Design And Construction

AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0062020	701163	601990	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -			$ -
2020	2,000,000	-	-	2,000,000		-
2021	4,000,000	-	-	4,000,000	-	-
2022	-	-	-		-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025						
Thereafter	-	-	-	-	-	-
TOTAL	$ 6,000,000	$ -	$ -	$ 6,000,000	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/30/2020	$ 6,000,000			$ 6,000,000

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

The detailed design for this project will not be completed until after the main 2020 construction season ends. Therefore, this amendment will defer $1,500,000 to 2021.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -		$ -	$ -
2020	500,000	-	-	500,000		-
2021	5,500,000	-	-	5,500,000	-	-
2022	-	-	-		-	-
2023	-	-	-		-	-
2024	-	-	-	-	-	-
2025						
Thereafter	-	-	-	-	-	-
TOTAL	$ 6,000,000	$ -	$ -	$ 6,000,000	$ -	$ -

Budget Change

TOTAL	$ -	$ -	$ -	$ -		$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	n/a
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment: 3-25. Q2 2020 Fiscal Amendment Forms (Q2 2020 Capital Budget Fiscal Amendments Update)

Attachment 6

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Building Lifecycle 2017-2021

AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0052017	700860	601447 (Multiple)	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 3,674,960	$ -	$ -	$ 3,674,960	$ -	$ -
2020	3,812,960	-	-	3,812,960	-	-
2021	3,912,960	-	-	3,912,960	-	-
2022	3,110,000	-	-	3,110,000	-	-
2023	-	-	-		-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 14,510,880	$ -	$ -	$ 14,510,880	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/30/2020	$ 14,510,880	$ -	$ 661,424	$ 13,849,456

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This amendment is to adjust the cashflow to align with the project timelines.

Several initiatives are going to miss the construction season for 2020, so they are being deferred to 2021 and will commence next year instead.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 3,674,960	$ -	$ -	$ 3,674,960	$ -	$ -
2020	3,350,000	-	-	3,350,000	-	-
2021	4,112,960	-	-	4,112,960	-	-
2022	3,372,960	-	-	3,372,960	-	-
2023	-	-	-		-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 14,510,880	$ -	$ -	$ 14,510,880	$ -	$ -

Budget Change

TOTAL	$ -	$ -	$ -	$ -	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	n/a
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment: 3-25. Q2 2020 Fiscal Amendment Forms (Q2 2020 Capital Budget Fiscal Amendments Update)

Attachment 7

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Casman Centre Rink Boards Structural Steel Replacement

AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0152020	701172	601999	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	205,000	-	-	205,000	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 205,000	$ -	$ -	$ 205,000	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/30/2020	$ 205,000	$ -	$ -	$ 205,000

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This amendment is to adjust the cashflow to align with the project timeline.

Due to the hockey season and the Oil Barons Home games the construction period for 2020 will be missed. Project is being deferred to 2021 when the construction can be completed.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	-	-	-	-	-	-
2021	205,000	-	-	205,000	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 205,000	$ -	$ -	$ 205,000	$ -	$ -

Budget Change

TOTAL	$ -	$ -	$ -	$ -	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	n/a
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment 8

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Confederation Way Sanitary Sewer Phase II - Construction

AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0152016	700749	601309/601550/ 601558	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 19,529,702	$ -	$ -	$ 19,529,702	$ -	$ -
2020	6,700,000	-	-	6,700,000		-
2021	7,000,000	-	-	7,000,000	-	-
2022	4,000,000	-	-	4,000,000	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 37,229,702	$ -	$ -	$ 37,229,702	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/6/2020	$ 37,229,702	$ 16,236,127	$ 2,719,528	$ 18,274,047

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This program is for construction phase II and consists of three (3)contracts, out of which 2 contracts are complete.

Additional funds are requested as the bids received for Contract 3 came in higher than the estimated amount.

This amendment is a request for additional funds to permit the award of Contract 3.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 19,529,702	$ -	$ -	$ 19,529,702	$ -	$ -
2020	13,470,298	-	-	13,470,298		-
2021	7,000,000	-	-	7,000,000	-	-
2022	4,000,000	-	-	4,000,000	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 44,000,000	$ -	$ -	$ 44,000,000	$ -	$ -

Budget Change

TOTAL	$ 6,770,298	$ -	$ -	$ 6,770,298	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	n/a
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment 9

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Fire Training Area and Site Preparation
AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	
ORDER CODES (if assigned):	0152018	700991	601689	Project Amendment

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 3,000,000	$ -	$ -	$ 3,000,000		$ -
2020	$ -	-	-			-
2021	$ -	-	-		-	-
2022	$ -	-	-		-	-
2023	$ -	-	-	-	-	-
2024	$ -	-	-	-	-	-
2025						
Thereafter	$ -	-	-	-	-	-
TOTAL	$ 3,000,000	$ -	$ -	$ 3,000,000	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/22/2020	$ 3,000,000	$ 1,646,473	$ 1,338,622	$ 14,906

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

Regional Emergency Services (RES) is leading a separate project; the supply and installation of a training facility structure, and Engineering has been requested to include the foundation as a part of the scope of work for the "*Fire Training Area and Site Preparation*" project.

Initially all of the details of the structure were no supplied by the vendor and a simple concrete foundation was considered at the time for the original estimate. However, additional information has been provided and accordingly the designed foundation has 30 piles.

This amendment is to request additional funding to complete the foundation as per the new load requirements. This also includes electrical and mechanical costs. This will allow RES to continue with their project of installing a training facility.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 3,000,000	$ -	$ -	$ 3,000,000	$ -	$ -
2020	1,000,000	-	-	1,000,000		-
2021	-	-	-		-	-
2022	-	-	-		-	-
2023	-	-	-		-	-
2024	-	-	-	-	-	-
2025						
Thereafter	-	-	-	-	-	-
TOTAL	$ 4,000,000	$ -	$ -	$ 4,000,000	$ -	$ -

Budget Change

TOTAL	$ 1,000,000	$ -	$ -	$ 1,000,000		$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	No
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	Yes
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment 10

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Flood Mitigation - Design/Build
AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0222014	700494	600870	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 6,500,000	$ -	$ -	$ 6,500,000	$ -	$ -
2020	5,000,000	-	-	5,000,000	-	-
2021	10,000,000	-	-	10,000,000	-	-
2022	10,000,000	-	-	10,000,000	-	-
2023	10,000,000	-	-	10,000,000	-	-
2024	10,000,000	-	-	10,000,000	-	-
2025	91,500,000	-	-	91,500,000	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 143,000,000	$ -	$ -	$ 143,000,000	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/7/2020	$ 143,000,000	$ 3,777,866	$ 1,836,414	$ 137,385,720

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This amendment is to adjust the funding sources for the Flood Mitigation - Design/Build budget.

Alberta Community Resilience Program (ACRP) grant funds of $6,590,000 will be allocated to this budget in exchange for the CIR funds that are currently allocated, thereby reducing the overall CIR funding source.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 6,500,000	$ -	$ 1,590,000	$ 4,910,000	$ -	$ -
2020	5,000,000	-	5,000,000	-	-	-
2021	10,000,000	-	-	10,000,000	-	-
2022	10,000,000	-	-	10,000,000	-	-
2023	10,000,000	-	-	10,000,000	-	-
2024	10,000,000	-	-	10,000,000	-	-
2025	91,500,000	-	-	91,500,000	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 143,000,000	$ -	$ 6,590,000	$ 136,410,000	$ -	$ -

Budget Change

TOTAL	$ -	$ -	$ 6,590,000	$ (6,590,000)	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	No
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment 11

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Fort Chipewyan 6 Bay Garage and Animal Control Facility

AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0242019	701082	601860	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 100,000	$ -	$ -	$ 100,000	$ -	$ -
2020	6,000,000	-	-	6,000,000	-	-
2021	1,000,000	-	-	1,000,000	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 7,100,000	$ -	$ -	$ 7,100,000	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/30/2020	$ 7,100,000	$ -	$ -	$ 7,100,000

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This amendment is to adjust the cashflow to align with the project timelines.

The design and engineering will be completed in 2020 and the construction will commence in 2021 and be completed in 2022.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 100,000	$ -	$ -	$ 100,000	$ -	$ -
2020	600,000	-	-	600,000	-	-
2021	5,400,000	-	-	5,400,000	-	-
2022	1,000,000	-	-	1,000,000	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 7,100,000	$ -	$ -	$ 7,100,000	$ -	$ -

Budget Change

TOTAL	$ -	$ -	$ -	$ -	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	n/a
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment: 3-25. Q2 2020 Fiscal Amendment Forms (Q2 2020 Capital Budget Fiscal Amendments Update)

Attachment 12

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Fort Chipewyan Lift Station Upgrades - Construction

AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0172018	700993	601691	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 11,000,000	$ -	$ -	$ 11,000,000		$ -
2020	7,000,000	-	-	7,000,000		-
2021	9,000,000	-	-	9,000,000	-	-
2022	3,000,000	-	-	3,000,000	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025						
Thereafter	-	-	-	-	-	-
TOTAL	$ 30,000,000	$ -	$ -	$ 30,000,000	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/29/2020	$ 30,000,000	$ 9,072,659	$ 885,393	$ 20,041,948

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This amendment is to adjust the cashflow to align with the project timelines.

Bids received are currently being reviewed by SCM. This along with the Pandemic curfew in Fort Chipewyan will leave us with a short construction season, and therefore the cashflow is revised based on the current construction timelines.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 11,000,000	$ -	$ -	$ 11,000,000	$ -	$ -
2020	1,000,000	-	-	1,000,000		-
2021	15,000,000	-	-	15,000,000	-	-
2022	3,000,000	-	-	3,000,000	-	-
2023	-	-	-		-	-
2024	-	-	-	-	-	-
2025						
Thereafter	-	-	-	-	-	-
TOTAL	$ 30,000,000	$ -	$ -	$ 30,000,000	$ -	$ -

Budget Change

TOTAL	$ -	$ -	$ -	$ -		$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	n/a
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment: 3-25. Q2 2020 Fiscal Amendment Forms (Q2 2020 Capital Budget Fiscal Amendments Update)

Attachment 13

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Fort Chipewyan New Cemetery Design Build

AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0012017	700790	601351	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 2,813,000	$ -	$ -	$ 2,813,000	$ -	$ -
2020	-	-	-	-	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 2,813,000	$ -	$ -	$ 2,813,000	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
3/23/2020	$ 2,813,000	$ 2,323,071	$ 489,929	$ -

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

a) Alberta Health Services requires that the Municipality undertake groundwater monitoring of the Fort Chipewyan Cemetery as a condition of their Provisional Approval (required by the Provincial Director of Cemeteries, approval of the site). Four groundwater monitoring wells have been proposed. b) The new cemetery site was designed under winter conditions, and the impact of offsite neighbourhood drainage was not fully understood at the time. With a wet 2019 construction season, additional mitigative measures were identified to address local stormwater runoff, which includes regrading to the north east of the site and the installation of (3) rock filled dry well***s.***

This amendment is to request additional budget for these mitigative measures.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 2,813,000	$ -	$ -	$ 2,813,000	$ -	$ -
2020	76,941	-	-	76,941	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 2,889,941	$ -	$ -	$ 2,889,941	$ -	$ -

Budget Change

TOTAL	$ 76,941	$ -	$ -	$ 76,941	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	No
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	Yes
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment: 3-25. Q2 2020 Fiscal Amendment Forms (Q2 2020 Capital Budget Fiscal Amendments Update)

Attachment 14

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Fort McMurray Landfill Closure Cell 1,2,3 Lateral Expansion and Old Landfill

AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	
ORDER CODES (if assigned):	0332019	701091	601869	Project Amendment

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	6,500,000	-	-	6,500,000	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 6,500,000	$ -	$ -	$ 6,500,000	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/30/2020	$ 6,500,000	$ -	$ -	$ 6,500,000

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This amendment is to adjust the cashflow to align with the project timelines.

AEP approval is currently in process which could take longer than anticipated and based on the approval timeline, construction would take place in 2021.
The funds allocated in 2020 is to procure a consultant for design and tender services, therefore the cash flow is reflected based on the current project timelines.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	500,000	-	-	500,000		-
2021	6,000,000	-	-	6,000,000		-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 6,500,000	$ -	$ -	$ 6,500,000	$ -	$ -

Budget Change

TOTAL	$ -	$ -	$ -	$ -	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	n/a
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment: 3-25. Q2 2020 Fiscal Amendment Forms (Q2 2020 Capital Budget Fiscal Amendments Update)

Attachment 15

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Janvier School Field Upgrades
AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0212020	701178	602005	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	535,000	-	-	535,000	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 535,000	$ -	$ -	$ 535,000	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/30/2020	$ 535,000	$ -	$ 535,000	$ -

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This amendment is to adjust the cashflow to align with project timelines.

Parks suggested a cost savings for 2020 by deferring a portion of the project to 2021. With this adjustment, Parks could move forward with the playground replacement and correct drainage issues. This direction is a matter of cost savings only, due to the current economical environment, and not due to any project conditions or requirements.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	300,000	-	-	300,000	-	-
2021	235,000	-	-	235,000	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 535,000	$ -	$ -	$ 535,000	$ -	$ -

Budget Change

TOTAL	$ -	$ -	$ -	$ -	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	No
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment 16

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Jubilee Major Maintenance 2020
AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0082020	701165	601992	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	1,800,000	-	-	1,800,000	-	-
2021	509,000	-	-	509,000	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 2,309,000	$ -	$ -	$ 2,309,000	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/30/2020	$ 2,309,000	$ -	$ -	$ 2,309,000

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This amendment is to adjust the cashflow to align with the project timelines.

The design and engineering will occur in 2020 and the construction will commence in 2021, thus deferring $1.5 M from 2020 to 2021

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	300,000	-	-	300,000	-	-
2021	2,009,000	-	-	2,009,000	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 2,309,000	$ -	$ -	$ 2,309,000	$ -	$ -

Budget Change

TOTAL	$ -	$ -	$ -	$ -	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	n/a
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment: 3-25. Q2 2020 Fiscal Amendment Forms (Q2 2020 Capital Budget Fiscal Amendments Update)

Attachment 17

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Overhead Crane Modifications 1A Lift Station
AMENDED PROJECT NAME: 1A Lift Station Hoist Systems

Project Amendment

	Group I/O	Revenue I/O	Expense I/O
ORDER CODES (if assigned):	0462019	701104	601882

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 500,000	$ -	$ -	$ 500,000	$ -	$ -
2020	-	-	-	-	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 500,000	$ -	$ -	$ 500,000	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/13/2020	$ 500,000	$ 64,501	$ 134,941	$ 300,557

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This amendment is to address the following:
1. Suggested name change to reflect the proper terminology of the system and the original scope of work
2. Requesting additional funds of $745,343 to award the contract. The tender closed on June 09, 2020 and one bid was received. The bid was in line with the pre-tender estimate.

The 1A Lift Station is located downtown and is the largest lift station in Fort McMurray. All sewage from the downtown area and South Fort McMurray passes through the 1A Lift Station to reach the Wastewater Treatment Plant. The 1A Lift Station is comprised of a wet side and a dry side, that each has chambers under the floor.

The current hoist systems do not allow for safe removal of the two large pumps and grinder for servicing. This project is to create two hoist systems, one for each side to allow for removal of equipment for maintenance. Performing regular maintenance on equipment is compulsory to ensure continual operation of the 1A Lift Station.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 500,000	$ -	$ -	$ 500,000	$ -	$ -
2020	745,343	-	-	745,343	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 1,245,343	$ -	$ -	$ 1,245,343	$ -	$ -

Budget Change

TOTAL	$ 745,343	$ -	$ -	$ 745,343	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	No
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment 18

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Pedestrian Actuated Crosswalk 2020

AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0222020	701179	602006	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	60,000	-	-	60,000	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 60,000	$ -	$ -	$ 60,000	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/30/2020	$ 60,000	$ -	$ -	$ 60,000

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

The budget of $60,000 was based on crosswalk having side mount flashing lights. After a site visit with the Traffic Signals Contractor and the RMWB Traffic Supervisor it was determined overhead lights attached onto 9 M Arms extending over the road would be needed at this location.

This amendment is to request an increase in the 2020 budget.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	91,500	-	-	91,500	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 91,500	$ -	$ -	$ 91,500	$ -	$ -

Budget Change

TOTAL	$ 31,500	$ -	$ -	$ 31,500	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	n/a
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment: 3-25. Q2 2020 Fiscal Amendment Forms (Q2 2020 Capital Budget Fiscal Amendments Update)

Attachment 19

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Public Works North Facilities
AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0102020	701167	601994	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -			$ -
2020	1,600,000	-	-	1,600,000		-
2021	7,000,000	-	-	7,000,000	-	-
2022	8,000,000	-	-	8,000,000	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025						
Thereafter	-	-	-	-	-	-
TOTAL	$ 16,600,000	$ -	$ -	$ 16,600,000	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/27/2020	$ 16,600,000			$ 16,600,000

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This amendment is to adjust the cashflow to align with the project timelines.

The design portion of this project will start in 2020. However, the construction will begin in 2021. The Request for Proposals (RFP) for consulting services closed in April and based on the value of the finalized proposal, estimated 2020 spending is $800,000. Therefore, $800,000 of the 2020 budget can be moved to 2021.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -		$ -	$ -
2020	800,000	-	-	800,000		-
2021	7,800,000	-	-	7,800,000	-	-
2022	8,000,000	-	-	8,000,000	-	-
2023	-	-	-		-	-
2024	-	-	-	-	-	-
2025						
Thereafter	-	-	-	-	-	-
TOTAL	$ 16,600,000	$ -	$ -	$ 16,600,000	$ -	$ -

Budget Change

TOTAL	$ -	$ -	$ -	$ -		$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	No
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment 20

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Rural Broadband - Southern Hamlets
AMENDED PROJECT NAME: Rural Broadband

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0442020	701201	602028	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	7,760,000	-	-	7,760,000	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 7,760,000	$ -	$ -	$ 7,760,000	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
3/9/2020	$ 7,760,000	$ -	$ 7,760,000	$ -

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This will confirm that at the Council Meeting November 27-29, 2019 the following resolution was passed by Council: "THAT Fort McKay, Fort Chipewyan and Draper be added to the Rural Broadband Southern Hamlets Capital Project." An RFP was evaluated with the inclusion of these hamlets and the successful proposal is more than the approved budget amount. In order to complete the project, additional funding is required.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	10,500,000	-	-	10,500,000	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 10,500,000	$ -	$ -	$ 10,500,000	$ -	$ -

Budget Change

TOTAL	$ 2,740,000	$ -	$ -	$ 2,740,000	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	n/a
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	No
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	No
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment 21

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Rural Water and Sewer Servicing - Construction
AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0572014	700529	600953	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 145,100,000	$ 250,000	$ 31,184,286	$ 113,665,714	$ -	$ -
2020	6,900,000	-	-	6,900,000	-	-
2021	30,000,000	-	-	30,000,000	-	-
2022	38,000,000	-	-	38,000,000	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 220,000,000	$ 250,000	$ 31,184,286	$ 188,565,714	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/7/2020	$ 220,000,000	$ 96,609,764	$ 50,232,742	$ 73,157,493

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This amendment is to adjust the funding sources for the Rural Water and Sewer Servicing - Construction budget. Municipal Sustainability Initiative (MSI) grant funds of $910,007 will be allocated to this budget in exchange for the CIR funds that are currently allocated, thereby reducing the overall CIR funding source.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 145,100,000	$ 250,000	$ 31,184,286	$ 113,665,714	$ -	$ -
2020	6,900,000		910,007	5,989,993	-	-
2021	30,000,000	-	-	30,000,000	-	-
2022	38,000,000	-	-	38,000,000	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 220,000,000	$ 250,000	$ 32,094,293	$ 187,655,707	$ -	$ -

Budget Change

TOTAL	$ -	$ -	$ 910,007	$ (910,007)	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	No
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment: 3-25. Q2 2020 Fiscal Amendment Forms (Q2 2020 Capital Budget Fiscal Amendments Update)

Attachment 22

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Thickwood Perimeter Sewer - Construction
AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0302017	700885	601479	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 19,941,939	$ 12,315,516	$ -	$ 7,626,423	$ -	$ -
2020	13,525,000	-	-	13,525,000	-	-
2021	13,000,000	-	-	13,000,000	-	-
2022	15,500,000	-	-	15,500,000	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 61,966,939	$ 12,315,516	$ -	$ 49,651,423	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/7/2020	$ 61,966,939	$ 22,105,510	$ 9,284,069	$ 30,577,360

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This amendment is to adjust the funding sources for the Thickwood Perimeter Sewer Construction budget. Gas Tax Fund (GTF) grant funds of $6,620,692 will be allocated to this budget in exchange for the CIR funds that are currently allocated, thereby reducing the overall CIR funding source.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 19,941,939	$ 12,315,516	$ -	$ 7,626,423	$ -	$ -
2020	13,525,000	6,620,692	-	6,904,308	-	-
2021	13,000,000	-	-	13,000,000	-	-
2022	15,500,000	-	-	15,500,000	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 61,966,939	$ 18,936,208	$ -	$ 43,030,731	$ -	$ -

Budget Change

TOTAL	$ -	$ 6,620,692	$ -	$ (6,620,692)	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	No
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment 23

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Thickwood Perimeter Sewer - Construction
AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0302017	700885	601479	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 19,941,939	$ 12,315,516	$ -	$ 7,626,423	$ -	$ -
2020	13,525,000	6,620,692	-	6,904,308	-	-
2021	13,000,000	-	-	13,000,000	-	-
2022	15,500,000	-	-	15,500,000	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 61,966,939	$ 18,936,208	$ -	$ 43,030,731	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
5/4/2020	$ 61,966,939	$ 22,116,168	$ 9,273,411	$ 30,577,360

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This amendment is to adjust the funding sources for the Thickwood Perimeter Sewer Construction budget. Gas Tax Fund (GTF) grant funds of $1,896,024 will be allocated to this budget in exchange for the CIR funds that are currently allocated, thereby reducing the overall CIR funding source.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 19,941,939	$ 12,315,516	$ -	$ 7,626,423	$ -	$ -
2020	13,525,000	8,516,716	-	5,008,284	-	-
2021	13,000,000	-	-	13,000,000	-	-
2022	15,500,000	-	-	15,500,000	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 61,966,939	$ 20,832,232	$ -	$ 41,134,707	$ -	$ -

Budget Change

TOTAL	$ -	$ 1,896,024	$ -	$ (1,896,024)	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	No
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment 24

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Timberlea PRV Station #2 - Design and Construction

AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0162019	701119	601897	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 330,000	$ -	$ -	$ 330,000	$ -	$ -
2020	-	-	-	-	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 330,000	$ -	$ -	$ 330,000	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
4/9/2020	$ 330,000	$ -	$ -	$ 330,000

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This project consists of replacing the Timberlea pressure reducing valve station located on Loutit Road. The station is undersized causing pressure reduction which is detrimental to the downstream main.

Additional funds are requested as the proposals from proponent came higher than the budget.

This is a request for additional funds to permit the proceeding with award.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ 330,000	$ -	$ -	$ 330,000	$ -	$ -
2020	500,000	-	-	500,000	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 830,000	$ -	$ -	$ 830,000	$ -	$ -

Budget Change

TOTAL	$ 500,000	$ -	$ -	$ 500,000	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	No
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	n/a
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment 25

REGIONAL MUNICIPALITY OF WOOD BUFFALO

CAPITAL BUDGET AMENDMENT

Fiscal

CURRENT PROJECT NAME: Transit Bus Operator Security Doors

AMENDED PROJECT NAME:

	Group I/O	Revenue I/O	Expense I/O	Project Amendment
ORDER CODES (if assigned):	0312020	701188	602015	

CURRENT PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	463,600	-	-	463,600	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 463,600	$ -	$ -	$ 463,600	$ -	$ -

CURRENT COST AND COMMITMENT

As at	Current Budget	Actual to Date	Commitments	Available
6/9/2020	$ 463,600	$ -	$ 447,605	$ 15,995

DESCRIPTION/RATIONALE FOR BUDGET AMENDMENT

This amendment is to request additional funding for the purchase of an operator security door that has extended sliding glass.

This option costs more, however will provide a better sanitation barrier for the operators. This will ensure our operators have a barrier during this COVID pandemic. The total cost of this project will be $488,000 including installation.

AMENDED PROJECT BUDGET

Year	Annual Cost	Fed Grants	Prov Grants	Reserves	Other Sources	Debenture Financed
2019 & Prior	$ -	$ -	$ -	$ -	$ -	$ -
2020	488,000	-	-	488,000	-	-
2021	-	-	-	-	-	-
2022	-	-	-	-	-	-
2023	-	-	-	-	-	-
2024	-	-	-	-	-	-
2025	-	-	-	-	-	-
Thereafter	-	-	-	-	-	-
TOTAL	$ 488,000	$ -	$ -	$ 488,000	$ -	$ -

Budget Change

TOTAL	$ 24,400	$ -	$ -	$ 24,400	$ -	$ -

FISCAL RESPONSIBILITY POLICY CRITERIA:

Will the change result in an efficient administrative and project delivery process?	Yes
Will the change result in an addition or cancellation of a capital project?	No
Will the underlying scope change alter the nature and type of capital project?	No
Where additional funding is required, are the funds from a combination of savings from fully tendered projects, other uncommitted sources such as grants and offsite levies, and cash flow management with other capital projects?	Yes
Will the change result in Council set debt and debt service limits being exceeded?	No

In order for this to be a Fiscal Management Policy Amendment the questions above must answer, Yes, No, No, Yes, No, respectively.

Attachment: 3-25. Q2 2020 Fiscal Amendment Forms (Q2 2020 Capital Budget Fiscal Amendments Update)

COUNCIL REPORT

Meeting Date: September 14, 2020

Regional Municipality of Wood Buffalo

Subject: Heart of Wood Buffalo Excellence Awards

APPROVALS:

Jamie Doyle

Director	Chief Administrative Officer

Recommended Motion:

THAT the recommended recipients of the Heart of Wood Buffalo Excellence Awards, as outlined on Attachment 1 (confidential), be approved and kept confidential until the award recipients are announced by FuseSocial on Monday, October 19, 2020.

Summary:

The Heart of Wood Buffalo Excellence Awards honours the achievements of leaders, philanthropists, organizations and all those that embody the spirit of community, innovation, capacity building and dedication to making Wood Buffalo an amazing region to work, play, and live in.

This year the Regional Municipality of Wood Buffalo's Citizen Recognition Program has merged with the Heart of Wood Buffalo Excellence Awards. The Council's Excellence Awards are in the following categories: Citizen of the Year, Everyday Hero, Indigenous Advocate and Youth.

Background:

A total of 26 nominations for the Council's Excellence Awards were reviewed and evaluated by Council. Nominees were scored based on the merits of the information provided in the nomination and the respective criteria for the award for which they were nominated.

Budget/Financial Implications:

The Regional Municipality of Wood Buffalo is supporting the 2020 Heart of Wood Buffalo Excellence Awards in the amount of $20,000.

Rationale for Recommendation:

The confidential Council recommended recipients are listed on the attachment.

Strategic Priorities:

Responsible Government
Downtown Revitalization
Regional Economic Development
Rural and Indigenous Communities and Partnerships

Attachments:

Heart of Wood Buffalo Excellence Awards Recipients

HEART OF WOOD BUFFALO EXCELLENCE AWARDS
COUNCIL'S EXCELLENCE AWARDS

Recipients

Citizen of the Year Award
Melanie Antoine

Everyday Hero Award
Nayef Maghoub

Indigenous Advocate Award
First Nations, Metis, Inuit Student Advisory Council (FMNI SAC)

Youth Award
Tanisha Kadia
Fareedah Sadek

COUNCIL REPORT

Meeting Date: September 14, 2020

Regional Municipality of Wood Buffalo

Subject: Nomination for the Federation of Canadian Municipalities Board of Directors

APPROVALS:

Jamie Doyle

Director	Chief Administrative Officer

Recommended Motion:

WHEREAS the Federation of Canadian Municipalities (FCM) represents the interests of municipalities on policy and program matters that fall within federal jurisdiction;

WHEREAS FCM's Board of Directors is comprised of elected municipal officials from all regions and sizes of communities to form a broad base of support and provide FCM with the prestige required to carry the municipal message to the federal government; and

BE IT RESOLVED that Council of the Regional Municipality of Wood Buffalo endorse Councillor Krista Balsom to stand for election on FCM's Board of Directors for a term expiring June 2021; and

BE IT FURTHER RESOLVED that Council assume all costs associated with Councillor Krista Balsom attending FCM's Board of Directors meetings.

Summary:

Councillor Krista Balsom is requesting Council's endorsement for her nomination for re-election to the Federation of Canadian Municipalities (FCM) Board of Directors. To run for a position on the FCM Board of Directors, an official resolution of Council is required. If this resolution is passed, it will be submitted to the FCM Chief Elections Officer in advance of the deadline date of September 14, 2020.

Background:

Each year the FCM conducts an election to vote on the representatives who have submitted a nomination for a position on the FCM Board of Directors. This normally takes place during the annual conference in June; however, due to the COVID-19 pandemic, the annual conference has been cancelled. The FCM will therefore be holding virtual elections for Director positions from October 5 - 7, 2020.

Councillor Krista Balsom was elected as a representative on the Board of Directors for the 2019-2020 year and is seeking re-election for the 2020-2021 year.

Budget/Financial Implications:

Any costs associated with Councillor Balsom's travel to Board of Director meetings would be assumed under Council's approved budget.

Strategic Priorities:

Responsible Government

COUNCIL REPORT

Meeting Date: September 14, 2020

REGIONAL MUNICIPALITY OF WOOD BUFFALO

Subject: Bylaw No. 20/024 - Face Covering Bylaw	
APPROVALS:	Jamie Doyle
_____	_____
Director	Chief Administrative Officer

Recommended Motion:

THAT Bylaw No. 20/024, being the Face Covering Bylaw, be read a third and final time.

Summary:

The RMWB has seen a recent surge in the number of COVID-19 cases. This, along with the recent opening of schools, has prompted concerns that the rate of spread may continue to rapidly increase.

There is substantial evidence indicating that the widespread use of face coverings among the public has a mitigating effect on the spread and severity of COVID-19.

On September 8, 2020, Council passed the following resolution:

> "THAT a Special Council Meeting be scheduled for Monday September 14, 2020 at 4:00 p.m. to bring forward a mandatory mask bylaw for consideration at that meeting."

Therefore, Administration recommends that Council enact the attached *Face Covering Bylaw* No. 20/024.

Background:

The provincial and federal governments recommend that the general public wear "face coverings" or "non-medical masks" while in crowded indoor areas where social distancing is not otherwise possible. Mandatory face covering laws have become widespread in other jurisdictions. First appearing in Ontario and Quebec in mid-June,[1] these bylaws have since been adopted by several major municipalities including Toronto, Ottawa, Calgary, and Edmonton, and many Alberta communities including Grande Prairie, Red Deer, Lethbridge, and others.

COVID-19 is a present and continuing issue in the RMWB. As of September 8th, 2020:

a. There were 66 active cases of COVID-19 in Fort McMurray and 2 active

cases outside of the Urban Service area, totaling to 68 active cases within the region.

b. Of the 66 active cases in Fort McMurray, 40 of those were reported over the September long weekend, representing roughly a twofold increase in 3 days. Sadly, during the same period, one person in Fort McMurray had passed away due to COVID-19.

c. Currently, the Government of Alberta has reported that there are 4 active outbreaks in the region:

    i. the Northern Lights Regional Health Centre,

    ii. CNRL Albian,

    iii. Suncor base plant, and

    iv. the Syncrude Mildred Lake site.

d. The status of the RMWB on the Government of Alberta's COVID-19 Status Relaunch map changed over the long weekend, from "Open" to "Watch". A community's status moves to "Watch" when there are at least 10 active cases and more than 50 active cases per 100,000.

e. Superstore, Rona, McDonalds, and Earls have each recently had to close to perform cleaning and disinfection protocols, as a result of an employee testing positive for COVID-19. On September 8, 2020, portions of the Suncor Community Leisure Centre were temporarily closed for deep cleaning and sanitizing as a result of a confirmed case through contact tracing of COVID-19.

f. In the RMWB, Syncrude, Walmart, Starbucks, and Superstore have implemented their own face covering requirements for employees or customers entering their premises.

g. Fort McKay Métis Community Association president Ron Quintal made a presentation at Council's September 8, 2020, meeting confirming that face coverings are currently mandatory in the community of Fort McKay.

Syncrude and Suncor are supportive of a mandatory face covering bylaw.[2]

Current Understanding of Face Covering Effectiveness:

There is a strong body of evidence supporting widespread use of face coverings as an effective tool for mitigating the spread of COVID-19.

Physical Mechanism

The current scientific consensus is that COVID-19 is primarily spread through small droplets of fluid produced by breathing, talking, or singing.[3] Face coverings work by capturing the majority of these droplets, thus reducing the chance of infection.

In early April, a study examining the breath of people with influenza and similar infections found that those who breathed through a surgical mask (that is a "disposable mask") had significantly reduced or nearly eliminated the percentage of normal coronavirus particles in the breath.[4]

A more recent study examining the filtration effect of various materials against droplets equivalent to those exhaled while breathing found that, while respirators (that is N95 masks) were estimated to prevent 99% of predicted infections,[5] "non-traditional materials" (that is cotton, silk, and other common clothing materials) would still be able to prevent at minimum 44% of short-term infection events.[6]

Regional Studies

The primary source of data regarding face coverings has been retrospective studies examining the spread and severity of COVID-19 through countries and locations with varying degrees of face covering usage. The consistent finding is that widespread face covering usage strongly correlates with a severe drop in the rate of spread.

A forerunner of these studies (published in April) examined the per capita number of COVID-19 cases in 8 countries 100 days after the first confirmed infection. These numbers were compared with those of the Hong Kong Administrative Region, as the region bore a uniquely high rate of mask adoption (96.6%). Hong Kong, despite being a highly dense urban region, had a mere 129 cases per million, compared to 2983.2 per million in Spain (which had minimal face covering use at the time) and 200.5 in South Korea (which began implementing mandatory face covering rules soon after the first reported case).[7]

A similar study examined the German city of Jena, which adopted a mandatory face covering law two weeks before the surrounding state.[8] Comparing the rate of increase between Jena and its state, researchers concluded that masks reduced the rate of spread by 40-60%.[9]

Another US study compared the rates of spread for the 16 states which implemented public mandatory face covering laws between April 1 and May 21. The authors estimate that these mandates may have prevented 230,000 - 450,000 COVID-19 infections during that period.[10]

Decreased Mortality

Recent thinking has emerged that face coverings not only reduce the spread but also the *severity* of COVID-19 cases. This idea is born from the fact that in jurisdictions and locations where face coverings usage is widespread the mortality rate is far lower than in regions going without.

Research demonstrates that a person wearing a face covering has a better chance of developing into a mild or asymptomatic case, rather than a severe case.[11] This explains why countries with high levels of face covering usage often have much lower rates of spread *and* mortality.[12]

Implementation in other Jurisdictions

At least 17 municipalities in Alberta have enacted a mandatory face covering bylaw which largely contain the following general provisions:

a. A requirement to wear a face covering in an indoor, public place.[13]

b. All have exceptions to the general face covering requirement, which include:

i. children ranging from the age of 2 to 10 years old,

ii. persons with a medical condition, disability, or who otherwise cannot safely use or remove a mask,

iii. persons eating or drinking at an establishment traditionally offering food or beverages,

iv. persons engaged in a fitness or athletic activity,

v. persons providing a caregiving service where wearing a mask would impair their ability to deliver that service,

vi. persons engaging in a service requiring the temporary removal of a mask, and

vii. persons in an indoor area not accessible to the public, or otherwise separated from the public by physical barriers (that is plexiglass shields).

c. A requirement for businesses to put up signs indicating the requirement for face coverings while indoors.

d. A fine for non-compliance ranging from $50-$250,[14] with most having a penalty of $100 for the first offence and $200 for subsequent offences.

The City of Edmonton's face covering bylaw initially allowed residents to obtain an exemption card if they had a "legitimate exemption" reason as set out in the bylaw. This provision was ended within 4 days of the bylaw's enactment due to widespread abuse by "individuals who do not have legitimate exemptions".[15]

Transit services in Toronto, Montreal, Edmonton, and Calgary found that mask compliance went up to 90 to 97 percent upon the issuance of a mandatory face covering bylaw. In Vancouver, the transit service found that there was very little need to

enforce the bylaw.[16]

Though there have been some public protests against the use of face coverings in general, these have remained relatively minor and inconsistent events.[17] For example, protests against Edmonton's bylaw on the day of its implementation drew roughly 50 people,[18] and a similar protest to Lethbridge's face covering bylaw drew 60-80 people.[19]

Additionally, the RMWB has been distributing free non-medical masks on public transit buses.

Rationale for Recommendation:

There is a robust body of evidence supporting the idea that widespread use of face coverings can reduce the spread of COVID-19.

Requiring mandatory face coverings in the RMWB will help ensure as few people as possible suffer an infection and will help limit the duration of the pandemic's presence in the region.

Endnotes:

(1) Implemented in Guelph, Wellington County, and Dufferin County, Ontario, by the local medical officer of health, see Kate Bueckert, "Masks must be worn in Guelph or Wellington County, medical officer of health says", June 10 2020, CBC News Kitchener Waterloo, online at: <cbc.ca/news/canada/kitchener-waterloo/masks-must-be-worn-commercial-businesses-guelph-wellington-1.5606133>.

(2) Vincent McDermott, "Scott warns region 'trending in the wrong direction' as Fort McMurray sees five new cases" (September 9, 2020) Fort McMurray Today, online at: <fortmcmurraytoday.com/news/local-news/scott-warns-region-trending-in-the-wrong-direction-as-fort-mcmurray-sees-five-new-cases>.

(3) See generally World Health Organization, "Modes of transmission of virus causing COVID-19: implications for IPC precaution recommendations", online at: <who.int/news-room/commentaries/detail/modes-of-transmission-of-virus-causing-covid-19-implications-for-ipc-precaution-recommendations>.

(4) Nancy Leung, "Respiratory virus shedding in exhaled breath and efficacy of face masks", (2020) Nature Medicine 26, online at: <nature.com/articles/s41591-020-0843-2#Sec3>.

(5) This estimation was based on mathematical modelling of the likelihood of infection if a person was exposed to a consistent source of COVID-19 bearing droplets over a period of 30 seconds.

(6) AM Wilson et al, “COVID-19 and use of non-traditional masks: how do various materials compare in reducing the risk of infection for mask wearers?”, (2020) J Hospital Infections 105(4), online at: <ncbi.nlm.nih.gov/pmc/articles/PMC7264937/>.

(7) Vincent Cheng et al, “The role of community-wide wearing of face mask for control of coronavirus disease 2019 (COVID-19) epidemic due to SARS-CoV-2”, (2020) J Infection 81, online at: <sciencedirect.com/science/article/pii/S0163445320302358>.

(8) This was during the “post easement period” when many social distancing measures were being lifted, but soon reintroduced and extended. See generally The Local, “EXPLAINED: What to know about Germany's social distancing rules”, (June 11, 2020), online at: <thelocal.de/20200527/explained-what-to-know-about-germanys-new-coronavirus-social-distancing-rules-june>.

(9) Timo Mitze et al, “Face Masks Considerably Reduce COVID-19 Cases in Germany: A Synthetic Control Method Approach”, (2020) Institute of Labour Economics (Discussion Paper, 13319), at 12, online at: <iza.org/publications/dp/13319/face-masks-considerably-reduce-covid-19-cases-in-germany-a-synthetic-control-method-approach>.

(10) Wie Lyu and George Wehby, “Community Use Of Face Masks And COVID-19: Evidence From A Natural Experiment Of State Mandates In The US”, (2020) Health Affairs, 30:8, at 1422, online at: <healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.00818>.

(11) Monica Gandhi et al, “Masks Do More Than Protect Others During COVID-19: Reducing the Inoculum of SARS-CoV-2 to Protect the Wearer”, (2020) J GIM, online at: <link.springer.com/article/10.1007/s11606-020-06067-8#ref-CR37>.

(12) See Vincent Cheng et al, supra note 9.

(13) Toronto’s bylaw being the interesting exception in that it technically only requires that business develop a policy requiring people to wear masks while on the premises.

(14) Some municipalities simply place the fine at “not less than $10,000”, which is the maximum amount allowed for a municipal bylaw fine as set out in the *Municipal Government Act*, RSA 2000 c M-26, s 8(i)(ii).

(15) Dustin Cook, “City of Edmonton abruptly ends contentious mask exemption card distribution after four days”, (August 12, 2020) Edmonton Journal, online at: <edmontonjournal.com/news/local-news/city-of-edmonton-abruptly-ends-mask-exemption-card-distribution-after-four-days>.

(16) Jennifer Saltman, “COVID-19: Transit agencies report high compliance with mandatory mask rules”, (August 11, 2020) *Vancouver Sun*, online at: <vancouversun.com/news/covid-19-transit-agencies-report-high-compliance-with-mandatory-mask-rules>.

(17) See generally Demi Knight, “Anti-mask rallies draw crowds in Calgary and Edmonton amid coronavirus pandemic”, (July 19, 2020) *Global News*, online at: <globalnews.ca/news/7193611/calgary-edmonton-anti-mask-rally-july-19-coronavirus-covid-19/>.

(18) Lauren Boothby, “Masks face some resistance in Edmonton on first day of bylaw”, (August 2, 2020) Edmonton Journal, online at: <edmontonjournal.com/news/local-news/masks-face-some-resistance-in-edmonton-on-first-day-of-bylaw>.

(19) CBC News, “Lethbridge anti-mask protesters crowd city council meeting”, (September 9, 2020) CBC News Calgary, online at: <cbc.ca/news/canada/calgary/lethbridge-anti-mask-protest-city-council-1.5717826>.

Strategic Priorities:

Responsible Government
Regional Economic Development
Rural and Indigenous Communities and Partnerships

Attachments:

1. Bylaw No. 20/024

2. Bylaw No 20-024 Face Covering Bylaw - as amended

3. Bylaw No 20-024 Face Covering Bylaw - Redlined

BYLAW NO. 20/024

BEING A BYLAW OF THE REGIONAL MUNICIPALITY OF WOOD BUFFALO TO REGULATE AND CONTROL THE WEARING OF FACE COVERINGS WITHIN THE REGIONAL MUNICIPALITY OF WOOD BUFFALO

WHEREAS on March 11, 2020, the World Health Organization declared a global pandemic related to the spread of the COVID-19 virus and because COVID-19 continues to remain a global health risk;

AND WHEREAS the World Health Organization, Chief Public Health Officer for Canada and the Chief Medical Officer of Health for Alberta have identified face coverings as a preventative measure to help reduce the risk of spreading COVID-19 in circumstances where physical distancing may not be possible;

AND WHEREAS physical distancing may not be possible in Public Places and in Public Vehicles;

AND WHEREAS pursuant to section 7 of the *Municipal Government Act,* RSA 2000, c. M-26 a council of a municipality may pass bylaws respecting:

(a) the safety, health and welfare of people and the protection of people and property;

(b) people, activities and things in, on or near a public place or place that is open to the public;

(c) transport and transportation systems; and

(d) businesses, business activities and persons engaged in business.

AND WHEREAS Council deems it desirable and necessary for the health, safety, and welfare of its citizens of the Regional Municipality of Wood Buffalo to require the wearing of a Face Covering in Public Places and in Public Vehicles;

NOW THEREFORE, the Council of the Regional Municipality of Wood Buffalo, duly assembled, hereby enacts as follows:

Short Title

1. This Bylaw may be cited as the “Face Covering Bylaw”.

Definitions

2. In this Bylaw:

(a) “Act” means the *Municipal Government Act*, R.S.A. 2000, c. M-26;

(b) "Employer" means any person(s) who as the owner, proprietor, manager, superintendent of any activity, business, work, trade, occupation or profession, has control over or direction of, or is directly or indirectly responsible for the employment of a person and responsible for the day to day operations of a Public Place or Public Vehicle;

(c) "Face Covering" means a mask or other covering that covers the mouth, nose and chin ensuring a barrier that limits the transmission of respiratory droplets;

(d) "Municipal Tag" means a document prepared by the Municipality alleging an offence issued pursuant to this Bylaw;

(e) "Municipality" means the Regional Municipality of Wood Buffalo;

(f) "Officer" means a Bylaw Enforcement Officer appointed pursuant to the *Enforcement Officer Bylaw 20/005*, a peace officer appointed pursuant to the *Peace Officer Act*, RSA 2006, c. P-3.5, or a police officer appointed pursuant to the *Police Act*, RSA 2000, c. P-17;

(g) "Operator" includes the person responsible for the day to day operations of a Public Place or Public Vehicle and a proprietor of a Public Places;

(h) "Proprietor" means the person who controls, governs or directs the activity carried on within any Public Places or Public Vehicle referred to in this Bylaw and includes the person usually in charge thereof;

(i) "Public Place" means any part of a building, structure or other enclosed area within the Municipality, whether privately or publicly owned, to which the public reasonably has or is permitted to have access, whether upon payment or otherwise.

(j) "Public Vehicle" means a bus operated by the Regional Municipality of Wood Buffalo, or a vehicle for hire as defined in the *Vehicle for Hire Bylaw 13/001*;

(k) "Violation Ticket" means a ticket issued pursuant to the current *Provincial Offences Procedure Act,* RSA 2000 c P-34, as amended or replaced and regulations thereunder;

Interpretation

3. Nothing in this Bylaw relieves a person from complying with any provision of any Federal, Provincial or Municipal law or regulation or any requirement of any lawful permit, order or license.

4. Should any section, subsection, clause or provision of this Bylaw be declared by a court of competent jurisdiction to be invalid, the same shall not affect the validity of this Bylaw as a whole, or any part thereof, other than the part so declared to be invalid.

Prohibition

5. A person must wear a Face Covering while in a Public Place or a Public Vehicle.

6. No person shall harass or intimidate a person who is not wearing a Face Covering as a result of any provision in Section 8.

7. No person shall hinder or impede any Officer in the performance of any duty authorized by this Bylaw, performance of their powers and duties under this Bylaw.

Exceptions

8. Section 5 does not apply to:

   (a) children under 2 years of age;

   (b) persons who are unable to place, use, or remove a Face Covering safely without assistance;

   (c) persons unable to wear a Face Covering due to a mental or physical limitation, or protected ground under the *Alberta Human Rights Act*;

   (d) persons who are caregiving for or accompanying a person with a disability where wearing a Face Covering would hinder that caregiving or assistance; or

   (e) persons who have temporarily removed their Face Covering in a Public Place:

      (i) to provide or receive a service;
      (ii) while consuming food or drink in a designated seating area; and
      (iii) while engaged in an athletic or fitness activity.

Signage

9. An Employer, Operator or Proprietor must prominently display a sign, in the form and containing the content set out in Schedule "A", in a location that is visible to a person immediately upon entering the Public Place or a Public Vehicle.

Offence and Penalty

10. A person who contravenes this Bylaw is guilty of an offence.

11. In the case of an offence that is of a continuing nature, a contravention of a provision of this Bylaw constitutes a separate offence in respect of each day, or party of a day, on which it continues, and a person guilty of such an offence is liable, upon summary conviction, to a fine in an amount not less than that established by this Bylaw for each such day.

12. A person who is guilty of an offence under this Bylaw is liable to:

    (a) A fine in the amount as prescribed in Schedule "B"; or

    (b) Upon summary conviction, a fine not exceeding $10,000 or a period of imprisonment of not more than one year, or both.

Municipal Tag

13. A Peace Officer may issue, with respect to an offence under this Bylaw, a municipal tag specifying the fine amount as prescribed in Schedule "B" of this Bylaw as the amount payable.

14. Where a municipal tag is issued, the amount payable may be paid in accordance with the instructions on the tag, and if paid a Violation Ticket shall not be issued for that offence.

Violation Ticket

15. A Peace Officer may issue, with respect to an offence under this Bylaw, a Violation Ticket:

    (a) Specifying the amount set out in Schedule "B" of this Bylaw as the fine for the offence; or

    (b) Require an appearance in court without specifying a fine amount and without the option of making a voluntary payment.

16. Where a Violation Ticket specifies a fine amount, a voluntary payment equal to the specified fine amount may be made as directed on the Violation Ticket.

Coming into Force

17. This Bylaw comes into effect when it is passed.

READ a first time this _____ day of _____, 2020.

READ a second time this _____ day of _____, 2020.

READ a third and final time this _____ day of _____, 2020.

SIGNED and PASSED this _____ day of _____, 2020.

_____
Mayor

_____
Chief Legislative Officer

SCHEDULE "A"

Face Coverings MANDATORY

Effective September 15, 2020 wearing a face covering is mandatory in all indoor public places and in public vehicles.

The Regional Municipality of Wood Buffalo Bylaw 20/024

Visit rmwb.ca/covid19 for more information

Regional Municipality of Wood Buffalo

SCHEDULE "B"

PENALTIES

Section	Description of Offence	Specified Penalty
5	Failure to wear Face Covering where required.	First offence $100 Second and concurrent offence $200
9	Failure to display prescribed signage.	$200

BYLAW NO. 20/024

BEING A BYLAW OF THE REGIONAL MUNICIPALITY OF WOOD BUFFALO TO REGULATE AND CONTROL THE WEARING OF FACE COVERINGS WITHIN THE REGIONAL MUNICIPALITY OF WOOD BUFFALO

WHEREAS on March 11, 2020, the World Health Organization declared a global pandemic related to the spread of the COVID-19 virus and because COVID-19 continues to remain a global health risk;

AND WHEREAS the World Health Organization, Chief Public Health Officer for Canada and the Chief Medical Officer of Health for Alberta have identified face coverings as a preventative measure to help reduce the risk of spreading COVID-19 in circumstances where physical distancing may not be possible;

AND WHEREAS physical distancing may not be possible in Public Places and in Public Vehicles;

AND WHEREAS pursuant to section 7 of the *Municipal Government Act,* RSA 2000, c. M-26 a council of a municipality may pass bylaws respecting:

(a) the safety, health and welfare of people and the protection of people and property;

(b) people, activities and things in, on or near a public place or place that is open to the public;

(c) transport and transportation systems; and

(d) businesses, business activities and persons engaged in business.

AND WHEREAS Council deems it desirable and necessary for the health, safety, and welfare of its citizens of the Regional Municipality of Wood Buffalo to require the wearing of a Face Covering in Public Places and in Public Vehicles;

NOW THEREFORE, the Council of the Regional Municipality of Wood Buffalo, duly assembled, hereby enacts as follows:

Short Title

1. This Bylaw may be cited as the “Face Covering Bylaw”.

Definitions

2. In this Bylaw:

(a) “Act” means the *Municipal Government Act*, R.S.A. 2000, c. M-26;

(b) "Employer" means any person(s) who as the owner, proprietor, manager, superintendent of any activity, business, work, trade, occupation or profession, has control over or direction of, or is directly or indirectly responsible for the employment of a person and responsible for the day to day operations of a Public Place or Public Vehicle;

(c) "Face Covering" means a mask or other covering that covers the mouth, nose and chin ensuring a barrier that limits the transmission of respiratory droplets;

(d) "Municipal Tag" means a document prepared by the Municipality alleging an offence issued pursuant to this Bylaw;

(e) "Municipality" means the Regional Municipality of Wood Buffalo;

(f) "Officer" means a Bylaw Enforcement Officer appointed pursuant to the *Enforcement Officer Bylaw 20/005*, a peace officer appointed pursuant to the *Peace Officer Act*, RSA 2006, c. P-3.5, or a police officer appointed pursuant to the *Police Act*, RSA 2000, c. P-17;

(g) "Operator" includes the person responsible for the day to day operations of a Public Place or Public Vehicle and a proprietor of a Public Places;

(h) "Proprietor" means the person who controls, governs or directs the activity carried on within any Public Places or Public Vehicle referred to in this Bylaw and includes the person usually in charge thereof;

(i) "Public Place" means any part of a building, structure or other enclosed area within the Municipality, whether privately or publicly owned, to which the public reasonably has or is permitted to have access, whether upon payment or otherwise.

(j) "Public Vehicle" means a bus operated by the Regional Municipality of Wood Buffalo, or a vehicle for hire as defined in the *Vehicle for Hire Bylaw 13/001*;

(k) "Violation Ticket" means a ticket issued pursuant to the current *Provincial Offences Procedure Act,* RSA 2000 c P-34, as amended or replaced and regulations thereunder;

Interpretation

3. Nothing in this Bylaw relieves a person from complying with any provision of any Federal, Provincial or Municipal law or regulation or any requirement of any lawful permit, order or license.

4. Should any section, subsection, clause or provision of this Bylaw be declared by a court of competent jurisdiction to be invalid, the same shall not affect the validity of this Bylaw as a whole, or any part thereof, other than the part so declared to be invalid.

Prohibition

5. A person must wear a Face Covering while in a Public Place or a Public Vehicle.

6. No person shall harass or intimidate a person who is not wearing a Face Covering as a result of any provision in Section 8.

7. No person shall hinder or impede any Officer in the performance of their powers and duties under this Bylaw.

Exceptions

8. Section 5 does not apply to:

   (a) children under 5 years of age;

   (b) persons who are unable to place, use, or remove a Face Covering safely without assistance;

   (c) persons unable to wear a Face Covering due to a mental or physical limitation, or protected ground under the *Alberta Human Rights Act*;

   (d) persons who are caregiving for or accompanying a person with a disability where wearing a Face Covering would hinder that caregiving or assistance; or

   (e) persons who have temporarily removed their Face Covering in a Public Place:

      (i) to provide or receive a service;
      (ii) while consuming food or drink in a designated seating area; and
      (iii) while engaged in an athletic or fitness activity; and
      (iv) while attending or leading a religious or worship activity.

Signage

9. An Employer, Operator or Proprietor must prominently display a sign, in the form and containing the content set out in Schedule "A", in a location that is visible to a person immediately upon entering the Public Place or a Public Vehicle.

Offence and Penalty

10. There will be efforts to educate prior to taking enforcement action against a person who contravenes this Bylaw.

11. A person who contravenes this Bylaw is guilty of an offence.

12. In the case of an offence that is of a continuing nature, a contravention of a provision of this Bylaw constitutes a separate offence in respect of each day, or party of a day, on which it continues, and a person guilty of such an offence is liable, upon summary conviction, to a fine in an amount not less than that established by this Bylaw for each such day.

13. A person who is guilty of an offence under this Bylaw is liable to:

    (a) A fine in the amount as prescribed in Schedule "B".

    (b) A fine in the amount as determined in accordance with the Provincial Offences Procedures Act, R.S.A. 2000, Chapter P-34.

Municipal Tag

14. A Peace Officer may issue, with respect to an offence under this Bylaw, a municipal tag specifying the fine amount as prescribed in Schedule "B" of this Bylaw as the amount payable.

15. Where a municipal tag is issued, the amount payable may be paid in accordance with the instructions on the tag, and if paid a Violation Ticket shall not be issued for that offence.

Violation Ticket

16. A Peace Officer may issue, with respect to an offence under this Bylaw, a Violation Ticket:

    (a) Specifying the amount set out in Schedule "B" of this Bylaw as the fine for the offence; or

(b) Require an appearance in court without specifying a fine amount and without the option of making a voluntary payment.

17. Where a Violation Ticket specifies a fine amount, a voluntary payment equal to the specified fine amount may be made as directed on the Violation Ticket.

Coming into Force

18. This Bylaw comes into effect when it is passed.

Review

19. This Bylaw shall be reviewed by Council no later than January 31, 2021.

READ a first time this 14th day of September, A.D. 2020.

READ a second time this 14th day of September, A.D. 2020.

READ a third and final time this _____ day of _____, A.D. 2020.

SIGNED and PASSED this _____ day of _____, A.D. 2020.

_____
Mayor

_____
Chief Legislative Officer

SCHEDULE "A"

Face Coverings MANDATORY

Effective September 15, 2020 wearing a face covering is mandatory in all indoor public places and in public vehicles.

The Regional Municipality of Wood Buffalo Bylaw 20/024

Visit **rmwb.ca/covid19** for more information

Regional Municipality of Wood Buffalo

SCHEDULE "B"

PENALTIES

Section	Description of Offence	Specified Penalty
5	Failure to wear Face Covering where required.	First offence $100 Second and concurrent offence $200
9	Failure to display prescribed signage.	$200
6	Harassment and Intimidation	First offence $100 Second and concurrent offence $200

BYLAW NO. 20/024

BEING A BYLAW OF THE REGIONAL MUNICIPALITY OF WOOD BUFFALO TO REGULATE AND CONTROL THE WEARING OF FACE COVERINGS WITHIN THE REGIONAL MUNICIPALITY OF WOOD BUFFALO

WHEREAS on March 11, 2020, the World Health Organization declared a global pandemic related to the spread of the COVID-19 virus and because COVID-19 continues to remain a global health risk;

AND WHEREAS the World Health Organization, Chief Public Health Officer for Canada and the Chief Medical Officer of Health for Alberta have identified face coverings as a preventative measure to help reduce the risk of spreading COVID-19 in circumstances where physical distancing may not be possible;

AND WHEREAS physical distancing may not be possible in Public Places and in Public Vehicles;

AND WHEREAS pursuant to section 7 of the *Municipal Government Act,* RSA 2000, c. M-26 a council of a municipality may pass bylaws respecting:

(a) the safety, health and welfare of people and the protection of people and property;

(b) people, activities and things in, on or near a public place or place that is open to the public;

(c) transport and transportation systems; and

(d) businesses, business activities and persons engaged in business.

AND WHEREAS Council deems it desirable and necessary for the health, safety, and welfare of its citizens of the Regional Municipality of Wood Buffalo to require the wearing of a Face Covering in Public Places and in Public Vehicles;

NOW THEREFORE, the Council of the Regional Municipality of Wood Buffalo, duly assembled, hereby enacts as follows:

Short Title

1. This Bylaw may be cited as the “Face Covering Bylaw”.

Definitions

2. In this Bylaw:

(a) “Act” means the *Municipal Government Act*, R.S.A. 2000, c. M-26;

(b) "Employer" means any person(s) who as the owner, proprietor, manager, superintendent of any activity, business, work, trade, occupation or profession, has control over or direction of, or is directly or indirectly responsible for the employment of a person and responsible for the day to day operations of a Public Place or Public Vehicle;

(c) "Face Covering" means a mask or other covering that covers the mouth, nose and chin ensuring a barrier that limits the transmission of respiratory droplets;

(d) "Municipal Tag" means a document prepared by the Municipality alleging an offence issued pursuant to this Bylaw;

(e) "Municipality" means the Regional Municipality of Wood Buffalo;

(f) "Officer" means a Bylaw Enforcement Officer appointed pursuant to the *Enforcement Officer Bylaw 20/005*, a peace officer appointed pursuant to the *Peace Officer Act*, RSA 2006, c. P-3.5, or a police officer appointed pursuant to the *Police Act*, RSA 2000, c. P-17;

(g) "Operator" includes the person responsible for the day to day operations of a Public Place or Public Vehicle and a proprietor of a Public Places;

(h) "Proprietor" means the person who controls, governs or directs the activity carried on within any Public Places or Public Vehicle referred to in this Bylaw and includes the person usually in charge thereof;

(i) "Public Place" means any part of a building, structure or other enclosed area within the Municipality, whether privately or publicly owned, to which the public reasonably has or is permitted to have access, whether upon payment or otherwise.

(j) "Public Vehicle" means a bus operated by the Regional Municipality of Wood Buffalo, or a vehicle for hire as defined in the *Vehicle for Hire Bylaw 13/001*;

(k) "Violation Ticket" means a ticket issued pursuant to the current *Provincial Offences Procedure Act,* RSA 2000 c P-34, as amended or replaced and regulations thereunder;

Interpretation

3. Nothing in this Bylaw relieves a person from complying with any provision of any Federal, Provincial or Municipal law or regulation or any requirement of any lawful permit, order or license.

4. Should any section, subsection, clause or provision of this Bylaw be declared by a court of competent jurisdiction to be invalid, the same shall not affect the validity of this Bylaw as a whole, or any part thereof, other than the part so declared to be invalid.

Prohibition

5. A person must wear a Face Covering while in a Public Place or a Public Vehicle.

6. No person shall harass or intimidate a person who is not wearing a Face Covering as a result of any provision in Section 8.

7. No person shall hinder or impede any Officer in the performance of their powers and duties under this Bylaw.

Exceptions

8. Section 5 does not apply to:

   (a) children under ~~2~~ – 5 years of age;

   (b) persons who are unable to place, use, or remove a Face Covering safely without assistance;

   (c) persons unable to wear a Face Covering due to a mental or physical limitation, or protected ground under the *Alberta Human Rights Act*;

   (d) persons who are caregiving for or accompanying a person with a disability where wearing a Face Covering would hinder that caregiving or assistance; or

   (e) persons who have temporarily removed their Face Covering in a Public Place:

      (i) to provide or receive a service;
      (ii) while consuming food or drink in a designated seating area; and
      (iii) while engaged in an athletic or fitness activity; and
      (iv) while attending or leading a religious or worship activity.

Signage

9. An Employer, Operator or Proprietor must prominently display a sign, in the form and containing the content set out in Schedule "A", in a location that is visible to a person immediately upon entering the Public Place or a Public Vehicle.

Offence and Penalty

10. There will be efforts to educate prior to taking enforcement action against a person who contravenes this Bylaw.

11. A person who contravenes this Bylaw is guilty of an offence.

12. In the case of an offence that is of a continuing nature, a contravention of a provision of this Bylaw constitutes a separate offence in respect of each day, or party of a day, on which it continues, and a person guilty of such an offence is liable, upon summary conviction, to a fine in an amount not less than that established by this Bylaw for each such day.

13. A person who is guilty of an offence under this Bylaw is liable to:

    (a) A fine in the amount as prescribed in Schedule "B".

    (b) ~~Upon summary conviction, a fine not exceeding $10,000 or a period of imprisonment of not more than one year, or both.~~ A fine in the amount as determined in accordance with the Provincial Offences Procedures Act, R.S.A. 2000, Chapter P-34.

Municipal Tag

14. A Peace Officer may issue, with respect to an offence under this Bylaw, a municipal tag specifying the fine amount as prescribed in Schedule "B" of this Bylaw as the amount payable.

15. Where a municipal tag is issued, the amount payable may be paid in accordance with the instructions on the tag, and if paid a Violation Ticket shall not be issued for that offence.

Violation Ticket

16. A Peace Officer may issue, with respect to an offence under this Bylaw, a Violation Ticket:

    (a) Specifying the amount set out in Schedule "B" of this Bylaw as the fine for the offence; or

(b) Require an appearance in court without specifying a fine amount and without the option of making a voluntary payment.

17. Where a Violation Ticket specifies a fine amount, a voluntary payment equal to the specified fine amount may be made as directed on the Violation Ticket.

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SCHEDULE "B"

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Bylaw No.20/024 Face Covering Bylaw

Intake 1: Written Submissions

1. Rachel Atkinson
2. Carol Hopkins
3. Johanna Koeppen
4. Roy and Brenda Mann
5. A. Quinn
6. Sunni-Paige Swyers
7. Amanda White
8. Mushtaque Ahmed
9. Sabrina Angell
10. Lisa Harlick
11. Ashley Deschenes
12. Chris Diprose
13. Cory Hancock
14. Chelsea Heath
15. Doug Hunt
16. Kirsten Larsen
17. Rod Lavechia
18. Sarah Lawrence
19. Jacquie McFarlane
20. Oil Sands Community Alliance
21. Shyloh Prescott
22. Contessa Short
23. Cal Watson

From: Rachel Atkinson
Sent: Wednesday, September 9, 2020
To: Legislative Assistants
Subject: Fwd: Mask

Sent from my iPhone

Begin forwarded message:

Sent from my iPhone

Begin forwarded message:

From: Rachel Atkinson FOIP ACT s.17(1)
Date: September 9, 2020 at 12:58:47 PM MDT
To: don.scott
Subject: Mask

I just wanted to put my thoughts in on the mandating of masks. We in Fort McMurray have been doing something right because we have very few cases. Unfortunately we have had a death and some number have now risen.

Mandating masks has not worked at SIGHT. As the Fort Mcmurray News paper say they have a outbreak at sight right now. Sight has had a mask policy in place for months now. Mandating masks will only close more of are already struggling businesses.

I do hope council realizes the deter-mental effect it will have on small and large business on a whole.

Thanks for listening.

Sent from my iPhone

From: Carol Hopkins
To: Legislative Assistants
Subject: MAKE MASKS MANDATORY
Date: Wednesday, September 9, 2020

Hello
My name is Carol Hopkins and I am writing to entreat town council to make masks mandatory in the city of Fort McMurray. My husband is a diabetic and receives dialysis treatments three times a week. He has heart disease, kidney disease, and his lungs are also damaged. Needless to say between these and other health issues he would be near the top of the list of vulnerable people. If he were to contract covid 19 it is highly unlikely he would survive.

Since March we both wear masks whenever we have to be in any public arena. The stress has been unbelievable! In addition I will only go into stores that I absolutely have to enter such as the pharmacy and grocery stores. It does little good for us to wear masks when other people refuse to do so, for whatever reason. I am certain we are not the only residents in the city who have a vulnerable individual in their household. A mandatory mask bylaw would greatly decrease stress levels and may contribute to the economy as people feel safer to enter public places.

I urge you to make masks mandatory in the Regional Municipality of Wood Buffalo.

Sincerely,
Carol Hopkins

From: Johanna Koeppen
To: Legislative Assistants
Subject: In favor of mandatory masks
Date: Wednesday, September 9, 2020

I understand that after news broke recently about the possibility of mandatory masks, you have probably been inundated with emails.

I would like to state, for the record, that I believe this is in the best interest of our region. I am a resident of Fort McMurray and a teacher at St. Kateri Catholic School. However, I am currently on a medical leave in the US, helping care for my elderly parents, as they were both hospitalized within a week of each other (not covid related).

In Canada, we see a lot on the news about the viral numbers in the United States and freely feel the right to criticize the arrogance of Americans for lifting restrictions too soon, not wearing masks, etc. My parents live in Cleveland, Tennessee, which is similar in size to our municipality, in both population and area. All businesses here require a mask upon entry, though it is not a bylaw. I am unsure as to how long this has been in effect, as it was in place when I got here. There are no demonstrations or anarchy about this. Sure, there might be some under-the-breath grumbling occasionally, but people realize that FOR NOW, this is what is necessary. This is what keeps exposure out of our homes, out of our schools, out of our nursing homes, and keeps businesses open and from going bankrupt, keeps schools open and children in front of their teachers, keeps elderly and those at risk alive. People have, during an extremely turbulent time racially and politically in the region, come together on this issue.

One question I have is how many of these cases in Wood Buffalo are related to camp workers or those who freely fly in-fly out? As so many recent cases seem to center on site, I would be curious to know the answer to this.

I have friends that stand vehemently on both sides of this issue, as is their right to express themselves and their opinion. Regardless of how each of us feels about the media hysteria and over-sensationalization worldwide (though mostly in North America) or our personal feelings on the effecacy of mask wearing, it is my hope that, as a municipality (as well as province and country), we realize that a small glimmer of hope is still hope and that, in our homes and community, having hope for the health and safety of our children, our elderly, our medically at-risk, and the general populous is worth the risk temporarily.

Though I will not be able to be there in person or virtually, I give permission for this rmail to be read aloud in my stead.

Thank you.

Respectfully,

Johanna Koeppen

From: Roy & Brenda Mann

To: Legislative Assistants
Subject: Mandatory Mask Meeting
Date: Wednesday, September 9, 2020

Hello,

I want to voice ahead of the Council meeting Sept 14, that I am NOT in favour of mandatory masks in public spaces.

Thanks,

Roy

From: A. Quinn
Sent: Wednesday, September 9, 2020
To: Legislative Assistants
Subject: september 14th meeting/comments for the mandatory mask bylaw

Hi,

As per the suggestions from the office of the mayor, please include my comments below for the meeting of September 14th, 2020 with respect mandatory masking. Please vote NO for mandatory masking. It is extremely harmful, and serves no beneficial purpose. These are my written comments. Thank-you.

I hope you are well. Thank-you for your service!

I am writing the following e-mail which I hope can be of assistance to you. I would like to ask you questions, why the following medical journals, and science have said mandatory masking not only is not effective, but can cause severe health issues? Please do NOT implement mandatory masking. On top of that "covid cases" are based on "faulty tests" (according to the test on the WHO, it tests human DNA, not a virus).

Could you please let me know, for example, while although information is heavily censored in the mainstream media, why a "goat", "papaya" (a fruit), and a "quail" were tested "covid positive"? https://globalnews.ca/news/6910821/coronavirus-papaya-goat-tanzania/)

If an individual believes the fear & media hype, let them choose to wear a mask. Please do not force it on the rest of the healthy population. Some reasons being pushed to issue such a mandate include "Protecting others". It does no such thing. It does not prevent any kind of protection from a virus either. Why does the OHSA (Occupational Safety & Hazard Association) teach employees that

- N95 Masks are used to prevent inhalation of tiny particles, but when exhaling is just raw, unfiltered air?
- Surgical masks are not designed for outside air, and only supposed to be used in sterile environments, and its filtration only works on the exhale?
- The masks (cloth, etc) are so laden with your own bacteria after a few minutes, and ineffective, that the OSHA does not advise using it under any circumstances?

I've observed a disturbing pattern where municipalities have been being pressured by certain media conglomerates and other paid actors pressuring to pass a "mandatory masking bylaw" despite of all the medical and scientific evidence to the contrary. I've also personally observed some very disturbing things in communities that have had a mandatory mask bylaw for more than a couple weeks, and am including that below.

Not only are masks ineffective, but they cause illness. Please let me know why following authorative documents all say that mandatory masking will have severe physical, psychological and mental health issues for the long term?

If there are other influences, pressures, or contrary information affecting your decision that I am not aware of, please do let me know what they are. While I am trying to keep this e-mail succint, I have another 35+ medical journal articles that support my statements concerning the dire mental, pyschological and mental torture that will ensue on the general population if it is not rescinded, that I can forward to you if you wish.

Finally, please let me know if I can be of any other assistance. Thank-you for your time in reviewing this.

A. Quinn

1. Medical Data from very Authoratative Publications (essentially the 'Harvard' & 'Princeton' universities of medicine):

The following medical articles, journals and so forth state that mandatory mask wearing is a very bad idea, and not only is ineffective, but can cause severe health issues.

- The New England Journal of Medicine (May 21, 2020) (masks ineffective): https://www.nejm.org/doi/full/10.1056/NEJMp2006372
- British Medical Journal (Test conducted in 2011) (masks cause illness, and this advises against their use): https://bmjopen.bmj.com/content/5/4/e006577
- The WHO's stance on masking (April/June 2020) (masks ineffective): https://apps.who.int/iris/bitstream/handle/10665/331693/WHO-2019-nCov-IPC_Masks-2020.3-eng.pdf

In addition, these medical articles talk about some of the dangers of mandatory mask wearing:

- Reduce blood oxygenation (http://scielo.isciii.es/pdf/neuro/v19n2/3.pdf)
- It concentrates exhaled viruses in the nasal passages (https://www.jpost.com/health-science/could-wearing-a-mask-for-long-periods-be-detrimental-to-health-628400)
- Increase risk of headaches (https://www.healio.com/news/primary-care/20200407/ppeassociated-headaches-increase-among-health-care-workers-amid-covid19)
- It can cause contact dermatitis (https://pubmed.ncbi.nlm.nih.gov/32170800/)
- And then a business publication, talking about faulty masks (https://www.businessinsider.com/coroanvirus-holland-recalls-over-half-a-million-masks-imported-from-china-2020-3)

There is even a very well researched site, with video & 50+ reserach links showing how bad masks are both physically, and pyschologically. It can be accessed here: https://themodelhealthshow.com/maskfacts/

2. The Actual Test Itself shows it is inconclusive and inaccurate

- https://www.cdc.gov/coronavirus/2019-ncov/testing/serology-overview.html
- https://www.cdc.gov/nchs/nvss/vsrr/covid19/tech_notes.htm

The CDC is one of the most authoratative government website in the world. It works in conjunction with the WHO, which declared this "pandemic" in the first place.

The actual "test" itself appears to be inaccurate & inconclusive. In other words, people are being "tested" without every questioning the "test" itself. On it - it states that being tested postive 'may or may not' you have anything, and being tested negative 'may or may not' mean you have anything. It also states that you may have simply had the common cold recently. In other words - it doesn't really give a definitive result on anything, other than to say you "may" have "something" which might simply be the "common cold".

Most recently - they 'corrected' a 'mistake' - saying only 6% of deaths were specifically related to "covid" (which is also based on a faulty test) - while the other 94% had other serious underlying health conditions (i.e., cancer, diabetes, obesity, old age, etc, etc)

3. Personal observations from communities that have implemented mandatory masking bylaws:

In the very short time in communities where mandatory mask bylaws have been implemented, I have personally observed the following issues:

- Elderly, overweight men and women, fully masked, standing in the heat outside waiting to enter, panting in the heat with a mask on, and audibly stating that they can't breathe. However, they are allowing authority to override their common sense. One lady nearly passed out.
- In the shopping malls, fully masked children between the ages of 3-12 with their parents, stating that they can't breathe. And the parents telling them they must continue to wear the mask.
- Makeshift masks, made out of cotton, fabric, plastic, toilet paper, paper towels, etc, that do absolutely nothing other than restrict airflow and cause breathing issues.
- Open "mask-shaming" on local radio, making fun of and putting down anyone who does not comply. One of the specific radio shows was referring to individuals in their 20's unable to wear a mask, but shaming them by saying "since they are young, they must be healthy, therefore couldn't possibly be exempt".
- Posters and signage on businesses omitting the exemptions, in addition to uninformed staff and 'security' guards mandating mask usage.
- Staff within establishments performing activities that cause physical exertion, but afraid to take off their mask because of customer pressure.
- Staff within establishments that do suffer from medical conditions and/or performing activities that cause physical exertion, but have been threatened that they will be fired from their job if they do not wear a mask
- Excessive mask usage, for periods of 6, 8, and 10 hour shifts causing brain fog, reduced performance, etc
- Individuals biking, jogging, or doing other forms of physical activity in extreme heat with masks on.
- Firemen, in full fireman gear, in extreme heat, all wearing thick mask coverings while running up stairs and carrying heavy loads.
- Heightened constant anxiety and fear in individuals, potentially leading to long term pyschological disorders

4. Statistics are being manipulated to drive fear, and decisions.

a) "Case counts", without the corresponding number of "conducted tests", paint an inaccurate picture of what is really happening. For example, in the media - headlines read "Cases on Day 1 were 10. Now 30 days later they are 100! It increased 900%" While the statement itself is factually accurate, it is misleading. "Day 1" may have had only 10 tests (so 10/10 = 100% "infection" rate). Then day 30, had 1000 tests (so 100/1000 = 10% "infection rate"). So the reality is - the "infection" rate has gone from 100% to 10% - yet the media paints the picture of a 'ravaging' virus. "Case Counts" without the corresponding number of tests conducted are meaningless.

b) An "argument" that the "USA" is "ravaging" while Canada is fine is also very misleading, so arguments like "don't be like the USA", and the "borders" should be "closed" are being made. The reality is - Canada is very similar to the USA, and in fact, with the current statistics - it is actually safer in the USA if you are "diagnosed" with "covid", than it is in Canada.

How is the possible? The USA is 8.6x as large as Canada. And the USA has performed 14x as many "tests" as Canada has. So naturally, "case counts" will be much, much higher. The media neglets to mention this.

When the statistics are properly adjusted (something called "normalization"), you get the following.
Original Data

USA - 5,321,520 cases, Deceased: 168,236, Tests Conducted: 67,067,797, Population: 328.2 million
Canada - 122,376 cases, Deceased: 9,037, Tests Conducted: 4,541,747, Population: 37.59 million

x 8.6 for Canada (to compare apples to apples - in other words - if Canada had the same population as the USA)
Canada - 1,052,433 cases, Deceased: 77,718, Tests Conducted: 39,059,024, Population: 328.2 million

x 1.71 for Canada (now to get compare results as if the same # of tests were conducted, since the USA still outperforms canada for # of tests even with the population adjustment):
Canada - 1,799,660 cases, Deceased: 132,897, Tests Conducted: 67,067,797

In other words - if you were comparing "apples" to "apples" - Canada has very similar "case counts" and "death counts" to the USA. Interestingly enough, the "case count" in Canada trails the USA by about 1-2 weeks (in otherwords, properly adjusted, in about 2 weeks the "case count" would be at the "5 million mark" like the USA).

Finally - the mortality rate (based on a faulty test remember) is higher in Canada, than in the USA. Canada (deaths/cases) = 7.38%. USA = 3.16%

So - if you ever get a "positive test" from Covid, you are much more likely to make a full recovery in the USA than you are in Canada.

5. Finally, if you have read this far, I appreciate it.

The following article I came across makes much more sense why masks that are ineffective are being mandated. It has nothing to do with health. I do not know if you have a religious background, but you may be interested in reviewing the following. It is very concerning why this agenda is being pushed on the entire world population, for a virus that has not been isolated by health canada, has a 99.9% survival rate, plus much more.
https://haveyenotread.com/occult-ritual-transformation-and-coronavirus/

Thank-you for your time in reviewing the above.

A. Quinn

Written Submission from Sunni-Paige Swyers

Open Letter

September 9, 2020.

Dear Councillors of the Regional Municipality of Woodbuffalo,

With the upcoming debate to be held on September 14, 2020, I write to you as a concerned citizen of Fort McMurray. I am asking that you strongly consider not making masks a mandated bylaw.

By **John Carpay** "The curve is flat, and has been for months. COVID-19 deaths peaked in March or April (depending on which jurisdiction) and now continue to decline, even while increased testing exposes more "cases." If masks were not required to flatten the curve, why should they be required now?

Many leading doctors and public health officials from around the world support mandatory mask-wearing. But this does not mean that the science is settled.

One study states that cloth masks pose a 13 percent increased risk of influenza-like illness infection to those wearing them, noting that "moisture retention, reuse of cloth masks, and poor filtration may result in an increased risk of infection." This past April, the World Health Organization (WHO) also confirmed that masks "offer a false sense of security, leading to potentially less adherence to other preventive measures."

The same WHO document points to problems with self-contamination that can occur by touching and reusing contaminated masks, and potential breathing difficulties due to decreases in oxygen levels.

Health professionals observe rampant misuse of masks in the community. Contamination by the incorrect removal of masks is a persistent problem, even among trained medical personnel. England's deputy chief medical officer, Dr. Jenny Harries notes that one "can actually trap the virus in the mask and start breathing it in" and that "people can adversely put themselves at more risk than less."

The New England Journal of Medicine explained recently that "wearing a mask outside health care facilities offers little, if any, protection from infection," and that masks "serve symbolic roles" as "talismans" that may help increase a "perceived sense of safety" and do more to reduce anxiety than to reduce the transmission of Covid-19. Likewise, Dr. Anthony Fauci, member of the U.S. White House's coronavirus task force, recently said that masks are symbolic of being a responsible citizen rather than a dependable infection-control measure.

A WHO guideline from June 5, 2020 states: "At present, there is no direct evidence (from studies on COVID-19 and in healthy people in the community) on the effectiveness of universal masking of healthy people in the community to prevent infection with respiratory viruses, including COVID-19. … At the present time, the widespread use of masks by healthy people in the community setting is not yet supported by high quality or direct scientific evidence and there are potential benefits and harms to consider."

Masks impair communication, harshly impacting vulnerable people with mental-health disorders and developmental disabilities; the deaf and hard of hearing; those with cognitive impairments; and children. Dangerous miscommunications can result when those who suffer from hearing loss are not able to hear someone who is wearing a mask. These risks are even greater in multicultural settings, where a person often needs to see the speaker's mouth and face to fully understand what is being said.

Assuming for a moment that the spread of COVID-19 is actually reduced by forcing the public to wear non-medical masks, this still does not address the violation of personal autonomy and human dignity, which are protected by the *Canadian Charter of Rights and Freedoms*.

Faces are the glue that holds us together, giving us our identity. Recognizing a face is vital to our social lives. By seeing each other's faces, we discern emotional expressions such as joy, fear or anger. As the Czech-and-French author Milan Kundera wrote in his 1988 book *Immortality*: "The serial number of a human specimen is the face, that accidental and unrepeatable combination of features."

The significance of the uncovered face was underscored not long ago by the heated debate over Quebec's law banning face-coverings. Quebec Premier Philippe Couillard argued: "We are just saying that for reasons linked to communication, identification and safety, public services should be given and received with an open face… We are in a free and democratic society. You speak to me, I should see your face, and you should see mine. It's as simple as that."

Opponents of this Quebec law argue that living in a free society means being able to choose what to wear, and what not to wear. To cover or expose one's face is a profoundly personal choice that carries with it political, cultural, psychological and spiritual implications.

Few would disagree that an "open face" helps with communication, identification and safety. Antifa thugs and criminals wear masks for a reason.

The *Charter* requires politicians to justify laws that diminish the realm of personal choice. Even if mask-wearing really does reduce the spread of COVID, it's necessary to distinguish the fearmongering of this past March from the facts we now know in July. In March, the politicians relied on claims by Dr. Neil Ferguson of Imperial College that COVID-19 would kill 510,000 people in the UK and 2.2 million Americans. We were told in March that COVID threatened everyone, including children and healthy adults.

Today we know that what politicians and chief medical officers said in March was not just false, but demonstrably false. Alberta Premier Jason Kenney and Chief Medical Officer Deena Hinshaw claimed that as many as 32,000 Albertans could die of COVID. As of July 23, the number was 176 (not 32,000) and 97 percent of deaths were amongst people over 60.

Today, government data tells us that COVID poses very little threat to children or youth. Like other viruses, it threatens elderly people with one or more serious health conditions. We now know that four fifths of COVID deaths occurred in nursing homes, amongst elderly people who were already very sick. As a cause of death, the impact of COVID on healthy adults under 60 has

been negligible in comparison to so many other causes of death. Statistically speaking, healthy adults have more to fear from driving than they do of dying of COVID.

On a global scale, COVID deaths are a small fraction of the number of lives claimed by the Asian Flu (1957-58) and the Hong Kong Flu (1968-69). In Alberta and other jurisdictions, the average age of death from COVID is higher than the average life expectancy; COVID has little if any impact on life expectancy.

Yet government policies are still based on the panic of March, rather than on the facts known in July. The media continue to speak about COVID as though death is not a natural part of life, and as though no person has ever died (whether wholly or partly) from a virus. Government policy seems to be predicated on the notion that we can somehow make people live forever (or for a very long time) even when they are already very elderly and very sick.

What is "unprecedented" in 2020 is not COVID but a new social and political experiment of locking up an entire population of millions of healthy people, pushing many of them into unemployment, poverty, depression and loneliness, all of which significantly reduce overall health. This is completely different from quarantine: the ages-old practice of isolating the sick.

Another "unprecedented" feature of 2020 is politicians and chief medical officers who ignore settled medical opinion that the best way to vanquish a virus (and to protect the vulnerable from it) is to allow it to spread amongst people who are younger, stronger and healthier. Once "population immunity" ("herd immunity") is established, the virus cannot easily spread further, and therefore has far less chance of harming the vulnerable. If wearing a mask truly works to reduce the spread of a virus, then mask-wearing will hurt the vulnerable by delaying the acquisition of population immunity.

Settled medical opinion about herd immunity cannot simply be disregarded or dismissed. Those who believe that we can and should try to stop the spread of a virus amongst healthy and invulnerable people must prove and justify their novel approach."

Again, I write this letter and beg you not to pass the mask bylaw.

Sincerely,

A Concerned Citizen

https://www.jccf.ca/making-face-masks-mandatory-is-not-backed-by-science-or-law/

https://apps.who.int/iris/bitstream/handle/10665/331693/WHO-2019-nCov-IPC_Masks-2020.3-eng.pdf?sequence=1&isAllowed=y

https://www.independent.co.uk/news/health/coronavirus-news-face-masks-increase-risk-infection-doctor-jenny-harries-a9396811.html

https://www.nejm.org/doi/full/10.1056/NEJMp2006372?query=TOC

https://apps.who.int/iris/handle/10665/332293

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4420971/

https://www.educateadvocateca.com/face-masks-and-social-distancing/

https://www.acpjournals.org/doi/10.7326/M20-1342

https://www.realclearpolitics.com/video/2020/05/12/flashback_march_2020_fauci_says_theres_no_reason_to_be_walking_around_with_a_mask.html

From: Amanda White

To: Legislative Assistants
Subject: Mandatory mask - submission
Date: Wednesday, September 9, 2020

I am writing to plead with you to consider the FACTS surrounding masks.

This is a very hot topic. For some it's lack of science, some it's an infringement on rights, others it's concern for themselves or others.

It does not matter how you FEEL about this or even what you think about this topic. It's not about fitting in and no matter what decision is made, some people will be happy and some angry.

Fact - the chief medical officer has NOT made masks mandatory. End of story. She knows what is best, she is not concerned enough to force this issue.

Food for thought- many people, for or against masks do not wear them properly, do not put their mask on or remove the mask properly, some use an old garbage shirt to make a mask. These people think they are doing good and protecting themselves or others. They are in fact acting under a false sense of security and feel they are potentially actively spreading the virus. As an example: at a store I have witnessed multiple people touching high contact surfaces then immediately adjusting their mask, scratching their neck, removing their mask or pulling it to their chin or neck then replacing the mask back over their face. This is not just the odd person, this is multiple people on multiple occasions. If they come into contact with the virus, they then go to work, school, family gathering etc, they then have passed the virus to numerous people. Please help me understand how mandatory masks will be better?

Thank you for your time.
Amanda

Sent from my iPhone

From: Mushtaque Ahmed [redacted]
Sent: September 11, 2020
To: Legislative Assistants

Dear Councillors,
I am Mushtaque Ahmed, President of the Bangladeshi Society of WoodBuffalo and express our full hearted support in favour of the motion of making the face mask mandatory in this city.
Thank you.
Mushtaque Ahmed
President BSWB
Ex-President
Multicultural Association of Fort McMurray

From: Sabrina Angell [redacted]ber
Sent: 11, 2020
To: Legislative Assistants
Subject: Re: Pending mask bylaw

Follow Up Flag: Follow up
Flag Status: Flagged

Revised
On Fri, Sep 11, 2020 Sabrina Angell FOIP ACT s.17(1) [redacted] wrote:

To Whom it may concern,

The mask bylaw Jeff Peddle is proposing is crazy and I for one will not follow this bylaw.

I will not be wearing a mask or any mask the council is proposing.
Ron Quintal has also thrown concern and is pro mask wearing, than him and such should wear a mask.

As I am out and about in town, I notice a lot of people are choosing to wear a mask where ever they go.
Why not just leave it at that?
We don't need any council to make it a bylaw.

Let us the people decide if we want to wear a mask or not. Or better yet let the people vote online.
Let the people decide not the council.

From: lisa harlick [redacted]
Sent: Friday, September 11, 2020
To: Legislative Assistants
Subject: The Not So Great Mask Debacle

Good Day to All,

As you can see the town is divided on whether to mask or not. This is a subject that bears a lot of weight on all of us. We all have our reasons for what we chose to wear on our face and our body. Its a freedom of choice that we hold dear. What we put in and on our bodies whether its clothing, tattoos or piercings, and vaccines its a freedom of choice. This is something only we as individuals can make for ourselves, only we have total control and power over OUR BODY.

When something very personal gets taken away from us we go into flight or fight mode. Our brains interpret this as a threat and this threat creates stress and in turn stress wear downs our body and our immune system takes a hit. If we choose to "flight" our immune systems get weak, our mental health and ability to clearly think goes down. Our bodies deteriorate. NOT GOOD. Suicides and mental health will be on a major rise. On the other hand if you chose to fight back for our rights, things can get ugly as a community and the whole situation gets escalated needlessly. People will turn against one another and Fort McMurray will not be a strong loving community any longer. There could be riots and unwanted violence in the streets. We suffer as a whole. Not a good situation either. When you look at things its a lose / lose situation.

Also, when you take away our right to chose whether we wear a mask or not you are infringing upon our Charter of Rights and Freedoms as Canadians. Imposing the use of mandatory face coverings in commercial establishments breached s. 7, s. 15 and s. 8 of the Canadian Charter of Rights and Freedoms. Making masks mandatory violates the right to liberty of the person under s. 7 because it forces people to cover their faces and interferes with their bodily integrity. It also infringes the right to non-discrimination on the basis of disability under s. 15 since it imposes a disproportionate burden on persons with disabilities, including breathing problems like asthma and emphysema or trauma-based phobia of breathing obstructions. Making a by-law is just not acceptable for Canadians.

Then we have another very valid point. Masks don't help at all, no medical doctor is pushing for mandatory masks. Please see this link for an open unbiased video from a scientist. Please also see the attached files from real clinic studies that debunk the use of face masks.

Mask Facts - The Model Health Show

Apart from the uselessness of face masks, we need to address the real struggles for mental health that people face from wearing masks. Please see the link that support how damaging the COVID restrictions are on children and adults.
Children show increase in mental health difficulties over COVID-19 lockdown

Children show increase in mental health difficulties over COVID-19 lockdown

Parents/carers of children aged 4-10 years of age reported that over a one-month period in lockdown, they saw in...

Speaking about psychological and physiological problems, this is where it really touches home for me and my family. We are not afraid of contracting Covid 19 at all. My biggest fear is the judgement I get when I leave my house to get supplies for my family. I get anxious and very stressed. I do not like being judged for choosing not to wear a face mask. I do not want to leave my house and see people, I rather shop online and get everything at my front door with out having to see people. I know I am not alone in saying that shopping from home is better than being in public, this eventually will ruin our economy and our community. Our town is already in a dire situation and forcing masks will cripple it even more. When forced to wear a mask I get nauseous, I get headaches and my heart races, I get dizzy and light headed, I put it under my chin. I CAN NOT AND WILL NOT WEAR A MASK. As for my children, I am a single mom, I work very hard to support them.

This year I have decided to pull all 4 of my children from school so they do not have to wear a mask. Its not right, I do not believe a mask should be forced on anyone. I noticed that my daughters have developed anxiety, they have panic attacks. They have chest pains, breathing problems and just start crying out of nowhere. This never happened before all the restrictions. This is not fair to anyone. My children do not want to leave the house anymore unless they are going for a car ride. They refuse to be out in public. Mandatory lockdowns and masks is robbing my family their right to live happy and have a normal life without fear of judgement from others. This is taking a toll on my family's mental health and not acceptable in any way for a governing body to take away our freedoms and our quality of life.

So just a quick recap, mandatory masks - Infringement on our Charter of Rights and Freedoms
- Negative impact psychologically and physiologically
- Masks do not work!!!!!
- cause major divisions in the community and higher possibility of violence and loss of security among our neighbors

When will this end???? COVID -19 is here forever, it will never go away. It is a strain of the flu. We deal with the flu all the time and in fact there are more deaths associated with the flu then with COVID-19. We never had to do things differently before, now all of the sudden we have to. It doesn't make any sense. We are are not ever going to get rid of it. Masks make us sicker and lower our immunity. We were born with immunity we should just rely on our body's capabilities instead of following the media and what the ELITES think is OK. This is all out of fear mongering and mainstream agenda to suppress civilians rights and fit into their hidden agenda.

Have a look at these links, the numbers are all fabricated and skewed to induce fear mongering and control over the people.
New study: 90% of COVID-19 cases have “barely any virus”

New study: 90% of COVID-19 cases have “barely any virus”

The fearless source of news, opinion, and activism that you won't find anywhere else.

https://standupcanada.ca/canada-wide-declarations-of-emergency/

CANADIAN CHARTER RIGHTS – FOR INDIVIDUALS

CANADIAN CHARTER RIGHTS – FOR INDIVIDUALS

Understanding your Rights and Freedoms - and how they are being violated.

I am for pro choice. If someone wishes to wear a mask, then let them. If someone chooses not to wear a mask, then let them. If a business chooses to have their employees wear a mask, you can choose to work there or not. If a business chooses that anyone that walks through their doors has to wear a mask we can chose to shop there or not. Mandatory masks do not work and therefore should not be enforced. We have the freedoms to choose what goes in or on our bodies whether its clothing, tattoo, jewelry or a vaccine. No one makes the decision for us.

Sincerely,

Lisa Clifton

Int J Nurs Stud. 2020 Aug; 108: 103629.
Published online 2020 Apr 30. doi: 10.1016/j.ijnurstu.2020.103629

A rapid systematic review of the efficacy of face masks a against coronaviruses and other respiratory transmissible community, healthcare workers and sick patients

C. Raina MacIntyre[a] and Abrar Ahmad Chughtai[b,*]

▸ Author information ▸ Article notes ▸ Copyright and License information Disclaimer

Abstract

Background

The pandemic of COVID-19 is growing, and a shortage of masks and respirators globally. Policies of health organizations for healthcare workers are inconsistent, the US for universal face mask use. The aim of this study was to review the evide masks and respirators for healthcare workers, sick patients and the general public

Methods

A systematic review of randomized controlled clinical trials on use of respiratory workers, sick patients and community members was conducted. Articles were sea Embase using key search terms.

Results

A total of 19 randomised controlled trials were included in this study – 8 in comm healthcare settings and 5 as source control. Most of these randomised controlled t interventions and outcome measures. In the community, masks appeared to be eff hand hygiene, and both together are more protective. Randomised controlled trial showed that respirators, if worn continually during a shift, were effective but not Medical masks were not effective, and cloth masks even less effective. When use randomised controlled trials suggested protection of well contacts.

From: Ashley Deschenes
To: Legislative Assistants
Subject: Masks should not be mandatory.
Date: September 11, 2020

This is from an OSHA inspector that doesn't seem to have an agenda, only facts. I am pretty sure you will be surprised at his findings.

From an OSHA Inspector Below:

I wanted to put this out there. I have worked in a clean room for 23 years and 10 years on submarines before that. OSHA is the standard that you have to live by in these environments. So for the people that are going to say, listen to the experts, OSHA would be those experts on face masks.
Please read the following with an open mind.
So MASKS?
I am OSHA 10&30 certified. I know some of you are too. I don't really know WHY OSHA hasn't come forward and stopped the nonsense BUT I want to cover 3 things
• N95 masks and masks with exhale ports
• surgical masks
• filter or cloth masks

Okay, so upon further inspection, OSHA says some masks are okay and not okay in certain situations.
If you're working with fumes and aerosol chemicals and you give your employees the wrong masks and they get sick, you can be sued.
• N95 masks: are designed for CONTAMINATED environments. That means when you exhale through N95 the design is that you are exhaling into contamination. The exhale from N95 masks are vented to breath straight out without filtration. They don't filter the air on the way out. They don't need to.
Conclusion: if you're in Target and the guy with Covid has a N95 mask, his covid breath is unfiltered being exhaled into Target (because it was designed for already contaminated environments, it's not filtering your air on the way out).
• Surgical Mask: these masks were designed and approved for STERILE environments. The amount of particles and contaminants in the outside and indoor environments where people are, are CLOGGING these masks very, VERY quickly. The moisture from your breath combined with the clogged mask will render it "useless" IF you come in contact with Covid and your mask traps it, YOU become a walking virus dispenser. Everytime you put your mask on you are breathing the germs from EVERYWHERE you went. They should be changed or thrown out every "20-30 minutes in a non sterile environment."
• Cloth masks: I can't even believe I'm having to explain this, but here it goes. Today, three people pointed to their masks as they walked by me entering Lowe's. They said "ya gotta wear your mask BRO" I said very clearly "those masks don't work bro, in fact they MAKE you sicker" they "pshh'd" me. By now hopefully you all know CLOTH masks do not filter anything. You mean the American flag one my aunt made? Yes. The one with sunflowers that looks so cute? Yes. The bandanna, the cut up t-shirt, the scarf ALL of them offer NO FILTERING whatsoever. As you exhale, you are ridding your lungs of contaminants and carbon dioxide. Cloth masks trap this carbon dioxide the best. It actually risks your health, rather than protect it. The moisture caught in these masks can become mildew ridden over

night. Dry coughing, enhanced allergies, sore throat are all symptoms of a micro-mold in your mask.
-Ultimate Answer:
*N95 blows the virus into the air from a contaminated person.
*The surgical mask is not designed for the outside world and will not filter the virus upon inhaling through it. It's filtration works on the exhale, (Like a vacuum bag, it only works one way) but likely stops after 20 minutes, rendering it useless outside of a STERILE ENVIRONMENT (correct Becky, they don't work in a bar, not even a little bit).
*Cloth masks are WORSE than none. It's equivalent to using a chain link fence to stop mosquitos.
The CDC wants us to keep wearing masks. The masks don't work. They're being used to provide false comfort and push forward a specific agenda. For the love of God, research each mask's designed use and purpose, I bet you will find NONE are used in the way of "viral defense."
Just like EVERY Flu season kids, wash your hands. Sanitize your hands. Don't touch stuff. Sanitize your phone. Don't touch people. And keep your distance. Why? Because your breath stinks, your deodorant is failing, your shoes are old and stink, that shirts not clean, & I like my space. Trust me I can hear you from here. Lots of reasons to keep your distance and work on body hygiene. But trust me, the masks do not work.
*Occupational Safety & Hazard Association sited.
The top American organization for safety.
They regulate and educate asbestos workers, surgical rooms, you name it.
I know, facts suck. They throw a wrench into the perfectly (seeming) packaged pill you are willingly swallowing. Facts make you have to form your OWN OPINION, instead of regurgitating someone else's, and I know how uncomfortable that makes a lot of you. If your mask gives you security, by all means wear it. Just know it is a false sense of security and you shouldn't shame anyone into partaking in such "conspiracies."

From: Chris Diprose [redacted]
Sent: Friday, September 11, 2020
To: Legislative Assistants
Subject: What do I do if I can not wear a mask

To Whom : This is a written submission to be read out at the meeting

If mandatory masks bylaw is passed and for medical reasons I can not wear a mask
Is a doctors note sufficient for my wife and I to go grocery shopping and laundry and odd jobs ?
We are seniors, what are options ?

Thank you for your attention

Yours Terese and Chris Diprose

Sent from Mail for Windows 10

From: Cory Hancock
To: Legislative Assistants
Subject: Sep 14, 2020 - Special meeting, masks
Date: September 11, 2020

Hi

I'm a resident on Parry Cres, and I don't support the mandatory mask by-law.
We have gotten this far without, we are fine.
If a business choses to, so be it, but should not be forced on.

Cory Hancock

From: Chelsea Heath [redacted]
Sent: Friday, September 11, 2020
To: Legislative Assistants
Subject: Mask By-Law written submission

Good Evening,

I am writing to voice my support for a mask bylaw to help keep case counts low. Keeping cases counts low during the start of the school year can help keep us safer during Thanksgiving and Halloween, when touching, visiting and chatting with those outside our households is higher than usual.

Please dont forget:
1) Edmonton and Calgary have had their cases increase after the mask bylaw implementation because this is also the time were people are returning from summer vacation and school shopping. Please refer to Jasper's or Banff's case counts, both of which have had bylaws in place for over a month and routinely sees influx of visitors every weekend, long weekend and in addition to those that spent longer periods of time in the area.

2) Pre-existing conditions are more than just the types of illnesses and diseases that can drastically shorten someone's life. These conditions also include those are are born with a genetic link to these disease, like Type 1 (Juvinile) Diabetes or asthma.

3) People are not sheep for using masks because someone with a higher education and understanding of the situation advises to use them. We all live in a town that prides itself on safety in the workplace, by following all protocol and using applicable PPE that is available in the workplace. Why is this PPE used? Because someone with a higher education and understanding of the situation has concluded that the PPE works as intended when used as directed. On site, there are very few people who have seen first hand the effects of a workplace injury. Yet, you'll see nearly 100% compliance with PPE meant to prevent a similar workplace accident. I have yet to hear of a team bullying someone or calling them a sheep for using PPE. Hopefully, that level of stupidity never creeps back into the workplace.

Thank you for your time.

Get Outlook for Android

From: Doug Hunt [redacted]
Sent: Friday, September 11, 2020
To: Legislative Assistants
Subject: No mask bylaw

A mask bylaw seems incomprehensible to myself and many others in Fort McMurray. Every single statistic is less than 1 percent with the exception of survival and recovery rate. Active cases would have to hit approximately 800 before it gets to 1%.

I could entertain the idea if we had thousands of active cases, however there are less than 100 active cases and over 99% of people recover from this virus. You will not stop deaths by adding a mask law, this virus will continue to exist regardless of masks and we are currently keeping the active rate of infection at less than 0.25% of the population.

The most recent outbreak on the mining sites happened while every site has required masks for over 6 months. A mask law will not save lives and will not stop infections. If it doesn't work on a small scale it will not work on a larger scale.

Please do not waste taxpayer dollars enforcing a bad law that will not help people.

From: Kirsten Larsen [redacted]
Sent: September 11, 2020 1
To: BoardsandCommittees
Subject: No mandatory masks

I, Kirsten Larsen as a long term Fort Mcmurray resident am completely opposed to mandatory masks. I will not support any council members that vote for this.
There is a significant amount of medical evidence that supports the health risks of masks and there is also no evidence to support masks provide any protection against Covid.
According to our chief medical officer, she is not in support of mandatory masks or masks for young children.
So does this council have any medical or scientific evidence that supports this?

Regards
Kirsten Larsen

From: Rod Lavechia [redacted]
Sent: Friday, September 11, 2020
To: Legislative Assistants
Subject: Concerns over Mask Bylaw

September 11, 2020

Dear Council,

I am writing this letter with regard to the upcoming debate (September 14, 2020) on mandatory masks in wood buffalo and I wanted to address some of my concerns.
As a Machinist and an armchair Stock Trader, I tend to be a "numbers guy". From what I am seeing with regard to the number of "Covid" cases and deaths in our region during the last 7 months of this "pandemic", masks; at this point seem very moot.
I cannot comprehend the logic behind stripping people's rights and freedoms, to give others' a false sense of security during an apparent "pandemic" that has possibly taken the life of one person in the region.
I know the main stream sentiment, if you listen to radio or watch the MSM, they all make it appear that people want this. I can tell you that I live in reality and speak with people every day that are not down with this "muzzle" agenda. I would say 9 of 10 are not down with it! If you choose to make our freedom end where others' fear begin, that would be a hasty decision to which there would be ramifications come election season. I can assure you of that!
The Eco Fascists that are pushing this agenda (worldwide) would love nothing more than to see Fort McMurray go bankrupt. I feel there is a great opportunity to push back and keep the True North Strong and **FREE**!
If you look across the Pacific to another Commonwealth Country, you will see how dangerous of a slope this really could become if calmer heads don't prevail.
Currently, in Melbourne Australia, you have a virtual Police State, with hard lockdown that began with allocated masks. The totalitarian tiptoe then continued with curfew, closed state borders, Police checkpoints, work permits for travel, drone surveillance, chopper patrols, 1hr a day outdoor exercise only, mandatory medical testing procedures, banned travel, food rations, closed Churches, denied sunshine, School closures, shopping times, Police access to homes without a warrant, no wedding celebrations, decimated economy, limited attendees at funerals, business closures, no family visits, no movement beyond 5km range, Military patrols, Government removal of children, censorship across social media, suicides, 1 million unemployed and a massive increase in domestic violence.
Is this what you envision for us and Canada? Please do not tell me "it's just a mask" or "it's for the greater good"! The People already fell for the "it's just 14 days to flatten the curve" narrative.
Please don't allow this nonsense to come to the great city of Fort McMurray. Let the freedom to choose reign in the The True North Strong and **FREE**!!
We know a cloth mask can't stop or prevent viral spread (unfortunately the science doesn't back it). If you choose to muzzle the People, we will not forget we will not forgive.
Regards,
Rodney Lavechia.

Sent from Outlook

From: Sarah Lawrence [redacted]
Sent: September 10, 2020
To: Legislative Assistants
Subject: Proposed Mask Bylaw

Good Evening,

I would this email to serve as proof of my support for the proposed mask bylaw within the regional municipality of wood buffalo.

I feel it is in the communities best interest to protect each other in any way possible.

Our children need to stay in school, people need to continue to work to support their families, the elderly need to be kept safe. All this can be done if everyone complies with wearing a mask. It's the least we can do to look out for those in our community.

Sarah lawrence
FOIP ACT [redacted]
Resident of Fort McMurray

Get Outlook for iOS

From: Jacquie McFarlane
To: Legislative Assistants
Subject: Mask bylaw
Date: September 11, 2020

Good afternoon Mayor and Council,

I'm writing in opposition to the proposed mask bylaw proposed by the municipality.
I personally am opposed to forcing people to wear masks when they don't want to be wearing them. I feel like this bylaw could have a lot of ramifications to local businesses.

Personally I will be avoiding shopping locally if required to wear a mask while out in public. Since the recent rise in numbers I have noticed more people wearing masks in public and that is great that they feel safer doing so. I'm not opposed to anyone choosing to do so not will I call them names or berate them.

For me and my family however we prefer to do other measures to prevent spread. I will wear a mask when required to however if a mandatory mask bylaw is put in to place then I will lessen the amount that I need to be wearing it. Previous to this our family were very strong supporters of shop local, but a forced mask bylaw will change my shopping habits. I am not saying this as a threat but as a realistic representation of what I know my habits will be. If it was between wearing a mask to go in to a store to shop and look around or finding what I need on Amazon and getting it delivered in two days probably for cheaper I'm more than likely going to do the latter. In the same way that some people won't cross the bridge to shop or eat at a certain establishment because of the inconvenience I see this as being another impediment as to why people won't be shopping local.
And I'm fairly certain there will be many other people who feel the same way.

I just want this to be considered when the decision making is being done on this proposed mandatory mask bylaw.

Thank you for your consideration.

Jacquie McFarlane
FOIP ACT s.17(1)

September 11, 2020

RMWB Mayor and Council
Regional Municipal of Wood Buffalo
7th Floor, 9909 Franklin Avenue
Fort McMurray, Alberta T9H 2K4

RE: Mandatory Mask for Public Spaces Bylaw

Dear Mayor and Council,

Since March 2020, OSCA has been navigating the COVID-19 pandemic with our member companies, Alberta Health Services (AHS) and community stakeholders including the RMWB. Safety is a key part of the oil sands industry and the well-being of our communities and employees is our top priority.

In order to reduce the risk of COVID-19 exposure, OSCA members have implemented stringent protocols, and procedures to keep employees safe and sites operational that include:

- Screening questionnaires and procedures;
- Stringent self-isolation protocols;
- Physical distancing in the workplace, on buses and flights;
- Enhanced sanitation, workplace hygiene and cleaning;
- Face mask protocol that requires employees to wear masks on flights and buses as well as on site.

Companies continue to implement these protocols, and work with AHS to limit exposure and spread of COVID-19.

The COVID-19 pandemic has negatively impacted the region, businesses and the oil sands industry. With Alberta's phased re-launch strategy, we have seen similar protocols implemented in workplaces, schools, and on public transportation as the province and our region opens up. With the rise in cases over the last two weeks, and the potential of a second wave, having a consistent approach and aligning on protocols is necessary. A mandatory mask bylaw, is a key approach to ensure community safety, to limit exposure and continue to keep businesses open.

The oil sands industry has been an essential service during this pandemic and will continue to play a pivotal role as we turn our attention to recovery and the path forward for Alberta and Canada. To ensure the safety and well-being of employees and

the community, oil sands companies will continue to implement strict measures and work with AHS to enhance pandemic plans and procedures. For reasons mentioned above, we encourage Council to pass proposed mask bylaw.

Sincerely,

FOIP ACT s.17(1) [redacted]

Shafak Sajid
Oil Sands Community Alliance

From: Shyloh Prescott [redacted]
Sent: Friday, September 11, 2020
To: Legislative Assistants; Mike Allen; Krista Balsom; Keith McGrath; Phil Meagher; Verna Murphy; Sheila Lalonde; Claris Voyageur; Jeff Peddle; Don Scott; Bruce Inglis; Jane Stroud
Subject: Mandatory mask bylaw council vote Sept 14

Hello,

My name is Shyloh Prescott, and I have lived here in Fort McMurray for almost 2 years, and I love this town! It has struggled over the last few years but it is very evident that most people here love Fort McMurray. The natural scenery and beauty is breathtaking and I love the abundance of wild berries and plants that are able to grow here. The birchwood trails are wonderful and we are so lucky to be so close to the forest. Thank you to all in council who continue to work hard for us, especially during this challenging time. I understand that these are difficult times and I do want you to know that council is very much appreciated.

In saying this, I am emailing all of you today to let you know that my family and I do NOT support mandatory masking indoors. The data shows overwhelmingly that masking of healthy people is not effective in preventing transmission of most illnesses, including Covid 19. The Journal of the American Medical Association (JAMA) and The British Medical Journal(BMJ), among others, have published multiple studies that find this to be consistent. They have also published studies showing that the highest risk factors for having a serious reaction to Covid 19 is **obesity, type 2 diabetes, and hypertension,** and completed studies showing that handwashing is far more effective than masks at preventing the spread of illness.

I'm sure you are all aware that there is a huge difference between the gold standard RANDOMISED CONTROL studies published by JAMA and BIJ regarding clinical AND community use of all types of masks, and the OBSERVATIONAL studies that some doctors and politicians are citing. Please read up on these studies as they are conflicting but the randomised control studies should be taken seriously as they are the highest quality and far more data-driven than the observational studies. They are very detailed and explicit in their data regarding cloth, surgical, and N95 masks and the effectiveness of each.

Most importantly, our government has not recommended mandatory masks indoors, and in fact, Dr Deena Hinshaw, our Chief Medical Officer and top doctor, has not encouraged mandatory masking. Just yesterday (Sept 9), she stated that most transmissions are happening in social settings and NOT businesses and believes that no further restrictions are needed at this time. She stated "That seems to be what's driving the majority of cases - are social interactions, household interactions, close contact interactions - where it really is outside of that formal business environment".

The average age of Covid related fatalities in Alberta is 84 while the average life expectancy is 83. The majority of those people also had severe underlying health issues/comorbidities and a large percentage were in nursing homes. This demographic does not reflect the demographic of almost everyone visiting a grocery store, going to the Registries office, taking their child to the library, or having dinner at a restaurant. Protect the people who are most vulnerable - the majority are seniors in long term care or nursing homes - but be logical in knowing that the general public out and about running errands shouldn't be the focus.

Please see data from Calgary and Edmonton since they began mandating masks indoors. There has been no decrease in cases. And now what do they do? Remove the mandatory mask bylaw? Keep it? Where do they go from here? What would we do in the same situation? Businesses aren't the driving force of transmissions and the data supports that.

The information we are receiving barely focuses on how to keep our bodies healthy and boost our immune systems so we can actually protect ourselves the way we are supposed to. Is there a way that council could encourage our population to get more Vitamin D (a known and scientifically proven immune booster, not to mention the multiple well known studies showing that Vitamin D deficiency or insufficiency was present in almost all ICU Covid cases and deaths) as many people in northern climates do not usually have adequate levels? Could we encourage people to get outside, exercise more often, and try to eat better to actually have a healthier body? This would lower the risk of becoming seriously ill for everyone, which is a good thing! Vitamin D is very inexpensive to buy at any store and is readily available. Could you run a billboard sign or radio ad or flyer campaign encouraging people to improve their own health? To wash their hands more often? Take a walk around the block? Even just to sit outside in the sun for a few minutes? I don't know if this is an option, but they seem to be reasonable, down to earth suggestions based on the facts.

The increasing focus on number of cases being reported while also not discussing the data surrounding the number of hospitalisations, ICU admissions and capacity, and daily deaths is very problematic. Canada recorded 2 deaths yesterday (Sept 9) for the entire country. The average has been between 2-7 deaths per day for at least the last month. Why is the focus on case counts when deaths are very low? How long do we drag out less than 7 deaths per day? I feel very sad for those that have lost their lives because of this, but compare it to the death rates for heart disease, cancer, suicides, and drug overdoses that are not reported on. They are exponentially greater. Have we not been effective in what our original goal is, which is to flatten the curve? Our current mandates and the general public's compliance have been proven to work in our current state, and anyone looking in should be able to logically look at that and make a decision.

The data EXISTS. It's all there. Of course there is fear and worry. It's extremely unfortunate that we had our first Covid related death in the community last weekend. But it's going to happen. We have done extremely well to have had ONLY 1 death since the pandemic was learned of 8 months ago, and that should be very encouraging. No one wants to see loved ones or themselves go through this. But please look at the data. Dr Hinshaw seems to be following the data. Follow her lead, please.

In the end, how we all feel about this or if we agree or disagree doesn't matter. It shouldn't matter. I know that no matter what you decide, you will not be able to please everyone. BUT IT DOESN'T MATTER. All that should matter is data and proof. And the fact is, Dr Hinshaw has not made masks mandatory for a reason.

With that, I will end my ramble. Thank you very much to all of you for your time and consideration.

Shyloh Prescott

From: Contessa Short

September 11, 2020

Mask Mandate – Bylaw
Attention: Mayor and Council

This letter has been written to provide my comments in support of the Mandatory Mask Mandate for RMWB.

Like many other individuals, it is hard to find the appropriate words to express my feelings towards the new "standard of normal that has been imposed upon my life". However, I have accepted these changes and have done my best to adhere and comply where possible. As I grapple with this new reality, this is made even further difficult by certain individuals that feel their rights have been imposed upon by having to wear a mask or follow certain public health orders. While I sympathize with everyone during these difficult times, the lack of regard and understanding of utilizing the only means that seems reliable in preventing the spread and inevitable deaths, is unbelievable.

The world is a different place today than it was 6 months ago and I am unsure when we will see what we interpret as normal again. It is extremely IMPORTANT that we are kind to our neighbours and begin to take precautions to protect ourselves and the people around us. The small acts of kindness and consideration that we show each other today, will make big impacts tomorrow. Putting on a mask in public, and spaces where MAINTINING 6FT PHYSICAL DISTANCING IS DIFFICULT is just a simple demonstration of kindness, love and care for each other's safety!

We need to learn to be compassionate, accepting and kind through our most difficult times.
We are all scared! We NEED to take steps to protect our future! WE ARE OUR BOTHERS' KEEPER!!!
I want to be remembered for trying my best, for being kind, and for acknowledging how I can do better. If this starts with wearing a simple mask to get groceries, then so be it.

I live on the opposite side of the country from my grandparents. They made MANY sacrifices throughout their lifetime to ensure that my mom, aunts and uncles grew up as decent human beings. They also made many sacrifices for my sister and I (I credit them for the many things I have achieved) …. It is an unimaginable fear, when I consider all that they have been through, that it could be for NOTHING, just to catch the virus from someone that decided wearing a mask impeded their "rights" and "freedoms", and through the exercise of their rights, become a vector-Spreader of the virus that could potentially infect and kill my grand parents.

We all want to set good examples for our children. Let's show them we can make a difference and protect one another with the simple act of wearing a mask when in public. Let us also use this time to teach lessons on proper disposal practices of our used masks and ensure we are protecting the environment at the same time.

I see many comments made on social media about the virus being a conspiracy theory, or that masks impede people's rights, or that this is a way to get us to disconnect from one another, or this is just a flu. Please give your heads a shake! I am NOT trying to downplay peoples' rights; I want to emphasise the need for a balance in the reality of the NEW NORMAL. Our economy is suffering, businesses are closing that will never reopen – all at a loss to something that can hopefully be minimalized by wearing a mask. People are losing their lives. Individuals that have recovered are experiencing what could be life lone

complications. Children are contracting a form of the virus and we have no idea the potential life long impacts.

Comparing death statistics for other diseases like diabetes or the flu is ignorant, these diseases have been around for many years and we understand the complexities of these diseases. We have NO idea what COVID-19 is capable of.

I wear a mask knowing it may not make a difference. What am I loosing by wearing a mask? About 5 seconds of extra time to make sure I have it with me. What are you "loosing" by NOT wearing a mask? Maybe your life, maybe the life of someone else.

If wearing a mask DOES make a difference in preventing the spread, then I have contributed to the better good of the community and I know I did my part to keep your children safe, your sick family members safe, your elders safe, highly vulnerable people safe and myself safe. If wearing a mask DOES NOT make a difference, then at least I can say, "I tried".

Walmart, Loblaws, Costco, Airline and many more businesses require mandatory masks. This is no different than the general norms we all believe in **"no shirt, no shoes, no service"** … please be considerate of others as we all patiently discover what our new lives are shaping in to.

Masks are being implemented all around us (companies are not waiting for bylaws to be introduced, they are taking their employees safety into their own hands). In the words of Mr. Peddle, I am shocked that this hasn't been a Provincial mandate. BUT why do we need to wait for it to be mandated to TRY?
In a city so driven by safety – demonstrated by the successful evacuation of our beautiful city during the wildfire, evacuation of the downtown core during the floods – it is hard to believe that the members of this community still question the precautionary measure at this point. We set an example for the WORLD then, let us be the example that the WORLD needs right now!

We need to take care of one another! If we loose sight of what makes us humans and a collective society, then we have already lost the battle before it has even started.

I am pleading on ALL Councillors of the RMWB to make the right choice and vote in favor of the mask mandate. We need to do what we can to flatten the curve. As leaders, please contribute to making this flattening possible in the RMWB and take part by contributing to the decisions that help in mitigating the spread of the COVID-19 VIRUS. The virus spreads by both droplets and aerosols. Wearing masks reduce the spread!!

Thank you for your time.

Let's make a difference TOGETHER!

Thank you,
Contessa Short

From: Cal Watson

RMWB MASK MANDATE SUGGESTION

Please consider this suggestion instead of a mask mandate;

At this time the RMWB Mayor and Council have decided not to institute a mandatory mask bylaw. We do however ask that anyone going into a public place they can not properly social distance please wear some sort of face covering. If you are unable or unwilling to wear a face covering, we ask that you are courteous, keep your distance and perhaps go at times when crowding is minimal such as early in the morning or later in the evening.

Cal Watson

FOIP ACT s.17(1)

[redacted]

Bylaw No.20/024 Face Covering Bylaw
Intake 2: Written Submissions

1. Sabrina Angell
2. Cindy Archer
3. Sara Archer
4. Eric Bildfell
5. Tiffany Boettcher
6. C. Breitkreuz
7. Kim Coish
8. Stephen Cornish
9. James Cox
10. Jason Cyprien
11. Gary DaCamara
12. Gabriel Dalley
13. Mark Dorsday
14. Steve Dubeck
15. Duncan Paul
16. Rachel Eldridge
17. Dinah Fillier
18. Leslie Foote
19. Emily Forster
20. Elizabeth Gallagher
21. Kathy Guillard
22. Jonathan Gilles
23. Elsa Gifrvin
24. Lee Hanson
25. Paul Hanson
26. Chelsea Heath
27. Jamie Hewat
28. Aoife House
29. Brianna House
30. Gregory House
31. Jan & Katie Indenbosch
32. Nadia Jonson
33. Justin kelly
34. Lindsey King
35. Wilhelf & Hilda Kristman
36. Kristy Laidlaw
37. Rodney Lavechia
38. Tiffany Lavechia

39. Brittany Lequereux
40. Sara Lichti
41. James Lichti
42. Sara Lichti
43. James Long
44. Allie MacKenzie
45. Marita MacKinnon
46. Adrian Manolache
47. Deanna Martic
48. Nyasha Matengu
49. Megan McKay
50. Dorothy McSheffery
51. Megan Noseworthy
52. Phil Osborne
53. Craig Peckford
54. Sonja Petereit
55. Pamela Pittman
56. Jillaine Proudfood
57. Cheryl Richards
58. John Ridley
59. Sam Roberts
60. Megan Robertson
61. C. Robinson
62. Jocelyn Routhier
63. Elise Ryland
64. Johnny Sheppard
65. Nicole Sheppard
66. Samantha Short
67. Dave Simcoe
68. Cara Stapleton
69. Johanie St-Pierre
70. Sharon Stuve Mitchelmore
71. Sunni-Page Swyers
72. Amy Thibodeau
73. Shauna Thompson
74. April Tollman
75. Alisa Unruh
76. Christine Unruh
77. Allen Waldner
78. Rochelle Young
79. Joanne Zelmer

From: Sabrina Angell
To: Legislative Assistants
Subject: Revised again
Date: Sunday, September 13, 2020 9:15:15 PM

To whom it may concern,

The mask bylaw that Jeff Peddle is proposing is crazy and I for one will not follow this bylaw.

I will not be wearing a mask, as the city counsel is proposing.
Ron Quintal has thrown concern and is for mask wearing as well. I believe that if he or anyone else feels this way than they can and should wear a mask.
However I do believe that this should be a CHOICE. Not because some people and council feel like we should..

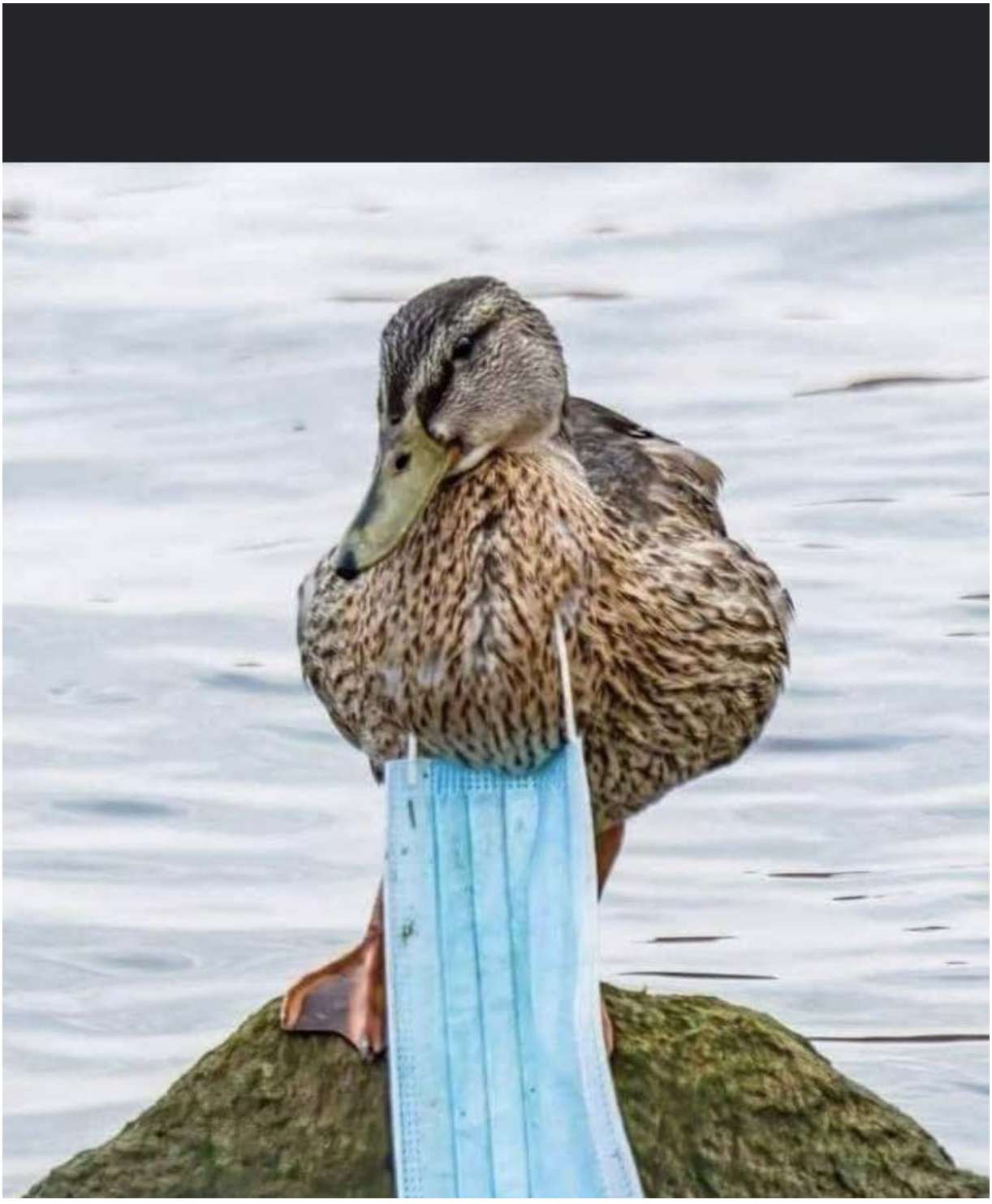
As I am out and about in town, I noticed people are choosing to wear a mask where ever they go. This is their choice.
Why not just leave it at that? Let this be OUR choice.
We don't need council to make the it a bylaw!

Let us people decide if we want to wear a mask or not. Let us decide what is better for our families needs.
Or better yet let the people vote online.
Let the people decide not the council.

Thank you

From: Sabrina Angell
To: Legislative Assistants
Subject: Picture
Date: Monday, September 14, 2020 9:28:19 AM

I have also attached a picture as we went bagless for a bylaw.
And from my understanding we still have that bylaw. So mask wearing is not that great for our animals either.
Maybe take that into consideration as well.



September 11, 2020

To Mayor Don Scott and Council

Re: Covid 19

The fear of Covid 19 is destroying our lives, our community and country.

I have tremendous concern for our children! Today being the first day of school for my grand daughter, started out with great anxiety for her. After school she greeted us with sheer happiness! She rated the day an 8 out of 10. Knowing the kids at her school from volunteering, they rated the day as "awesome" and were obviously happy to be with their friends.

I know the kids and teachers will be sick this fall and winter as I've worked in the school system a long time and it happens every year. I don't want to see this blamed on Covid 19. We cannot take all of the skills offered by the schools away from our kids. In Fort McMurray our kids have missed a lot of school between the fire, Covid 19 and the flood. These schools take such good care of our kids.

None of us want to get pneumonia, H1N1, Hepatitis, Ebola, Covid 19……etc. We sure don't want to here the statistics on them daily either. Wear a mask if you want too, social distance and wash your hands often.

This epidemic cannot become a disability issue, legislative issue or worse a severe mental health issue. People are dying because of Covid protocol in the hospitals now and people are dying alone!

Please support us and 'let us live!' Life is very short! Let us have the option of wearing a mask or not.

Yours respectfully,

Cindy Archer

September 9, 2020

I would like to thank you for reading my letter. I will start with some facts.

Statistics as of September 8, 2020

Alberta population 4,428,247

Alberta Covid cases 15,191

Alberta Covid deaths 248

Fort McMurray population 66,570

Fort McMurray active Covid cases 66

Fort McMurray Covid deaths 1

Based on those stats:

In Alberta you have a 0.00005% chance of dying of Covid

In Fort McMurray you have a 0.001% chance of catching Covid and a 0.00001% chance of dying of Covid

Some will argue that the number of confirmed cases does not matter because there still could be asymptomatic cases or unconfirmed cases. Okay let's assume there is 100 more unconfirmed cases of Covid in Fort McMurray today bringing our case total up to 166. That gives us a 0.002 chance of catching Covid.

Jason Kenney stated yesterday that we need to not live in fear and realize that Covid is not going anywhere. We need to learn to live with it. It is normal to see cases rise now that schools have opened etc. People need to work and begin their lives once again.

The World Health Organization has stated the following:

"a healthy person should only wear a mask if he/she is taking care of a sick person or a person with symptoms of the virus"

In Fort McMurray we have dealt with the crash of our economy, the fire, the flood and the virus. Our numbers have shown how well we have done without crazy lockdown measures and a mask bylaw. Mentally people here are suffering enough right now, implementing a mask bylaw 6 months into the pandemic would only take away hope and cause added stress/frustration to many. People need to return to living and not be tortured by fear. During the flood this spring we all came together shoulder to shoulder and the virus was completely forgotten about to save our community and fellow neighbors. My mother's home is in Waterways so I was in the heart of it all daily and did not see one person wearing a mask. There was not an increase in Covid cases afterwards. Currently in Fort McMurray public spaces people are wearing a face mask or social distancing. There is a lot to be said about giving a citizen the right to choose especially when it comes to something going on their body.

Some people are unable to wear a face mask or visor due to medical issues. Examples are autism and other neurodevelopment disorders, skin conditions, sensory issues, COPD, anxiety, breathing disorders, someone on oxygen etc. I personally struggle with PTSD due to a traumatic event in my past, I cannot

bare to have anything wrapped around my head or over my face. Several doctors in town are refusing to write medical mask exemption letters due to how politicized this virus has became. I have experienced this.

I feel that a compromise to please everyone would be to keep the ads out that the RMWB currently has online asking people to wear a mask. Also, if there were signs posted at every public space stating that people are strongly encouraged to wear masks. I feel most would choose to wear the mask, if they feel forced many will refuse. Another alternative to a mandatory bylaw would be to do what Drumheller Alberta has done and reward people for wearing a mask instead or forcing it on to the residents with a mandatory bylaw. We will see a greater outcome.

Fort McMurray is a resilient town and I have been proud to call it home since 1981. Thanks again for your time,

Sara Archer

From: Eric Bildfell
To: Legislative Assistants
Subject: Please no
Date: Sunday, September 13, 2020 2:23:10 PM

Please for the love of all things pure and holy, do not make masks mandatory. All they do is create a place for bacteria to grow right in front of our faces all day. The numbers show across the board the masks truly do more harm then good. A virus is not going to be stopped through some dainty mask. If you're going to mandate that you may as well mandate gloves and a fishbowl to stuff our heads into to catch all the virus that the mask is not catching through top bottom and sides. I have been taking a class the last two weeks at keyano and we wear a mask all day. In that time I have had a season voice every night and felt slightly headachy all the time. I did not experience that at all before this. Then on the weekends when I'm not in class I'm 100% again. Please no

From: Tiffany Boettcher
To: Legislative Assistants
Subject: Mask law
Date: Monday, September 14, 2020 11:07:29 AM

As a resident of the woodbuffalo region for almost 15 years. I want to voice that the new mask law that is being proposed goes way to far. Leave it to individual stores. Individuals themselves. Do not force people. Of all ages. Toddlers included who some can not wear one, or have anything on their face. To force this. With jail time as a result is a sad pathetic attempt at control. Shame on the council for even suggesting such atrocities. I along with my family are against this. And I hope the council will do better going forward.

From: C. Breitkreuz
To: Legislative Assistants
Subject: Mask Bylaw
Date: Sunday, September 13, 2020 5:27:31 PM

Dear Honoured Council Members,

It is my opinion that masks should not be mandatory for all of the public; That should be the determination of the individual.

As the individual has the right to choose with the majority of health and safety issues, it should be up to the individual -as well as individual businesses- to determine the level of personal risk: it should not be a bylaw.

Sincerely,

A Concerned RMWB Citizen

From: Kim Coish and Alan Erickson
To: Legislative Assistants
Subject: Face mask
Date: Friday, September 11, 2020 7:05:21 PM

Hi,

I’m writing to say my husband & I believe face mask *should not* be mandatory in RMWB.

Thank you,
Kim Coish
Alan Erickson
Section 17 (1) FOIP

Sent from my iPhone

From: Stephen Cornish
To: Legislative Assistants
Cc: Jeff Peddle
Subject: Bylaw No. 20/024 - Face Covering Bylaw
Date: Monday, September 14, 2020 12:25:04 PM

Hello,
I am very much in favour of this bylaw.
I work at the Real Canadian Superstore on Haineault St. and there has been three colleagues who have tested positive for Covid-19 in the past week.
The company's policy about masks is that if someone isn't wearing one, currently we will allow it.
This bylaw will help protect every day people such as myself who are trying to keep Fort McMurray a community and not just an after effect of the oil fields.
I live in Fort McMurray, have a normal job and use public transportation.

I am in contact with the public constantly and without this bylaw the effort 90% of the population, wearing masks, will be for nothing. The last 10%, who are not exempt for medical reasons, don't see this as a Public Health issue and won't wear a mask. The number of cases has jumped alarmingly and without he bylaw I don't see how the RMWB will continue to function.

Yours,
Stephen Cornish
Section 17 (1) FOIP
Fort McMurray

From: james Cox
To: Legislative Assistants
Subject: Mask bylaw
Date: Sunday, September 13, 2020 9:36:54 PM

Submitted by Jackie Cox

I know I speak for many when I asked you not to make masks mandatory in the RMWB. It seems ludicrous that governments and corporations are suddenly deciding, months after 'flattening the curve' that they must all suddenly impose masks on everyone, so as not to appear less virtuous and responsible as the next municipality or corporation. There is no evidence that masks prevent the spread of Covid 19. Even the box they come in states this clearly. My son has asthma and has enough difficulty breathing at times without adding the restriction of a mask. On the contrary, there are numerous health professionals speaking out against mask wearing due to the serious respiratory infections they can cause, not to mention the impact on mental health, particularly in children who are already frightened and confused by having their lives turned upside these past several months, then forced to have their breathing restricted and to interact with others, having no ability to read facial expressions.

Obviously some people are very concerned about Covid and feel that masks protect them. They are already free to wear a mask if they choose but that is exactly what it should be, a choice, not an overreaching government that assumes we are not intelligent or responsible enough to make our own decisions. Please consider these points when you vote today. Let us choose for ourselves.

Thank you

From: Jason Cyprien
To: Legislative Assistants
Subject: Masking law
Date: Monday, September 14, 2020 10:15:58 AM

Hello my name is Jason Cyprien I am a Father if 3 children and my wife and I are both on the same opinion. We do not believe in the masking laws and we also do not support trying any masking laws. Especially since proven to do more harm than good.

Thank you
Jason Cyprien

From: Gary DaCamera
To: Legislative Assistants
Subject: No masks
Date: Friday, September 11, 2020 9:38:09 PM

Hello fort McMurray council
This is in regards to the violation of
Our civil liberties by forcing masks on everyone, because of the views of one
Person who IS NOT A DOCTOR, does the council have any scientific research done by Canadian scientists and Doctors to back this up. I will Not be forced to wear a mask, to be oppressed like other cities. Does the severity (99% survival rate)of this pandemic justify violating the rights of everyone in fort McMurray and surrounding areas.

Gary DaCamara

From: Gabriel Dalley
To: Legislative Assistants
Subject: Mask Bylaw
Date: Sunday, September 13, 2020 12:39:55 AM

Masks do not prevent Covid-19, it has been stated by medical professionals. It has been clearly printed on boxes of masks. Medical masks are designed for a sterile surgical environment. That's it. Forcing the citizens of our city to wear this garbage will create more problems than it will solve. People will not do this. We all know this city is not a liberal sheep city. People will fight this. It will be nothing more than a waste of police resources and another cash cow from the tickets for the RMWB. As elected officials elected to lead this city by the people of this city, listen to us and do not enforce this farce. People are sick and tired of this crap we do not need more legislation in the affirmative of this. People have the right to choose. Someone wants to wear a mask? Fine. It doesn't mean that we all should. Please stop the madness and use your own heads. Not just what the liberals are telling us all to think.

Thank You for your time. And the opportunity to have my say.

Gabriel Dalley
16 year Fort McMurray Resident.

From: Mark Dorsay
To: Legislative Assistants
Subject: Face coverings
Date: Monday, September 14, 2020 11:21:19 AM

DEAR Council, regarding bylaw readings of # 20/024 . I Mark Dorsay of Fort McMurray would like to voice my opposition to the above bylaw. Face masks are useless against this virus that is no worse than a seasonal flu. Face mask provide as much protection as a chain link fence when you throw a handful of sand at it. Most of the sand would get through just like the virus will pass through and around a mask . Please use your critical thinking skills and reject this nonsense bylaw. .
Sincerely,
Mark Dorsay

From: Steve Dubeck
To: Legislative Assistants
Subject: No to the proposed bylaw for mandatory face masks
Date: Monday, September 14, 2020 10:38:42 AM

NO. The municipality needs to let the people decide for themselves if they want to wear a face mask, or not.

The evidence just isn't there to support such a life altering, freedom taking event. Having a 99.8% survival rate of COVID doesn't make sense to implement such a bizarre bylaw.

It's very strange that the council members of this community would even consider such an idea.

So it's a massive NO from me.

Instead, maybe you all could figure out ways to promote healthier lifestyle choices (ie: fitness campaigns, take your vitamins slogans, or even discuss stress management solutions). Being healthy and wearing a mask to suck in the CO2 you're emitting isn't healthy. Long term studies are going to show this.

Steve Dubeck

From: Paul Duncan
To: Legislative Assistants
Subject: Mask wearing Debates/Council Meetings
Date: Friday, September 11, 2020 8:55:22 PM

To RMWB Representative,

I wanted to share this documentary on Mask Science as helpful education on making a decision whether or not to make mask wearing a mandatory By-Law.

I suggest everyone who is making decisions on mask wearing in RMWB watch this before making a final decision.

If you choose to not watch this you will most likely be making a poorly informed decision and therefore threatening the health of the residence of RMWB.

I trust the Democratic process will succeed and you will make a responsible and scientific decision on RMWB mask wearing.

“The Science & History Of Masks In Medicine”
The Model Health Show
With Shawn Stevenson

https://youtu.be/XHQ7zDNXKj0

Thanks,

Paul.

From: Rachel Eldridge
To: Legislative Assistants
Subject: Mask mandate
Date: Saturday, September 12, 2020 8:24:54 PM

I cannot take part in these meeting but I want to express my support to make masks mandatory if this is not the right place to send this please let me know where is

Sent from my iPhone

On Sep 11, 2020, at 1:12 PM, Dinah Fillier
wrote:

Hello,
My name is Dinah Fillier. I am
Writing in concern about the mandatory mask bylaw
that's up for discussion.. please please don't do
This to us. We are begging you. My kids, my family,
my friends. We need to at least keep some form of
freedom. If ppl want to wear them, by all means... but
don't make us and treat us like criminals cause we don't
want to. There are
So many doctors telling us about how bad it is... but it's
not even that.. it's about our freedom. No dancing, no
singing, no hugging no human contact, no cash...
depression ... ppl losing all
Faith in
Our government to do the right thing .. wear a mask
when your having sex.. when does it end?? We are all
Sooo sick of this.. and frustrated. My daughter sits in
school for 8 hours with a mask on... because they Don't
have separate desks.. it's sooo sad and her face is broke
out in acne.. and she's sweating when she gets
home.... it's just sad. Let us at least have the right to
chose. What has this world come to. I never thought In
my life I would see this day.. sad sad. Please I'm
Begging You. I would probably move if I'd had to wear
a mask everywhere. It's depressing and not normal and
it's not practicing our rights. I will keep my distance...
and wash my hands but my god, cover my face
now....???? We need to be able to live. Please don't
take Way this one last humane thing we have!!
I trust you are on that board to serve our community.

Please Do so by not taking away this.... our right to breath the
air god gave us without a mask on.

Sincerely,
Dinah Fillier
Sent from my iPhone

From: Leslie Foote
To: Legislative Assistants
Subject: NO to mandatory masks
Date: Monday, September 14, 2020 10:27:35 AM

Hello!

As a resident of 18 years in fort Mcmurray !!
I am saying NO!!!!!! To the mandatory mask!!!
Please NO!!
Let us decide as humans if we want to wear them! This is sad for our kids!!! The rules are ridiculous ! We need to learn to live with this not hide behind it !! Like every other disease.

No no no to mandatory masks!!!
Leslie Foote

From: Emily Forster
To: Legislative Assistants
Subject: Mask Bylaw
Date: Monday, September 14, 2020 10:42:45 AM

Dear Sir's and Madam's,

As a resident of this municipality for over 15 years, I am saddened and concerned about the mandatory mask bylaw which is before council.
I understand there are many opinions regarding the wearing of masks, and the effectiveness of them in disease prevention. Some feel strongly to wear them, some feel strongly against them, some are in the middle ground where they see both sides. For me, the issue with this bylaw is not one of mask wearing, but of citizens rights being taken away. I support businesses making masks mandatory in their establishments, if they feel this is the best course of action for them. I support us being sensitive and understanding of the high risk population. I support us all working together for a healthier community.
I have 4 children.
I teach them to respect others and the laws of this land. But it is not healthy for my children to be forced to continually wear a covering on their faces whenever they are not on my property. To wear a mask when walking or biking the trails, all day in school, or when playing in a public green space where there is plenty of fresh air and space to distance themselves from others is not something I cannot support.
I cannot condone or support this bylaw which removes my right to choose.

Sincerely,
A concerned citizen

Sent from my iPhone

From: Elizabeth Gallagher
To: Legislative Assistants
Subject: Bylaw no. 20/024 face covering bylaw
Date: Monday, September 14, 2020 10:59:17 AM

Please make the right decision today. Please think of the many people who live in this community who have underlying illnesses and are at high risk for severe complications and/or death if they contract Covid. Please think of the sick children and elderly citizens who live here too, that we do not want to lose. Please make the right decision to protect these people instead of opting to satisfy the ones who don't feel like wearing masks for aesthetic purposes. Now is not the time. It's obvious that if the people opposing mask use had underlying illnesses or sick children they would also be begging for your basic protection the way we are. At the VERY LEAST we deserve to have masks made mandatory in the places that we NEED to enter to obtain our bare necessities; ie grocery stores, all medical and dental settings, post offices, etc. We should NOT have to go without and we should NOT have to cancel our appointments and out of hospital surgeries out of fear.
This decision should not have been left open to individual business owners as they are obviously biased and will not mandate mask use due to fear of losing business. You're making them choose between their livelihood and protecting the citizens of Fort McMurray and that's not their job, it's yours.
I keep reading the same thing, "If you want to wear one go for it, but we shouldn't have to." Please educate yourselves. If it were as simple as some of us wearing masks and being protected, sure, but it's not. By wearing a mask we are protecting YOU. By not wearing one you're still putting US at risk. Hence this entire ordeal. We simply need everyone who is entering a shared public space to practice the bare minimum of common respect by using a mask and containing their own potentially harmful droplets. It's mind blowing and so sad that people are complaining about having to wear a square of material over their mouths and noses while directly sharing the air with those who are in severe danger if they catch this virus. This is the definition of helping your neighbour. Come on, people.

Elizabeth Gallagher

From: Kathy Gillard
To: Mike Allen; Krista Balsom; Keith McGrath; Phil Meagher; Verna Murphy; Sheila Lalonde; Claris Voyageur; Jeff Peddle; Don Scott; Bruce Inglis; Jane Stroud; Legislative Assistants
Subject: No to Mandatory Mask Bylaw
Date: Sunday, September 13, 2020 9:45:28 AM

Dear council members,

My name is Kathy Gillard, I am the owner of Kathy's Fiber Arts & Crafts here in Fort McMurray. I am writing you to express my concern with the new proposal of a mandated mask bylaw. I for one as an individual and a local business owner are against the proposed bylaw.

After dealing with the difficulties of Covid and then the flooding of my business down town where we lost over 75% of our inventory and our insurance company only covered $10,000 in costs to the damages. You can imagine how hard it's been for us to reopen and get fully restocked again. I have incurred more debt in keeping this business open then most people would probably be comfortable incurring themselves if they were in my shoes. That being said I feel that my business is a necessity in this community with the huge amount of crafters and artists who rely on us to stock them with supplies and materials.

At this time with Covid , recession and now this proposed bylaw, I feel that it will cause more people who are against wearing masks to choose the easy option and shop online like amazon instead of wearing a mask to shop in person. I have already seen the pushback on Facebook over other stores who have chosen to make masks mandatory already and how people are just stating " well I won't shop there then". This can not happen to the rest of our small businesses like mine who are just hanging on at this point.

Please consider this when addressing the issue this coming week. We can't lose the last of our small businesses we have left.

Thank you

Kathy Gillard

Sent from my iPhone

From: Jonathan Gillies
To: Legislative Assistants
Subject: Regarding the Proposed Mandatory Mask Bylaw From a Health Care Worker
Date: Sunday, September 13, 2020 1:11:52 PM

Hello Councillors of the RMWB,

I wish to address the upcoming mandatory mask bylaw being brought up at this Monday's meeting. I am not against masks where warranted: being a health care worker, I regularly wear masks for my job. I think if people are sick, working with the sick or when visiting at-risk persons with compromised immune systems, masks should be worn. What I would like to speak to is the idea of mandatory masking and why I believe this is unwise for our region.

First off, there is the fact that improper wearing of masks can actually increase the risk of contracting viruses and disease. We have all had to wear masks these past few months and I ask each of you to recall what the most common action one performs while wearing any mask, which is to readjust it. Doing this incorrectly greatly increases the risk of bacteria or virus pathogens coming into contact with our mucous membranes. Similarly, improper donning and doffing of masks can also increase risk of infection. Dr. Jerome Adams, the US surgeon general, said this year in an interview: "Folks who don't know how to wear them properly tend to touch their faces a lot and actually can increase the spread of coronavirus."

Not all face coverings are created eqaual, and there are a wide variety of options on the market. A recent study showed certain materials may actually increase the spread of droplets, and others that are improperly fitted or not worn correctly do not effectively block droplet transfer. Masks may also create a false sense of security and lead to increased close contact and high risk activities. Ideally, if one's sole goal is to avoid contracting Covid-19, it is better to practice social distancing, hand washing, and avoiding face touching.

We need to look at the risk versus benefit of mandatory masking. If we ignore the above points about the risks involved with wearing masks, then we need to examine what we are doing at a regional level. If the right mask is worn and donned/doffed we may reduce droplets in some spaces, but the trade-offs are immense. For one, we further decrease the convenience of supporting local businesses during a time when they are already suffering. Amazon is at an all time high and if people have to choose whether to mask up their entire family (and then fight to keep the masks on) before deciding to go to a local business, citizens

will continue to shift that business online. People, particularly those with young children, are very unlikely to go shopping if it means the extra headache of fighting to keep their childs' masks on. Similarly, those with eyeglasses are also inconvenienced unless they can find a mask that does not fog up their glasses and obstruct their vision.

The use of disposable masks also increases waste and pollution. In a city that prides itself on our environmental initiatives such as the reusable bag bylaw (one that has gone by the wayside for many during these times) and our carbon capture oil sands technology, why would we drastically increase our waste each day with non-reusable masks constantly breaking, being soiled or otherwise being discarded, many times via being polluted into our green spaces and community. It adds to the stress of daily living with headaches, strain on our ears, constantly fussing children, and neighbours reporting neighbours for not following the new rules. After all we have gone through as a city since 2016, why are we adding additional stress onto our citizens?

We need to also explore the risk to our unique community. With the vast majority of those at risk from being severely ill or dying from Covid-19 being patients with comorbidities and of advanced age, often 80+, we are unique in that we do not have as elderly of a population as other cities. We have had a single death in the region since the pandemic began. More studies have shown that the number of people actually infected with Covid to be substantially higher than our positive test amount, which means that the ICU and death rate percentage of patients that contract Covid-19 is also substantially lower than what we think it is. This virus is not as lethal as it was expected to be, and especially not as much in a young and relatively healthy population like what exists in the RMWB.

We are also different in that we are not a large city with major public locations frequented by thousands. It's quite possible to perform social distancing much of the time while living in the region. And creating a mandatory masking law simply because other different cities have also created one is not a good reason.

Many businesses and organizations have chosen to create their own mandatory-masking rules and it is their right to do so. Likewise, others can choose not to and individuals should be equally free and able to choose what requirements to enact for themselves.

Lastly, wearing a mask while entering a restaurant, then removing it at your table, then putting it back on to go to the bathroom, then taking it off again and so on

creates many opportunities for cross-contamination and still creates an indoor environment where people are not masked. Likewise for gyms and other places where they are or can be constantly removed.

An additional issue arrises in the enforcment of this bylaw. Firstly it turns citizens against each other as they report infractions to our already overtaxed bylaw and RCMPofficers. Secondly, monetary fines and at its worst jail time, are extreme measures to take on citizens for a bylaw such as this.

So please let us make our own decisions on masks, don't make our lives more stressful and drive us further into isolation and negatively affect the mental health of RMWB citizens and our businesses.

Sincerely,
A concerned RMWB citizen

__references__

Dr. Adams on improper mask-wearing: https://www.cnn.com/2020/03/02/health/surgeon-general-coronavirus-masks-risk-trnd/index.html
Study on different mask types: https://www.cnbc.com/2020/08/11/study-bandanas-and-neck-gaiters-not-effective-as-surgical-face-masks.html
Infection rate is drastically higher than positive test rate: https://globalnews.ca/news/7182892/coronavirus-serology-study-b-c/
Another study done in Italy showing infection versus postive rate: https://www.sciencedaily.com/releases/2020/06/200630103557.htm

From: Elsa Girvin
To: Legislative Assistants
Subject: September 14, 2020 Council Vote Regarding Mandating Masks
Date: Monday, September 14, 2020 11:13:55 AM

September 14, 2020

Agenda item: Sept 14 Council Vote on Mask Mandate

Dear Councillors and Meeting Attendees,

My name is Elsa Girvin, I have been a member of this great community since 2006. I am writing to inform you, had you not already heard, of the rapidly growing body of people citywide, province-wide, countrywide, and worldwide, who are now uniting to stand up, speak up, protest, march, and rally in opposition to the unprecedented health measures being imposed at the level of government on free societies around the globe.

The people have had enough, will you hear them?

I will also take a moment to remind you of the oath you all have taken to uphold our Charter of Rights and Freedoms. This alone should be of grave concern to you all in casting your votes today. If you think we will stop pushing back after today's vote, you are sorely mistaken. We will continue to organize, assemble, and to grow in numbers. The residents of our great city who are willing to be the face and the voice of this movement to defend our rights and freedoms may appear relatively small today, but make no mistake, the silent majority is large, growing, equally fed up, and ready to stand.

I am urging you to stop NOW with the micromanaging of Fort McMurray's already proven-to-be STRONG citizens. Allow each individual the right and responsibility to govern their own personal health, and the health of their children. Do not make this city a nanny state.

The mental and emotional health issues that we have already seen in children and adults alike will surely continue to arise as a result, and that will be at your hands. Suicide and drug overdose has skyrocketed since March, are you going to consider that fact in your decision?

School has been a horror for Albertan children, the reports are streaming in now as we start the second full week and parents are finding out the atrocities from their children, rather than being properly informed by the schools. Kids with rashes, kids taking restroom breaks so they can catch their breath, kids having faint and dizzy spells, kids being denied access to water, no help opening snacks, being yelled at. How are they learning? It sounds like they're all there to be berated and abused over mask protocol for 7 hours a day.

The science is still out on masks, due to the improper use, storage, and cleaning. Show me an entire populace engaged in a perfect practice of mask using, and perhaps there may be an argument. Because this has never, and will never be the case with masking, efficacy is nonsense and it has been painful watching politicians and journalists attempt to spin sense out of the rubbish. Masking is only an ideological fairytale based on the presumption that the mask protocol is being followed to a "T" by all. Let's get real, it isn't. While we are being real, masks are only a symbolic gesture to soothe the anxiety of the fearful. THEY DO NOT WORK.

Tides are turning, people are rising up exponentially, the science and data does not add up, children are suffering and we won't stand for it. I implore you today, council members of The RMWB, to say no to mandatory masks, and say yes to personal choice. What side of history will you be on? Choose wisely.

In closing, I have decided to add a quote from RFK Jr's speech, Aug 29, 2020 in Berlin.

Please read and reflect:

"The newspapers in the US are claiming I came to Berlin to speak to 5000 Nazis and when I will return, they will

write I spoke to 8000 Nazis. But when I look at the crowd, I see no Nazis. I see people who want real democracy and freedom! People want leaders who don‘t lie to them! Leaders who will not orchestrate rules and measurements to control the population. We want health officials who have no financial connection to the ‘Big Pharma‘. We want health officials who care for our children and us, but not for the governments and ‘Big Pharma Companies‘!”

He continued..

“I look at this crowd and see all the flags of Europe! I see people of every color, every religion, and every political party. All they care is about human dignity, about children‘s health and political freedom, which is the opposite of Nazism.
Governments ‘love‘ pandemics! They ‘love‘ pandemics for the same reason they ‘love‘ war! Because, it gives them the ability to control the population, which a population, otherwise, would never accept! The great instruments for imposing fear and obedience. I am going to tell you something. It‘s a big mystery to me why all of the so called important people like Bill Gates and Tony Fauci have been planning this pandemic for decades and when it comes we will all be saved! But now it‘s here, they don‘t seem to know what are they talking about! It‘s seems they’re making it up as it goes along. They are making up numbers and figures and actually they can‘t tell you the fatality rate of COVID-19! Also, they can‘t give us a PCR test that really works! They change the cause of deaths on many death certificates, to make it more dangerous. The one thing they are good at is pumping up fear!”

Powerful words, keep them in mind. Will you fear monger? Or will you choose freedom?

Sincerely,
Elsa Girvin
Resident since 2006
FORT MAC STRONG

Cc. Councillors, Mike Allen, Krista Balsom, Keith McGrath, Phil Meagher, Verna Murphy, Sheila LaLonde, Claris Voyageur, Jeff Peddle, Don Scott, Bruce Inglis

Sent from my iPad

From: Lee Hanson
To: Legislative Assistants
Subject: Covid mask bylaw
Date: Sunday, September 13, 2020 1:43:00 PM

Completely against this bylaw. Masks should be worn by high risk people only. It's a complete wast of supplies and is proven not to work (n95 being the only acception). All it is, is a visual feer mongering effect on a virus that is nowhere near as dangerous as the official's led us to believe at the beginning, and continue to stumble there way through this disaster. Open things up, allow business to thrive. Masking everyone will just result in less buying local and more ordering online as anyone with a brain is sick of this by now.

Lee Hanson
Born and raised resident of Fort McMurray

Get Outlook for Android

From: Paul Hanson
To: Legislative Assistants
Subject: Manditory mask By-Law
Date: Monday, September 14, 2020 8:35:13 AM
Attachments: s12879-019-4109-x.pdf

Hello,

On the topic of manditory mask Bylaws I do not believe ANYONE should be able to pass any Bylaw or temporary law or any kind of law that affects people's health without seeking multiple medical sources from within our community. The majority of the people that would now be required to wear a mask (if you choose to push this forward) would unfortunately not wear them properly, handle them properly, or maintain the cleanliness required in order to have the masks do their job properly. If these proper protocols are not followed masks are actually MORE hazardous not only the wearers health, but to those around them.

If you choose to pass a by-law you MUST also ensure the public in all areas they would be required to wear a mask, ensure the proper protocols are not only followed but provide the people with a way to do so.

The city IF it chooses to require people to wear a mask should this provide EVERYONE that lives in the RMWB at the bare minimum two, reusable cloth makes each to ensure one can always be available and sanitized while the other is no longer reusable until cleaned. With providing said masks you should be giving everyone ample hand sanitizer to ensure they can don and doff the masks PROPERLY with clean sanitized hands. You must also provide the public with a sanitary, washable container for the masks to be placed in when not in use to allowed masks to be stored PROPERLY when not required to wear them.

Government officials should NOT be making this decision, this decision should be coming from our community doctors with facts and science. Actual facts and science not just someone saying masks help because droplets or someone with a meme that proves it by saying of you pee with no pants on it goes everywhere if you pee with pants on it stops it. Scientific documentation, attached is a medical document/study that shows contamination of masks and how they CAN help but also CAN make things worse.

If people are walking around sick not wearing a mask while completing essential tasks, yes they should be subject to progressive disciplinary action.

Let us listen to SCIENCE and MEDICAL PROFESSIONALS. Not fear mongering, far left ideas (I think our elections have proven time and time again Wood Buffalo is not a prodominantly liberal mindset of people), and people who shout the loudest.

I fear for our local economy and our local "mom and pop" shops in our community and requiring manditory masks will further push the people to not shop local, not support local, and potentially RUIN people's lives with more people losing their shirts trying to stay afloat in trying times.

I sincerely hope that the city council and the mayor GENUINELY take this email into consideration and actually listen to the "silent majority" and not the a few people that shout loud and make people feel horrible for having their own personal opinion.

A by-law brought in place by government and not medical professionals will not be respected and the council and mayor; in my opinion would lost alot of support coming the next election cycle. Not a threat, an opinion and an assumption based on someone that is born and raised in fort mcmurray. People that don't respect the bylaw will not wear or use masks properly, we can already see masks littering our streets (hazardous medical waste essentialy as we do not know who has worn them or what symptoms they may or may not have had. Children pick things up off the ground, masks in playgrounds. This would create a hazardous environment go all UNLESS you take this email into consideration.

If you would like to further talk to be about this email, respond to this one or send a new one and I will provide my phone number and we can talk more.

Concerned citizen,

Paul Hanson

Chughtai et al. BMC Infectious Diseases (2019) 19:491
https://doi.org/10.1186/s12879-019-4109-x

BMC Infectious Diseases

RESEARCH ARTICLE Open Access

Contamination by respiratory viruses on outer surface of medical masks used by hospital healthcare workers

Abrar Ahmad Chughtai[1*], Sacha Stelzer-Braid[2], William Rawlinson[3], Giulietta Pontivivo[4], Quanyi Wang[5], Yang Pan[5], Daitao Zhang[5], Yi Zhang[5], Lili Li[6] and C. Raina MacIntyre[7,8]

Abstract

Background: Medical masks are commonly used in health care settings to protect healthcare workers (HCWs) from respiratory and other infections. Airborne respiratory pathogens may settle on the surface of used masks layers, resulting in contamination. The main aim of this study was to study the presence of viruses on the surface of medical masks.

Methods: Two pilot studies in laboratory and clinical settings were carried out to determine the areas of masks likely to contain maximum viral particles. A laboratory study using a mannequin and fluorescent spray showed maximum particles concentrated on upper right, middle and left sections of the medical masks. These findings were confirmed through a small clinical study. The main study was then conducted in high-risk wards of three selected hospitals in Beijing China. Participants ($n = 148$) were asked to wear medical masks for a shift (6–8 h) or as long as they could tolerate. Used samples of medical masks were tested for presence of respiratory viruses in upper sections of the medical masks, in line with the pilot studies.

Results: Overall virus positivity rate was 10.1% (15/148). Commonly isolated viruses from masks samples were *adenovirus* ($n = 7$), *bocavirus* ($n = 2$), *respiratory syncytial virus* (n = 2) and *influenza virus* (n = 2). Virus positivity was significantly higher in masks samples worn for > 6 h (14.1%, 14/99 versus 1.2%, 1/49, OR 7.9, 95% CI 1.01–61.99) and in samples used by participants who examined > 25 patients per day (16.9%, 12/71 versus 3.9%, 3/77, OR 5.02, 95% CI 1.35–18.60). Most of the participants (83.8%, 124/148) reported at least one problem associated with mask use. Commonly reported problems were pressure on face (16.9%, 25/148), breathing difficulty (12.2%, 18/148), discomfort (9.5% 14/148), trouble communicating with the patient (7.4%, 11/148) and headache (6.1%, 9/148).

Conclusion: Respiratory pathogens on the outer surface of the used medical masks may result in self-contamination. The risk is higher with longer duration of mask use (> 6 h) and with higher rates of clinical contact. Protocols on duration of mask use should specify a maximum time of continuous use, and should consider guidance in high contact settings. Viruses were isolated from the upper sections of around 10% samples, but other sections of masks may also be contaminated. HCWs should be aware of these risks in order to protect themselves and people around them.

Keywords: Mask, Health care workers, Viruses, Infection control

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Full list of author information is available at the end of the article

Background

Infectious diseases are a continuing threat, with constant emergence or re-emergence of serious diseases in various parts of the world and healthcare workers (HCWs) are particularly at-risk of exposure to index cases [1–4]. Various types of personal protective equipment (PPE) are recommended and used by HCWs to protect from infections, including medical masks, respirators, gloves, gowns, goggles and face shield [5, 6]. In healthcare settings, medical masks are used by HCWs to protect from splashes and sprays of blood and body fluids, and by sick individuals to prevent spread of respiratory infections to others [7]. Reuse and extended use of masks are also common in many parts of the world, particularly during outbreaks and pandemics [8, 9]. Respiratory pathogens may be present on used masks layers and lead to infection of the wearer [10]. In hospital settings, these pathogens may be generated from breathing, coughing or sneezing patients or during aerosol generating medical procedures [11]. Studies have shown that influenza virus can remain airborne for 3 h after a patient has passed through an emergency department [12]. While using masks, or during long periods of time of re-using them, these pathogens may cause infection through hand or skin contamination, ingestion, or mucus membrane contact [10].

Currently there are limited data on the presence of respiratory pathogens on surface of PPE and other fomites in hospital settings. Previous studies show that influenza and respiratory syncytial virus (RSV) may survive on outer surface of PPE [11–14]. A study showed that influenza viruses may survive on hard surfaces for 24–48 h, on cloth up to 8–12 h and on hands for up to 5 min [13]. A previous study in an Australian Neonatal Intensive Care Unit (NICU), respiratory syncytial virus (RSV) RNA was identified from 4% of dress samples and 9% of environmental samples [14]. If health departments do not provide clear guidance on the use of masks in these situations, HCWs may continue using contaminated masks and may get infection [15]. The risk of self-contamination of HCWs is influenced by the mask itself, its shape and properties, and the virus concentration on its surface. To our knowledge, only one study examined the presence of contamination on mask and various bacteria were isolated from outer surface of medical masks [16]. The main aim of this study was to study the level of contamination on the surface of medical masks.

Methods

Pilot studies

Medical masks were tested as per protocols developed through two pilot studies in Sydney Australia.

Pilot study 1 (laboratory testing)

The aim of this pilot study was to identify areas of maximum virus concentration on the surface of masks. Medical masks were donned on a simple mannequin in a laboratory setting and fluorescent particles (UV Glow powder) were sprayed front on and side on from a distance of approximately 1 m using a spray bottle. We performed three experiments from the front and three experiments from the sides of mannequin. UV light was used to quantify the density of particles on mask surface and to identify area of maximum concentration. In all three experiments, most particles were concentrated on upper right, middle and left sections of the masks (Figs. 1 and 2).

Pilot study 2 (clinical testing)

The second pilot study was conducted in two tertiary referral hospitals in Sydney Australia to develop testing methodology. Twelve HCWs (doctors and nurses) from the infectious diseases, respiratory/ chest wards and intensive care unit (ICU) participated in the study. HCWs were asked to wear medical masks for a shift (minimum 30 min) used masks were tested in the Virology Research Laboratory, University of New South Wales and Prince of Wales Hospital Sydney Australia. If a respirator was indicated due to airborne inflictions, HCWs were excluded from the study and were allowed to use a respirator.

Medical masks were divided into six sections as shown in Fig. 3. Samples were taken from upper three sections of masks i.e. 36 samples were tested in total (12 masks X 3 samples). The outer layer of the mask was removed using sterile tweezers. The mask layer was placed into a 15 ml falcon tube containing 700 µl of Phosphate buffered saline and vortexed for 20 s. After 10 min incubation the mask was placed in a custom made filter tube inside an eppendorf tube and centrifuged briefly. The filtrate was then transferred to 1.5 ml Eppendorf tube. Total nucleic acid was extracted on the Kingfisher Flex (Thermo Scientific) using the MagNA Pure Total Nucleic Acid Isolation Kit (Roche) according to the manufacturer's instructions. Presence of respiratory viruses was detected using the Seegene Allplex™ Respiratory Panel Assays 1,2,3 (Seegene).

Main study

The main study was conducted in respiratory wards and fever clinics of three selected hospitals in Beijing China from December 2017 to January 2018. Doctors and nurses from selected wards were invited to participate in the study. Participants include nursing and medical staff aged > 18 years working full time in the ward who were able to provide written and informed consent. Participants with pre-existing respiratory, medical illness or

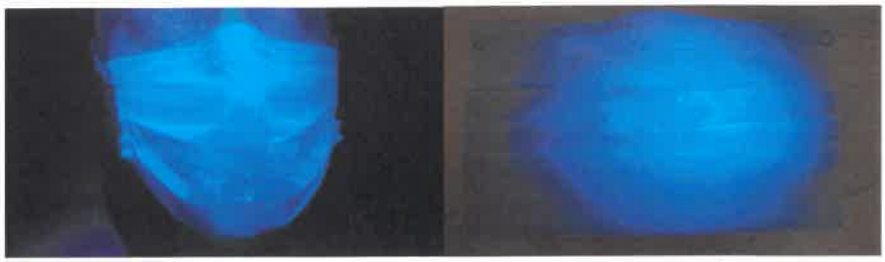

Fig. 1 Fluorescent particles (UV Glow power) following spraying from 1 m from the front of the mask

pregnancy were excluded. As we did not test the participants, detail history on respiratory symptoms was taken to rule out contamination of masks by participants themselves.

HCWs from the participating wards were asked to wear medical masks for a shift (6–8 h), or as long as they could tolerate the masks with no adverse event. Three layered standard medical masks were used. If HCWs used more than one mask during their shift, first sample was collected and tested. Used medical masks were collected at the end of the day and were stored immediately in zip-lock bags. HCWs were advised to store masks in in zip-lock bags while they take off the masks during break time. All masks samples were labelled with participants' ID and hospital ID. At the end of the study, HCWs were asked to complete a short survey to collect information on mask use in routine (type of mask used, number of masks used and situations when masks were normally used) and during the study period (wearing time, number of patients seen, situations when masks were used, aerosol generating procedures performed and hand hygiene during donning and doffing). Participants reported "number of masks used" and "number of patients seen" in absolute numbers. "Duration of mask use" was recorded in hours as, < 1 h, 1 to 2 h, 2 to 4 h, 5 to 6 h, 7 to 8 h, > 8 h. "Situations when masks were used" were categorized into: "used continuously", "used continuously except during breaks", "used only during patients' encounters" and "used only high-risk patient encounters".

Mask testing for the main study

Medical masks were tested in the Beijing CDC laboratory. All masks were collected immediately after use in zip-lock bags and kept at − 80 °C until testing. Pilot studies showed that upper sections of masks were more contaminated (Figs. 1 and 2). The outer layers of upper right, middle and left mask were separated with a same size, placed into separated tubes containing 700 μl PBS buffer (Gibco, USA), vortexed for 1 min, and finally aliquoted 50 μl for viral testing. We performed three tests on upper right, middle and upper left sections of the masks on around a quarter mask sample (26%) and performed one test on the remaining mask samples (74%). For one testing, outer layers of upper right, middle and left section of mask were separated and placed into the same tube. Viral DNA/RNA was extracted using KingFisher Flex 96 viral DNA/RNA purification kit (Thermo Fisher, USA) according to the manufacturer's instructions. The reverse-transcription polymerase chain reaction was performed to amplify 15 viral target genes, including influenza A/B virus, influenza A(H1N1) and A(H3N2), parainfluenza viruses 1–4, rhinoviruses, bocavirus, human metapneumovirus, adenovirus, respiratory syncytial virus, coronaviruses OC43, 229E, NL63 and HKU1 using a commercial multiplex combined real-time PCR detection kit for Respiratory virus, which is developed by "Jiangsu Uninovo Biological Technology Co. Ltd." in China.

Sample size

Currently there is very limited data on testing of masks surface for presence of pathogens. In previous studies

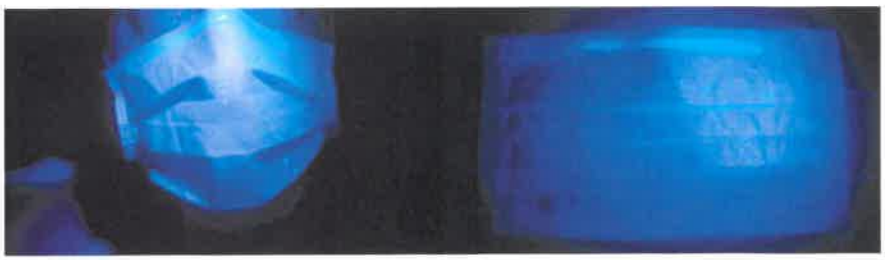

Fig. 2 Fluorescent particles (UV Glow powder) following spraying from 1 m from the side of the mask

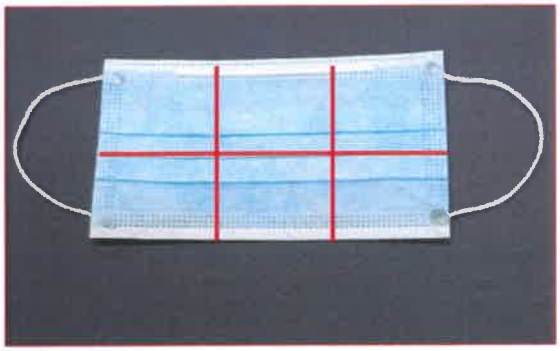

Fig. 3 Sections of medical masks for testing

influenza virus was detected on over 50% of the fomites tested in community settings during influenza season [17]. The rate is expected to be higher in the healthcare setting and moreover other viruses will also be tested. Assuming 25% higher positivity rate in the healthcare setting, the required sample size would be 134 masks, with 80% power and two-sided 5% significance level for detecting a significant difference. Some HCWs might not be able to provide mask samples, we aimed to recruited 145 HCWs in total for this study.

Analysis

Descriptive analysis was conducted, and rates and frequencies were calculated. Univariate analysis was performed to identify the factors associated with mask positivity. Logistic regression was used to calculate odds ratio (OR) and 95% confidence intervals (CI) Data were analyzed in SAS (SAS Institute Inc., USA) version 9.4.

Ethics and consent to participate

Ethics approval for pilot study was sought from South Eastern Sydney Local Health District (SESLHD). Ethics approval for the main study was sought from Human Research Ethics Committee UNSW (HC16703) and IBR China. Written consent as obtained from all participants.

Results

Of 36 samples in pilot testing, three samples were positive for *human enterovirus*. Two samples were positive from outer sections of mask, while one sample was positive from middle section. No other viruses were detected in mask samples.

A total of 158 participants were recruited from three hospitals in the main study. Ten participants provided more than one samples for the testing, so we excluded these cases from analysis due to uncertainty around the duration of mask use being tested. Most participants were recruited from Hospital A (52%, 77/148), largely from the respiratory ward 47.3%, 70/148). Around half of the participants were doctors (45.9%, 68/148), and majority were female (81.8%, 121/148). In routine clinical practice, almost all participants (98.6%, 146/148) had previously used disposable medical masks. Generally, most of the participants had been using 1 or 2 medical masks per day (90.6%, 134/148) and around two third participant (68.2%, 101/148) had been using mask all the time during the clinical work (Table 1).

During the study period, around 2/3 participants used masks for > 6 h – "7–8 h" 80 participants (54.1%) and "> 8 h" 19 participants (12.8%). The remaining 1/3 used masks for ≤6 h – "1–2 h" 1 participant (0.7%), "3–4 h" 8 participants (5.4%) and "5–6 h" 40 participants (27%). Most participants (78.4%, 116/148) used masks either continuously or continuously except breaks. The majority of participants (83.8%,124/148) reported at least one problem

Table 1 Demographic data

Variables	Number (n = 148)	Percent
Hospital		
Hospital A	77	52.0
Hospital B	26	17.6
Hospital C	45	30.4
Ward		
Internal medicine	52	35.1
Respiratory	70	47.3
Pediatrics	26	17.6
Position		
Doctor	68	45.9
Nurse	80	54.1
Age		
≤ 30 year	41	27.7
31–40 years	68	45.9
≥ 41 years	39	26.4
Gender		
Male	27	18.2
Female	121	81.8
Type of mask normally used in the hospital		
Cloth re-usable facial masks	2	1.4
Disposable medical masks	146	98.6
Number of masks routinely used in the hospital		
1	46	31.1
2	88	59.5
3	10	6.8
4	4	2.7
When masks are normally used		
All the time	101	68.2
When treating certain patients	47	32.8

associated with masks use. Commonly reported problems were pressure on face (16.9%, 25/148), breathing difficulty (12.2%, 18/148), discomfort (9.5% 14/148), trouble communicating with the patient (7.4%, 11/148) and headache (6.1%, 9/148). Majority of participants washed their hand during donning (91.2%, 135/148) /doffing (88.5%, 131/148) of medical masks and before (74.3%, 110/148) /after (85.1%, 126/148) touching patients. During the study period, 68% (101/148) participants used other PPE as well – mostly gloves and hair covers.

Overall virus positivity rate was 10.1% (15/148) and rates were similar after 1 testing on mask (10%, 11/110) compared to three testing (10.5%, 4 /38) (OR 1.06, 95% CI 0.32–3.55). *Adenovirus* was most commonly isolated from the masks ($n = 7$), followed by *bocavirus* ($n = 2$), RSV (n = 2) and *influenza* virus (n = 2) (Table 2).

Compared to the participants working in internal medicine department, virus positivity rates were lower among those working in respiratory (OR 0.04, 95% CI 0.01–0.34) and pediatric (OR 0.12, 95% CI 0.01–0.97) departments. Virus positivity was significantly higher on masks samples worn by participants who used masks for > 6 h, compared to those who used mask for ≤6 h that day (OR 7.9, 95% CI 1.01–61.99). Similarly, virus positivity was significantly higher on masks samples worn by participants who examined > 25 patients per day, compared to who examined ≤25 patients (OR 5.02, 95% CI 1.35–18.60). Virus positivity rates were also higher in mask samples collected from males, participants who used mask during encounters with high risk patients and those who performed aerosol generating procedures (AGPs), however the difference was not statistically significant (Table 3).

Discussion

To our knowledge this is the first study examining the presence of respiratory viruses on the outer surface of used medical masks. One in ten masks were positive for any virus which highlights the risk of self-contamination to the wearer, particularly on doffing [18]. Reuse and extended use of masks are very common, particularly in low income countries and during outbreaks and pandemics when supplies are short, and demand is high [19, 20]. Staff should be aware of the risk associated with the reuse and extended use of masks and respiratory protective devices and high clinical contact. Large scale studies should be conducted to determine the contamination on other PPEs as well and to quantify the risk of infection among HCWs.

Epidemics of a new infectious disease may be devastating due to global spread, disease burden and high case fatality. PPE are generally considered lowest among infection control hierarchy and recommended to be used with other administrative and environmental control measures [21]. However, masks, respirators and other PPE are important during initial phase of outbreak and pandemic when drugs and vaccine are not available [22]. PPE can easily get contaminated during clinical care of sick patients which may result in an increased risk of infection in wearer [18]. Many simulation studies have also shown presence of particles on the potential surface of PPE and associated risk of self-contamination during doffing of PPE [5, 22–24]. In this study we only tested the presence of viruses on the medical masks. Overall virus positivity rate in this was 10.1% (15/148) and adenovirus was isolated from 7 mask samples while bocavirus, RSV and influenza viruses were isolated from 2 samples each. Prospero et al. conducted a study in dental settings and estimated the bacterial contamination on surface of masks used by dentist, lamps, areas near spittoons, and mobile trays. Sterile nitrocellulose filters were applied on these surfaces to isolate pathogens. Highest levels of bacterial contamination (Streptococcus species 42%, Staphylococcus species 41%, and gram-negative bacteria 17%) were recorded on the external surface of masks wore by dentist [16]. Large scale studies should be conducted to examine presence of various pathogens on the surface of masks and other PPE.

In this study, the risk of mask contamination was associated with duration of masks use and number of patients seen. Currently there is no standard duration for the time period that facemasks and respirators can safely

Table 2 Pathogens isolated from outer surface of masks

Viruses	Positive in one test (Total tests 110)	Positive in three tests & sample location (Total test 38)
Adenovirus[a]	6	1 middle section of mask
Bocavirus[a]	2	0
Human metapneumovirus[a]	0	1 right section of mask
Influenza B & type 4 parainfluenza virus[b]	1	0
Influenza H1N1 & influenza B[c]	1	0
Respiratory syncytial virus[a]	1	1 middle section of mask
Type 2 parainfluenza virus[a]	0	1 right section of mask
Total positive (Positivity rate)	11 (9.4%)	4 (9.8%)

[a] Isolated from internal medicine ward, [b] isolated from pediatric ward [c] isolated from respiratory ward

Table 3 Factors associated with virus positivity on masks surface

Variables	Positive for any virus		Odds ratio (OR) (95% CI)
	Number	Percent	
Hospital			
Hospital A	12/77	15.6	Ref[a]
Hospital B	1/26	3.8	0.22 (0.03–1.75)
Hospital C	2/45	4.4	0.25 (0.05–1.18)
Ward			
Internal medicine department	13/52	25	Ref
Respiratory department	1/70	1.4	0.04 (0.01–0.34)[d]
Pediatrics department	1/26	3.8	0.12 (0.01–0.97)[d]
Gender			
Male	4/27	14.8	Ref
Female	11/121	9.1	0.57 (0.16–1.97)
Position			
Doctor	7/68	10.3	Ref
Nurse	8/80	10	0.97 (0.33–2.82)
Age			
≤ 30 years	5/41	12.2	Ref
31–40 years	5/68	7.4	0.57 (0.15–2.11)
≥ 41 years	5/39	12.8	1.06 (0.28–3.98)
Mask use time during the study			
≤ 6 h	1/49	2	Ref
> 6 h	14/99	14.1	7.9 (1.01–61.99)[d]
Patients' seen			
≤ 25 cases	3/77	3.9	Ref
> 25 cases	12/71	16.9	5.02 (1.35–18.60)[d]
How medical masks were used			
Used continuously	4/28	14.3	Ref
Used continuously except breaks[b]	9/88	10.2	0.65 (0.19–2.22)
Used only during patients encounters	0/26	0	0.10 (0.01–2.12)
Used only high-risk patient encounters	2/6	33.3	3.02 (0.43–21.44)
Preformed AGPs [c] during the study			
No	7/95	7.4	Ref
Yes	8/53	15.1	2.24 (0.76–6.55)
Hand wash			
No	2/13	15.4	Ref
Yes	13/135	9.6	0.59 (0.12–2.94)

[a] Reference [b] lunch, tea and toilet [c] aerosol generating procedures [d]Significant results

be used. Theoretically, there may be a risk of infection in wearer if contaminated masks are used for prolonged time. Currently there are no data around risk associated with reuse and extended used of masks and other PPE. One study showed that influenza virus may survive on mask surface and maintained infectivity for at least 8 h [25]. Our study showed very low infection among HCWs who used masks for ≤6 h. High virus positivity on masks samples worn by HCWs who examined > 25 patients, may be due to more frequent clinical contact with infective cases and transfer of more pathogens from patients to mask surface. Virus positivity rates were also higher in those working in internal medicine department compared to respiratory and pediatric departments. The reason of high virus positivity in internal medicine department is not clear, but this may be due to using

varying infection control policies and practices. High risk perception and more infection control measures may result in low virus positivity in in respiratory and pediatric departments. However, the sample sizes and number of positive results were too low to make meaningful comparisons between departments. There is a need for more research to define the exact threshold of safe duration, and to develop a comprehensive policy on the use of masks in hospital settings and protocols should specify a maximum time of continuous use and should consider guidance in high contact settings.

We also aimed to identify the area on the mask surface with maximum respiratory virus concentration. Laboratory based pilot study showed maximum fluorescent contamination on upper sections of the masks, which is also the likely area to be touched on removal. Of the three positive tests in hospital-based pilot study, two samples were positive from outer sections of mask, while one sample was positive from middle section. In the main study we were able to check the location of contamination on a quarter of mask samples. Of the 38 mask samples, one or more viruses were isolated from four (10.5%) samples – two from middle section of masks and two from right section of the masks. This presents a large area of potential contamination which place HCW at risk when removing a mask. These data may assist in developing policies on for doffing of masks after encounter with infective cases. As a general rule, HCWs should not reuse masks, should restrict use to less than 6 h and avoid touching the outer surface of mask during doffing, and practice hand hygiene after removal.

There are limitations of this study. Due to funding constraints we tested selected masks samples. We performed three tests on a sub-sample (26%) to identify the area of maximum concentration. Moreover, we just tested upper three sections of medical masks based on the first pilot study, while lower three sections should also be tested. Then we tested only outer layer of masks and did not check filtering layer and inner layer due to funding constraints. Ideally all sections and layers of masks should be tested. We collected detail history from the participants to rule out any existing respiratory illness. Although none of the participant had a respiratory or a medical illness, it is not possible to determine whether viruses isolated from the masks surface were from exogenous or endogenous source. For example, adenovirus was most commonly identified in this study and is associated with mild or no respiratory illnesses. Ideally participants should also be swabbed to rule out infections, and the inside surface should also be tested. However, given the large variations of infection probability in different types of wards, it is unlikely that all viruses came from the background infection. To overcome this limitation, detailed history on respiratory symptoms was taken to rule out contamination of masks by clinically ill participants themselves. Moreover, we only examined viruses on the masks, while bacteria and other pathogens may also be present [16]. Mask use was not monitored, and self-reported compliance was recorded. Previous studies show that self-reported compliance is generally reported to be higher compared to the actual compliance [26, 27]. We also did not document the method of mask removal, nor the number of times the HCW touched the mask.

Conclusion

To maintain the functionality and capacity of the health care workforce during outbreaks or pandemics of emerging infections, HCWs need to be protected. This study provides new data, which will help developing policies for safe workplace environment. The study shows that the prolonged use of medical masks (> 6 h) and frequent clinical contact in healthcare setting increase the risk to health workers through contaminated PPE. Protocols on duration of mask use should specify a maximum time of continuous use.

Abbreviations

AGPs: Aerosol generating procedures; HCW: Healthcare workers; ICU: Intensive care unit; NICU: Neonatal Intensive Care Unit; PPE: Personal protective equipment; RSV: Respiratory syncytial virus; SESLHD: South Sydney Local Health District

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Authors' contributions

AAC - Conception and design of study, data analysis and manuscript writing. SSB, WR, GP – Data/ sample collection and lab testing for pilot studies in Australia, manuscript review. QW, YP, YZ and LL – Data/ sample collection for the main study in China, manuscript review. DZ - Testing for the main study in China, manuscript review. CRM - Contributed to study design and manuscript writing. All authors approved the study.

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Availability of data and materials

The datasets used and/or analysed during the current study are available from the corresponding author on reasonable request.

Ethics approval and consent to participate

Ethics approval for pilot study was sought from Eastern Sydney Local Health District (SESLHD). Ethics approval for the main study was sought from Human Research Ethics Committee UNSW (HC16703) and IBR China. Consent was obtained from all participants before recruitment.

Consent for publication
Not applicable .

Competing interests
All authors have completed the Unified Competing Interests form (available on request from the corresponding author) and declare that: AAC had testing of filtration of masks by 3 M for PhD. CRM has held an Australian Research Council Linkage Grant with 3 M as the industry partner, for investigator driven research. 3 M have also contributed supplies of masks and respirators for investigator-driven clinical trials. She has received research grants and laboratory testing as in-kind support from Pfizer, GSK and Bio-CSL for investigator-driven research. The remaining authors declare that they have no competing interests and have no non-financial interests that may be relevant to the submitted work.

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References

1. Bui CM, Chughtai AA, Adam DC, et al. An overview of the epidemiology and emergence of influenza a infection in humans over time. Archives Public Health. 2017;75(1):15.
2. BanachMD DB, BielangMD R, CalfeeMD DP. Factors associated with unprotected exposure to 2009 H1N1 influenza a among healthcare workers during the first wave of the pandemic. Infect Control Hosp Epidemiol. 2011; 32(3):293–5.
3. World Health Organization (WHO). Summary of probable SARS cases with onset of illness from 1 November 2002 to 31 July 2003 2014 [Available from: http://www.who.int/csr/sars/country/table2004_04_21/en/. Accessed 15 June 2018.
4. MacIntyre CR, Chughtai AA, Seale H, et al. Respiratory protection for healthcare workers treating Ebola virus disease (EVD): are facemasks sufficient to meet occupational health and safety obligations? Int J Nurs Stud. 2014;51(11):1421–6.
5. McLaws M-L, Chughtai AA, Salmon S, et al. A highly precautionary doffing sequence for health care workers after caring for wet Ebola patients to further reduce occupational acquisition of Ebola. Am J Infection Control (In press https://doi.org/10.1016/jajic201512034). 2016.
6. (WHO). WHO. Epidemic-prone & pandemic-prone acute respiratory diseases: infection prevention and control in health-care facilities. 2007.
7. World Health Organization (WHO). Infection prevention and control of epidemic- and pandemic-prone acute respiratory infections in health care. 2014.
8. Swaminathan A, Martin R, Gamon S, et al. Personal protective equipment and antiviral drug use during hospitalization for suspected avian or pandemic influenza. Emerg Infect Dis. 2007;13(10):1541–7.
9. Phin NF, Rylands AJ, Allan J, et al. Personal protective equipment in an influenza pandemic: a UK simulation exercise. J Hosp Infect. 2009;71(1): 15–21.
10. Institute of Medicine (IOM) National Academy of Sciences. Reusability of facemasks during an influenza pandemic: facing the flu. 2006.
11. Stelzer-Braid S, Oliver BG, Blazey AJ, et al. Exhalation of respiratory viruses by breathing, coughing, and talking. J Med Virol. 2009;81(9):1674–9.
12. Blachere FM, Lindsley WG, Pearce TA, et al. Measurement of airborne influenza virus in a hospital emergency department. Clin Infect Dis. 2009; 48(4):438–40.
13. Bean B, Moore BM, Sterner B, et al. Survival of influenza viruses on environmental surfaces. J Infect Dis. 1982;146(1):47–51.
14. Homaira N, Sheils J, Stelzer-Braid S, et al. Respiratory syncytial virus is present in the neonatal intensive care unit. J Med Virol. 2016;88(2):196–201.
15. Chughtai AA, Seale H, Chi Dung T, et al. Current practices and barriers to the use of facemasks and respirators among hospital-based health care workers in Vietnam. Am J Infect Control. 2015;43(1):72–7.
16. Prospero E, Savini S, Annino I. Microbial aerosol contamination of dental healthcare workers' faces and other surfaces in dental practice. Infect Control Hosp Epidemiol. 2003;24(2):139–41.
17. Boone SA, Gerba CP. The occurrence of influenza a virus on household and day care center fomites. J Infect. 2005;51(2):103–9.
18. Chughtai AA, Chen X, Macintyre CR. Risk of self-contamination during doffing of personal protective equipment. Am J Infect Control. 2018;46(12): 1329–34.
19. Chughtai AA, MacIntyre CR, Peng Y, et al. Practices around the use of masks and respirators among hospital health care workers in 3 diverse populations. Am J Infect Control. 2015;43:1116–8.
20. Chughtai AA, MacIntyre CR, Zheng Y, et al. Examining the policies and guidelines around the use of masks and respirators by healthcare workers in China, Pakistan and Vietnam. J Infect Prev. 2015;16(2):68–74.
21. Siegel JD, Rhinehart E, Jackson M, et al. 2007 guideline for isolation precautions: preventing transmission of infectious agents in health care settings. Am J Infect Control. 2007;35(10 Suppl 2):S65–164.
22. Beam EL, Gibbs SG, Boulter KC, et al. A method for evaluating health care workers' personal protective equipment technique. Am J Infect Control. 2011;39(5):415–20.
23. Zellmer C, Van Hoof S, Safdar N. Variation in health care worker removal of personal protective equipment. Am J Infect Control. 2015;43(7):750–1.
24. Tomas ME, Kundrapu S, Thota P, et al. Contamination of health care personnel during removal of personal protective equipment. JAMA Intern Med. 2015;175(12):1904–10.
25. Sakaguchi H, Wada K, Kajioka J, et al. Maintenance of influenza virus infectivity on the surfaces of personal protective equipment and clothing used in healthcare settings. Environ Health Prev Med. 2010;15(6):344.
26. Martel J, Bui-Xuan EF, Carreau AM, et al. Respiratory hygiene in emergency departments: compliance, beliefs, and perceptions. Am J Infect Control. 2013;41(1):14–8.
27. Chughtai AA, Seale H, Dung TC, Hayen A, Rahman B, Raina MacIntyre C. Compliance with the use of medical and cloth masks among healthcare Workers in Vietnam. Annals of Occupational Hygiene. 2016;60(5):619–30.

Publisher's Note

From: Chelsea Heath
To: Legislative Assistants
Subject: Fwd: Mask By-Law written submission
Date: Friday, September 11, 2020 9:09:00 PM

Chelsea Heath Section 17 (1) FOIP
Parsons Cree
[redacted]

Good Evening,

I am writing to voice my support for a mask bylaw to help keep case counts low. Keeping cases counts low during the start of the school year can help keep us safer during Thanksgiving and Halloween, when touching, visiting and chatting with those outside our households is higher than usual.

Please dont forget:
1) Edmonton and Calgary have had their cases increase after the mask bylaw implementation because this is also the time were people are returning from summer vacation and school shopping. Please refer to Jasper's or Banff's case counts, both of which have had bylaws in place for over a month and routinely sees influx of visitors every weekend, long weekend and in addition to those that spent longer periods of time in the area.

2) Pre-existing conditions are more than just the types of illnesses and diseases that can drastically shorten someone's life. These conditions also include those are are born with a genetic link to these disease, like Type 1 (Juvinile) Diabetes or asthma.

3) People are not sheep for using masks because someone with a higher education and understanding of the situation advises to use them. We all live in a town that prides itself on safety in the workplace, by following all protocol and using applicable PPE that is available in the workplace. Why is this PPE used? Because someone with a higher education and understanding of the situation has concluded that the PPE works as intended when used as directed. On site, there are very few people who have seen first hand the effects of a workplace injury. Yet, you'll see nearly 100% compliance with PPE meant to prevent a similar workplace accident. I have yet to hear of a team bullying someone or calling them a sheep for using PPE. Hopefully, that level of stupidity never creeps back into the workplace.

Thank you for your time.

Get Outlook for Android

Submitted by Jamie Hewat

Dear Mayor and members of Council,

I've been a proud and local resident of Fort McMurray for over 20 years. This community is an incredible place that I've been blessed to call home and raise my family. Covid-19 has impacted all our lives, including yours I'm sure, in various ways over the last 6 months. In March, the beginning of this pandemic, it's safe to say our city came together to do what we could to support our friends, family, and community members, while being mindful of the potential threat of this virus, and the unknowns of what we were dealing with. During all of this and in the middle of the lockdown, our community members stepped up, once again when large parts of our city were impacted by a devastating flood. Friends, family members, businesses, and strangers (both local and out of town), came together for weeks and months to help with demolishing flooded basements, taking friends and families into their own homes, organizing food, clothing, shelter, and providing a shoulder (and many much needed hugs) to comfort and support those in our community who needed it. Much of this was done with little to no pre-cautions in place. No 6ft distance, larger groups, most without masks. Sharing of food. And all without a result in huge surge of cases.

It really saddens me that the mask debate has become so dividing for our community. Myself, like most others I've talked to who oppose this bylaw, are not 'anti-mask'. Those who choose to wear non-medical mask should definitely do so, if that's right for them and their family, and used properly.

Dr. Hindshaw had some great advice on Masks when it was discussed on March 25, 2020:

" What we've seen from studies in previous occasions, so whether that's the previous pandemic in 2009, or in SARS is that if you wear a face mask alone while you're well and just out and about, it doesn't seem to add a great deal of protection over and above hand washing and avoiding touching your face with unwashed hands. And, in fact, IF PEOPLE ARE NOT WEARING FACE MASKS IN A WAY THAT IS NOT CORRECT, so say they're putting a face mask on with unwashed hands or taking it off with unwashed hands, IT CAN ACTUALLY CONTAMINATE THEMSELVES AND POTENTIALLY CAUSE MORE RISK. So, it really depends how face masks are worn. And, again the recommendation is people who are sick should wear those to prevent spread to others".

On March 30th Dr. Tam stated in an interview regarding masks: "What we worry about is the potential negative aspects of wearing a masks wear people are not protecting their eyes or other aspects of where the virus could enter your body, and that gives you a false sense of confidence, but also it increases the touching of your face, if you think about it. If you've got a mask around your face you can't help it because you're just touching parts of your face. The other thing is the outside of the mask could be contaminated as well, also the key is handwashing,……, it doesn't matter what you're doing, it's absolutely key, when you're removing a mask. Numerous infectious diseases, even in a hospital setting, we find that it's actually removing personal protective equipment that can lead to infections. So if people try to use these measures, they have to be really really careful and must wash their hands…."

More recent guidance from both Dr. Hindshaw as well as Dr. Tam, do support and encourage the voluntary use of non-medical masks as measures, where social distancing cannot be in place, with strict mask hygiene and use protocols in place.

I've gone to a restaurant, and watched a waitress stand at our table and take our order. In the 2 minutes she was there, she touched her mask 6 times. And then proceeded to walk to the computer, put in an

order, and go to the back and grab food to serve to another table. I've seen this on numerous occasions. My youngest children are currently exempt from wearing masks in school (6&8), yet this bylaw includes all children over the age of 2. When my youngest wears his balaclava to cover his face in the winter, it's soaked with saliva within 10 minutes, because he's a 6 year old boy and tries to chew on it, and constantly touches and readjusts it with his hands. I'm quite certain it will be the same for a non-medical face covering. I remember when he was 3- trying to get him to keep just a hat on in winter for 5 minutes, was exhausting at times. Ever drive by a business and watch an employee come outside, pull their mask down to their chin, smoke a cigarette, and then touch the mask again with their hands to pull it back up?? Masks are also required in some restaurants while walking to your table, or to and from the bathroom. That mask is then taken off to eat and drink once seated-Where do these masks go for temporary storage while not using? In purses, on top of tables, on seats or benches, in pockets, where it collects dust, droplets, bacteria and virus particles only to be put back onto that persons face, with unwashed hands, to leave the establishment. They are left on the seat and floor of cars until the next time it's needed to go into a public place. In stores where they are mandatory currently, people wander through, unconsciously re-adjusting their mask and touching their face, while browsing and touching items throughout the store. Trying to not touch your mask and face with a mask is extremely difficult for adults, and nearly impossible for children. I know this isn't the case for all. That there are those who wear masks and follow the sanitizing/cleaning masks guidelines, as best they can. But potential for contamination due to improper mask usage, is why I am opposed to a mandatory mask bylaw.

Our Amazing community has been through economic downturn, catastrophic fire, and devastating floods, and we have ALWAYS supported each other, have stepped up when we were needed. Can't we be trusted to take personal responsibility for the health and safety of our own lives, whilst still being compassionate and respectful of the space of others that are near us in public? We all do our best to comply with recommendations and guidance by our provincial government, we don't need our municipality to be threatening fines and jail time for non-compliance. Fort McMurray currently has 58 cases. That's less than 0.08% of our population. How long is this bylaw to be in effect, 1 month? 6 months? indefinitely? Until there are less than 50 cases? 30? 15? 0?? What's the magic number, the end goal? Other cities have seen a rise in cases since their mandated mask bylaws, not a decrease. Unfortunately, we cannot prevent all infections, nor can we prevent all deaths. The lockdown for months was in place to give time to prepare to treat and manage larger number of cases. Our hospital is not overloaded. While we all wish we could, we cannot stomp out or eradicate a global virus in our community. Can we learn to live with it, In support of one another, instead of as a divided community. A mandatory mask bylaw will only cause more divide and alienation.

While we may not all agree on how to get there, I truly believe that everyone wants the same goal.

Your concerned community member,

From: Aoife House
To: Legislative Assistants
Subject: September 14 - Special Council meeting on Mask Bi-law
Date: Monday, September 14, 2020 10:45:25 AM

Good afternoon Mayor Scott and Council,

I would like to share support for the mask bi-law that is being proposed in Fort McMurray, and are hoping you will be voting in favour to protect our citizens, economy, and future.

I have lived in Fort McMurray for 40 years, my husband a little over 40 and both are children were born here. The growing cases in our region is very disturbing especially as my husband is considered high risk due to medical reasons. Because of the risk to him with COVID my eldest daughter has chose to do her grade 12 year online to reduce the chances of him contracting COVID. This is sad as she misses out on her band instruction and classes and she is looking to major in music compositions in university so this may adversely affect her. I see daily how frustrated my kids are that adults in our community have little or no regard for following social distancing and basic hygiene, if we can't get individuals to social distance then masks are the only way to ensure they are not spending their germs.

Our students are being asked to wear masks all day, I work at a company that requires the same, and many businesses are now having to put up their own signs and hope for the best without local support. This puts us as citizens at risk when others don't follow the recommendations and I now choose not to go into establishments who don't support mask usage, which affects our economy as I will buy online if I can't shop locally safely.

Although our provincial government won't mandate mask usage, they strongly suggesting mask utilization in indoor spaces and when social distancing can't be maintained, we need your help to protect our region. When our province fails to lead, our council MUST, for the protection of our community.

Thank you for your time and I look forward to the discussion on Monday..

Aoife House

From: Brianna House
To: Legislative Assistants
Subject: Speaking at council this evening.
Date: Monday, September 14, 2020 7:09:34 AM

I will no longer be able to speak at the council meeting this evening but I would like my response to be submitted as a written response, it will be in the part below.

Hi, my name is Brianna house i am a grade 9 student and in my past years I've been apart of macoy on the urban planning team. Regarding the mask bylaw I believe it should be put into place… wearing masks in public places protects our citizens from possibly catching the corona virus. Wearing masks limits the amount of spread through catching the moisture that we would normally place into our atmosphere. Since we are coming into the flu season and the beginning symptom signs of covid are closely similar to flu symptoms citizens may believe they can participate in their normal activities without a covid test since were coming into this flu season and without the mask bylaw being put into place covid will be able to spread more rapidly. If we also look at our school system, the province has put into place that masks must be worn by students and staff within the building, this is around 6 hours of the day that we ask of our youth to do this, we should hold our adults to the same account within public places. If we do not put this mask bylaw into place I believe it gives the impression that we value economy and education over the health and well-being of our own citizens. This is why I believe the mask bylaw should be put into place.

Brianna House

From: Gregory House
To: Legislative Assistants
Subject: Mask Bylaw Support
Date: Friday, September 11, 2020 6:12:41 PM

Good Evening,

While there may be some argument against the use of masks in preventing the spread of this virus, there is no denying the fact that it makes many people, including my pregnant wife, feel safer, more secure and less stressed when leaving the house. As a person who wears glasses I understand the inconvenience of this. But if it makes people feel safer around me then it's enough for me.

Where is the compassion for at risk population? Why isn't it enough for people to want to make everyone else feel safe?

I say tell this town to stop being so selfish and just put a mask on. It doesn't cause them any distress, pain, or financial stress. This town needs to grow the hell up and think about other people for once. And that's coming from someone who is born and raised here and loves this town more than most.

I fully support a mask bylaw.

Thank you for your time.

Gregory House

From: Jan And Katie Indenbosch
To: Legislative Assistants
Subject: Re: Face Covering Bylaw
Date: Sunday, September 13, 2020 11:21:49 PM

Hello!

We are writing to submit an opinion on the proposed face covering bylaw, as we would not support its passing for our home city of Fort McMurray.

In our current global pandemic situation, we realize that there are many health risks for all individuals, and especially our vulnerable loved ones. With this in mind, each individual and business must assess their own personal situation to decide what risks they are and are not willing to take. We believe this choice must be protected by our government.

As members of our community, we are aware of many vulnerable individuals and know/ care about many personally. We do desire to show our consideration and make efforts to protect them, and already wear masks in settings where physical distancing cannot be maintained or we are aware of special circumstances suggesting increased value to masking.

Please do not pass this bylaw. Businesses and individuals must continue to have the right to make their own informed decision about risk management measures.

We are especially concerned for the children in our schools if this face covering bylaw is passed. Alberta Health Services and the Fort McMurray Public School District has already made the decision that masks will only be necessary in specific situations. Parents are aware of this decision and many have sent their children to school with the understanding that masks will not be mandatory. Please respect these decisions already in place and do not add more unwelcome changes to their school year.

Private businesses should have the right to decide what restrictions to place on their clientele. As will many other consumers, we will be more likely to shop online than locally if this bylaw is passed, which would have unfortunate consequences for the community.

Please also consider the additional burden on the judicial system (which is already burdened beyond its mandate) that a Face Covering Bylaw would cause. To enforce and prosecute a controversial by-law would, in our opinion, be unsustainable. The controversial nature of the mask issue will drive so-called violators into court to plead their case, as is their constitutional right, which would quickly overwhelm the court with minor infractions.

We have all seen how Covid-19 has impacted our community at a deeply emotional level. People are starkly divided over the mask issue. A by-law will not increase harmony within our community, but will likely serve to further divide the people of Fort McMurray. Mandating one side of a controversial issue that can easily be left to individuals and businesses to resolve will only add fuel to the fire of resentment and anger from our own neighbors. Please allow the citizens of Fort McMurray the freedom to make their own choice. We believe that given the opportunity, most will choose the path most harmonious to the community.

Thank you for your consideration.

Jan and Katie Indenbosch

From: Nadia Johnson
To: Legislative Assistants
Subject: Yes to mandatory mask!!!
Date: Friday, September 11, 2020 6:52:51 PM

Please make mask mandatory, it's getting out of control!! As a family of health issues we need this more then ever to feel safe to even go to the store, fort Mac has been though enough over the years we don't another out break let's stop this now before it get worse!!!!

Thanks
Sent from my iPhone

From: Justin Kelly
To: Legislative Assistants
Subject: Mandatory masks.
Date: Monday, September 14, 2020 10:29:30 AM

Good morning. I just want to speak as for the potential mandatory mask bylaw that may come into effect. I feel that mandatory masks will not benefit anything. Yes we have cases but looking at larger cities such as edmonton and or calgary as bylaws already and the cases are continuing to grow. So as per normal businesses should have the option to choose if they want their customers to wear masks or not. Wearing masks in public outside is not gonna fix anything and I WILL NOT wear a mask inside my car nor will my family. Please take other peoples opinions in consideration this virus is just the same as SARS and H1N1 and we didn't take as much caution at that point. So I dont see why we have to take as much now and also the common flu kills more per year then this corona virus.
Thank you.
Have a good day

Get Outlook for Android

From: Lindsey King
To: Legislative Assistants
Subject: Mask Bylaw
Date: September 11, 2020 3:44:37 PM

I would like it on the record that I do not support a mask bylaw. I especially do not support this mask bylaw for indoor and outdoor. Other Alberta cities that have implemented such measures have not seen a fall in cases, there is no scientific proof that a piece of fabric over your face protects you! It causes people to touch their faces unnecessarily! Clean hands is how you battle this flu! Just like other flus, let's I courage hand washing and sanitizing and the Sofia distancing. It's unfair to bring this onto the public because 100's of people all flicked back to town for the beginning of the school year and picked up germs from other places and came home sick. The Alberta government does not believe we need this, many local residents do not believe we need this! Let it be a choice not forced on us! Our cases are already going down. It's jumping the gun!!!

Sent from my iPhone

Begin forwarded message:

Wilhelm and Hilda Kristman

13 Sep 2020

Dear RMWB Mayor and Council,

It is with great distress I write this note to tell you DO NOT invoke any health bylaws. Do you know something the CMO of the province doesn't? She has not mandated masks. Is the RMWB incentivized by any other organization to mandate masks in our region? Does it provide a financial benefit?

RMWB should not interfere in the health care of citizens. My health is already much intruded on so you'll have to wait your turn and stand in line behind AHS Hinshaw, Provincial Kenney, Federal Tam, and of course PMJT, with their travel bans, quarantines, mandatory screening, endless restrictions and absurd rules. I don't need you too. My health is none of your business. If you mandate masks 'for our safety' are you taking on the responsibility for the health of the citizens of the RMWB? If a citizen contracts the virus in any of our public facilities, does that give them justification to sue RMWB for health liability? If I get sick can I sue you?

A truth which must be faced is that some citizens can not wear a mask prevented by real physical or mental causes that can not be pushed aside with insults. So these people will be sacrificed - can't go out, can't work, can't go to the store. There are those who won't wear a mask because they do not believe it is a health emergency. Science facts do not support these unwarranted restrictions and masks - healthy people should not quarantine or mask up. Sweden is the best counter example to support no intervention.

The belief is this emergency is being used by others to promote division and conflict among ordinary citizens, households, and families. We agree with councillor LaLonde who voted against the mask motion because (paraphrasing) 'this is setting us up for the mask police to be verbally assaulting and physically assaulting people' - in this case the mask police might include vigilante citizens as well as RCMP.

Each and every one of us already knows what to do and we have looked after ourselves for our whole lives until now. It is time you had confidence and trust the citizens of RMWB to do the right thing - after all, these are the same courageous and resilient folks who survived fire and flood. We will survive bad government too and we will not forget who is responsible for our pain. When violence erupts and police begin arresting the good citizens of Fort McMurray I will blame you.

Wilhelm and Hilda Kristman

From: Kristy Laidlaw
To: Legislative Assistants
Subject: Mandatory masking
Date: Monday, September 14, 2020 12:01:37 PM

Good morning,

I'm writing in regard to the mandatory masking law the RMWB is considering. I do not believe we should be mandated to wear and mask in public. Denmark and Sweden have not and the CDC and WHO have both said it is unnecessary. They are not even calling it a pandemic anymore as it does not meet the qualifications of one. When looking at this as a pandemic you have to look at the death rate. Morbidity levels are not high here! One death in 6 months within our municipality is no different than any other year. William Farr, a physician from the 1800's is credited with Farr's law -Farr's Law of Epidemics states that epidemics tend to rise and fall in a roughly symmetrical pattern or bell-shaped curve. The flu season operates under the same curve. It rises is fall and descends in spring. That also has something to do with the weather.

Kids are back to school and as per usual there is sickness happening but now instead of just assuming it's normal snuffles everyone has to get this COVID-19 test And sit home and wait until they're cleared in order to go back to school and for parents to go back to work.

I also don't agree with what you're proposing in your bylaw. I will not be able to walk around with a drink and have a sip. I will not be able to feed my child while another child is at their dance event or hockey practice. I will have to have a mascon unless I am basically at my own house. This does not make sense and is unacceptable.

Please vote no for a mandatory mask by law. It is not necessary and Science does not support it. Look at Edmonton and Calgary where they've had mandatory byelaws for mass for how long now? They are no better for having them than we are for not having them.

I am also afraid that with this mask by law people, such as myself, will do more shopping online which will harm our businesses. I already to choose to shop at other stores that have mask mandates such as superstore and Walmart. If I have to wear a mask at all the other stores I can guarantee you I will be doing more online shopping and not supporting our local municipality which is what I would like to do but you're forcing my hand to make me choose online shopping and not shop in my own municipality because of this law.

News is also coming from the states where kids have gone to school a few weeks ahead of us and there's already complaints of kids being sick and oxygen deprived and parents pulling their kids from school because of having to wear a mask all day. And now with this new byelaw you would make all the kids even a little ones have to wear a mask all day at school. This is not good for their oxygen levels! This is not good for their psyche! We are traumatizing our kids when does CDC and the WHO are telling us the pandemic is over we need to let fear go and get back to some sort of normalcy so we can develop herd immunity and get on with our lives!

Sincerely,

Kristy L.

From:	Tiffany Grant
To:	Legislative Assistants
Cc:	Mike Allen; Krista Balsom; Keith McGrath; Phil Meagher; Verna Murphy; Sheila Lalonde; Claris Voyageur; Jeff Peddle; Don Scott; Bruce Inglis; Jane Stroud
Subject:	Agenda Item 3 (New Business) September 14 Council Meeting
Date:	Monday, September 14, 2020 9:35:52 AM

September 14, 2020

Dear Councillors and Meeting Attendees,

My name is Tiffany Lavechia and I am writing this letter in hopes of having it read during today's council meeting, specifically to have the Section 3 (New Business) on the agenda addressed.

I've attached a link to an online petition that I started regarding the mandate of a Face Covering Bylaw being passed, which includes 922 currently (and climbing) signatures of people who are opposed to the mandate. I'm hoping I can rely on at least one Council member to present this petition at today's meeting.

I speak for both myself, my child, my family and many others when I say that we feel mandating a bylaw on face coverings is a grave mistake and one that strips us as Canadians' from some of our basic citizen rights. "The right not to be subjected to any cruel and unusual treatment" and "the right of individual life, liberty and security of the person".

My rejection in the passing of this mandate simply isn't about wearing a mask to protect myself and others. I feel it is 100% a person's responsibility to protect themselves and others from any harm that could come to them. However, mandating how one chooses to do so, simply takes away their free choice.

I personally have a child who is medically exempt from wearing a face covering. I fear he will be ostracized by the public for not wearing a face covering, simply because some of the public doesn't understand. We've already witnessed this type of scenario with the recent West Jet flight that was cancelled and the family that was discriminated against, simply because they couldn't have there 18-month-old keep it on.

I am begging you as a resident of Fort McMurray, a tax paying citizen, a Mother and a Canadian to not pass this bylaw.

Sincerely,

Tiffany Lavechia

Cc. Councillors, Mike Allen, Krista Balsom, Keith McGrath, Phil Meagher, Verna Murphy, Sheila LaLonde, Claris Voyageur, Jeff Peddle, Don Scott, Bruce Inglis, Jane Stroud

Link to Petition: http://chng.it/2myxtN7s

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Link to Petition: http://chng.it/2myxtN7s

From: Brittany Lequereux
To: Legislative Assistants
Subject: Mandatory Masks Meeting
Date: Friday, September 11, 2020 8:56:18 PM

To Whom It May Concern,

Unfortunately I will be on shift during your meeting this coming Monday regarding the mandatory mask legislation.

However, I would encourage all council members to watch the following 53 min video by Shawn Stevenson regarding the history and science of medical masks. All studies regarding the legitimacy of masks have been compiled and thoroughly examined without cognitive bias.

https://youtu.be/XHQ7zDNXKj0

For this reason, compromising the health of the population is not a good and logical argument to enforce masks.

Thank you for taking the time to watch, listen, and get educated.

Thanks,
Brittany Lequereux

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Submitted by: Sara Lichti

Open Letter

September 9, 2020.

Dear Councillors of the Regional Municipality of Woodbuffalo,

With the upcoming debate to be held on September 14, 2020, I write to you as a concerned citizen of Fort McMurray. I am asking that you strongly consider not making masks a mandated bylaw.

By **John Carpay** "The curve is flat, and has been for months. COVID-19 deaths peaked in March or April (depending on which jurisdiction) and now continue to decline, even while increased testing exposes more "cases." If masks were not required to flatten the curve, why should they be required now?

Many leading doctors and public health officials from around the world support mandatory mask-wearing. But this does not mean that the science is settled.

One study states that cloth masks pose a 13 percent increased risk of influenza-like illness infection to those wearing them, noting that "moisture retention, reuse of cloth masks, and poor filtration may result in an increased risk of infection." This past April, the World Health Organization (WHO) also confirmed that masks "offer a false sense of security, leading to potentially less adherence to other preventive measures."

The same WHO document points to problems with self-contamination that can occur by touching and reusing contaminated masks, and potential breathing difficulties due to decreases in oxygen levels.

Health professionals observe rampant misuse of masks in the community. Contamination by the incorrect removal of masks is a persistent problem, even among trained medical personnel. England's deputy chief medical officer, Dr. Jenny Harries notes that one "can actually trap the virus in the mask and start breathing it in" and that "people can adversely put themselves at more risk than less."

The New England Journal of Medicine explained recently that "wearing a mask outside health care facilities offers little, if any, protection from infection," and that masks "serve symbolic roles" as "talismans" that may help increase a "perceived sense of safety" and do more to reduce anxiety than to reduce the transmission of Covid-19. Likewise, Dr. Anthony Fauci, member of the U.S. White House's coronavirus task force, recently said that masks are symbolic of being a responsible citizen rather than a dependable infection-control measure.

A WHO guideline from June 5, 2020 states: "At present, there is no direct evidence (from studies on COVID-19 and in healthy people in the community) on the effectiveness of universal masking of healthy people in the community to prevent infection with respiratory viruses, including COVID-19. … At the present time, the widespread use of masks by healthy people in the community setting is not yet supported by high quality or direct scientific evidence and there are potential benefits and harms to consider."

Masks impair communication, harshly impacting vulnerable people with mental-health disorders and developmental disabilities; the deaf and hard of hearing; those with cognitive impairments; and children. Dangerous miscommunications can result when those who suffer from hearing loss are not able to hear someone who is wearing a mask. These risks are even greater in multicultural settings, where a person often needs to see the speaker's mouth and face to fully understand what is being said.

Assuming for a moment that the spread of COVID-19 is actually reduced by forcing the public to wear non-medical masks, this still does not address the violation of personal autonomy and human dignity, which are protected by the *Canadian Charter of Rights and Freedoms*.

Faces are the glue that holds us together, giving us our identity. Recognizing a face is vital to our social lives. By seeing each other's faces, we discern emotional expressions such as joy, fear or anger. As the Czech-and-French author Milan Kundera wrote in his 1988 book *Immortality*: "The serial number of a human specimen is the face, that accidental and unrepeatable combination of features."

The significance of the uncovered face was underscored not long ago by the heated debate over Quebec's law banning face-coverings. Quebec Premier Philippe Couillard argued: "We are just saying that for reasons linked to communication, identification and safety, public services should be given and received with an open face… We are in a free and democratic society. You speak to me, I should see your face, and you should see mine. It's as simple as that."

Opponents of this Quebec law argue that living in a free society means being able to choose what to wear, and what not to wear. To cover or expose one's face is a profoundly personal choice that carries with it political, cultural, psychological and spiritual implications.

Few would disagree that an "open face" helps with communication, identification and safety. Antifa thugs and criminals wear masks for a reason.

The *Charter* requires politicians to justify laws that diminish the realm of personal choice. Even if mask-wearing really does reduce the spread of COVID, it's necessary to distinguish the fearmongering of this past March from the facts we now know in July. In March, the politicians relied on claims by Dr. Neil Ferguson of Imperial College that COVID-19 would kill 510,000 people in the UK and 2.2 million Americans. We were told in March that COVID threatened everyone, including children and healthy adults.

Today we know that what politicians and chief medical officers said in March was not just false, but demonstrably false. Alberta Premier Jason Kenney and Chief Medical Officer Deena Hinshaw claimed that as many as 32,000 Albertans could die of COVID. As of July 23, the number was 176 (not 32,000) and 97 percent of deaths were amongst people over 60.

Today, government data tells us that COVID poses very little threat to children or youth. Like other viruses, it threatens elderly people with one or more serious health conditions. We now know that four fifths of COVID deaths occurred in nursing homes, amongst elderly people who were already very sick. As a cause of death, the impact of COVID on healthy adults under 60 has

been negligible in comparison to so many other causes of death. Statistically speaking, healthy adults have more to fear from driving than they do of dying of COVID.

On a global scale, COVID deaths are a small fraction of the number of lives claimed by the Asian Flu (1957-58) and the Hong Kong Flu (1968-69). In Alberta and other jurisdictions, the average age of death from COVID is higher than the average life expectancy; COVID has little if any impact on life expectancy.

Yet government policies are still based on the panic of March, rather than on the facts known in July. The media continue to speak about COVID as though death is not a natural part of life, and as though no person has ever died (whether wholly or partly) from a virus. Government policy seems to be predicated on the notion that we can somehow make people live forever (or for a very long time) even when they are already very elderly and very sick.

What is “unprecedented” in 2020 is not COVID but a new social and political experiment of locking up an entire population of millions of healthy people, pushing many of them into unemployment, poverty, depression and loneliness, all of which significantly reduce overall health. This is completely different from quarantine: the ages-old practice of isolating the sick.

Another “unprecedented” feature of 2020 is politicians and chief medical officers who ignore settled medical opinion that the best way to vanquish a virus (and to protect the vulnerable from it) is to allow it to spread amongst people who are younger, stronger and healthier. Once “population immunity” (“herd immunity”) is established, the virus cannot easily spread further, and therefore has far less chance of harming the vulnerable. If wearing a mask truly works to reduce the spread of a virus, then mask-wearing will hurt the vulnerable by delaying the acquisition of population immunity.

Settled medical opinion about herd immunity cannot simply be disregarded or dismissed. Those who believe that we can and should try to stop the spread of a virus amongst healthy and invulnerable people must prove and justify their novel approach.”

Again, I write this letter and beg you not to pass the mask bylaw.

Sincerely,

A Concerned Citizen

https://www.jccf.ca/making-face-masks-mandatory-is-not-backed-by-science-or-law/

https://apps.who.int/iris/bitstream/handle/10665/331693/WHO-2019-nCov-IPC_Masks-2020.3-eng.pdf?sequence=1&isAllowed=y

https://www.independent.co.uk/news/health/coronavirus-news-face-masks-increase-risk-infection-doctor-jenny-harries-a9396811.html

https://www.nejm.org/doi/full/10.1056/NEJMp2006372?query=TOC

https://apps.who.int/iris/handle/10665/332293

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4420971/

https://www.educateadvocateca.com/face-masks-and-social-distancing/

https://www.acpjournals.org/doi/10.7326/M20-1342

https://www.realclearpolitics.com/video/2020/05/12/flashback_march_2020_fauci_says_theres_no_reason_to_be_walking_around_with_a_mask.html

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Again, I write this letter and beg you not to pass the mask bylaw.

Sincerely,

A Concerned Citizen

https://www.jccf.ca/making-face-masks-mandatory-is-not-backed-by-science-or-law/

https://apps.who.int/iris/bitstream/handle/10665/331693/WHO-2019-nCov-IPC_Masks-2020.3-eng.pdf?sequence=1&isAllowed=y

https://www.independent.co.uk/news/health/coronavirus-news-face-masks-increase-risk-infection-doctor-jenny-harries-a9396811.html

https://www.nejm.org/doi/full/10.1056/NEJMp2006372?query=TOC

https://apps.who.int/iris/handle/10665/332293

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4420971/

https://www.educateadvocateca.com/face-masks-and-social-distancing/

https://www.acpjournals.org/doi/10.7326/M20-1342

https://www.realclearpolitics.com/video/2020/05/12/flashback_march_2020_fauci_says_theres_no_reason_to_be_walking_around_with_a_mask.html

Sara Lichti
Resident of RMWB

September 14, 2020

Attn:Regional Municipality of Wood Buffalo
Re: Mask Bylaw

Dear Councillors & Mayor,

I am writing to you today to express my concerns regarding the proposed Mask Bylaw. There is no scientific evidence that can accurately claim that masks reduce the transmission of viruses. Countless medical professionals, scientists, professors & experts advise AGAINST mask use, but for sake of time I would like to read a citation by Professor Denis Rancourt, and an open letter written by Chris Schaefer.

Professor Denis Rancourt Ph.D & lead analyst on this topic at the Ontario Civil Liberties Association states:

"In the many studies, in which the known bias of self-reporting is eliminated by using laboratory-confirmed infection detection, no statistically meaningful advantage is ever found, in either health-care or community settings, with either surgical masks or N95 respirators. No study, and there have been many, has been able to establish any advantage of wearing a mask or respirator, with viral respiratory diseases.

This means that, even in controlled professional health-care settings, any benefit is too small to be detected by science, and that other factors must be overwhelmingly more important.

Regarding all viral respiratory diseases — which are both known to be transmitted by small aerosol `particles (i.e., "droplets" of less than a few microns in diameter) and known to be highly infectious in terms of the so-called minimum-infective-dose (i.e., the number of virions that will likely be sufficient to cause illness or detectable infection) — in plain language, this means "masks don't work". (A "virion" is a single virus unit, the RNA and its shell.)

Therefore, any societal debate about the virtue or responsibility of wearing a mask to reduce the risk of infection,… is occurring in a science vacuum. ***It is a political and psychological debate, not one that is science-based."***

<u>Open Letter to Physicians and the Public of Alberta</u>

Dear Dr. Hinshaw,

Re: Alberta Health recommendation that Albertans wear N95, surgical or non-medical masks in public to reduce the likelihood of transmitting or developing a condition from the coronavirus known as COVID-19

I have been teaching and conducting respirator fit testing for over 20 years and now currently for my company SafeCom Training Services Inc. My clients include many government departments, our military, healthcare providers with Alberta Health Services, educational institutions and private industry. I am a published author and a recognized authority on this subject.

Filter respirator masks, especially N95, surgical and non-medical masks, provide negligible COVID-19 protection for the following reasons:

1. Viruses in the fluid envelopes that surround them can be very small, so small in fact that you would need an electron microscope to see them. N95 masks filter 95% of particles with a diameter of 0.3 microns or larger. COVID-19 particles are .08 - .12 microns.

2. Viruses don't just enter us through our mouth and nose, but can also enter through our eyes and even the pores of our skin. The only effective barrier one can wear to protect against virus exposure would be a fully encapsulated hazmat suit with cuffs by ankles taped to boots and cuffs by wrists taped to gloves, while receiving breathing air from a self-contained breathing apparatus (SCBA).

This barrier is standard gear to protect against a biohazard (viruses) and would have to be worn in a possible virus hazard environment 24/7 and you wouldn't be able to remove any part of it even to have a sip of water, eat or use the washroom while in the virus environment. If you did, you would become exposed and would negate all the prior precautions you had taken.

3. Not only are N95, surgical and non-medical masks useless as protection from COVID-19, but in addition, they also create very real risks and possible serious threats to a wearer's health for the following reasons:

A. Wearing these masks increases breathing resistance, making it more difficult to both inhale and exhale. According to our Alberta government regulations on respirator (mask) use, anyone that is required to wear a respirator mask should be screened to determine their ability to safely wear one.

Any covering of the mouth and nose increases breathing resistance, whether the mask is certified or not. Those individuals with pre-existing medical conditions of shortness of breath, lung disease, panic attacks, breathing difficulties, chest pain in exertion, cardiovascular disease, fainting spells, claustrophobia, chronic bronchitis, heart problems, asthma, allergies, diabetes, seizures, high blood pressure and pacemakers need to be pre-screened by a medical professional to be approved to be able to safely wear one. Wearing these masks could cause a medical emergency for anyone with any of these conditions.

Pregnancy-related high blood pressure is possible. More research is necessary to determine the impact of wearing a mask for extended periods of time on pregnancy.

It is dangerous to recommend, much less mandate anyone with medical conditions to wear a mask without educating them about the risks involved in wearing them without having been pre-screened and approved by a medical professional first.

B. In order for any respirator mask to offer protection to a specific user, that user must be individually fitted with the right type, right size, if male – face must be clean shaven (only short moustache allowed). Next, the user must be fit tested with that respirator by a trained professional to determine whether or not the respirator is providing the user with an air-tight seal – a requirement for any respirator mask.

C. N95 masks – N for not resistant to oil particles, 95 for the percentage of protection – the lowest level of all respirator masks

These masks even when properly sized and fitted will not protect against virus exposure, however they are capable of adequate protection from larger particles such as pet dander, pollen and sawdust.

Surgical masks (the paper ones that loop around the ears) – do not seal to the face and do not filter anything.

Nonmedical and/or homemade masks are dangerous because:

● Not engineered for the efficient yet protective requirements of easy inhalation and effective purging of exhaled carbon dioxide
● Could cause an oxygen deficiency for the user
● Could cause an accumulation of carbon dioxide for the user
● Shouldn’t be recommended under any circumstance

D. They increase body temperature and physical stress – could cause a high temperature alert on a thermometer gun

E. They impede verbal communication

F. N95, surgical and nonmedical masks can create infections and possible disease all by themselves by causing exhaled warm, moist air to accumulate on the inside material of the mask, right in front of the user’s mouth and nose, which is the perfect environment for bacteria to form, grow and multiply. That is why N95 and other disposable masks were only designed to be short duration, specific task use and then immediately discarded.

So if masks are not effective in preventing illness, what is? How about the age-old tried, tested and proven method of protecting our health with a healthy diet, clean water, avoidance of processed, junk and fast foods, plenty of fresh air, sunshine, moderate exercise, adequate restful sleep and avoidance of stress?
We all have an immune system that can fight and overcome any COVID-19 threat if it is healthy and we nurture it.

Thank you for reading this open letter and letting me share my expertise. I ask that you share this with the public via media statement as we are all committed to promoting good health for all Albertans. If you or any of the public wish to contact me with a question or comment, I would love to hear from you. I can best be reached chris@safecom-inc.com.

Sincerely,

Chris Schaefer
Director
SafeCom Training Services Inc.

From: James Long
To: Legislative Assistants
Subject: No mandatory mask
Date: Friday, September 11, 2020 10:57:49 PM

I don’t believe we should have mandatory masks. If you look at all other big cities that have done it there cases have gone up. Once you take away freedom to choose you have gone too far. I know as one if put in I won’t be going into local shops I will just order everything I can offline. I refuse to wear one. I refuse to make my 4yr old to wear one. There is science to show that healthy immune systems can suffer if you try sanitize and keep all germs away and this is one more unnecessary step in that direction. If people just use common sense and wash hands and stay home when sick that is one step In right direction. How can a small group of people think they can put something in place for 80,000 people that is so much of a step back. There is so many people that feel same as I do. There is so much fear
Mongering and lies of information with this whole thing. World “leaders” and health “officials” seem to be changing daily on what is the truth. If you decide to go this route I can promise you this is one household that won’t be following it. We all have healthy immune systems and have a better chance fighting it if we keep up our immune systems then following this bull.
Thanks
James

Sent from my iPhone

From: Allie Mackenzie
To: Legislative Assistants
Subject: MASKS
Date: September 11, 2020 4:23:01 PM

Good Afternoon,

As I saw there will be a meeting held on monday about the Face Covering Bylaw and I'm emailing today to say I feel like mask wearing should be a personal choice. Edmonton has done this and it has not helped.
I'm asking what our objective is? We will never get to a zero case formula. I totally understand we are trying to flatten the curve but I can have any virus and pass it to anyone the past 25 years I've been alive. The rules of mask wearing is silly, wearing it upon entry to stores - yet still seeing people walking around inside without a mask. Schools making masks mandatory yet in classrooms not having to wear them? Having to wear them while working but not in lunch rooms, etc? Wearing them inside certain stores but not the mall? I see blue medical masks hanging from the majority of vehicles rear view mirrors..... Are those used once? If you see that nose piece pushed slightly together, most likely not.
The objective should be to make people knowledgeable on how virus' spread. When I was a kid I had my teacher explain - "we have red soldiers inside us, those are bad bacterias, and green soldiers those are good bacterias. When we constantly use antibacterial soaps/sanitizers we are killing ALL bacterias. We need those green soldiers to fight the red ones so we aren't sick anymore" .
We need to practice hygiene and maybe working on a formula for "sick notes" or "sick days" for work and school.
If it makes an individual feel secure to wear a mask - wear that mask. But i don't feel it should be a mandatory bylaw for everyone. If you have allergies and need to go to the store sure slap one on. Or a sniffly nose because it's winter and you'd like to wear one, ok.... But if i am feeling perfectly fine why should i have to wear one?
We can work on stores sanitizing carts and baskets, tills, etc as it should've been all along. I've been wiping carts down since I was just young as I don't know who touched what, where and this provides a job to someone in need.

There are many virus' out there that kill, not just covid. We are only freaking out because we don't know much about this virus. But forcing everyone to wear a mask is not the answer.

Thanks for taking the time to read this!

Allison

From: Marita MacKinnon
To: Legislative Assistants
Subject: Mandatory masks
Date: Monday, September 14, 2020 11:43:49 AM

Hello,

We should not be making mask mandatory in RMWB. This is a huge overstep of government taking rights away from the people. The masks have not been proven effective, officials are swaying back and forth and contradicting themselves saying to wear or not wear them. It’s your right to choose to wear it or not.

Sent from my iPhone

From: Adrian Manolache
To: Legislative Assistants
Subject: Concerned Citizen of Fort McMurray
Date: Saturday, September 12, 2020 7:05:42 AM

Dear Fellow Citizens of Wood Buffalo,
I wil ask you to re-consider the decision of making the mask mandatory in our region!
We , the citizens of this Beautiful Part of Alberta ,went Through a lot of Stressful, Life Threatening Situations, in the last few years ! Our Moral and Sanity are at the End of the Limit ! If you have families and children and grandchildren, please do not put them going through this HORRIBLE, not necessary, not backed by any scientists and might effect EVERYONE PSYCHOLOGICAL! I was born and raised in a communist/socialist country and went through this kind of social experiments . They do not work and will creat Social Unrest ! Most of the People of this Region can not take this kind of Scare Tactics! We Lost Financially and Socially almost Everything! We just want to work and be treated with Respect ang Dignity! We , elected you to represent us , not to control Our Lives

Kind Regards ,
Adrian Manolache

From: Deanna Martic
To: Legislative Assistants
Subject: Open-Letter-to-RMWB.pdf
Date: Saturday, September 12, 2020 10:04:06 AM
Attachments: Open-Letter-to-RMWB.pdf

To whom it may concern,

Please do mandate the mask in our town. The decision to mask or not to mask should be personal decision NOT a mandate.

Each individual has their own personal reasons, feelings and beliefs for and against wearing a mask. All is correct in their own way. Again, please do not force either way.

We should however implement strategies to embrace differences and eliminate hate.

Thank you.
Deanna Martic

Open Letter

September 9, 2020.

Dear Councillors of the Regional Municipality of Woodbuffalo,

With the upcoming debate to be held on September 14, 2020, I write to you as a concerned citizen of Fort McMurray. I am asking that you strongly consider not making masks a mandated bylaw.

By **John Carpay** "The curve is flat, and has been for months. COVID-19 deaths peaked in March or April (depending on which jurisdiction) and now continue to decline, even while increased testing exposes more "cases." If masks were not required to flatten the curve, why should they be required now?

Many leading doctors and public health officials from around the world support mandatory mask-wearing. But this does not mean that the science is settled.

One study states that cloth masks pose a 13 percent increased risk of influenza-like illness infection to those wearing them, noting that "moisture retention, reuse of cloth masks, and poor filtration may result in an increased risk of infection." This past April, the World Health Organization (WHO) also confirmed that masks "offer a false sense of security, leading to potentially less adherence to other preventive measures."

The same WHO document points to problems with self-contamination that can occur by touching and reusing contaminated masks, and potential breathing difficulties due to decreases in oxygen levels.

Health professionals observe rampant misuse of masks in the community. Contamination by the incorrect removal of masks is a persistent problem, even among trained medical personnel. England's deputy chief medical officer, Dr. Jenny Harries notes that one "can actually trap the virus in the mask and start breathing it in" and that "people can adversely put themselves at more risk than less."

The New England Journal of Medicine explained recently that "wearing a mask outside health care facilities offers little, if any, protection from infection," and that masks "serve symbolic roles" as "talismans" that may help increase a "perceived sense of safety" and do more to reduce anxiety than to reduce the transmission of Covid-19. Likewise, Dr. Anthony Fauci, member of the U.S. White House's coronavirus task force, recently said that masks are symbolic of being a responsible citizen rather than a dependable infection-control measure.

A WHO guideline from June 5, 2020 states: "At present, there is no direct evidence (from studies on COVID-19 and in healthy people in the community) on the effectiveness of universal masking of healthy people in the community to prevent infection with respiratory viruses, including COVID-19. … At the present time, the widespread use of masks by healthy people in the community setting is not yet supported by high quality or direct scientific evidence and there are potential benefits and harms to consider."

Masks impair communication, harshly impacting vulnerable people with mental-health disorders and developmental disabilities; the deaf and hard of hearing; those with cognitive impairments; and children. Dangerous miscommunications can result when those who suffer from hearing loss are not able to hear someone who is wearing a mask. These risks are even greater in multicultural settings, where a person often needs to see the speaker's mouth and face to fully understand what is being said.

Assuming for a moment that the spread of COVID-19 is actually reduced by forcing the public to wear non-medical masks, this still does not address the violation of personal autonomy and human dignity, which are protected by the *Canadian Charter of Rights and Freedoms*.

Faces are the glue that holds us together, giving us our identity. Recognizing a face is vital to our social lives. By seeing each other's faces, we discern emotional expressions such as joy, fear or anger. As the Czech-and-French author Milan Kundera wrote in his 1988 book *Immortality*: "The serial number of a human specimen is the face, that accidental and unrepeatable combination of features."

The significance of the uncovered face was underscored not long ago by the heated debate over Quebec's law banning face-coverings. Quebec Premier Philippe Couillard argued: "We are just saying that for reasons linked to communication, identification and safety, public services should be given and received with an open face… We are in a free and democratic society. You speak to me, I should see your face, and you should see mine. It's as simple as that."

Opponents of this Quebec law argue that living in a free society means being able to choose what to wear, and what not to wear. To cover or expose one's face is a profoundly personal choice that carries with it political, cultural, psychological and spiritual implications.

Few would disagree that an "open face" helps with communication, identification and safety. Antifa thugs and criminals wear masks for a reason.

The *Charter* requires politicians to justify laws that diminish the realm of personal choice. Even if mask-wearing really does reduce the spread of COVID, it's necessary to distinguish the fearmongering of this past March from the facts we now know in July. In March, the politicians relied on claims by Dr. Neil Ferguson of Imperial College that COVID-19 would kill 510,000 people in the UK and 2.2 million Americans. We were told in March that COVID threatened everyone, including children and healthy adults.

Today we know that what politicians and chief medical officers said in March was not just false, but demonstrably false. Alberta Premier Jason Kenney and Chief Medical Officer Deena Hinshaw claimed that as many as 32,000 Albertans could die of COVID. As of July 23, the number was 176 (not 32,000) and 97 percent of deaths were amongst people over 60.

Today, government data tells us that COVID poses very little threat to children or youth. Like other viruses, it threatens elderly people with one or more serious health conditions. We now know that four fifths of COVID deaths occurred in nursing homes, amongst elderly people who were already very sick. As a cause of death, the impact of COVID on healthy adults under 60 has

been negligible in comparison to so many other causes of death. Statistically speaking, healthy adults have more to fear from driving than they do of dying of COVID.

On a global scale, COVID deaths are a small fraction of the number of lives claimed by the Asian Flu (1957-58) and the Hong Kong Flu (1968-69). In Alberta and other jurisdictions, the average age of death from COVID is higher than the average life expectancy; COVID has little if any impact on life expectancy.

Yet government policies are still based on the panic of March, rather than on the facts known in July. The media continue to speak about COVID as though death is not a natural part of life, and as though no person has ever died (whether wholly or partly) from a virus. Government policy seems to be predicated on the notion that we can somehow make people live forever (or for a very long time) even when they are already very elderly and very sick.

What is "unprecedented" in 2020 is not COVID but a new social and political experiment of locking up an entire population of millions of healthy people, pushing many of them into unemployment, poverty, depression and loneliness, all of which significantly reduce overall health. This is completely different from quarantine: the ages-old practice of isolating the sick.

Another "unprecedented" feature of 2020 is politicians and chief medical officers who ignore settled medical opinion that the best way to vanquish a virus (and to protect the vulnerable from it) is to allow it to spread amongst people who are younger, stronger and healthier. Once "population immunity" ("herd immunity") is established, the virus cannot easily spread further, and therefore has far less chance of harming the vulnerable. If wearing a mask truly works to reduce the spread of a virus, then mask-wearing will hurt the vulnerable by delaying the acquisition of population immunity.

Settled medical opinion about herd immunity cannot simply be disregarded or dismissed. Those who believe that we can and should try to stop the spread of a virus amongst healthy and invulnerable people must prove and justify their novel approach."

Again, I write this letter and beg you not to pass the mask bylaw.

Sincerely,

A Concerned Citizen

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https://www.nejm.org/doi/full/10.1056/NEJMp2006372?query=TOC

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https://www.realclearpolitics.com/video/2020/05/12/flashback_march_2020_fauci_says_theres_no_reason_to_be_walking_around_with_a_mask.html

Submitted by Nyasha Matengu

From: Nyasha M
To: Legislative Assistants
Subject: Face covering question
Date: Friday, September 11, 2020 5:34:24 PM

Hello,

I had a question to submit

My question is will there be an exemption for children especially those with disabilities to not have to wear a mask. My child is 3 but will not keep a mask on no matter how hard I try

Thank you

Nyasha

From: Megan McKay
To: Legislative Assistants
Subject: Mask Mandate By-law Submission.
Date: Monday, September 14, 2020 10:37:21 AM

Fort McMurray Mask Mandate By-law - An Open Letter September 14, 2020

Good evening Councillors,

There are countless reasons to NOT mandate masks for the people of Fort McMurray. Lack of science proving effectiveness of the cloth mask, especially for children, in limiting the spread of covid is one. But I would like to address the elephant in the room and that is the mental health crisis we are facing not due to covid but heavy-handed government lockdowns and "public health" measures.

While not a single child has died from the virus across our country, we are now faced with an epidemic of suicide and most disturbingly, child suicide and suicidal ideation.

In a recent report from Statistics Canada, the latest data shows that the leading cause of death in 10-14 year olds since the pandemic began is now suicide. We have made life unbearable for our children and in many cases have directly and indirectly told them they are vectors of disease and may kill their grandparents and loved ones. How twisted and dark to put this on children.

Back in March no one really knew what we were facing. The original covid death model for our province stated 32,000 Albertans would likely die from the virus. As we sit here today, we have had 253 deaths in our province of 4 million. The median age of covid deaths in our province is 84. The average life expectancy in Alberta is 83. I trust we all know the difference of dying FROM covid and WITH covid by now.

It is more than fair to say that this virus has absolutely and unequivocally NOT turned out to be the dire threat that was anticipated, with a survival rate of over 99.74%. Recent data shows that Canadians under 60 years of age have a 0.0001% chance of dying with, not from covid.

Instead of this coming as comforting news, we have experienced a continual bombardment from the government and media of how terrifying and devastating this virus is and it is categorically untrue. Instead of gathering in the streets to rejoice and embrace one another and carry on with living, we are now 7 months in, wasting our time and energy here today, talking about an asinine mask mandate that violates our most basic human right to breathe freely.

Everyone I have connected with and talked to who is against this mandate is not "anti-mask" but pro-choice and pro-liberty and pro-personal responsibility. We do not care to be continually divided in this manner.

If people want to wear masks, that is absolutely their right. The government can absolutely take measures to protect the immune-compromised and elderly, without devastating our mental health, economic prosperity, rights, freedoms and liberties. How quickly we forget those who willingly fought and died for our freedoms that we so frivolously bargain with today.

Those who want to live in fear and don cloth masks, are more than welcome to do so but not at the expense of the rest of us, the majority of us, who are not keen on having our lives micro-managed and prefer to take personal responsibility for our health. If you would like to live in an Orwellian nightmare, that is all yours to enjoy in your personal lives, not mine and not anyone else's if they prefer to choose living, over spending it in an perpetual state of fear.

In an attempt to "save lives" the government has, in a few short months, doubled our country's overall debt. We are still paying for WWI, 100 years later through income tax. What are the long-term implications for future

generations of driving us into further economic despair?

When people say “it’s just a mask” or “its to protect others’ what they are failing to acknowledge is, the consequences of all these measures on our lives now and in the future.

It’s not “just a mask”

It is perpetuating this mass paranoid psychosis and is a powerful visual queue for society to remain in a fight or flight mode and to drag out the real pandemic that is deaths of despair, caused by asinine and forceful government measures.

When most of us know more people who have died by suicide and overdose during this time than from the virus itself, is it really about “public health”?

As elected officials, you swore an oath to uphold our Charter of Rights and Freedoms, and to violate them, the onus is on you to perform your due diligence and present valid justification for stripping us of those rights. The fact that more people, including our children are dying from suicide, overdose and isolation in the elderly population as a direct result of lockdown measures, INCLUDING MASK MANDATES, shows us all that you have simply not upheld your responsibility.

It’s not “just a mask”. And the majority of residents of Fort McMurray are through with all this fear-mongering and would like to move on. A mask mandate at this point, given Fort McMurray’s overall covid stats and our country's is moot.

If you truly want to take actions to keep our community safe and strong, you will drop this proposal and begin to take a hard look at the bigger picture which is not at all one-dimensional. We have been through a lot these past 6 years and I’m confident that we will make it through this as well, by following facts and logic and taking into consideration the toll these types of decisions will have on our community now and in the future.

Thank you for your time. I hope you all choose well.

-Megan McKay

https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html#a5

https://www.alberta.ca/stats/covid-19-alberta-statistics.htm

https://swprs.org/who-mask-study-seriously-flawed/?fbclid=IwAR2YYayM4cDMe-9DsZb2qb86CT7HZqlaq_GxrWY7lpEgYlJ9i1gPjDVzxTg

https://standupcanada.ca/wp-content/uploads/2020/09/Isolation-Virus-UK-1.pdf?fbclid=IwAR2YYayM4cDMe-9DsZb2qb86CT7HZqlaq_GxrWY7lpEgYlJ9i1gPjDVzxTg

https://www.jccf.ca/making-face-masks-mandatory-is-not-backed-by-science-or-law/?fbclid=IwAR2YYayM4cDMe-9DsZb2qb86CT7HZqlaq_GxrWY7lpEgYlJ9i1gPjDVzxTg

https://www.lifesitenews.com/news/suicides-higher-than-covid-19-deaths-amid-school-lockdown-cdc-chief-warns

https://globalnews.ca/news/7310153/report-covid-19-children-safety-wellbeing-statistics/?fbclid=IwAR2YYayM4cDMe-9DsZb2qb86CT7HZqlaq_GxrWY7lpEgYlJ9i1gPjDVzxTg

https://globalnews.ca/news/7251536/coronavirus-canadians-mental-illness-study/?fbclid=IwAR2YYayM4cDMe-9DsZb2qb86CT7HZqlaq_GxrWY7lpEgYlJ9i1gPjDVzxTg

From: Dorothy McSheffery
To: Legislative Assistants
Subject: Mandatory Masks
Date: Sunday, September 13, 2020 9:21:37 PM

I'm writing to voice my concerns with the proposed mandatory mask policy.

We had a devastating flood in the spring, when people reached out to help their neighbours. They offered helping hands, literally, working hand in hand, filling and placing sandbags, helping people pull water soaked debris from their homes, loading food into boxes, and many more activities.
Where was our massive outbreak? If we were going to have one, we would have had one at that time. Companies were bringing in lots of extra staff from other regions, working closely with locals...and still, people remained safe.

Now, you want to implement mandatory mask wearing. Why? A man from a community with no cases made an interesting presentation that warrants everyone wearing a mask? I'm a senior, with respiratory issues, but I practise good hygiene and maintain distancing with people who aren't in my small circle. I only wear a mask when I'm required to such as at the hospital or doctor's offices.

I understand that people are afraid; our whole existence has changed since March. And now, we've had a death in our region. That's very sad, but I'm willing to bet we've lost people to the annual flu outbreak in our region over the years.

After all is said, stores can, and some have, made mask wearing store policy. That's their right. Why does the municipality feel they need to make it law? Who will enforce it? The same people who are tasked with making sure people are picking up after their pets, and not parking where they shouldn't be, etc? And that's assuming you don't plan on making it mandatory outside, too.

I walk a great deal, for exercise, and to enjoy our beautiful area. If mask wearing becomes mandatory outside, too, you will take away everything that makes this place worth living in.

Please be cautious. We have enough real issues in this area. We certainly don't need to create a big problem when one doesn't really exist.

Sincerely,
Dorothy McSheffery

From: Megan Noseworthy
To: Legislative Assistants
Subject: Mask By-law
Date: Monday, September 14, 2020 8:59:11 AM

To whom it may concern,

I am writing in hopes that this letter will reach you and my words will have a positive affect. As we all know this year has has been a rollercoaster of change. The “new normal” as the main stream media and government keep repeating.

Wearing a medical mask or fabric mask has done nothing but cause more division, stress, worry and pollution then help with our “new normal”. Making a law on mandatory masks is not the right way to handle this. People are not wearing them properly, the disposable medical masks are not properly disposed, and are littered all around our community.

If you want to wear a mask then it should be your own choice, but forcing and fining healthy people because they do not comply is not the answer. Remember this day as day that you can stand your ground and so no to the “new normal” , this is my town and community and we listened to our people. We will not wear a mask and get fined hundreds of dollars when we are healthy.

Signed,
A concerned citizen

Five Reasons Why Proposed Face-covering Bylaw is Bunk

By Phil Osborne
To be read at RMWB special council meeting on 14 September 2020

1. It is un-Canadian

Until the Order in Council 99/2020 is lifted and the council chamber at City Hall is re-opened, the ability of native indigenous citizens to have their say in the decisions that affect them is greatly hindered by having to pre-register in order to participate remotely in a meeting that is held behind physically-closed doors, doors which are guarded by dimwitted security guards. Any bylaw passed during this time would be in direct opposition to the parliamentary democratic system that is a hallmark of free Canadian society, and would therefore cause sweeping negative repercussions.

As was mentioned at the last council meeting by one councillor who has some sense, we do not want "mask police". We already have legitimate police who struggle enough to balance the Canadian Charter of Rights and Freedoms with the task of law enforcement. One may only wonder what conduct is to be expected when masked thuggery is encouraged in the streets? Trying to enforce a law that many people do not even see the need for will be counterproductive because it will cause resentment, not to mention the problem of thousands of littered masks.

2. Immunity

Everyone has an immune system that encounters thousands of novel germs every single day. In fact, there are seven known species of coronavirus, each with a plethora of mutated strains. These types of germs and viruses have coexisted with humans for thousands of years. Everyone has already been infected, and developed immunity to at least one of these. Because the majority of the population has a healthy immune system that functions through constant interaction with viruses and bacteria both in and outside the body, a mandatory face covering would be completely arbitrary and unnecessary, and harmful to the correct functioning of body and mind.

3. Ineffectiveness of masks

Dust masks are generally ineffective in the general population for the purpose of stopping or appreciably slowing viral transmission. This is because they only last for a few hours, if they even happen to be worn properly. So, unless a person is doing surgery, or working in a dusty environment, wearing a mask to protect oneself or others from invisible, or quite likely, imaginary particles is purely theatrical. We do not need laws to mandate this silliness.

If the goal truly is to protect those who have weak immune systems who are at risk, then it is wholly unnecessary for the general population to be ritually or symbolically masked, only those who are in close proximity to those with weak immune systems, as in a hospital or institutional setting, where the correct procedures and equipment are both available, and for the most part, actually effective.

4. Effectiveness of hygiene

The common-sense hygiene that has been generally practiced and promoted for as long as anyone has been alive is quite sufficient: i.e. coughing or sneezing into one's sleeve, and regular hand-washing with soap and water. No one, regardless of whether they may, or may not be infected, is going around coughing or spitting on the faces of elderly or immune-compromised people, therefore the risk is negligible. Furthermore, those who are elderly or immune-compromised are already living in a bubble of sorts that makes what other people choose to do, largely irrelevant to how long they have left to live.

5. Mortality

The cold hard fact is that everyone is going to die, whether or not the general population wears masks, and as a society, we MUST come to terms with this in a way that does not stigmatize the general population one way or the other. Life MUST go on despite the fact that people inevitably die. The fact is that no coronavirus has ever been the main cause of human death. So, it is total nonsense to say "If it saves just one life, then wearing a mask is worth it," because such a statement absolutely neglects that

a. the person will die anyway, and probably not from a coronavirus, and
b. there is substantial cost to the livelihood or wellbeing of everyone when a personal choice such as one's facial attire, or lack thereof is made the subject of a proposed bylaw for the general population.

Conclusion

In a society where a native indigenous citizen can be made to wear a face mask for no reason besides mandate, such an individual could be mandated to do just about anything. Such a society would not only be conducting a massive, unwarranted experiment in behavioural psychology, but would also find itself on the verge of tyranny.

From: Craig Peckford
To: Mike Allen; Krista Balsom; Keith McGrath; Phil Meagher; Verna Murphy; Sheila Lalonde; Claris Voyageur; Jeff Peddle; Don Scott; Bruce Inglis; Jane Stroud; Legislative Assistants
Cc: Craig Peckford
Subject: Mask by law
Date: Sunday, September 13, 2020 2:16:01 PM

Hello,
I'm sure over the last week or so you have recieved many emails concerning this issue. Normally I wouldn't write emails nor go on social media expressing my opinion on matters, and I try to see both sides to situations, but this new proposed bylaw concerns me to the point that I felt the need to not stand by without voicing my concerns.

I feel that council has already made up their mind and that we will see this by law, which in my mind is taking one of our freedoms from us. The freedom to choose. I know people will say its to protect others which I'm sorry I disagree because there is no concrete evidence that the use of masks helps...most masks that people are wearing aren't even rated to protect against viruses. Wearing a mask gives people a false sense that they are protected from this virus, and it is obvious they completely disregard the social distancing aspect for fighting the spread. Over the past few months I've been paying close attention to the mask wearers (because I don't think its necessary)and I've noticed that they get really close to others when walking, stand on the escalator in the mall, standing in lines, etc. I also notice a lot of face mask touching with their hands, or the mask is in their cars hanging from the mirror for when they have to run into a store.....not getting clean as often as they should.

Calgary and Edmonton has had this bylaw in for months now and cases are still happening there.
There are 55 cases here that is why this is being brought forth. With the 55 cases how many are in the hospital and how many are told to go home and isolate until recovered? I know 55 is a lot more then we've had so far, but you have to take in consideration that many people are getting tested because of where they work, any little thing they have to go for a test so a positive result even if A symptomatic. I've said to many people if we tested for cancer this much we would catch cancer in many people long before it got to a stage 4 cancer case and that would save many peoples lives.

So my next question is for how long. How long will this by law be in place. What will be the deciding factor to remove this by law when we have 20 cases, 15 cases, 0 cases. This town has so many people coming to from all over Canada for work every week so 55 case to me isn't that much when you think of how many people commute to this great town to better themselves. So a 0 case isn't a realistic number to be looking at.

I'm also curious to why we think we need this by law in place when our provinces chief medical officer hasn't suggested anything like this at this time and not even when this started back in March. I've see videos of both Dr Hinshaw and Dr. Tam say that healthy people shouldn't wear masks and yet we are here talking about making everyone have to wear one, and if not fining them up to $10,000 and possibly jail time. I feel that we are heading down a very slippery slope as a town and as a society that if not handled properly we will look back to say I wish things could be the way the used to be. This is more then just about masks and I hope you can see this.

Lastly I want to say that I love this town. It has been great to me and my family and I would

defend this place when people have said bad about it. Saying that, when I read an ad from our city two days ago stating "be kind and wear a mask" I was saddened and disgusted. In a time where anti bullying is so widely talked about I find my town is bullying anyone that chooses not to wear a mask. It suggests that anyone who doesn't wear a mask, regardless of reason as unkind.....remember, these people that you are painting as unkind are the same people that open their bank accounts to give to the many charities that we have in this town....the people that you suggest as unkind are the same people that dropped everything they were doing to run and help the many people that needed help during the flood this year. I can go on and on about the many acts of kindness that the people of this city do every year whether they wear a mask or not. Whoever said it was ok to run such an ad should be ashamed of themselves and maybe take a good look around this great city and remember the people that are in it.

I'm am a pro choice for this topic of wearing a mask if your healthy. I hope that this email actually gets read and my concerns are taken into consideration, but if I'm being honest I really don't get the feeling that they will or this will even be read....I hope I'm wrong.

A concerned citizen
Craig Peckford

Sent from my Bell Samsung device over Canada’s largest network.

From: Sonja Petereit
To: Legislative Assistants
Subject: No to mask bylaw
Date: Monday, September 14, 2020 10:14:03 AM

Hi there my name is Sonja Regnier I am a resident of Fort McMurray and I am against the proposed mask bylaw. Masks are not working to prevent the spread of Covid 19. Please do not force us to wear masks

Thank you

Get Outlook for iOS

From: Pamela Pittman
To: Legislative Assistants
Subject: Fwd: Mandatory mask bylaw
Date: September 11, 2020 4:27:38 PM

Get Outlook for Android

From: Keith McGrath <Keith.McGrath@rmwb.ca>
Sent: Thursday, September 10, 2020 9:34:45 AM
To: Pamela Pittman <teskep@hotmail.com>
Cc: Jeff Peddle <Jeff.Peddle@rmwb.ca>; Claris Voyageur <claris.voyageur@rmwb.ca>; Mike Allen <Mike.Allen@rmwb.ca>; Krista Balsom <Krista.Balsom@rmwb.ca>; Phil Meagher <Phil.Meagher@rmwb.ca>; Verna Murphy <Verna.Murphy@rmwb.ca>; Sheila Lalonde <Sheila.Lalonde@rmwb.ca>
Subject: Re: Mandatory mask bylaw

Thanks

Best Regards

Councillor Keith McGrath
Serving Others Gracefully
Regional Municipality of Wood Buffalo
T: 780.531.5998

> On Sep 9, 2020, at 3:11 PM, Pamela Pittman <teskep@hotmail.com> wrote:
>
> Open Letter
>
> September 9, 2020.
>
> Dear Councillors of the Regional Municipality of Woodbuffalo,
>
> With the upcoming debate to be held on September 14, 2020, I write to you as a concerned citizen of Fort McMurray. I am asking that you strongly consider not making masks a mandated bylaw.
> By John Carpay “The curve is flat, and has been for months. COVID-19 deaths peaked in March or April (depending on which jurisdiction) and now continue to decline, even while increased testing exposes more “cases.” If masks were not required to flatten the

curve, why
should they be required now?
Many leading doctors and public health officials from around the world support mandatory
mask-wearing. But this does not mean that the science is settled.
One study states that cloth masks pose a 13 percent increased risk of influenza-like illness
infection to those wearing them, noting that “moisture retention, reuse of cloth masks, and poor
filtration may result in an increased risk of infection.” This past April, the World Health
Organization (WHO) also confirmed that masks “offer a false sense of security, leading to
potentially less adherence to other preventive measures.”
The same WHO document points to problems with self-contamination that can occur by
touching and reusing contaminated masks, and potential breathing difficulties due to decreases in
oxygen levels.
Health professionals observe rampant misuse of masks in the community. Contamination by the
incorrect removal of masks is a persistent problem, even among trained medical personnel.
England’s deputy chief medical officer, Dr. Jenny Harries notes that one “can actually trap the
virus in the mask and start breathing it in” and that “people can adversely put themselves at more
risk than less.”
The New England Journal of Medicine explained recently that “wearing a mask outside health
care facilities offers little, if any, protection from infection,” and that masks “serve symbolic
roles” as “talismans” that may help increase a “perceived sense of safety” and do more to reduce
anxiety than to reduce the transmission of Covid-19. Likewise, Dr. Anthony Fauci, member of
the U.S. White House’s coronavirus task force, recently said that masks are symbolic of being a
responsible citizen rather than a dependable infection-control measure.
A WHO guideline from June 5, 2020 states: “At present, there is no direct evidence (from studies
on COVID-19 and in healthy people in the community) on the effectiveness of universal
masking of healthy people in the community to prevent infection with respiratory viruses,
including COVID-19. … At the present time, the widespread use of masks by healthy people in
the community setting is not yet supported by high quality or direct scientific evidence and there
Masks impair communication, harshly impacting vulnerable people with mental-

health disorders
and developmental disabilities; the deaf and hard of hearing; those with cognitive impairments;
and children. Dangerous miscommunications can result when those who suffer from hearing loss
are not able to hear someone who is wearing a mask. These risks are even greater in multicultural
settings, where a person often needs to see the speaker's mouth and face to fully understand what
is being said.
Assuming for a moment that the spread of COVID-19 is actually reduced by forcing the public to
wear non-medical masks, this still does not address the violation of personal autonomy and
human dignity, which are protected by the Canadian Charter of Rights and Freedoms.
Faces are the glue that holds us together, giving us our identity. Recognizing a face is vital to our
social lives. By seeing each other's faces, we discern emotional expressions such as joy, fear or
anger. As the Czech-and-French author Milan Kundera wrote in his 1988 book Immortality:
"The serial number of a human specimen is the face, that accidental and unrepeatable
combination of features."
The significance of the uncovered face was underscored not long ago by the heated debate over
Quebec's law banning face-coverings. Quebec Premier Philippe Couillard argued: "We are just
saying that for reasons linked to communication, identification and safety, public services should
be given and received with an open face… We are in a free and democratic society. You speak to
me, I should see your face, and you should see mine. It's as simple as that."
Opponents of this Quebec law argue that living in a free society means being able to choose what
to wear, and what not to wear. To cover or expose one's face is a profoundly personal choice that
carries with it political, cultural, psychological and spiritual implications.
Few would disagree that an "open face" helps with communication, identification and safety.
Antifa thugs and criminals wear masks for a reason.
The Charter requires politicians to justify laws that diminish the realm of personal choice. Even
if mask-wearing really does reduce the spread of COVID, it's necessary to distinguish the
fearmongering of this past March from the facts we now know in July. In March, the politicians
relied on claims by Dr. Neil Ferguson of Imperial College that COVID-19 would kill 510,000

people in the UK and 2.2 million Americans. We were told in March that COVID threatened
everyone, including children and healthy adults.
Today we know that what politicians and chief medical officers said in March was not just false,
but demonstrably false. Alberta Premier Jason Kenney and Chief Medical Officer Deena
Hinshaw claimed that as many as 32,000 Albertans could die of COVID. As of July 23, the
number was 176 (not 32,000) and 97 percent of deaths were amongst people over 60.
Today, government data tells us that COVID poses very little threat to children or youth. Like
other viruses, it threatens elderly people with one or more serious health conditions. We now
know that four fifths of COVID deaths occurred in nursing homes, amongst elderly people who
were already very sick. As a cause of death, the impact of COVID on healthy adults under 60 has been negligible in comparison to so many other causes of death. Statistically speaking, healthy
adults have more to fear from driving than they do of dying of COVID.
On a global scale, COVID deaths are a small fraction of the number of lives claimed by the
Asian Flu (1957-58) and the Hong Kong Flu (1968-69). In Alberta and other jurisdictions, the
average age of death from COVID is higher than the average life expectancy; COVID has little if
any impact on life expectancy.
Yet government policies are still based on the panic of March, rather than on the facts known in
July. The media continue to speak about COVID as though death is not a natural part of life, and
as though no person has ever died (whether wholly or partly) from a virus. Government policy
seems to be predicated on the notion that we can somehow make people live forever (or for a
very long time) even when they are already very elderly and very sick.
What is “unprecedented” in 2020 is not COVID but a new social and political experiment of
locking up an entire population of millions of healthy people, pushing many of them into
unemployment, poverty, depression and loneliness, all of which significantly reduce overall
health. This is completely different from quarantine: the ages-old practice of isolating the sick.
Another “unprecedented” feature of 2020 is politicians and chief medical officers who ignore
settled medical opinion that the best way to vanquish a virus (and to protect the vulnerable from
it) is to allow it to spread amongst people who are younger, stronger and healthier.

Once
“population immunity” (“herd immunity”) is established, the virus cannot easily spread further,
and therefore has far less chance of harming the vulnerable. If wearing a mask truly works to
reduce the spread of a virus, then mask-wearing will hurt the vulnerable by delaying the
acquisition of population immunity.
Settled medical opinion about herd immunity cannot simply be disregarded or dismissed. Those
who believe that we can and should try to stop the spread of a virus amongst healthy and
invulnerable people must prove and justify their novel approach.”
Again, I write this letter and beg you not to pass the mask bylaw.
Sincerely,

Pamela Pittman
A Concerned Citizen

https://www.jccf.ca/making-face-masks-mandatory-is-not-backed-by-science-or-law/
https://apps.who.int/iris/bitstream/handle/10665/331693/WHO-2019-nCov-IPC_Masks-2020.3-eng.pdf?sequence=1&isAllowed=y
https://www.independent.co.uk/news/health/coronavirus-news-face-masks-increase-risk-infectiondoctor-jenny-harries-a9396811.html
https://www.nejm.org/doi/full/10.1056/NEJMp2006372?query=TOC

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From: Jillaine Proudfoot
To: Legislative Assistants
Subject: Bylaw No. 20/024 - Face Covering Bylaw
Date: Sunday, September 13, 2020 3:07:33 PM

To Municipal Council,

I am writing to support the mandatory mask bylaw in indoor public places. I am a kindergarten teacher, and I really want schools to stay open this year! The only way Coronavirus will stay out of our schools is if it stays out of our community. Wearing masks will help prevent the spread within the Regional Municipality of Wood Buffalo.
The students of Fort McMurray deserve to be in school, in person. In my school, there has been very little issue with young students wearing masks. Residents of Fort McMurray should be able to wear them for short outings to the grocery store, coffee shop, or other businesses for the sake of Fort McMurray's children and youth.

Thank you,

Jillaine Proudfoot

From: Cheryl
To: Legislative Assistants
Subject: Mask Mandate
Date: Sunday, September 13, 2020 9:01:52 PM

Hello,

I am writing to let you know I am against a mask mandate in RMWB. I have based my decision on wearing masks from OSHA studies that show that mask wearing can have long term health consequences. They can cause bacterial infections due to moisture buildup and then antibiotics will be needed that will cause the immune system to weaken and put people at greater risk of having complications with COVID-19, or any flu virus. To top it all off, the medical masks don't stop droplets the size that carry the virus and the people wearing cloth masks are 23% more susceptible to catching the virus because of moisture buildup. We need to educate our community on how to strengthen their immune systems and be able to fight off the virus. For those who have severely weakened immune systems, they need to stay home to protect themselves, but let the rest of us get out there and get natural immunity to this virus. That is the only way to slow and eventually stop the spread, just like all viruses from the past. Yes people will unfortunately die from this virus as they do from other viruses, but I am concerned that the mask mandate will only cause more unnecessary deaths. Furthermore, there are a lot of people who for physical and mental reasons can't wear masks and this mandate will only cause more division within our great community.

Thank you for your time and allowing me to express my concerns.

Sincerely,

Cheryl Richards

Get Outlook for iOS

From: John Ridley
To: Legislative Assistants
Subject: Fwd: written submission, mask bylaw
Date: Monday, September 14, 2020 11:04:29 AM

Get Outlook for Android

From: Section 17 (1) FOIP
Sent: Monday, September 14, 2020, 8:52 AM
To: Section 17 (1) FOIP
Subject: Re:

Hello Mayor and Council,

I am writing to you today to support a proposed bylaw that would make face mask use mandatory for the majority of the population in Fort McMurray and surrounding area.

The use of masks as a means to reduce the spread of Coronavirus has been proven effective, however people seem to misunderstand how this works. Mask use, as I'm sure you are aware, is intended to prevent people who are currently incubating the virus, as well as asymptomatic carriers from easily transmitting the virus through the air, not as some of the population believes, to prevent you (the wearer) personally from getting ill.

This brings me to why I am in support of such a legislative measure. My primary concern, is that it is well documented that many people may be incubating and/or asymptomatic carriers of Coronavirus and as such, may also inadvertently be causing and contributing to community transmission of the virus. A simple requirement to don a face mask in public places would greatly reduce this possibility and as such should be passed as a municipal bylaw until such time as the current pandemic is deemed over by the World Health Organization.

You must pass a bylaw requiring the use of masks in indoor public spaces, not to protect the individual, but to protect the public at large from asymptomatic carriers. Manu public health officials have stated already that such measures, effectively enforced, would contain the spread of this disease in as little as four to six weeks, and with that containment would result in its virtual elimination shortly afterwards.

Kind Regards
J.Ridley

From: Sam Roberts
To: Legislative Assistants
Subject: sept 14th/mandatory masking debate
Date: Saturday, September 12, 2020 4:35:58 PM

Hi. Please include the following to be submitted in the Sept 14th debate.

Heard you were voting on a mask bylaw. Vote no.

First off, it is very humilating to be treated like a 5 year old child. We are all adults here, and those that aren't, have adults that can advise them on what to do. It's like being muzzled like a dog. If someone wants to wear a mask, let them. But don't force it on the entire population. Some people are scared - but that's because they watch sensationalistic news designed to cause fear, and the news do that to bump ad revenue.

Second, common sense. You wear a mask for a long period of time, you are doing slow brain damage in the long term. People don't breathe oxygen because they are bored have nothing better to do. People breathe oxgyen because they NEED it. If someone does not already realize a mask does absolutely nothing to protect against a virus - then chances are they've already breathed in a little too much CO2, and have already suffered a bit of brain damage.

Third, if you don't know it already, this is a very horrible, HORRIBLE and very corrupt power grab by a few very rich, very sick people. Look at what's happening in other countries. Australia, a population of 25 MILLION people, is "shut down" because of fear because of something that has less deaths than the COMMON COLD. ALL rights and freedoms have been stripped. In the name of "protecting" you - the ones in power are trying to FORCE a vaccine that makes people sick, and make it so to get a job, to travel, to do ANYTHING - you need to get injected by a vaccine from a guy who is KNOWN FOR VIRUSES. Bill Gates. The man quoted as saying he wants 7 BILLION people infected with his vaccine. And Bill Gates. Windows. What do you think of? VIRUSES! It's great system for getting viruses. Not for getting rid of them. And then TemperatureGUNS to measure temperature - conditioning people to thing having something pointed at their head, then pulling the trigger, and thinking that is "normal"? There are now "ISOLATION" centers (aka WORLD WAR II DETENTION CAMPS) being built in CANADA in the name of "protecting" you. This has GOT to stop.

People do not want this. People do not want this. LET ME REPEAT THAT - PEOPLE DO NOT WANT THIS. Don't we teach our daughers NO MEANS NO? What have we got to do? NO!!!

PLUS - Guess what - the media is manipulating the public into fear. They say "oh no! cases up!". First of all - it is based on a faulty test. LET ME REPEAT THAT. It is a faulty test. Second - without the corresponding number of "tests conducting" - the cases are meaningless. Like - if you had "10" cases on day 1, then "100" cases on day 30, the media would say "Oh no! CASES have INCREASED 1000% It's gone from 10 to 100 cases in ONLY 30 DAYS! LOCKDOWN EVERYTHING!". But they neglect to say that tests went from 10 to 10 THOUSAND. So on day 1, 10 "cases"/10 "tests" = 100% infection rate. On day 30, 100 "cases'/"10000 tests" = 1% infection rate. SO THE REALITY IS - ITS GONE FROM 100% to 1%. The media is manipulating people and making them FEARFUL. An guess what - postmedia owns most of the media in Canada. So it's not "independent news", but rather "manipulative news".

Do you WANT people to suffer?

And guess what - you wear a mask - you GET SICK! Then "they" will say " OH NO! CASES UP!" It is UTTER and COMPLETE BS. It's really really corrupt and absolutely disgusting.

There is a very sick, very disgusting agenda here. It's got ABSOLUTELY nothing to do with health. The OHSA (Occupational Health & Safety Organization) even says they do nothing. But one things masks DO do - is make you not breath properly, make you breath in your own bacteria culture you are growing to make you sick. Remember the petri dish with bacteria experiment in highschool? THAT is what is growing on your mask.

Say no to masks. This is a slippery slope. "They" talk about "eduation"? Educate the public PROPERLY. Not the media "education" designed to cause fear and panic. Get exercise. Breathe oxygen.

Also, zoom is really bad, not only because it can be used to track, monitor, and keep stats on everyone world wide - but it is isolation. You are talking to a t.v. If someone isn't sick - SOCIALIZE (humans are social creatures - this nonsense is designed to separate them and cause great anxiety, and stress - which guess what, is bad for you! And of course - if someone is coughing, hacking, sneezing, DONT socialize! Get well! It's common sense.

Getting exercise, breathing oxygen, eating properly - that is GREAT for the immune system. And you know what? The immune system PROTECTS you.

There are countries that chose to do ABSOLUTELY nothing (no masks, no quarantine, no nothing) - and guess what! They are PERFECTLY FINE.

IF someone wants to wear a mask to 'feel' better, let them. It does NOT "protect" other people. Not only do people not wear them correctly anyways, but viruses are teeny tiny particles. The mask fabric is like a white picket fence. Wearing a mask is like using a picket fence to try and stop flies from getting into your yard. The ONLY thing that could potentially stop "teensy tiny particles" from getting into a mask is an N95 mask OR BETTER. Everything else is a FASHION statement.

Let everyone else make their own decision. We are all adults here. And again, the ones that aren't have adults to guide them.

Vote no. Thank-you.

Sam Roberts

From: Megan Robertson
To: Legislative Assistants
Subject: Face Covering Bylaw
Date: Friday, September 11, 2020 7:13:55 PM

Council,

I have no doubt that this will be a divisive subject and that those opposed will likely be the loudest voices heard. However, for the safety and consideration of our city's population, I ask that wearing a mask while indoors in all public spaces become a bylaw. If it can slow the spread of COVID-19, even the smallest amount, we owe it to each other to at least try. This, in no way, is infringing on anyone's rights or freedoms. It simply comes down to basic human decency. Our resilient city has come together so many times for the good of its people. It is time to do so again.

Thank you for your consideration.

Megan Robertson

From: C. Robinson
To: Legislative Assistants
Subject: The upcoming mandatory mask bylaw VOTE
Date: Sunday, September 13, 2020 4:07:00 PM

Hello to my RMWB representatives,

I am writing regarding the wearing of masks in my area.

I understand that they are a benefit in certain circumstances, but I believe to have them mandatory for the general population would be extremely harmful for individuals as well as society as a whole.

We already have enough science and statistics to show that for the general public, wearing of masks increases the risk of catching virus' and disease. The wrong material, improper use, and a false security that increases risk-taking are some of these factors.

With regards to our local impact, I personally already avoid those businesses that require masks and I know of a few people that for health reasons cannot wear them. I know they have already experienced prejudice and hate over wearing them: I do not think in a free and wonderful country like Canada they should have to disclose personal information to random strangers in order to avoid abuse and to be able to access basic services! I believe that to make masks mandatory would increase this mentality and encourage such horrible behavior toward other citizens. For that, as well as other reasons, it would almost guarantee that patronizing local businesses would become less frequent as a result.

I still believe in the rights of an individual, and freedom for them to choose what is best for themselves. If you want to mask up, feel free; if you choose not to mask up, you should also be free to decide. We have already seen a host of regulations that contradict safety for the sake of appearance: It is time to see a rational decision made that allows us to continue in the freedom to which we were born. Just as I may choose to drive a car to work -knowing there are risks involved- i should be free to make such a personal decision -such as covering my face or not- for myself. There are already too many places in the world where those freedoms would be taken from me. Do you really want, as a society, to stoop to such a level? Is that really something that should be decided from a governmental body? I think not.

I believe the majority of people do not want mandatory masks. Most of the people I encounter see it as a detrimental inconvenience. With everything else this city has been through, why add this burden to our population? There have been so many people I have spoken to, from outside of town that have been so envious of the RMWB when I tell them we do not have mandatory masking in place. Up till this point, I have been proud of our city's stance on our right to choose. Please do not change this standpoint by forcing a mask on us.

Sincerely,

A Concerned RMWB Citizen

From: Jocelyn Routhier
To: Legislative Assistants
Subject: Re: Mandatory Masks
Date: Sunday, September 13, 2020 5:00:16 PM

I'm writing this email on behalf of myself Jocelyn Routhier of Fort McMurray.
I am 40yrs of age and I strongly oppose the implementation of mandatory masking being brought into Fort McMurray.
I do not agree with wearing a mask if you are a healthy person and I for one will not wear a mask.
I can not attend this meeting and want my voice heard.

Sincerely
Jocelyn Routhier
Sent from my iPhone

From: Elise Ryland
To: Legislative Assistants
Subject: RMWB Potential Mask By-law Feedback
Date: Sunday, September 13, 2020 9:28:50 PM

The Honourable Mayor Scott and Councillors of the Regional Municipality of Wood Buffalo,

It has come to my attention that the RMWB will be discussing the implementation of a mandatory mask by-law.

As a concerned citizen of the RMWB, I wish to address why I believe this will not be beneficial to our community.

When COVID-19 first made headlines back in March of 2020, members of the public were eager to suggest that Albertans should wear masks to contain the spread. However, at a press conference around the same time, Dr. Deena Hinshaw was quick to point out that masks were largely ineffective. She stated the following:

> "What we've seen from studies in previous occasions, so whether that's the previous pandemic in 2009, or in SARS, is that if you wear a face mask alone while you're well and just out and about, it doesn't seem to add a great deal of protection over and above regular hand washing and avoiding touching your face with unwashed hands. And, in fact, if people are wearing face masks in a way that is not correct, so say that they're putting a face mask on with unwashed hands or taking it off with unwashed hands, they can actually contaminate themselves and potentially cause more risk. So, it really depends on how face masks are worn. And, again the recommendation is that people who are sick should wear those to prevent spread to others."
>
> Source: https://globalnews.ca/video/6733752/albertas-dr-hinshaw-explains-who-should-use-a-face-mask

The potential for self-contamination is one reason why I am opposed to the mandatory face mask by-law. Dr. Hinshaw has clearly stated that people should have clean hands when putting on and taking off their masks. However, I can assure you that the majority of citizens are not washing or sanitizing their hands while handling their masks. Also, people are more likely to touch their face with contaminated hands as they constantly adjust their masks during wear. This leads to an increased risk of direct exposure to COVID-19 and other pathogens.

Another problem with imposing a mandatory mask by-law is that citizens are re-wearing dirty, contaminated masks. Some choose to hang their masks from their car's rear-view mirror or to keep them in purses and pockets and reuse them upon entering various stores. This is especially true of those who use cloth masks. This practice is neither sanitary nor useful in preventing the spread of COVID-19 and other diseases.

The Centre for Disease Control (CDC) in the United States of America notes:

> "The general public should be educated about mask use because cloth masks may give users a false sense of protection because of their limited protection against acquiring infection. Correctly putting on and taking off cloth masks improves protection. Taking a mask off is a high-risk process because pathogens may be present on the outer surface of the mask and may result in self-contamination during removal."
>
> Source: https://wwwnc.cdc.gov/eid/article/26/10/20-0948_article

Improper disposal of single-use masks is another concern for the RMWB. I have personally seen used masks left discarded on fresh produce and shelves at grocery stores in Fort McMurray. This is disgusting as it furthers the spread of a variety of germs and illnesses.

Also, improper mask disposal will likely have a negative environmental impact on our area, as it has in

other places. Countries around the world have seen an increase in masks and other PPE plastics in waterways and oceans. There has also been an impact on wildlife as animals are ingesting masks and becoming entangled in mask straps.

In July 2020, the United Nations News reported the following:

> "The UN Environment Programme (UNEP) has warned that, if the large increase in medical waste, much of it made from environmentally harmful single-use plastics, is not managed soundly, uncontrolled dumping could result.
>
> The potential consequences, says UNEP, which has produced a series of factsheets on the subject, include public health risks from infected used masks, and the open burning or uncontrolled incineration of masks, leading to the release of toxins in the environment, and to secondary transmission of diseases to humans.
>
> Because of fears of these potential secondary impacts on health and the environment, UNEP is urging governments to treat the management of waste, including medical and hazardous waste, as an essential public service. The agency argues that the safe handling, and final disposal of this waste is a vital element in an effective emergency response.
>
> 'Plastic pollution was already one of the greatest threats to our planet before the coronavirus outbreak," says Pamela Coke-Hamilton, UNCTAD's director of international trade. "The sudden boom in the daily use of certain products to keep people safe and stop the disease is making things much worse.'"
>
> Source: https://news.un.org/en/story/2020/07/1069151

Mandatory masks will negatively impact local businesses as well. People are already opting to shop online more than ever before. Implementing mandatory masks is likely to deter people from shopping locally as it makes it more inconvenient to visit local stores—especially for families with young children. Therefore, it should be left to the discretion of the business to determine whether they want to mandate masks for their employees and/or customers, as is the current practice.

Another concern I wish to address is regarding how long the by-law will be in place. Will there be a time limit on it? Will this by-law remain in place indefinitely? How will Council judge when it can be lifted? I cannot support a mask by-law that has no time restriction. Wearing masks in public indefinitely is certainly not plausible. This is something that needs to be discussed.

This past week, Fort McMurray Today reported on the penalties for those who fail to abide by the proposed mask by-law. Several citizens, including myself, were alarmed to see that jail time was included as a possible penalty. It hardly seems that the punishment fits the crime in this instance, especially given that prisons across Canada released criminals with far worse convictions due to the concern of COVID-19 potentially spreading within our prisons.

Source: More than 2,000 inmates released, 6 COVID-19 cases confirmed inside Ontario jails | CBC News

Masks are useful when they are correctly used in some circumstances, which is why they are part of a health care worker's PPE. However, they are not designed for everyday use by the general public and pose a greater risk than benefit to the environment and healthy citizens. Therefore, I respectfully ask that The RMWB allow masks to remain voluntary.

Thank you for your time.

Sincerely,

A Concerned Citizen of the RMWB

From: Jonathan Sheppard
To: Legislative Assistants
Subject: Mask
Date: Sunday, September 13, 2020 8:51:27 PM

Dear RMWB Personel,

The facts are there. The masks do not actually stop the spread of the virus. And this virus has a 99.67% survival rate. That's some pretty goods odds there. Why put our children though 6 hours of breathing in there CO2 at school. They have a higher odds getting mauled by a bear right now. This is not normal. This is so hard on the kids and all the workers.

If you are going too push this to make masks mandatory. We will push back. If the virus is that deadly these masks will have to be decomposed of the right way. In bio hazards containers, and incinerated. RMWB will be obviously responsible for placing many bio hazardous containers throughout the city so we can use them. Then everyday they will need to be taken and the proper steps have to be put in place to incinerate these deadly contaminated masks. Look around the hospital doors there's hundreds of masks all over the ground, who is responsible for the clean up. I can't touch them this is a deadly virus.

Edmonton already has 500 million dollars law suit for mask litter do you want the same here.

Thanks for your time,

Jonathan Sheppard

From: Nicole Sheppard
To: Legislative Assistants
Subject: . Masks
Date: Sunday, September 13, 2020 7:36:07 PM

Dear municipality,

When a simple piece of cloth covering the mouth becomes acceptable to stop the spread of a virus, we need to start questioning the intelligence of our health professionals.

Forcing healthy people to be masked for a disease that has a 99.76% survival rate is foolish.

Life is not a ‘one size fits all’ and it never will be. Leave the people alone to choose for themselves. We do it everyday and we’re actually pretty good at it. Assessing our own risk to situations and whether or not we want to do it. Driving, eating, swimming, sky diving, all put us at risk, but we do them anyways, so if you’re not about to make those acts illegal STOP THIS NONSENSE AND THIS ONE SIZE FITS ALL AGENDA.

Sincerely,

Nicole Sheppard

From: Samantha Short
Subject: Make Masks Mandatory
Date: Friday, September 11, 2020 4:49:25 PM

Dear Councillors of the Regional Municipality of Woodbuffalo,

I would like to stress my concerns that this town, the RMWB, Fort mcmurray Alberta, NEEDS Mandatory masks in all public areas!
I have an 11 week old baby, and since the moment she was born after leaving the hospital we have been confined to our home, the only place she goes is medical appointments because her respiratory system is to small And undeveloped to trust with this virus. I myself may have been to the store 5 times since she was born and have since stopped shopping locally with the inflated cases in town. I have also had to stop the small bubble of family we did have visiting to help us out. This is very depressing as a new mom I have no help and it takes a village to raise a child and due to covid there is no village. We live in such a transit town with people coming and going from all over with no requirements to isolate when arriving, so how is it fair to this town that we have to suffer? Masks can only be effective if everyone uses them (everyone that can that is). Please for the health and safety of everyone make this mandatory, it's a small price to pay in saving even just one life. Let's protect our elderly, our high risks, the babies and everyone. If we are truly fort Mac strong then there shouldn't even be a question. I have a newborn, I have grandparents in their 80's, I have a niece with muscular dystrophy, we are need to protect one another. If someone who has the virus and doesn't know is out in the public without a mask it's endangering everyone ones with masks and without, if everyone was to wear a mask then the risk of infection is almost zero. I'm not even sure how it's a question. Please please please for the safety of my loved ones and your loved ones, make masks mandatory.

Thank you,
Samantha Gillingham

From: Dave Simcoe on behalf of FOIP ACT
To: Legislative Assistants
Subject: Face Covering Bylaw
Date: Saturday, September 12, 2020 4:22:56 PM
Attachments: Violates charter.docx
economic devastation of Canada's pandemic response.docx
vcc-statement-of-claim-2020-redacted.pdf

<!--[if lte mso 15 || CheckWebRef]-->

simcoe.dave@shaw.ca has shared a OneDrive file with you. To view it, click the link below.

vcc-statement-of-claim-2020-redacted.pdf

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Wearing a mask is like installing a screen door in a submarine or It's like putting up a chain link fence to keep out mosquitoes or trying to stop a baseball with an open barn door!

Joking aside, there is No justification for mandatory face covering.
It is Kowtowing to Fear and Hysteria over a pandemic that has been **greatly exaggerated**, and the implementation of counter measures that are not supported by the quantitative data. At the onset of the virus, policy decisions were driven by models which were vastly overstated with questionable metrics. Models are intended to test hypothesis against **Real World Data**, not drive policy.

The following articles question the effectiveness of masks;

Research published in the *Annals of Internal Medicine* at the first of April indicated that "*both surgical and cotton masks seem to be **ineffective** in preventing the dissemination of SARS–CoV-2 from the coughs of patients with COVID-19.*"
Reference: www.acpjournals.org/doi/10.7326/M20-1342

In a 2008 study of surgical masks worn by 53 surgeons, researchers found that the mask **reduced the blood oxygen levels significantly**, creating a condition known as "**hypoxia**."
Reference: pubmed.ncbi.nlm.nih.gov/18500410/

Although the CDC recommends wearing masks, they admitted that **they do not have data** to confirm that wearing a mask reduces the risk of contracting or spreading COVID-19.
Reference: www.reuters.com/article/uk-factcheck-coronavirus-mask-efficacy/partly-false-claim-wear-a-face-mask-covid-19-risk-reduced-by-up-to-98-5-idUSKCN2252T6

Surgeon General Jerome Adams advised against the general public wearing face masks, saying they were "***not proven to be effective***" in preventing people from contracting COVID-19.
Reference: twitter.com/Surgeon_General/status/1234471968033951745

Face Mask Fact Sheet www.docdroid.net/hIVGIrz/covid-19-face-masks-05-pdf

Please review the attached;

Personnel Letter to Mayor and council
Statement of Claim Against Federal Government, Ontario Provincial Government and City of Toronto
Was confining much of the working-age population the right decision?

Regards,
Dave Simcoe

September 12th, 2020

ATTN: Mayor and Council

RE: **Face Covering By-Law**

COVID measures currently being undertaken by all levels of government Violates Section 2 7, 8 and 9 of the Charter of Rights and Freedoms:

> Section 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.
> section 7 – Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice
> section 8 – Everyone has the right to be secure against unreasonable search or seizure.
> section 9 - Everyone has the right not to be arbitrarily detained or imprisoned.

The unjustified and erratic closure of businesses, forced isolation, Social distancing and now, considering compulsory wearing of masks! **None of these measures have proven to be Scientifically nor Medically effective!**

The cure (hyper overreaction) has caused far more socio-economic damage to our society than any virus in our history,
E.g. Exponential increase in substance abuse, increased anxiety and depression, loss of life as a result of inaccessible elective surgeries,

business loss, employment loss, astronomical fiscal debt in both the private and public sector, etc.

Governments at all levels are consciously or unconsciously using metaphysical truths re COVID to instill fear and hysteria to control society. The ease with which we accepted the authority of so-called bureaucratic health experts and politicians to reshape our lives is probably largely due to a subconscious behaviour to suppress any moral sensibilities that might offer some resistance.
Secondly, instead of succumbing to the fear and hysteria propagated by government, mainstream media and especially social media, we need to take the time to educate ourselves on the issue. This will allow us to assess options and better-informed decisions. **It will also provide us the opportunity to discern what we should fear from what you shouldn't**.

Everybody needs to understand, the level of bureaucratic overreach "emergency Powers" taking place now, will result in all levels of government not relinquishing this control, once the emergency has passed. **Remember, Lord Acton's dictum, "Power tends to corrupt, and absolute power corrupts absolutely"**

Together, we must protect our God given right of "Free Will" and our freedoms guaranteed in our constitution and Bill of Rights.
Governments at all levels, have a fundamental accountability to preserve these rights and freedoms guaranteed in the charter! It is understood the government has a right to put a limitation on rights, e.g. wartime. However, it **Must** demonstrate that its **"*justified in a free and democratic society*"**!
It is highly unlikely the current COVID measures could be justified in a court of law.

Regards,

Dave Simcoe

FOIP ACT s.17(1) [redacted]

Note: By no means am I suggesting that we do not put controls in place to protect the most vulnerable.

After being all-but locked down since mid-March, Canadians are emerging to face the incomprehensible damage that has occurred in just 12 weeks. Besides the patients and valiant front-line workers who succumbed to the Covid-19 virus, shutting down large sectors of the economy caused thousands of lost businesses, millions of lost jobs, and billions (perhaps trillions) in lost savings. The Prime Minister's spending announcements, delivered from in front of Rideau Cottage, added more than $20 billion to our national debt – *per week*.

With the benefit of hindsight, let us examine two vital questions.

Was confining much of the working-age population the right decision?

The living should get easier this summertime, but the economic devastation of Canada's pandemic response will be felt for a long time.

According to Public Health Agency of Canada data, there had been 7,773 Covid-19 deaths in Canada as of June 7. Federal Chief Medical Officer Theresa Tam has confirmed that 81 percent of them were linked to long-term care facilities. Of the remaining 1,482 deaths, most were people over the age of 70. Only 229 of the total deaths were aged under 60 and almost all of those had pre-existing health conditions. Clearly, for a healthy working-age person, the risk of dying from Covid-19 is significantly lower than dying by accident or from other diseases.

If Canada's working-age people hadn't been removed from the workforce plus been subjected to such severe general restrictions – everything from being barred from medical and personal care appointments, to cancelling travel and being unable to go about their daily lives, nearly all of which involves economic activity of one sort or another – Canada's economy would have continued to function without the job losses, bankruptcies and tragic social impacts including mental health deterioration, suicides and family violence. And without the need for the crippling increases in our national debt. In hindsight, keeping healthy working-age people away from their jobs – the first such quarantine ever undertaken – may be the most damaging decision in Canadian history.

Did the shutdown of surgical wards to prepare for Covid-19 victims cost more lives than were saved?

These shutdowns came as Canadians in need of health care were already suffering on long waiting lists. A December 2019 Fraser Institute report found that waiting lists averaged 20 weeks and totalled more than 1 million people. Cancer, cardiac and other patients who had finally been given a surgical date were sent notices of indefinite postponement. The mental anguish of knowing that a tumour continues to grow or a blocked artery might cause a heart attack adds even further medical risk. Now, three months later, no one knows how much longer their wait will be. B.C., for example, has announced that it will take as long as two years to work through its 30,000 cancelled surgeries. Ironically, B.C. Health Minister Adrian Dix has now turned for help to the same private clinics he's been trying to shut down.

Waiting for a wave that never came: With Covid case modelling off by orders of magnitude, tens of thousands of other patients lost their much-needed healthcare. Preparing for the possibility that hospitals could become overwhelmed by Covid-19 victims was a prudent decision. The problem is that our medical system went into the crisis with essentially zero unused capacity and the longest waiting lists in the OECD.

Statistics Canada data shows that, in 2018, cancer and cardiac deaths totalled 132,699 nationally. Delays in treating these diseases seem likely to overwhelm the lives saved from focusing on Covid-19.

Severe impacts of the lockdowns are also being seen in other Western countries, except one. Sweden adopted a no-lockdown policy that Norway's State Epidemiologist criticized as "going against the whole world". Sweden has seen a relatively high death rate compared to its Scandinavian neighbors, but it is well below that of Britain, Spain, and Italy, and about the same as France. And Quebec, with 2 million fewer inhabitants, has had more deaths than Sweden.

Fear of another lockdown will hold the economy in a debilitating limbo because businesses cannot afford to take the risk of reopening. Many will simply close down permanently, adding to the already-immense toll. Few new projects will be started, because investors will remain on the sidelines.

While unemployment has risen, the Swedish economy remains essentially intact and there's been no need for massive increases in public debt. Also noteworthy about Sweden's response to the coronavirus was that it was implemented largely through persuasion and suggestion, and succeeded through social consensus, rather than through government edicts as in Canada. These at times seemed erratic and arbitrary as well as heavy-handed, and some are now facing constitutional legal challenges.

Although its approach came at a cost, Sweden's daily life went on — and its economy remained intact. Below, Sweden's State Epidemiologist, Anders Tagnel.

What were the main elements of Sweden's "going against the whole world" policy?

Swedes were encouraged to work from home, follow good personal hygiene and practice physical distancing. They were instructed to self-isolate if unwell. The elderly and immune-compromised were advised to stay home. Universities were closed, but schools for children under 16 remained open. Shops, daycares, bars, restaurants, and gyms also remained open. Gatherings were limited to 50 people.

Why reopen? Governments must assure Canadians there won't be another lockdown, or many businesses will simply stay closed forever.

These mid-pandemic measures are virtually the same as those planned in Canada for the phased *reopening* our economy. And that raises a crucial point. Epidemiologists are warning, "The virus is still out there". But with relatively few Canadians having gained immunity by contracting the virus, there's no reason for

our susceptibility to be any different than it was before the shutdowns. So why should we expect the final death toll to be any different than if, rather than impose the general lockdowns, Canadian governments had taken a more restrained approach and implemented those measures in the first place? What *is* dramatically different between Canada and Sweden is that we face the huge challenge of restarting a severely damaged economy. As Sweden's State Epidemiologist Anders Tagnel notes, "It's very hard to stop a lockdown".

Here are some items I believe are crucial as we take on that challenge.

Governments must immediately declare that the lockdowns will not be reinstated. Fear of another lockdown will hold the economy in a debilitating limbo because businesses cannot afford to take the risk of reopening. Many will simply close down permanently, adding to the already-immense toll. Few new projects will be started, because investors will remain on the sidelines.

Not at significant risk: Schools should reopen as soon as possible, while we focus on protecting those who are actually vulnerable.

Open the secondary schools. There have been zero deaths of children under age 16 in Canada. And there's a growing consensus that their light viral load makes children unlikely spreaders of the virus. Rather than being the most vulnerable, as they were to the Spanish Flu a century ago, they appear to be the *least* vulnerable to Covid-19. Reopening schools therefore poses low risks. When summer ends, many parents need to get back to work, rather being kept home supervising their children.

Students should bypass universities. Universities and many colleges have announced that in-person classes will not reopen in September (even if governments fully reopen the rest of society), while simultaneously increasing tuition. Students shouldn't simply accept this reduction in teaching quality combined with the affront of higher costs. Since they'll be forced to learn in a

virtual environment anyway, they should take advantage of other online learning opportunities to bypass universities and their high tuition fees. To support this choice, and signal to colleges and universities that their selfish tactics are unacceptable, governments should mandate the recognition of online credentials from credible providers.

Right all along: The pandemic response should have taken other critical factors into account. There'll be no excuse next time.

Don't leave pandemic response measures solely in the hands of Chief Medical Officers. They did their job of "flattening the curve" well. But the measures taken should have also considered the impact of hospital bed closures on treatment of other diseases, small business owners who face losing everything, stress-induced mental health deterioration, suicides, family violence, long-term unemployment and massive public debt.

The strategy to cope with any new outbreak should include our best financial, business, education and mental health experts working as a team. These teams should be assembled immediately as we navigate the unknown course of the corona virus. There's little point to sweeping measures that over-protect the entire population against a single virus if the resulting damage is so severe that the nation in its weakened state can't cope with future crises, whether those are health-related or otherwise. For such crises will surely occur.

Gwyn Morgan is the retired founding CEO of Encana Corporation.

ONTARIO

SUPERIOR COURT OF JUSTICE

B E T W E E N:

Vaccine Choice Canada (VCC)[redacted], and Denis RANCOURT

Plaintiffs

-and-

Justin TRUDEAU, Prime Minister of Canada, Dr. Theresa TAM, Chief Medical Officer for Canada, Marc GARNEAU, Canadian Transport Minister, Doug FORD, Premier of Ontario, Christine ELLIOT, Minister of Health and Long-Term Care for Ontario, Stephen LECCE, Minister of Education for Ontario, Dr. David WILLIAMS, Ontario Chief Medical Officer, CITY OF TORONTO, John TORY, Mayor City of Toronto, Dr. Eileen DE VILLA, Toronto Chief Medical Officer, The County of WELLINGTON-DUFFERIN-GUELPH ("CWDG"),
Nicola MERCER (Chief) Medical officer for CWDG,
WINDSOR-ESSEX COUNTY, Dr. Wajid AHMED (Chief) Medical Officer for Windsor-Essex County, Her Majesty the Queen in Right of Canada, Her Majesty the Queen in Right of Ontario, Attorney General of Canada, Attorney General of Ontario, The Canadian Broadcasting Corporation ("CBC"), Johns and James DOE, officials and employees of the above-noted Defendants

Defendants

STATEMENT OF CLAIM

TO THE DEFENDANT:

A LEGAL PROCEEDING HAS BEEN COMMENCED AGAINST YOU by the plaintiff. The claim made against you is set out in the following pages.

IF YOU WISH TO DEFEND THIS PROCEEDING, you or an Ontario lawyer acting for you must prepare a statement of defence in Form 18A prescribed by the Rules of Civil Procedure, serve it on the plaintiff's lawyer or, where the plaintiff does not have

a lawyer, serve it on the plaintiff, and file it, with proof of service, in this court office, WITHIN TWENTY DAYS after this statement of claim is served on you, if you are served in Ontario.

If you are served in another province or territory of Canada or in the United States of America, the period for serving and filing your statement of defence is forty days. If you are served outside of Canada and the United States of America, the period is sixty days.

Instead of serving and filing a statement of defence, you may serve and file a notice of intent to defend in Form 18B prescribed by the Rules of Civil Procedure. This will entitle you to ten more days within which to serve and file your statement of defence.

IF YOU FAIL TO DEFEND THIS PROCEEDING, JUDGMENT MAY BE GIVEN AGAINST YOU IN YOUR ABSENCE AND WITHOUT FURTHER NOTICE TO YOU. IF YOU WISH TO DEFEND THIS PROCEEDING BUT ARE UNABLE TO PAY LEGAL FEES, LEGAL AID MAY BE AVAILABLE TO YOU BY CONTACTING A LOCAL LEGAL AID OFFICE.

TAKE NOTICE: THIS ACTION WILL AUTOMATICALLY BE DISMISSED if it has not been set down for trial or terminated by any means within five years after the action was commenced unless otherwise ordered by the court.

Date: , 2020 Issued by:

Address of Local Office:
393 University
10th Floor Toronto, Ontario
M5G 1E6

TO: Attorney General of Canada
Department of Justice Canada
Ontario Regional Office
120 Adelaide Street West Suite #400
Toronto, Ontario M5H 1T1
Fax: (416) 954-8982
Tel: (416) 973-0942

AND TO: The Attorney General for Ontario
Crown Law office, Constitutional Law Branch
720 Bay St.
Toronto, Ontario
M7A 2S9
Tel: 416-326-4460
Fax: 416-326-401

AND TO: John Tory and City of Toronto,
City Solicitor's office, City of Toronto
100 Queen Street, W
Toronto, Ontario
M5H 2N2

AND TO: Dr Wajid Ahmed Medical Officer of Health
Windsor- Essex County Health Unit
Address: 1005 Oullette Ave Windsor ON N9A 4J8
Phone: 519-258-2146
Fax: 519-258-6003
Email: crd@wechu.org

AND TO: Dr Nicola Mercer Medical Officer of Health
WDG Health Unit
Address: 160 Chancellors Way Guelph ON N1G 0E1
Phone: 519-822-2715
Fax: 519-836-7215
Email: info@wdgpublichealth.ca

CLAIM

1. As against the Crown and Municipal Defendants the Plaintiffs claim:

a) A Declaration that the "COVID Measures" undertaken and orchestrated by Prime Minister Trudeau ("Trudeau") , and the Federal Crown, constitute a constitutional violation of "dispensing with Parliament, under the pretense of Royal Prerogative", contrary to the **English Bill of Rights (1689)** as read into our unwritten constitutional rights through the Pre-Amble of **the Constitution Act,1867,** emanating from the unwritten constitutional principles of Rule of Law, Constitutionalism and Democracy , as enunciated by the Supreme Court of Canada in, **inter alia , Quebec Secession Reference;**

b) A Declaration that:

(i) s. 7.0.1 through s.70.11 of the **Emergency Management and Civil Protection Act,** RSO 1990.C.e.9 (the **"Act),** and in particular vesting an indefinite emergency power in the Premier and Lt.-Governor, and further that the "COVID Measures", undertaken and orchestrated by Premier Doug FORD ("Ford") and the Provincial Crown, constitute a constitutional violation of "dispensing with Parliament, under the pretense of Royal Prerogative", contrary to the **English Bill of Rights (1689)** as read into our unwritten constitutional rights through the Pre-Amble of **the Constitution Act,1867,** emanating from the unwritten constitutional principles of Rule of Law, Constitutionalism and

Democracy , as enunciated by the Supreme Court of Canada in, **inter alia , Quebec Secession Reference;**

(ii) A further Declaration that the "emergency", COVID-19 "pandemic" declaration issued by Ontario, did not, and does not, meet the statutory requisite criteria set out in s.7.0.1(3) of that **Act,** and is in further contravention of s. 7.0.2(1) and (3) of that **Act** ,and that the declaration of emergency, and its extensions, be declared **ultra vires** the **Act;**

c) A Declaration that the COVID Measures taken by both Trudeau and Ford, and their respective governments, at the blind and unquestioned dictates of the World Health Organization ("WHO") bureaucrats, constitute a constitutional violation of the abdication of the duty to govern, as enunciated in, **inter alia**, the **Re Gray** and **Canada (Wheat Board)** v. **Hallett and Carey Ltd.** decisions of the Supreme Court of Canada;

d) A Declaration that the COVID Measures undertaken by Trudeau, and his officials, violate ss. 2, 7, 8, 9, and 15 of the **Charter,** specifically the measures:

(i) "self isolation";

(ii) "social distancing";

(iii) the compulsory wearing of face masks;

(iv) arbitrary and unjustified closure of businesses;

In that the Measures are not:

(i) scientifically, nor medically, based nor proven to be effective whatsoever;

(ii) pose physical and psychological harm; and

(iii) are extreme, unwarranted and unjustified;

And that the measures violate of s.2 (right of association) s. 7 (life, liberty, and security of person), s.8 (unlawful search and seizure), s. 9 (arbitrary detention by enforcement officers), s.15(equality before and under the law), are further not in accordance with the tenets of fundamental justice in their overbreadth, nor are they justified under s. 1 of the **Charter** in that they are not demonstrably justified in a free and democratic society;

e) A Declaration that the declaration of a public emergency in Ontario, and the very Legislation, Regulations and Orders enacted pursuant to the **Emergency Management and Civil Protection Act, 250 1990 c. E-9,** infringe s. 2, 7,s.8, 9, and 15 of the **Charter** specifically the measures of :

(v) "self isolation";

(vi) "social distancing";

(vii) the compulsory wearing of face masks;

(viii) arbitrary and unjustified closure of businesses;

(ix) the closure of schools, daycares, park amenities, and playgrounds;

(x) the discontinuance of access to education, medical, dental, chiropractic, naturopathic, hearing, dietary, therapeutic and other support, for the physically and mentally disabled, particularly special needs children with neurological disorders; and

(xi) the closing down of religious places of worship;

In that the Measures are not:

(i) scientifically, nor medically, based nor proven to be effective whatsoever;

(ii) pose physical and psychological harm; and

(iii) are extreme, unwarranted and unjustified.

And that the measures violate of s.2 (right of association) s. 7 (life, liberty, and security of person), s.8 (unlawful search and seizure), s. 9 (arbitrary detention by enforcement officers), s.15(equality before and under the law), are not in accordance with the tenets of fundamental justice in their overbreadth, nor are they justified under s. 1 of the **Charter** in that they are not demonstrably justified a in free and democratic society;

f) A Declaration that the Municipal COVID Measures enacted by By-Law, and Orders, by the City of Toronto, and conduct of John Tory, are **ultra vires** the Provincial **Act** and **Regulations,** and are further unconstitutional and are of no force and effect, for breaches of s.2 (right of association) s. 7 (life, liberty, and security of person), s. 8 (unlawful search and

seizure), s.9 (arbitrary detention by By-Law officers), and s. 15 of the **Charter**, specifically the measures of :

(i) "self isolation";

(ii) "social distancing";

(iii) the compulsory wearing of face masks;

(iv) arbitrary and unjustified closure of businesses;

(v) the closure of schools, daycares, park amenities, and playgrounds;

(vi) the discontinuance of access to education, medical, dental, chiropractic, naturopathic, hearing, dietary, therapeutic, and other support, for the physically and mentally disabled, particularly special needs children with neurological disorders;

(vii) the closing down of religious places of worship;

In that the Measures are not:

(i) scientifically, nor medically, based nor proven to be effective whatsoever;

(ii) pose physical and psychological harm; and

(iii) are extreme, unwarranted and unjustified.

And that the measures violate of s.2 (right of association) s. 7 (life, liberty, and security of person), s.8 (unlawful search and seizure), s. 9 (arbitrary detention by enforcement officers), s.15(equality before and under the law), are not in accordance with the tenets of fundamental

justice in their overbreadth, nor are they justified under s. 1 of the **Charter** in that they are not demonstrably justified in a free and democratic society;

g) A Declaration that, in the imposition of the COVID Measures, Trudeau, Ford, and Tory, and all the named Medical officer Defendants, have engaged in **ultra vires** and unconstitutional conduct and have acted in, abuse and excess of their authority;

h) A Declaration that the concept of "social distancing" is neither scientifically, nor medically based, and is an ineffective and a fictional concept, which has no scientific nor medical basis and hitherto unknown with respect to a seasonal viral respiratory illness;

i) A Declaration that:

(i) the orders from the Medical Officers from the Counties of Wellington-Dufferin-Guelph and Winsor-Essex, and any and all County or Municipal By-Law or Health Officers and orders, respecting mandatory wearing face-masks, is unconstitutional; and

(ii) a further Declaration that the mandatory wearing of face-masks is both ineffective and poses a health risk, and is a violation of s. 7 of the **Charter** (liberty and security of the person) in violating the physical and psychological integrity, by seriously restricting a person's primordial right to breath, as well as restricting the very right of liberty, to choose **how** to breath, as well as pose a physical and medical danger;

j) A Declaration that any **mandatory** vaccine scheme against any purported COVID-19, by way of **mandatory** vaccine, **without informed consent**, is unconstitutional, and no force and effect in that:

(i) It in infringes s. 2 of the **Charter** in violating freedom of conscience, religion and thought;

(ii) Infringes s. 7, life, liberty, and security of the person in violating physical and psychological integrity in denying the right to choose, based on informed medical consent;

(iii) Breaches the same parallel rights recognized prior to the **Charter**, as written constitutional rights through the Pre-Amble to the **Constitution Act, 1867;**

(iv) Breaches parallel international treaty rights to no medical treatment without informed consent, and right to bodily integrity, which international treaty rights are to be read in, as a minimal s. 7 **Charter** protection, as enunciated by the Supreme Court of Canada in, **inter alia** the **Hape** decision;

(v) And that, under no circumstances are mandatory vaccines, nor coerced compliance to vaccines, in accordance with the tenets of fundamental justice, nor demonstrably justified under s. 1 of the **Charter;**

k) A Declaration that social distancing, self-isolation, and limits as to the number of persons who can physically congregate, and where they can congregate, violate s. 2 **Charter** rights to freedom of association, thought,

belief, and religion in banning association, including religious gatherings, and further restricting physical and psychological liberty and security of the person rights under s.7 of the **Charter,** and are not in accordance with the tenets of fundamental justice, nor demonstrably justified under s. 1 of the **Charter;**

l) A Declaration that the arbitrary, irrational, and standardless sweep of closing businesses and stores as "non-essential", and the manner of determining and executing those closures, constitutes unreasonable search and seizure contrary to s. 8 of the **Charter** and not demonstrably justified under s.1 of the **Charter;**

m) A Declaration that the declared rationales and motives, and execution of COVID Measures, by the WHO, are not related to a **bona fide,** nor an actual "pandemic", and declaration of a **bona fide** pandemic, but for other political and socio-economic reasons, motives, and measures at the behest of global Billionaire, Corporate and Organizational Oligarchs;

n) A Declaration that prohibitions and obstacles to protest against COVID Measures in Ontario, and in Toronto, are a violation of the constitutional rights to freedom of expression, conscience, belief , and association, assembly, and petition, under s. 2 of the **Charter,** and not demonstrably justified by s. 1, as well as a violation of these constitutional rights, recognized **prior to** the **Charter,** through the Pre-Amble to the **Constitution Act, 1867** and against international treaty rights protected by s. 7 of the **Charter;**

o) A Declaration that any and all COVID Measures coercively restraining and curtailing the physical and psychological integrity of the Plaintiffs, and any and all physical and psychological restraints, including but not restricted to:

(i) "self-isolation";

(ii) no gatherings of more than five (5) and later ten (10)persons, or any set number;

(iii) the shutting down of children's playgrounds, daycares and schools;

(iv) "social distancing";

(v) the compelled wearing of face-masks;

(vi) prohibition and curtailment of freedom of assembly, including religious assembly, and petition;

(vii) the imposition of charges and fines for the purported breach thereof;

(viii) restriction of travel on public transport without compliance to physical distancing and masking

(ix) restrictions on shopping without compliance to masking and physical distancing;

(x) restrictions on attending restaurants and other food service establishments without compliance to masking, physical distancing, and providing name/address/contact information for contact tracing purposes.

Constitute a violation of ss. 2,7,8, 9, and ss. 15 of the **Charter** , to freedom of association, conscience religion, assembly, and express on under s. 2, liberty and security of the person in violating the physical and psychological integrity of the liberty and security of the person, not in accordance tenets of fundamental justice, contrary to s. 7, and further breach of the rights against unreasonable search and seizure contrary to s. 8, arbitrary detention under s. 9 of the **Charter** , and not demonstrably justified under s. 1, as well as breach of the unwritten parallel rights, recognized as constitutional rights, through the Pre-Amble of the **Constitution Act, 1867** and affected by means of removing measures against the "Liberty of the Subject" by way of **habeas corpus**;

(p) Further Declarations that:

(i) the thoughtless imposition of "social distancing" and self-isolation at home breaches s. 2 of the **Charter,** in denying the right to freedom of association and further breachs the right to physical and psychological integrity, under s. 7 of the **Charter** (liberty) in curtailing and restricting physical movement, which measures are wholly unjustified on any scientific or medical basis, and which are not in accordance with the tenets of fundamental justice in being vague, and suffering from overbreadth, and which cannot be justified under s. 1 of the **Charter;**

(ii) That the measures themselves, and the arbitrary detention, by enforcement officers, in enforcing these vague and over-broad, and often **ultra vires,** and contradictory "orders", is a violation of the right against arbitrary detention under s. 9 of the **Charter** and that, in the course of such "enforcement" the search and seizure of private information, including medical information, from individuals, being charged with purported violations of such orders, constitutes a violation of ss.7 and 8 of the **Charter,** and that neither violation of s. 7 or 8 are in accordance with the tenets of fundamental justice nor justified under s. 1 of the **Charter;**

(iii) That the use of "contact-tracing Apps" constitutes a violation of **s.** 8 of the **Charter**, and further violates ss. 7 and 8 of the **Charter** with respect to the constitutional rights to privacy, under both sections, and that such breaches are not in accordance with the tenets of fundamental justice, and are further not justified under s. 1 of the **Charter;**

(iv) That the compelled use of face masks breaches, in restricting the right to breath, at the crux of life itself, and the liberty to choose how to breath, infringes s. 7 to the **Charter** liberty, security of the person and is not in accordance with the tenets of fundamental justice and not justified by s. 1 of the **Charter;**

(v) That the above-noted infringements under s. 2, 7, 8, and 9, as well as the arbitrary decisions on what businesses to close, and which

ones to be left open, constitutes a. 15 of the **Charter** violation based on:

(i) Conscience, belief , and religion;

(ii) Association, assembly and petition;

(iii) Trade and profession;

And further that such measures are arbitrary, and discriminate before and under the law, contrary to s. 15 of the **Charter** (and not justified under s.1 of the **Charter**), and are further a violation of the unwritten constitutional right to equality recognized before the **Charter,** as unwritten constitutional rights through the Pre-Amble to the **Constitution Act, 1867** as emanating from the principles of Rule of Law, Constitutionalism, and Respect for Minorities as enunciated by the Supreme Court of Canada in **Quebec Secession Reference**;

r) A Declaration that any and/ all Municipal /County By-Laws and/or orders, with respect to compulsory face masks, are **ultra vires** the Provincial legislation in that the Province has expressly refused to make face-masking compulsory;

s) A Declaration that the unjustified, irrational, and arbitrary decisions of which businesses would remain open, and which would close, as being "essential", or not, was designed and implemented to favor mega-corporations and to **de facto** put most small businesses and activities out of business;

t) A Declaration that the WHO proposal, that it may be necessary to enter people's homes and remove children from parents, or separate families, who are tested positive for COVID-19, is flagrantly unconstitutional in violating the s.2 rights to freedom of association (the family unit) as well as violating the parent-child relationship protected by s.7 of the **Charter**, as established by the Supreme Court of Canada;

u) A Declaration that:

(i) the Defendant Federal Crown, and its agencies and officials, including but not restricted to the CRTC, have, by glaring acts and omissions, breached the rights of the Plaintiffs to freedom of speech, expression, and the press, by not taking any action to curtail what has been described by the UK scientific community as "Stalinist censorship", particularly the CBC in knowingly refusing to cover/or publish the valid and sound criticism of the COVID measures, by recognized experts;

(ii) a Declaration that the Federal Crown has in fact aided the suppressing and removing of "Facebook" and "YouTube" postings, even by experts, which in any way contradict or criticize the WHO and government measures as "misinformation" "contrary to community standards", by the federal Defendants threatening criminal sanction for such "misinformation";

thus violating s. 2 of the **Charter** by way of act, and omission, as delineated and ruled by the Supreme Court of Canada in, **inter alia** , **Vriend**;

v) A Declaration that the measures have a devastating impact on those with severe physical and neurological special needs, particularly children, and infringe s. 15 of the **Charter,** and the unwritten right to equality through the Pre-Amble to the **Constitution Act, 1867**, based on psychical and mental disability, and age, and not justified under s. 1 of the **Charter;**

2. Such further and/or other Declaratory relief as counsel may advise and this Honorable Court entertain.

3. As against the Crown and Municipal Defendants, Interim and/or final injunctive relief, from any mandatory vaccine, or compelled use of face-mask, and against any other compelled, coercive COVID-Measures, whether by legislative provision and/or Regulation / order thereunder, particularly measures which interfere with physical and psychological integrity without informed consent.

4. As against the CBC:

(a) A Declaration that:

(i) the CBC, as the publicly- funded broadcaster under the **Broadcast Act,** owes a fiduciary duty to be fair, independent, impartial, objective, and responsible, in its news coverage and investigation of the "pandemic", and COVID- Measures, which fiduciary duty it has flagrantly and knowingly breached;

(ii) that the CBC, owing a duty of care to the Plaintiffs as the national, publicly - funded broadcaster, has been grossly negligent in its coverage and reporting on the COVID-19;and

(iii) That the CBC has knowingly and intentionally suppressed, censored, and unjustifiably belittled expert opinion opposed and critical of the WHO and government line on COVID, and thus propagated "misinformation" and "false news" .

(b) General damages in the amount of $1 Million dollars;

(c) Punitive damages in the amount of $10 Million dollars;

(d) Such further or other injunctive relief as counsel may advise and this Honorable Court grant.

5. Cost of this action on a substantial indemnity basis and such further or other relief this Court deems just.

THE PARTIES

- **The Plaintiffs**

6. Vaccine Choice Canada ("VCC") is a federally registered not-for-profit educational society. VCC is committed to protecting health by informing of the existing and emerging scientific literature evaluating the risks, side effects, and potential long-term health effects of artificial immunization. VCC works to protect the right of all people to make fully informed and voluntary vaccine decisions, for themselves and their children. VCC further advocates for safe vaccines. VCC further works to advocate and support the statutory and constitutional rights tied to the right to vaccinate, and the right not to vaccinate, based on best science and medicine, with informed consent. Vaccine Choice Canada was originally incorporated as the Vaccination Risk Awareness Network ("VRAN") in 1982. It changed its name to Vaccine Choice Canada (VCC) in 2014.

7. The Plaintiff [redacted] is a resident of Ontario. Residing in Mississauga.

8. The Plaintiff, [redacted] is a mother to four (4) children and also a children's Mental Health Therapist. She works in an essential service and has found herself to be working from home since covid- 19 closed the province in March, 2020. She has been providing telephone sessions from March to April and video sessions have started as of May. She is finding that about 50% of the families that she would normally work with are not able to engage by telephone or by

video due to many barriers. She has found it challenging to work from home considering she now have four (4) small children at home who are also doing school virtually and need adult assistance. Covid measures have made it impossible to find childcare. [redacted] has had her own children interrupt client phone calls and video sessions in order to meet her children's needs. She would normally be able to work 7-9 hours from the office daily. But, since the shutdown, she is not able to do that but works significant reduced hours. Some of the families and youth and families that she has talked with are reporting an increase in anxiety/depression and suicidal ideation. Children are feeling extremely disconnected.

9. [redacted] states that personally, the Covid measures have affected her as follows:

(a) She has some significant allergies to corn and wheat and all of the hand sanitizer products contain alcohol made mostly from these two (2) products;

(b) She has been yelled at and shamed in public places for not using the sanitizer when it's a health issue for her;

(c) Her son also has the same reaction when he uses hand sanitizer;

(d) She has been told she cannot enter some stores or receive some services without using hand sanitizer first;

(e) Some of the stores that she would normally frequent have signs up saying that everyone has to wear masks;

(f) She cannot do groceries as she would normally in Wellington County because of the mandatory mask order;

(g) Local grocery shopping is pricier for her due to rural pricing;

(h) If she declines wearing a mask, she is told she "can't go into stores or receive services";

(i) She has asthma and has had lung issues over the years;

(j) She also has experienced trauma where a mask was held forcibly over her face to prevent her from screaming while she was being sexually and physically assaulted in a past crime;

(k) She now has to disclose personal health information in order to enter stores with which she disagrees, and is otherwise denied service;

(l) She no longer feels safe going out because of all of the above.

10. [redacted] further states that she objects to face-masks based on the fact that they are ineffective with respect to respiratory viruses, further pose physical and psychological health risks, and further violate her rights under s. 2 and 7 of the **Charter.**

11. [redacted]

12. [redacted]

13. [redacted]

14. [redacted]

15. [redacted]

16. [redacted]

[redacted]

17. [redacted]

(b) [redacted]

[redacted]

(c) [redacted]

[redacted]

(d) [redacted]

[redacted]

18. The Plaintiff, [redacted] is an Ontario resident residing in North Augusta. She recently moved there from Toronto.

19. On May 26th, 2020, at around 5:30pm, [redacted] and her 10yr old child had gone to Longo's, a supermarket at York Mills and Leslie in Toronto, for groceries, but we were stopped as they had entered the doors and an employee demanded that they wear a mask before entering. The store employee, and Manager, stipulated that they had the discretion, as a private business, as per the statements of Premier FORD, and Mayor TORY, to impose mask requirements. The Plaintiff and her daughter left the store as she refuses to wear masks because they are ineffective and dangerous to her health, and a violation of her constitutional rights. The Plaintiff and her daughter were forced to leave the store. The Plaintiff states, and fact is, that there were no Regulations or Orders requiring the wearing of masks to enter businesses that were deemed "essential". The Plaintiff states that public statements made by Ford and Tory had individuals enacting their own, arbitrary, and irrational laws with respect to "essential" services such as food, and further that Ford and Tory were not only reckless but also exceeded their authority in making these statements.

20. On June 13th, 2020, at around noon, the Plaintiff [redacted] was driving on highway 401 Eastbound, and pulled into the Cambridge "OnRoute" to use the washroom

and buy lunch. At the entrance there was a man with a mask that demanded the Plaintiff wear a mask. The Plaintiff informed him that she does not wear a mask and he informed the Plaintiff that it was "the law" to wear a mask if she wanted to enter the Onroute. The Plaintiff informed him that just the day before she had stopped at an Onroute and was not forced to wear a mask. He insisted that it was the law . [redacted] then asked him to show her the law. He pointed in the general direction of the door and said it was written on the door. He stated: "you can go see it on the door." [redacted] walked to the door, did not see anything that would stand out, and since she desperately needed to use the washroom she proceeded to walk to the washroom and used the facilities. [redacted] left the OnRoute without buying anything to eat. [redacted] then drove on to the OnRoute in Trenton, where she entered without a mask, and no one stopped her from using the facilities and purchasing her late lunch. The Plaintiff states, and the fact is, that such confusion, and consequent hardship and damage, is the result of the reckless and excess of authority statements made by Trudeau, Ford, Tory, and their Medical Officers, with respect to what Covid-measures have, or have not, actually put into law, and simply express the at-the-moment ill-informed views of these Defendants.

21. The Plaintiff [redacted] absolutely refuses the wearing of a face-masks. She further denies the efficacy of social distancing and sees both as a violation of her s. 2 and 7 **Charter** rights, as well as the fact that the indisputable science is that neither measure prevent the contraction of any virus and are otherwise detrimental to her health.

22. The Plaintiff, [redacted] is an Ontario Resident residing in the County of Wellington-Dufferin-Guelph.

23. The Plaintiff, [redacted] states that when lockdown started on March 17th, 2020, she was a new mother with a 6 -month old baby. The Plaintiff and child were just starting to get out into the world going to local infant events provided by the city and local businesses, going grocery shopping, meeting with friends for lunch, and other routine social activities. The Plaintiff states that the last day they went out was March 13th, 2020. They have not left the house except to go for walks since that day: no socializing, no music classes, no story readings, and no swim lessons- all cancelled or closed due to the emergency orders. Even meeting in a park and keeping physical distance was not allowed. As a new mother who suffered from birth trauma and is recovering from birth related PTSD, the Plaintiff states that being cut off from her new community has been traumatizing and psychologically and socially unhealthy. This had a negative effect on her mental health which she already had a history with prior to her daughter's birth. The Plaintiff was unable to continue with her health care services that were deemed "non-essential" by the provincial government, but to someone recovering from major surgery, they are extremely essential. This has left the Plaintiff in physical pain which has affected her ability to care for her family. The Plaintiff's daughter was also unable to continue with health services that she had previously, as they were also deemed non-essential by the provincial government. The early life experiences the Plaintiff planned to give her daughter for her growth and development were taken away.

24. The Plaintiff, [redacted] states that Wellington- Dufferin- Guelph County's mandatory mask order is adding insult to injury. The Plaintiff is opposed to the order for several reasons:

(a) It takes away her right to bodily autonomy, which the Plaintiff takes extremely seriously, as she is firm in her conviction in medical freedom and her right to choose what goes in and on her body. She finds it very scary to have that right taken away.

(b) It is not backed by scientific evidence. The Plaintiff was easily able to find science-based articles studies showing that masks, especially cloth ones, are not effective at protecting oneself or others. In fact, they can have a negative impact on physical and mental health. The Plaintiff further states that our public health officials should have been more prudent in their research if they truly want to protect the public's health.

(c) It has had a negative effect on her mental health. As someone who has suffered with, at times, debilitating anxiety that gives the sensation of not being able to breathe, wearing a mask is a huge trigger for the Plaintiff. Knowing that if she goes out without one, and claims medical exemption, the Plaintiff will be faced with questioning and perhaps even refusal of entry, which is also is also anxiety- inducing. The Plaintiff is then left with little options. Despite the fact that her County has been moved to "Phase 2", the Plaintiff states that her life has changed very little as she is still housebound and unable to attempt to return to some sense of normalcy due

the mandatory mask order of the County's Medical Officer, Nicola Mercer.

25. The Plaintiff [redacted] absolutely refuses the wearing of a face-masks. She further denies the efficacy of social distancing and sees both as a violation of her s. 2 and 7 **Charter** rights, as well as the fact that the indisputable science is that they do not prevent the contraction of any air-borne virus and are otherwise detrimental to your health.

26. The Plaintiff, [redacted] resides in Toronto and is a real-estate agent.

27. The Plaintiff, [redacted] states, and fact is, that Condo Boards across the GTA are allowed to make up their own rules for each individual building and quite a few are opting to have a "no showing" rule for condos listed for sale. Some allow showings only after a conditional offer is received. This is unfair to the owners of these units and it makes it very difficult to sell these units, sight unseen. Also, all condo buildings only allow two people per elevator ride. The Plaintiff has waited as long as 1.5 hours to get on an elevator. While this rule has been implemented for Covid-19, the Plaintiff states it has never been implemented for previous "pandemics" such as SARS. The Plaintiff states, and fact is that her clients are not happy with these restrictions, not to mention that many of the Plaintiff's clients are losing their incomes and livelihoods making them unable to buy and sell. The Plaintiff further states and fact is, that the uncertainty of the market, as a result of the Covid-measures, is also impacting purchases and sale prices greatly. The Plaintiff states that, despite real estate being deemed an "essential service, that showing procedures are very strict

when properties do allow showings such as: requesting a signed contract which enforces wearing masks and gloves, not using the toilet, only allowing one (1) client at a time in the property, and in most cases they are unable to touch anything inside the property.

28. [redacted] states that it has made it next-to-impossible to work under these conditions and that her income has dropped drastically. The Plaintiff further states that she refuses to wear a face-mask, and that the Covid-measures violate her rights under ss.2 and 7 of the **Charter.**

29. The Plaintiff, [redacted] is a Doctor of Chiropractory, residing in the County of Welling-Dufferin-Guelph, Ontario.

30. The Plaintiff, [redacted] opposes the COVID-measures enacted by the government(s) as set out below.

31. The Plaintiff , as a citizen, opposes these measures because :

(a) As an individual with a history of mental health struggles the emergency measures, including but not limited to: limitations in visiting people, physical and social distancing (i.e. not touching people or visits in groups larger than 5), threats of fines for non-compliance, disruptions in health care services that [redacted] had been using and needs, in order to support her own health and well-being, have imposed stress and strain on her mental and physical health and well-being. Prior to the declaration of emergency measures and lockdown, [redacted] was utilizing a variety of approaches to support herself and to heal these struggles, no longer available to her.

(b) More specifically, since approximately September, 2018 has been receiving regular nutritional therapy via I-V. was scheduled to receive her monthly I-V therapy a few days after the emergency measures were enacted, and therefore, did not receive them. had now been three (3) months without this nutritional support and is feeling the negative effects in her body.

(c) Further to this, in order to obtain this service, as a resident of Wellington-Dufferin-Guelph County, now must wear a mask to any such appointment, which she refuses to do for reasons set out below.

(d) was also in the process of scheduling necessary and non-routine dental work (amalgam extraction and replacement), immediately prior to the pandemic, and this service again, became inaccessible to her. Again, because of Ministry of Health ("MOH") guidelines for dentistry, must mask to enter the dental clinic , which she refuses to do.

(e) had also been going for regular craniosacral therapy appointments to support her health and well-being, which also, were cancelled and she has not had access to since the start of the emergency measures. does not feel the government has the right to take away her health care and decide what is 'essential' vs. 'non-essential' in this regard.

(f) also take serious objection with the suspension of Parliament and the lack of transparent process with how her government is currently

conducting itself. [redacted] states that the measures enacted have not been congruent with the scientific and medical data, with best scientific practices, and the best evidence available. [redacted] has written multiple letters to elected officials which are continually ignored or to which she receives the rare tepid response. [redacted] states, and the fact is , that this has all set a precedent for this to happen every influenza season, which would be devastating for her and many.

(g) On June 13th, 2020, [redacted] went to the Dollar Store on Stone Road in Guelph, to buy supplies for her children, and at first was denied entrance as she was not masked, despite clear exemption criteria allowing one to enter stores without a mask, if masking creates an issue with breathing or with parameters related to health and well-being. Only when [redacted] pushed back against the store manager that this was discrimination and illegal was she allowed to enter, "at her own peril", risking personally taking on the $5,000 fine for being unmasked if a spot-check was performed by Public Health. While [redacted] was inside, this all felt stressful for her. [redacted]s family have now made the decision to take their commercial activity outside WDG, adding to the already high level of strain in her family due to the heightened time which errands will now take, having to drive out of the County for all their needs..

32. [redacted], as a mother of two young children, aged five (5) [redacted] and two and a half (2.5) [redacted] years old, further objects to the emergency measures enacted and lock down for the following reasons:

(a) Loss of childcare. Both her children attended Star Seedlings, a licensed childcare centre in Guelph, at the time the emergency measures were declared and the centre was forced to close. As a working mother, this has placed an undue level of strain and stress on her life, as she struggled to juggle her own entrepreneurial business and supporting patients clinically, while her husband worked, and her two children were at home without childcare. Her children cannot go back at this time, as the plan had been to switch them to part- time at the end of June, and only full-time children are allowed back in this 'phase' of the Covid-19.

(b) Further to this, [redacted] objects based on the stress caused to her children, specifically her five (5) year old, who has asked near daily from the beginning about the closure of the childcare centre, when he can see his friends again, when he can see his teachers again, and when they can go out for things he enjoys such as bubble tea, to play in parks, and to have play dates at friends' houses. Her son turned five (5) on May 5, 2020 and was not able to have a birthday party as he wished, and [redacted] was left to deal with his disappointment and sadness over this.

(c) Furthermore, [redacted] has witnessed clear regression of her five (5) year-old, during the emergency, into tantrums and increased aggressive behaviour towards his sister, neither of which were occurring prior to

lockdown. Both her children have experienced sleep regressions since lockdown began. [redacted] has specifically observed [redacted] sucking his thumb, which he has never done, even as an infant.

(d) With many stores not allowing children to come inside, as well as the overtly fearful messaging and bizarre policies and procedures enacted within (physical distancing, wearing of PPE), all errands have been conducted by either [redacted] or her husband without their children, which is atypical for their home and has imposed further stress and strain on their family.

(e) [redacted]'s children also only saw their grandparents once during the emergency measures, notwithstanding that they could keep the number of people within the allowed limit of five (5), their grandfather was worried about the potential of a fine, and did not want to risk seeing the grand-children in person.

(f) [redacted]'s son also lost access to health care which was necessary for him and his development. Being four or five (4-5) years old during this time, virtual appointments are a poor option for him, as he will not reliably interact through one, and screen use is something they attempt to minimize. Specifically, he lost his speech therapy as well as craniosacral therapy appointments.

(g) [redacted] further objects to the WDG mandatory mask order for citizens under the age of five (5) as this is not congruent with best science, and what is known regarding masking, nor is it mentally or socially

healthy for children to see this or wear a mask. As her son is five (5), the order would stipulate he wear a mask. Her son has only seen people masked in person once and he reacted with extreme fear. He hid between his mother's legs, would not speak above a whisper, and only in her ear, and behaved in a highly atypical fashion for him. He later told [redacted] that the masks were scary.

(h) [redacted]'s son may also lose his Senior Kindergarten year of school this coming September, 2020, depending on what is 'allowed' and 'required' at that point in time. [redacted]'s husband has stated "[redacted] is basically in prison. I don't blame him for being squirrely."

33. As a chiropractor, [redacted] objects to the emergency measures and measures enacted by the various layers of government for the following reasons:

(a) When restrictions were lifted on the practice of chiropractic, her college followed mandates set forth by the Minister of Health ("MOH") that [redacted], as a practitioner, wear a medical-grade mask when unable to maintain a two-meter distance from her patients (i.e. during the treatment portion of the visit). This mandate occurred after she had written and sent two letters to government officials (one of these letters directly to Joel Friedman of CCO), detailing the lack of efficacy and benefit as well as the numerous risks to those wearing a mask or those they interact with. [redacted] states that this is not only a violation of her right to bodily integrity and right to choose, but also has had detrimental effects on both

her physical and mental health. There were no exemption criteria given for this mandate for chiropractors.

(b) Specifically, [redacted] has found that mask-wearing causes her to feel sleepy, mentally dull, and causes headaches. Furthermore, the mandate to mask served to activate previous personal trauma for her, and has been detrimental to her mental health in this regard.

(c) Forced reduction in activity has had a negative impact on her livelihood and her income, while she remained accountable for her expenses. Furthermore, some patients who cancelled their appointments, or have been without care, and who otherwise would have had in-person follow-up, have experienced exacerbations to pre-existing conditions, without those visits.

(d) Apparent harm to patient trust and rapport, with children being afraid to come near [redacted] for treatment and adults choosing to wear a mask after stating they cannot breathe, on her freshly disinfected table. As of June 18th, 2020, [redacted] can specifically cite: one (1) patient reporting having gone on anxiety medication specifically due to pandemic anxiety ; one (1) mother of a female child reporting her child screaming in fear prior to her appointment; one (1) mother of a three (3) year old reporting screaming of her child when seeing masks; one (1) new patient rating his health and wellbeing a 3/10 since lockdown, where prior to that he rated it as a 7-8/10 ; numerous conversations with patients about stress related to covid and the measures enacted - stress of working without

childcare, stress of lost job and financial uncertainty, stress of poor ergonomics working from home ; numerous conversations with other parents about how their children have been affected - including sleep problems, speech regressions, behavioral issues; numerous patients have spoken of stress around wearing a mask, and the negative effects they feel when wearing one (which was mandated by WDG region when entering commercial enterprises).

(e) [redacted] further states, and fact is, that at the outset of the emergency measures, messaging was delivered, by the Ministry of Health, to Ontario-based chiropractors, not to talk about or share how they can help improve resiliency and fortify immunity, on threat of receiving a professional complaint with no certainty as to how that complaint would be decided. This is not in alignment with the oath sworn upon entering practice to 'first do no harm', nor is it congruent with the right to freedom of expression.

(f) When [redacted] discussed this with the lawyer for the Chiropractor College of Ontario ("CCO") , Mr. Joel Friedman, the message was that if [redacted] speaks about anything, that she does so at her own professional peril. However Mr. Friedman was clear that CCO would **fully support** [redacted]s dissemination of the narrative coming from the MOH and government, but to speak against the MOH or government would be at her own risk, even if in alignment with published science and best available medical evidence.

(g) As a health careworker, with a background in research, [redacted] further objects to the WDG mandatory mask order because it is not aligned with best evidence and known science and creates unnecessary risk to physical health, mental health, relational and social health, as [redacted] clearly articulated in a third letter sent to various levels of elected officials, to which [redacted] has received no response. Furthermore, there is no end date on the order or even a date of re-assessment as would seem prudent for an evidence-informed approach to this. No cited science was given to support this order of mandatory masking.

34. The Plaintiff, [redacted] resides in Hamilton, Ontario.

35. [redacted] is a 23 year-old male with autism diagnosis since age three (3).

36. He is 6'3'', weighs 220 lbs., and has been assessed by a Philologist functioning at the level of a four (4) year-old Although he has speech, and can read some, his emotional and functional age is four (4).

37. [redacted] has been totally, mentally, devastated by the COVID-measures, in depriving him of his routine activities and social and emotional network, without recourse. He suffers severely, from not being able to understand, nor accommodate, under the Covid-measures, why he cannot play where he has played, or anywhere else, why he cannot do the other physical and social activities he did. He will not countenance wearing a mask , does not

understand and therefore cannot comply with "social distancing" or "isolation", given his severe neurological disability and his special needs. The plaintiff, through his litigation guardian, states that Scott's ss.2 and 7 **Charter** are being violated, and given his disability, his s.15 **Charter, through the acts and omissions** of the Covid-measures, are also being violated in that NO regard, thought, nor measures, whatsoever, were enacted or executed to mitigate the utterly devastating damage to the mentally and physically disabled as a result of the Covid-measures. The fact is that [redacted]s entire support, social, medical, and therapeutic network has been ripped away from him without any regard to his special needs.

38. The Plaintiff, Professor Denis RANCOURT, Ph. D., resides in Ottawa, Ontario.

39. Denis Rancourt, B.Sc., M.Sc., Ph.D., is a former tenured Full Professor of Physics, University of Ottawa. Full Professor is the highest academic rank. He is an expert in public health. He has taught over 2,000 university students, and supervised more than eighty (80) junior research terms or degrees at all levels from post-doctoral fellow to graduate students to NSERC undergraduate researchers. He headed a research laboratory, and attracted significant research funding for two decades. He supervised doctoral students in both physics and environmental science. He has been an invited plenary, keynote, or special session speaker at major scientific conferences nearly forty (40) times. He has published over one hundred (100) research papers in leading scientific journals, in the areas of physics, chemistry, geology, materials science and environmental science, including environmental nanoparticles. He co-discovered the

phenomenon of "superferromagnetism", and co-discovered the unique meteoritic alloy "antitaenite". He has a scientific impact factor (h-index) of 39 (84% of Nobel Prize winners in physics had h-indexes of at least 30), and his articles have been cited more than 5,000 times in peer-reviewed scientific journals.

40. Presently, Dr. Rancourt is a registered mentor for physics students at the University of Toronto, and is a Researcher (volunteer position) at the Ontario Civil Liberties Association (ocla.ca). He is a frequent media commentator. His articles and interviews are published in many media venues. His recent video interviews and reporting videos about the science of the COVID-19 epidemic and the science of masks for preventing viral respiratory diseases have already been viewed more than 0.5 million times. He is scheduled to be an invited opening speaker at the October, 2020 'Fifth International Public Conference on Vaccination', organized by the National Vaccine Information Center (NVIC) (USA).

41. The Plaintiff, RANCOURT, in April, 2020, published an article entitled **"Masks Don't Work: A review of science relevant to COVID-19 social policy"**. This was carried on the "Research Gate" website. Subsequently, "Research Gate" removed the article Rancourt's article after the article had received some four hundred thousand (400, 000) reads.

42. YouTube also removed three of 3 of RANCOURT's videos, which were part of his " PlayList" entitled "COVID-19 with Denis Rancourt". The 3 videos were entitled:

- "Masks don't work against COVID-19 article by Denis Rancourt"
- "Jane Scharf advocate for vulnerable persons reacts to COVID-19 policy"
- "Denis Rancourt - Why COVID-19 is global mass hysteria".

RANCOURT states . and the fact is, that Youtube removed the videos in accordance with its publicly- stated policy to remove any "misinformation" contrary to its "community standards", with respect to covid-measures, which is concededly applied to any and all opinions that run contrary to the official WHO dogma, notwithstanding that those contrary opinions come from recognized experts in their field.

43. RANCOURT has written or co-authored the following published authoritative documents about COVID-19:

- **"Masks Don't Work: a Review of Science Relevant to Covid-19 Social Policy"**, first published and widely distributed on 11 April 2020.
- **"Criticism of Government Response to COVID-19 in Canada"**, Report for the Ontario Civil Liberties Association (OCLA), first published and sent to governments and media on 18 April 2020.
- **"All-cause mortality during COVID-19: No plague and a likely signature of mass homicide by government response"**, first published and widely distributed on 2 June 2020, DOI: 10.13140/RG.2.2.24350.77125

- **"OCLA Asks WHO to Retract Recommendation Advising Use of Face Masks in General Population"**, 9-page letter, co-authored with OCLA Executive Director Dr. Joseph Hickey, sent to the WHO Director General, all MPs, all Premiers, all Ontario MPPs, and the media on June 21st, 2020.

Despite this timely and authoritative body of work, noted by the scientific community, and covered in the international media, the CBC has refused to make any mention of these works, and has not provided these perspectives and this scientific information to the Canadian public. RANCOURT further states that CBC has chosen to not cover any other experts who take critical or contrary view of the COVID measures executed by the Federal, Provincial, and Municipal governments at the direction and behest of the WHO.

44. A CBC high-profile journalist had interviewed RANCOURT, at length, about face masks, said the content would be on the evening news, on his blog, and on the radio, and then the content was never used.

45. RANCOURT states, and the fact is, that the Federal Crown, and respective Ministries and agencies charged with Broadcasting, and freedom of speech, expression, and the media, have chosen not to protect against this flagrant censorship, and as such, through omission, infringe RACOURT'S, and other Plaintiffs', right to freedom of speech, expression, and the media contrary to s.2 of the **Charter.** In fact the federal Crown further supports these violations by its threat to criminalize, under the **Criminal Code,** the same contrary opinions now being censored, as "misinformation", even where those opinions come from recognized experts. RANCOURT further states that he opposes all current

COVID-Measures because they are not scientifically or medically based, rely on false and distorted data , are based on a false declaration of a pandemic, and because they violate his ss.2, and 7 **Charter** rights.

- **The Defendants**

46. The Defendant, Justin Trudeau, is the current Prime Minister of Canada, and as such, a holder of a public office.

47. The Defendant, Dr. Theresa TAM, is Canada's Chief Public Health Officer and as such a holder of a public office.

48. The Defendant Her Majesty the Queen in Right of Canada, is statutorily and constitutionally liable for the acts and omissions of her officials.

49. The Defendant Attorney General of Canada is, constitutionally, the Chief Legal Officer, responsible for and defending the integrity of all legislation, as well as responding to declaratory relief, including with respect constitutional declaratory relief, and required to be named as a Defendant in any action for declaratory relief.

50. The Defendant Marc GARNEAU is the Federal Minister of Transport, and as such a public office holder.

51. The Defendant Her Majesty the Queen in Right of Ontario, is statutorily and constitutionally liable for the acts and omissions of her officials.

52. The Defendant Attorney General of Ontario, is, constitutionally, the Chief Legal Officer for Ontario, responsible for and defending the integrity of all legislation, as well as responding to declaratory relief with respect to legislation,

including with respect to its constitutionality, and required to be named as a Defendant in any action for declaratory relief.

53. The Defendant Doug FORD, is the current Premier of Ontario, and as such a holder of a public office.

54. The Defendant Dr. David WILLIAMS, is Ontario's Chief Medical officer, and as such a holder of a public office.

55. The Defendant, Christine ELLIOT, is the current Minister of Health and Long-Term Care for the Province of Ontario and as such a holder of a public office and Long-Term Care.

56. The Defendant Stephen Lecce, is the Minister of Education for Ontario.

57. The Defendant, The City of Toronto, is a Municipality in the Province of Ontario and governed by, inter alia, the **Municipal Act** and all other applicable Provincial Acts.

58. The Defendant JOHN TORY, is the Mayor of the City of Toronto, and as such a holder of a public office.

59. The Defendant Dr. Eileen De VILLA, is Toronto's Chief Medical Officer, and as such a holder of a public office.

60. The Defendant County of Wellington- Dufferin- Guelph is a County in the Province of Ontario and the Defendant, Nicola MERCER is its (Chief) Public Health Officer, and as such, Nicola MERCER is a holder of public office.

61. The Defendant County of Windsor-Essex is a County in the Province of Ontario and the Defendant, Wajid Ahmed is its (Chief) Public Health Officer, and as such, Wajid Ahmed is a holder of public office.

62. The Defendant unknown Johns and Janes DOE, are employees of the Crown and Municipal Defendants and as such are holders of a public office.

63. The Defendant, The Canadian Broadcasting Cor[oration ("CBC"), is Canada's publicly-funded broadcaster and governed , **inter alia**, under the Federal **Broadcast Act,** with a public mandate as Canada's national publicly-funded broadcaster.

THE (FURTHER) FACTS

A/ "COVID- 19"- THE TIMELINE

64. In 2000 Bill Gates steps down as Microsoft CEO and creates the 'Gates Foundation'' and (along with other partners) launches the 'Global Alliance for Vaccines and Immunization ('GAVI''). The Gates Foundation has given GAVI approximately $4.1 Billion. Gates has further lobbied other organizations, such as the World Economic Forum ("WEF") and governments to donate to GAVI including Canada and its current Prime Minister, Justin Trudeau, who has donated over $1 Billion dollars to Gates/GAVI.

65. **In 2002** Scientists engage in "gain-of-function" (GOF) research that seeks to generate viruses *"with properties that do not exist in nature"* and to *"alter a pathogen to make it more transmissible (to humans) or deadly."* [1] [2]

66. In **November, 2002,** China's Guangdong province reports the first case of ''atypical Pneumonia'', later labeled as SARS. In the same month at the University of North Carolina (UNC) Ralph Baric announced the creation of a **synthetic** clone of a mouse coronavirus.

67. On **October 28th, 2003** the Baric group at UNC announces a **synthetic** recreation of the SARS virus.

68. **In 2005** Research demonstrates that Chloroquine is a potent inhibitor of SARS coronavirus infection and transmission. [3]

[1] https://www.ncbi.nlm.nih.gov/books/NBK285579/
[2] https://www.sciencemag.org/news/2014/10/us-halts-funding-new-risky-virus-studies-calls-voluntary-moratorium
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1232869/

69. From **2009** to the present, the "Bill and Melinda Gates Foundation" donates millions to the 'Imperial College of London''(ICL), and further funded the debunked modeling, by Neil Ferguson, at the ICL, that set the COVID-19 'pandemic'' declaration in Motion and acceleration, through the WHO and governments around the globe following suit.

70. **In January 2010** Bill Gates pledges **$10 billion** in funding for the World Health Organization ("WHO") and announces "the Decade of Vaccines." In fact, Bill Gates and GAVI are the second and third largest funders of the WHO after the US government. Currently, the USA, through its President, has cut off funding's to WHO for loss of confidence in it. (Various other countries have also expelled the WHO on allegations of corruption, attempted bribery of its officials, and lack of confidence).

71. **In May 2010**, the Rockefeller Foundation writes a Report, later leaked, unintentionally from within the organization, with a study of a future pandemic scenario, where an unknown virus escapes Wuhan, China, and a "hypothetical" scenario on what the appropriate response would be, and its core scenario entitled "how to secure global governance in a pandemic". The Plaintiffs state , and the fact is, that the scenario scripted in this May 2010, Report is what has unfolded during the "COVID-19" so-called "pandemic".

72. **In 2011** a review of the literature by the British Columbia Centre for Disease Control to evaluate the effectiveness of social distancing measures such as school closures, travel restrictions, and restrictions on mass gatherings to address an influenza pandemic concluded that *"such drastic restrictions are not*

economically feasible and are predicted to delay viral spread but not impact overall morbidity." [4]

73. **In May, 2012,** the 194 Members States of the "World Health Assembly" endorse the 'Global Vaccine Action Plan (GVAP) led by the Bill and Melinda Gates Foundation in collaboration with GAVI, and the World Health Organization (WHO).

74. **In 2014** Under President Obama, the National Institute of Health (NIH) **halts federal funding** for gain-of-function (GOF) research. The funding hiatus applies to 21 studies "reasonably anticipated to confer attributes to influenza, MERS, or SARS viruses such that the virus would have enhanced pathogenicity and/or transmissibility in mammals via the respiratory route." NIH later allows 10 of the studies to **resume.**

75. **In 2015** NIAID awards a five-year, $3.7 million grant to conduct gain-of-function studies on the "risk of bat coronavirus emergence." Ten percent of the award goes to the Wuhan, China, Institute of Virology.

76. **In January, 2015** at a public appearance, Bill Gates states: '' We are taking things that are genetically modified organisms and we are injecting them into little kids' arms; we just shoot them right into the vein''.

77. **In 2017** Dr. Marc Lipsitch of the Harvard School of Public Health tells the *New York Times* that the type of gain-of-function experiments endorsed by Dr. Fauci's NIAID have "done **almost nothing** to improve our preparedness for pandemics, and yet risked creating an accidental pandemic."

[4] Social Distancing as a Pandemic Influenza Prevention Measure
https://nccid.ca/wp-content/uploads/sites/2/2015/04/H1N1_3_final.pdf

78. **In 2019** NIAID awards a six-year renewal grant of $3.7 million to EcoHealth Alliance and the Wuhan Institute of Virology (in China) to continue their gain-of-function studies on bat coronaviruses.

79. At the January, 2019, World Economic Forum in Davos, Switzerland, **on January 23rd, 2019,** on a CNBC interview Bill Gates boasts that he expects to have a "twenty-fold" return on his $10 Billion vaccine investment with the next few decades.

80. British and French researchers **publish** a study (May 5, 2020) estimating that COVID-19 could have started as early as **October 6, 2019.**

81. On **October 18th, through 27th, 2019** Wuhan, China hosts the Military World Games, held every four years, where more than 9,000 athletes, from 100 countries complete. The telecom systems for the Athletes' Village are powered with 5-G technology "showcasing its infrastructure and technological prowess''.

82. **On October 18, 2019 -** The Bill & Melinda Gates Foundation, the World Economic Forum and the Johns Hopkins Center for Health Security convene an invitation-only "tabletop exercise" called **Event 201** to map out the response to *a hypothetical global coronavirus pandemic.*

83. **In November-December, 2019, -** General practitioners in northern Italy start noticing a "**strange pneumonia."**

84. **On December 2nd and 3rd, 2019** Vaccine scientists attending the WHO's Global Vaccine Safety summit confirm **major problems** with vaccine safety around the world.

85. **On December 3rd, 2019**, At the Global Vaccine Safety Summit in Geneva Switzerland, Prof Heide Larson, MA PhD, Director of the "Vaccine Safety Project", stated:

> "I think that one of our biggest challenges is, as Bob said this morning, or yesterday, we're in a unique position in human history where we've shifted the human population to vaccine-induced, to dependency on vaccine-induced immunity and that's on the great assumption that populations would cooperate. And for many years, people lined up the six vaccines, people were there; they saw the reason. We're in a very fragile state now. We have developed a world that is dependent on vaccinations. We don't have a choice, but to make that effort."

86. **On December 18th, 2019,** researchers at the Massachusetts Institute of Technology (MIT) report the development of a novel way to record a patient's **vaccination history,** by using smart-phone readable nano-crystals called ''quantum dots'', **embedded** in the skin using micro-needles. In short, a vaccine chip embedded in the body. This work and research are funded by the Bill and Melinda Gates Foundation.

87. **On December 31,2019 -** Chinese officials inform the WHO about a **cluster** of "mysterious pneumonia" cases. Later, the *South China Morning Post* reports that it can trace the first case back to **November 17th , 2019.**

88. **On January 7th, 2020** - Chinese authorities formally **identify** a "novel" coronavirus.

89. **On January 11, 2020** - China records its **first death** attributed to the new coronavirus.

90. **On January 20, 2020 -** The first **U.S. coronavirus case** is reported in Washington State.

91. **On January 23rd, 2020,** Shi Zheng-Li releases a paper reporting that the new corona virus (COVID-19) is 96% identical to the strain that her lab isolated from bats in 2013 but never publicized.

92. **On January 30, 2020** - The WHO declares the new coronavirus a **"global health emergency."**

93. **In January, 2020** - A study of US military personnel confirms that those who received an influenza vaccine had an increased susceptibility to coronavirus infection. [5]

94. On **February 5th, 2020** - Bill and Melinda Gates announce **$100 million** in funding for coronavirus vaccine research and treatment efforts. **On February 11th, 2020** the WHO gives the virus its name: 'COVID-19''.

95. **On February 28th, 2020** - The WHO states that most people will have mild symptoms from SARS-CoV-2("COVID19") infection and get better without needing any special care.

96. **On February 28th, 2020 ,** the WHO announces that more than 20 vaccines are in development globally.

97. **On February 28th, 2020,** the WHO states – "Our greatest enemy right now is not the virus itself. It's fear, rumors and stigma." [6]

98. **On March 5th, 2020** - Dr. Peter Hotez of Baylor College told a US Congressional Committee that coronavirus vaccines have always had a "unique

[5] https://www.sciencedirect.com/science/article/pii/S0264410X19313647
[6] WHO Director-General's opening remarks at the media briefing on COVID-19 - 28 February 2020 https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---28-february-2020

potential safety problem" — a "kind of paradoxical immune enhancement phenomenon." [7]

99. On **March 11,2020** - The WHO declares COVID-19 a **pandemic.**

100. On **March 12th, 2020** Education Minister Stephen Lecce ordered the closing down of public schools, on the advice of Dr. Williams the co-Defendant.

101. On **March 16th, 2020** - Neil Ferguson of Imperial College London, scientific advisor to the UK government, publishes his computer simulations warning that there will be **over two million** COVID-19 deaths in the U.S. unless the country adopts "intensive and socially disruptive measures." **Imperial College London receives funding from Bill and Melinda Gates Foundation.**

102. On **March 16th, 2020** - Dr. Anthony Fauci tells Americans that they must be prepared to "**take more drastic steps"** and "hunker down significantly" to slow the coronavirus's spread.

103. On **March 16th, 2020** - NIAID launches a **Phase 1 trial** in 45 healthy adults of the mRNA-1273 (COVID-19) coronavirus vaccine co-developed by NIAID and Moderna, Inc. The trial skips the customary step of testing the vaccine in **animal models** prior to proceeding to human trials.

104. On **March 17th, 2020 –** Prime Minister Trudeau asks for lockdown measures, under the **Federal Quarantine Act,** banning travel**.** The same date Premier Doug FORD declares an Emergency in Ontario, under ots Provincial legislation.

105. **On March 19th, 2020** - The status of COVID-19 in the United Kingdom is downgraded. COVID-19 is no longer considered a high consequence infectious disease (HCID). The Advisory Committee on Dangerous Pathogens (ACDP) in

[7] https://www.c-span.org/video/?470035-1/house-science-space-technology-committee-hearing-coronavirus&start=1380

the UK is also of the opinion that COVID-19 should no longer be classified as an HCID (High Consequence Infectious Disease). [8] [9]

106. **On March 24th , 2020** - Global medical experts declared that efforts to contain the virus through self-isolation measures would negatively impact population immunity, maintain a high proportion of susceptible individuals in the population, prolong the outbreak putting more lives at risk, damage our economy and the mental stability and health of the more vulnerable. [10] [11]

107. **On March 24th, 2020** - Professor Peter Gotzche issues a statement - *"The coronavirus mass panic is not justified."*

108. On **March 24th,2020** - Bill Gates announces funding for a company that will blanket Earth with $1 billion in **video surveillance satellites.**

109. **On March 26th, 2020** Microsoft announces it is acquiring 'Affirmed Networks'' focused on 5-G and "edge" computing''.

110. On **March 26th, 2020** - Dr. Fauci publishes an **editorial** in the *New England Journal of Medicine* stating that "the overall clinical consequences of Covid-19 may ultimately be more akin to those of a severe seasonal influenza," with a case fatality rate of perhaps 0.1%.

[8] https://www.gov.uk/topic/health-protection/infectious-diseases
[9] https://prepforthat.com/uk-officials-covid-19-no-longer-high-consequence-infectious-disease/
[10] https://off-guardian.org/2020/03/24/12-experts-questioning-the-coronavirus-panic/
[11] https://www.europereloaded.com/twenty-two-experts-questioning-the-coronavirus-panic-videos-scientific-common-sense/

111. On **March 30th 2020,** Dr Michael J. Ryan, Executive Director of the Health Emergencies Programme at the World Health Organization publicly stated, during a press conference that:

> "And at the moment in most parts of the world due to lock-down most of the transmission that's actually happening in many countries now is happening in the household at family level.
> In some senses transmission has been taken off the streets and pushed back into family units. Now we need to go and look in families to find those people who may be sick and remove them
> and isolate them in a safe and dignified manner".

112. **March 31, 2020**, Dr. Theresa Tam states that, "it is not clear that masks actually help prevent infections, and may increase the risk for those wearing them."

113. On **April 2nd, 2020** - Bill Gates states that a coronavirus vaccine "is the only thing that will allow us to return to normal."

114. **In April, 2020-** A review of the scientific literature conducted by Denis Rancourt, Ph.D., with regards to the use of masking, concluded there is **no** scientific evidence to substantiate the effectiveness of masking of the general public to prevent infection and transmission. [12]

115. **On April 6th, 2020** - German epidemiologist, Knut Wittkowski, releases a statement warning that artificially suppressing the virus among low risk people like school children may *"increase the number of new infections"* as it keeps the virus circulating much longer than it normally would. [13]

116. On **April 6th, 2020** - Dr. Anthony Fauci states, "I hope we don't have so many people infected that we actually have **herd immunity."**

[12] https://www.researchgate.net/publication/340570735_Masks_Don't_Work_A_review_of_science_relevant_to_COVID-19_social_policy

[13] Stand Up for Your Rights, says Bio-Statistician Knut M. Wittkowski. American Institute for Economic Research. April 6, 2020 https://www.aier.org/article/stand-up-for-your-rights-says-professor-knut-m-wittkowski/

117. **On April 9th, 2020** - Canadian public health officials stated – "In a best-case scenario, Canada's total COVID-19 deaths can range from 11,000 to 22,000." And "In the bad scenarios, deaths go well over 300,000." (As of May 21, 2020, the total reported deaths from COVID 19 in Canada was 6,145.) The number of deaths attributed to COVID-19, is in line with typical yearly seasonal viral respiratory illness deaths in Canada. However, the Covid-death numbers are inflated based on the parameters dictated by the WHO to list a death as a Covid-death, namely anyone who has the Covid-19, at time of death ,regardless of whether another clear primary cause of death is evident apart from the simple presence of the covid-19 virus.

118. **On April 10th, 2020** - John Carpay, president of the Justice Centre for Constitutional Freedoms in Canada has stated there is reason to conclude that the government's response to the virus is deadlier than the disease itself. [14]

119. On **April 15th, 2020** - Bill Gates pledges another $150 million to coronavirus vaccine development and other measures. He states, "There are **seven billion** people on the planet. We are going to need to vaccinate nearly everyone."

120. **On April 18th, 2020,** US News reports corona virus tests are ineffective due to lab contamination at the EDC and the CDC's violation of its manufacturing standards.

121. On **April 24th, 2020** - The Ontario government took the "extraordinary step" to release a database to police with a list of everyone who has tested positive for COVID-19 in the province.[15]

[14] https://www.jccf.ca/the-cost-of-the-coronavirus-cure-could-be-deadlier-than-the-disease/

122. On **April 30th, 2020** - Bill Gates writes that "the world will be able to go back to the way things were . . . when **almost every person on the planet** has been vaccinated against coronavirus." Gates also states that "Governments will need to expedite their usual drug approval processes in order to deliver the vaccine to over 7 billion people quickly."

123. **On May 5th, 2020,** Neil Ferguson resigns from the UK government's Scientific Advisory Group for Emergencies (SAGE) after flouting and breaking his own social distancing rules. **On May 6th, 2020**, an anonymous soft-ware engineer (ex-Google) pronounces Neil Ferguson's COVID-19 computer model "unusable for scientific purposes''. In fact, Ferguson's COVID-19 model has been laughing-stock and debacle.

124. **On May 11th, 2020**, UK Chief Medical Officer Whitty states that COVID-19 is 'harmless' to the vast majority''.

125. **On May 14th, 2020**, Microsoft announces that it is acquiring UK-based 'Metaswitch Networks'', to expand its Azure 5-G strategy.

126. On **May 19th, 2020** - Health Canada approves human trials of a SARS-CoV-2 (COVID-19) vaccine without clear evidence that prior animal testing to identify the potential risk of pathogenic priming (immune enhancement) has been conducted.

127. **On May 21st, 2020** - Four Canadian infectious disease experts, Neil Rau, Susan Richardson, Martha Fulford and Dominik Mertz state - "the virus is unlikely to

[15] https://toronto.ctvnews.ca/mobile/ontario-takes-extraordinary-step-to-give-police-list-of-all-covid-19-patients-1.4910950?fbclid=IwAR10jfu_5OYq5BPZJKMyyqiN2P47dK_wbZzFMqC8WEpFxilhEFt81cGnfqc

disappear from Canada or the world any time soon" and "It is unlikely that zero infections can be achieved for COVID-19." [16]

128. **By May 2020** - Over six million Canadians have applied for unemployment benefits and 7.8 million Canadians required emergency income support from the Federal government, [17] because of economic shut-downs and closures dictated by Covid-measures.

129. **By May, 2020** - Estimates of the Federal deficit resulting from their response to SARS-CoV-2 (COVID-19) ranges up to $400 billion. [18] (This exceeds the Canada's national budget for a year).

130. On **May 20th, 2020** - Dr. Teresa Tam, Canada's Chief Medical Officer, publicly advised the use of non-medical masks for the general public to provide an *"added layer of protection"* that could help prevent asymptomatic or pre-symptomatic Covid-19 patients from unknowingly infecting others. Dr. Tam's advice is not supported by scientific evidence. [19]

131. **On May 21st, 2020** - A letter from Mark Lysyshyn, MD, Deputy Chief Medical Health Officer with Vancouver Coastal Health states – "Although children are often at increased risk for viral respiratory illnesses, that is not the case with COVID-19. Compared to adults, children are less likely to become infected with COVID-19, less likely to develop severe illness as a result of infection and less likely to transmit the infection to others." Dr. Lysyshyn further states – "Non-medical masks are not needed or recommended. Personal protective equipment

[16] https://nationalpost.com/opinion/opinion-we-are-infectious-disease-experts-its-time-to-lift-the-covid-19-lockdowns
[17] https://www.macdonaldlaurier.ca/beyond-lockdown-canadians-can-have-both-health-and-prosperity-an-open-letter-to-the-prime-minister/
[18] https://www.macdonaldlaurier.ca/beyond-lockdown-canadians-can-have-both-health-and-prosperity-an-open-letter-to-the-prime-minister/
[19] https://www.politico.com/news/2020/05/20/canada-non-medical-masks-provinces-reopen-271008

such as medical masks and gloves are not recommended in the school environment." [20]

132. On **May 22nd,2020** - Prime Minister Justin Trudeau told reporters that "contact tracing" needs to be ramped up across the county. Trudeau stated that he "strongly recommends" provinces use cell phone apps when they become available, and that this use would likely be mandated.

133. On or about **May 25th,2020**, the Federal government announced potential **Criminal Code** provisions, making it a criminal offence to publish "misinformation" about the COVID-19. "Misinformation" quickly evolves to mean as any opinion or statement, **even from recognized experts**, which contradicts or criticizes measures taken and/ or mandated by the WHO, to be implemented globally by national and regional governments.

134. **As of June 9th, 2020,** neither Prime Minister Trudeau, nor Premier Ford are willing and in fact refusing to disclose what medical advice, and from whom, they are acting upon.

135. **On June 11th, 2020** Toronto Mayor John Tory announces that mandatory face-masks will be implemented on the Toronto Transit Commission's (TTC) subways, busses and street cars, notwistanding that operations of the TTC continued as normal for the last four (4) months since the declared "out break" and "emergency" without neither any face-masks, nor any realistic way of reinforcing the six feet (2 meter) social distancing rule, on public transit. The Plaintiffs state, and the fact is, that face-masks, it has been scientifically and medically established, do NOTHING to prevent spread of air-borne viruses, and

[20] http://www.vch.ca/Documents/COVID-VCH-Schools-May-21-2020.pdf

in fact cause other health problems. The Plaintiffs state and the fact is, that the Defendants and their officials are stepping up compulsory face-masks in order to maintain a physical and visual tool to maintain panic, fear, and to enforce compliance of their baseless measures due to increasing public resistance, and of their groundless and false basis . The masks, further act as a visual and present symbol of intimidation and show of who is in power, and do not act to medically assist but to publicly muzzle, panic, instill fear, and exert compliance to irrational and ineffective COVID measures from the Plaintiffs and others. The Plaintiff states and the fact is, that these measures were up-stepped after a Canadian survey was released that revealed, **inter alia**, that:

(a) 50% of Canadians did not believe Justin Trudeau was being honest about the COVID-Measures ;

(b) 16% of the Canadians believe that the COVID-Measures are being used to effect mandatory vaccination and contract tracing and other surveillance;

(c) 19% of the Canadians do not believe that COVID-19 is no more harmful then a common flu; and

(d) 7% of the Canadians believe that COVID-19 does not exist at all and is being mis-used as pretext for other, ulterior motives.

136. On or about **June 11th, 2020**:

(a) Wellingtone- Dufferin – Guelph County, in Ontario, through its public health officer, Dr. Nicola Mercer, announced, ordered, that **all** customers and all employees, of **all** businesses in the County, would be required to

wear face-masks , including children under the age of 5 , and special-needs persons, who cannot and will not countenance a face-mask;

(b) On **June 3rd, 2020** Federal Minister of Transport, Marc Garneau , announced that face-masks are required by **all,** when taking public transportation in Canada whether by plane, train, ship, or transit.

(c) On **June 11th, 2020**, Toronto Mayor John Tory announced the coming compulsory wearing of face-masks on the Toronto transit Commission vehicles and property.

(d) On **June 18th, 2020** the County of Windsor-Essex, in Ontario, through its public health officer, Dr. Wajid Ahmed, announced ordered, that **all** customers and all employees, of **all** businesses in the County, would be required to wear face-masks.

137. Between **April 1st and June 15th, 2020** the Canadian Civil Liberties Association (CCLA) reports that approximately 10,000 Covid related charges were laid across Canada, 2,853 in Ontario.

138. **On June 17th, 2020,** the Toronto Hospital for Sick Children, considered the world's Premier Children's hospital completed an advisory report, publicly released days later, to the Minister of Health and Education, with respect to recommendations for the re-opening of school in September, 2020. The report was prepared by two experts (in Virology) , upon the **contribution and review** of another **twenty (20)** experts as well as the "SickKids Family Advisory Networks". The 11-page report is resound and clear on the facts stat:

(a) Children are at extremely **low** risk when it comes to COVID-19;

(b) Schools should re-pen in a normal setting in September, 2020 in Ontario;

(c) That **no** mask should be worn by children because of no evidence of effectiveness and in fact masks pose a health risk for children;

(d) Social distancing should not be employed; and

(e) That masks and social distancing pose significant physical and psychological health risks to children.[21]

139. **On June 23rd, 2020**, the Justice Centre for Constitutional Freedoms calls for, in a 69-page report, an end to the lock-down measures based on an analysis of the lack of medical and scientific evidence for their imposition and the infliction of unwarranted and severe **Charter** violations.[22]

140. **On June 26th , 2020**, Sweden's COVID-19 expert, Anders Tegnell, blasted the WHO'S response to COVID-19 and states that the "world went crazy" and further stingingly criticized the WHO as "mis-interpreting data" in branding Sweden as one of eleven (11) countries who are seeing a "resurgence" in COVID-19 cases. The Plaintiff state, and the fact is, that Sweden was one of the few countries in the World who did **not** adopt, wholesale, the WHO protocol and in fact faired much better then the countries who did, including Canada in that there was no economic shut-down in Sweden. Dr. Tegnell further stated that the lockdowns "fly in the face of what is known about handling virus pandemics.[23]

[21] "COVID-19: Recommendations for School Re-opening", Toronto Hospital for Sick Children, Report dated June 17th, 2020.
[22] "Unprecedented and unjustified: a Charter Analysis of Ontario's Response to COVID-19" June 22nd, 2020.
[23] "Daily Mail Online", Daily Mail.com, June 26th, 2020

141. On **June 18th, 2020** Premier Doug FORD announced an upcoming up-step and acceleration of the implementation of 'contract tracing'' surveillance through cellphones.

142. **On June 28th, 2020** The City of Toronto announces and put forward a mandatory mask By-Law for all indoor public venues including private businesses.

B/ THE COVID-19 MEASURES

- **Federal Measures**

143. On or about March 17th, 2020 Justin Trudeau announces a lock-down and invoked the following legislation with respect to "pandemic":

a) The **Federal Quarantine Act,** stipulating the lock-down of flights to Canada, and that Canadians returning to Canada, self-isolate and quarantine themselves for a 14- day period;

b) Various prices of legislation setting out financial assistance for various persons and sectors.

Trudeau further and effectively shut down Parliament. Parliament has only "convened", sparingly, to pass spending measures, with an amputated, hand-picked, selection of 25 MPs, notwithstanding that technology such as "Zoom", exists to accommodate and convene the entire Parliamentary contingency of the 338 MPs, to date it has not happened. Parliamentary Communities rested in a legislative coma until April, 2020, where after some sit virtually.

144. Justin Trudeau held (holds) daily press conferences to "inform" Canadians, and further issues decrees and orders, such as "stay home", which decrees and fiats

have no legal effect, notwithstanding, that they were acted upon by Municipal and Provincial enforcement officers, but at that no time has the Federal Parliament invoked the Federal **Emergencies Act .**

- **Provincial Measures**

145. On or about March, 17th, 2020 Premier of Ontario. Doug Ford and his government invoked the Provincial **Emergency Management and Civil Protection Act**, with a declared state of emergency, last extended to July 9th, 2020, and enacted to date, 48 **Regulations** thereunder with enforcement orders, which are:

In force

- Declaration of Emergency, O Reg 50/20
- Emergency Order Under Subsection 7.0.2 (4) of the Act, O Reg 51/20
- Emergency Order Under Subsection 7.0.2 (4) of the Act, O Reg 52/20
- Extension of Emergency Order Made Under the Act , O Reg 105/20
- Order Made Under the Act - Extensions and Renewals of Orders, O Reg 106/20
- Order Under Subsection 7.0.2 (4) of the Act - Streamlining Requirements for Long-Term Care Homes, O Reg 95/20
- Order Under Subsection 7.1 (2) of the Act - Limitation Periods, O Reg 73/20
- Standards, O Reg 380/04
- Subsection 7.0.2 (4) of the Act - Child Care Fees, Order Under, O Reg 139/20
- Subsection 7.0.2 (4) of the Act - Closure of Outdoor Recreational Amenities, Emergency Order Under, O Reg 104/20
- Subsection 7.0.2 (4) of the Act - Hospital Credentialing Processes, Order Under, O Reg 193/20
- Subsection 7.0.2 (4) of the Act - Stage 1 Closures, Order Under, O Reg 82/20
- Subsection 7.0.2 (4) of the Act - Stage 2 Closures, Order Under, O Reg 263/20

- Subsection 7.1 (2) of the Act - Treatment of Temporary Covid-19 Relief Payments to Employees, Order Under, O Reg 195/20

Repealed or Spent

- Order Under Subsection 7.0.2 (4) of the Act - Service Agreements for Services and Supports to Adults With Developmental Disabilities and Service Providers Providing Intervenor Services, Order Under, O Reg 121/20
- Subsection 7.0.2 (4) of the Act - Access to Covid-19 Status Information - Specified Persons, Order Under, O Reg 120/20
- Subsection 7.0.2 (4) of the Act - Access to Personal Health Information by Means of the Electronic Health Record, Order Under, O Reg 190/20
- Subsection 7.0.2 (4) of the Act - Agreements Between Health Service Providers and Retirement Homes, Order Under, O Reg 140/20
- Subsection 7.0.2 (4) of the Act - Certain Persons Enabled to Issue Medical Certificates of Death, Order Under, O Reg 192/20
- Subsection 7.0.2 (4) of the Act - Closure of Public Lands for Recreational Camping, Order Under, O Reg 142/20
- Subsection 7.0.2 (4) of the Act - Congregate Care Settings, Order Under, O Reg 177/20
- Subsection 7.0.2 (4) of the Act - Deployment of Employees of Service Provider Organizations, Order Under, O Reg 156/20
- Subsection 7.0.2 (4) of the Act - Drinking Water Systems and Sewage Works, Order Under, O Reg 75/20
- Subsection 7.0.2 (4) of the Act - Electricity Price for RPP Consumers, Order Under, O Reg 80/20
- Subsection 7.0.2 (4) of the Act- Electronic Service, Order Under, O Reg 76/20
- Subsection 7.0.2 (4) of The Act - Enforcement of Orders, Order Under, O Reg 114/20
- Subsection 7.0.2 (4) of the Act - Global Adjustment for Market Participants and Consumers, Order Under, O Reg 191/20
- Subsection 7.0.2 (4) of the Act - Limiting Work in a Single Long-Term Care Home, Order Under, O Reg 146/20
- Subsection 7.0.2 (4) of the Act - Limiting Work in a Single Retirement Home, Order Under, O Reg 158/20
- Subsection 7.0.2 (4) of the Act - Management of Long-Term Care Home Outbreak, Order Under, O Reg 210/20

- Subsection 7.0.2 (4) of the Act - Management of Retirement Homes in Outbreak, Order Under, O Reg 240/20
- Subsection 7.0.2 (4) of the Act - Pick Up and Delivery of Cannabis, Order Under, O Reg 128/20
- Subsection 7.0.2 (4) of the Act - Signatures in Wills and Powers of Attorney, Order Under, O Reg 129/20
- Subsection 7.0.2 (4) of the Act - Special Rules re Temporary Pandemic Pay, Order Under, O Reg 241/20
- Subsection 7.0.2 (4) of the Act - Temporary Health or Residential Facilities, Order Under, O Reg 141/20
- Subsection 7.0.2 (4) of the Act - Traffic Management, Order Under, O Reg 89/20
- Subsection 7.0.2 (4) of the Act - Use of Force and Firearms in Police Service, Order Under, O Reg 132/20
- Subsection 7.0.2 (4) of the Act - Work Deployment Measures for Hospital Health, Order Under, O Reg 116/20
- Subsection 7.0.2 (4) of the Act - Work Deployment Measures for Hospital Social Services Administration Boards, Order Under, O Reg 154/20
- Subsection 7.0.2 (4) of the Act - Work Deployment Measures in Mental Health and Addictions Agencies, Order Under, O Reg 163/20
- Subsection 7.0.2 (4) of the Act – Work Deployment Measures in Municipalities, Order Under, O Reg 157/20
- Subsection 7.0.2 (4) of the Act - Work Deployment Measures for Service Agencies Providing Violence Against Women Residential Services and Crisis Line Services, Order Under, O Reg 145/20
- Subsection 7.0.2 (4) of the Act - Work Deployment Measures in Long-Term Care Homes), Order Under, O Reg 77/20
- Subsection 7.0.2 (4) of the Act - Work Deployment Measures in Retirement Homes, Order Under, O Reg 118/20
- Subsection 7.0.2 (4) - Prohibition on Certain Persons Charging Unconscionable Prices for Sales of Necessary Goods, Order Under, O Reg 98/20
- Subsection 7.1 (2) of the Act - Corporations, Co-Operative Corporations and Condominium Corporations, Order Under, O Reg 107/20
- Under Subsection 7.0.2 (4) of the Act, Order Made, O Reg 74/20
- Under Subsection 7.0.2 (4) of the Act--Education Sector, Order Made, O Reg 205/20

146. The net, summary effect, of the orders contained in the above **Regulations** are as follows:

a) Ordering the shut-down of all business, except for 'essential'' businesses which were tied to food, medicine, doctors, and hospitals;

b) A 'social distancing'' of two (2) meters;

c) No 'public gathering'' of more than five (5) persons, who are un-related, with s 'social distancing'' of two (2) meters, which was later increased to ten (10) persons;

d) Restaurant and bar shut-downs, except for take-out service;

e) The physical closure of all public and private schools, daycares, and universities;

f) The mandatory use of face-masks, mandated by the Ministry of Health, to all the Medical Regulatory Medical Services Colleges, to direct all their licensed members to impose mandatory masking of all patients, employees, and members, in their place of work;

g) The shut-down of all park amenities including all play-grounds and facilities for children;

h) The elimination of one-on-one, and all other programs for special-needs children, and those suffering from neurological and physical disabilities;

i) Banning all public gatherings over five (5) persons, notwithstanding a social distancing of two (2) meters, including the banning of religious services, including a restriction on marriages, funerals, and other religious actions and ritual and rites.

j) The provision for offences, laying of charges, and imposition of heavy fines for breach of the orders, with an impossibility to challenge those fines as the Provincial Offences Court is physically closed and the **Provincial Offences Act** tickets make it clear that the charge and fine cannot be 'mailed in'' but that the person must attend, physically, at the **Provincial Offences Act** Court to file a defense of the charges, only to find a closed Courthouse.

147. In none of those Regulations did the Province require mandatory, community wearing of face-masking in public nor private locations. Premier Ford expressly declined to do so.

148. The Provincial Legislature, but-for rare convening to pass and invoke the legislation, has not regularly sat, despite the existing and easy technology to sit the full cogency of the MPPs of the Legislature. FORD has effectively dispensed with Parliament (the Provincial Legislature).

- **City of Toronto Municipal Measures**

149. The City of Toronto , through Mayer John Tory, on March 23rd, 2020 issued a "Declaration of an Emergency" invoking the following measures:

a) "Emergency order No.1 – "To impose Regulations requiring physical distancing within park and public Squares";

b) "Emergency No. 2 -"To impose physical distancing within Nathan Phillip Square in the same manner as other Public Squares".

It is to be noted that these two orders were NOT passed, pursuant to **Provincial legislation,** but under the City of Toronto's own By-Law **Municipal Code.** It is

further to be noted that the Municipal Measures in fact contradicted, and were more restrictive than the Provincial Measures and are therefore illegal and **ultra vires,** notwithstanding that Municipal enforcement offices then detained and charged persons under the **Provincial Offences Act,** for engaging in activities in compliance with Provincial law, covering the same matters(s) and activities.

150. The City of Toronto further passed By-Law 322- 2020, in which it banned, under s. 1, and s. 2, anyone remaining in a park or public space "for longer than an incidental period", and socially distancing with only "members of the same household", which is **completely** in contravention of the Provincial order in Provincial Regulation O Reg 104/20, s. 1(4), passed pursuant to s, 7.0.2(4) of the **Ontario Act**. The Plaintiffs state, and the fact is, that not only were these measures which were enforced, **ultra vires** the Provincial legislation, but further violated ss.2, 7,8, and 9 of the **Charter.** This By-Law further provides for the delegation of the By-Law provisions which was delegated to the Chief officer of Health, Eileen De Villa, a co-Defendant in the within claim.

151. On April 1st, 2020 a "Class Order" purportedly passed pursuant to s. 22(5.0.1) of the **Health Protection and Promotion Act,** Dr. Eileen De Villa, Toronto's Medical Officer of Health, made an order, for anyone who:

a) Is identified with a diagnosis of COVID-19;

b) Has signs and symptoms of COVID-19,or have been tested and awaiting results;

c) Otherwise has reasonable grounds to believe to have COVID-19;

d) Is in close contact with any in (a) to (c) above.

Were ordered by De Villa to:

a) Isolate and stay at home, with no visitors;

b) Remain in isolation for 14-days;

And further made an array of other orders respecting follow-up Medical advice and treatment. Exemptions to this order were made for:

a) Asymptotic person who provide essential services;

b) those receiving essential medical services; and

c) anyone who in the opinion of Toronto public health would not be in the public interest.

The enunciated rationale for this "class order was" on the grounds that, **inter alia,** COVID-19 was a communicable "disease".

152. The Plaintiffs state, and the fact is, that De Villa's orders were neither scientifically nor medically grounded, were statutorily **ultra vires** , and violate s. 2, 7, 8, and 9, and 15 of the **Charter.** The Plaintiffs further state that there was no evidence, scientific or medical, to have reasonable and probable grounds that it was any way more pervasive or dangerous than any other seasonal viral respiratory illness of the past fifteen (15) years.

153. **On June 28th, 2020,** the City of Toronto introduced a By-Law to require mandatory, community, face-masks requirements for indoors, of all "public" spaces, including private business open to the public. The city issued posters for store owners to post, which included the requirement of store owners to enforce masking, but NO mention of exemptions to masking.

154. **On June 30th, 2020,** the Canadian Civil Liberties Association called for the extraordinary step, calling on the public to engage in "civil disobedience" of the Toronto masking By-Law, based on the overwhelming scientific and medical evidence, that masks are ineffective and pose heath risks.

155. Moreover, the Plaintiffs state, and fact is, that the enforcement officers were, on the ground, stopping, detaining and charging individuals, under the **Provincial Offences Act,** such as a single person sitting by herself on a park bench with no-one around, or a child bicycle riding through a park with a parent based on the media reports of Trudeau, Ford , and Tory, and their respective Chief Medical Officers, illegally declaring to "Stay home" and "do not go out except for food and medicine", when in fact such prohibitions were nowhere to be found in the law.

- **Reckless and Unlawful Statements and Actions of Leaders**

156. The Plaintiffs state, and the fact is, that Trudeau, Ford, and Tory were (and continue to be) reckless in their groundless, ignorant, and arrogant dictates, without legal basis, so as to cause and instill a general atmosphere of fear, panic and confusion. Such decrees by Trudeau, Ford, and Tory include, but are not restricted to the following:

(a) With respect to Prime Minister Justine Trudeau, he made the following (mis)statements, for example:

(i) Prime Minister Justin Trudeau told Canadians: "**People should be staying home, self-isolating with family.**"[24]

[24] Retrieved at : https://ottawacitizen.com/news/local-news/covid-19-confirmed-cases-latest-news-and-other-developments-in-ottawa/

(ii) **"We've all seen the pictures of people online who seem to think they're invincible," Trudeau said. "Well, they're not. Go home and stay home."**[25]

(iii) Justin Trudeau has issued a stern warning to Canadians who ignore social distancing advice, telling citizens to "**go home and stay home!**" – and leaving open the possibility his government could take more extreme measures as the number of confirmed coronavirus cases continues to rise.[26]

(iv) "To all the kids out there, **who can't go on play dates** or on spring break vacation...I know this is a big change, but we have to do this for our grandparents and for the nurses and doctors in hospitals."[27]

(v) "So, to everyone**, stay at home,** and no matter what stay 2 meters apart, if you do have to go out. When it gets hard let's remember we are all in this together." (24:35) "…how important it is not just for ourselves, but for our loved ones and health care workers, for our seniors, **that we stay home,** that we stay 2 meters apart, as much as we can and that we continue to wash our hands regularly." (30:12)[28]

(vi) "I know it is tough to stay home, especially as the weather gets nicer. If you have kids, it is even tougher, but to get back outside and running around the playground and park as soon as possible, **you need to keep them inside for a little longer**. (10:22)[29]

(vii) "…but I can tell you that we know it is very difficult situation for Canadians. There are very challenging projections out there that will emphasize how important it is for all of us to do our part, **to stay home**, to keep ourselves safe, to keep our loved ones safe and get through this…"(42:26)[30]

(viii) More and more Canadians are avoiding public spaces. If your friends or family members are still going to parks and playgrounds, they are risking lives. Tell them to stop.[31]

(ix) On the topic of Asymptomatic viral shed contradiction puts to questions the merit of social distancing among healthy people: A

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[25] Retrieved at: https://www.vice.com/en_ca/article/g5xng4/coronavirus-updates-canada-ottawa-and-justin-trudeau-may-jail-and-fine-people-to-keep-them-home

[26] Retrieved at: https://www.theguardian.com/world/2020/mar/23/justin-trudeau-canada-coronavirus-stay-home

[27] https://www.richmond-news.com/news/trudeau-dodges-covid-19-lockdown-appeals-1.24103564

[28] Retrieved at: https://www.youtube.com/watch?v=76iqxbZz4X8

[29] Retrieved at: \https://www.youtube.com/watch?v=A3GDk8uHv5A

[30] Retrieved at : https://www.youtube.com/watch?v=mfAa0vLItn8

[31] https://pbs.twimg.com/media/EVf0_maXkAE7qBg.jpg

reporter asks Mr. Trudeau, after his wife had been tested positive for coronavirus, what kind of advice he had received from medical doctors.

> "In terms of advice I have gotten from medical professionals, it was explained to me that **as long as I do not show any symptoms at all, there is no value in having me tested."** (15:30)A reporter asks about the possibility of transmission to other members of the cabinet,17:02 "According to Health Officials **the fact that I have expressed no symptoms means that anyone that I engaged with throughout this week has not been put at risk** (17:12)[32]

(b) While Trudeau made the above-noted comments and decrees, **without legal basis whatsoever**, and further contradicted actual Provincial laws, Trudeau, all the while breaks social distancing Provincial Laws by: :

(i) On March 29, 2020 ; **Dr. Theresa Tam**, the **Chief Public Health Officer of Canada**:

"Urban dwellers/Cottagers should RESIST THE URGE to head to the cottage and rural properties as these communities have less capacity to manage COVID19."

(ii) On April 1st, 2020 the government of Quebec introduced strict **travel restrictions** across the province, including police checkpoints to prevent unnecessary travel in and out of Quebec.

(iii) Shortly after **calling on Canadians to "stay home"** and "Skype that big family dinner," Trudeau crossed the provincial border from Ottawa into Quebec on Easter

[32] Retrieved at: https://www.youtube.com/watch?v=SjEgtT98jqk

Weekend to visit his wife and three children who had been living at their Harrington Lake cottage since **March 29**, 2020.[33]

(c) With respect to Premier Doug Ford:

(i) Premier Ford tells business they can refuse customers that will not wear a mask.

> "Any business has the right to refuse anyone. That's their business," Ford said on a teleconference last week. Despite the fact that no mandatory masks order was in place, and contrary to the legal opinion of the Canadian Civil Liberties Association (CCLA);[34]

(ii) Ford tells people to stay away from their cottages but goes to visit his own cottage;[35]

(iii) Doug Ford has over his two daughters, and family, who each live in different households for a total of 6 – violating 5 person maximum orders.[36]

(d) With respect to Toronto Mayor John Tory:

(i) **On April 19, 2020:** numerous photos of social distancing violations during a parade to salute health care workers (pictured standing shoulder to shoulder down University Ave.)[37]

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[33] Retrieved at https://globalnews.ca/news/6815936/coronavirus-justin-trudeau-andrew-scheer-easter-travel/

[34] https://www.cambridgetimes.ca/news-story/9994798-doug-ford-says-businesses-can-refuse-anyone-not-wearing-a-mask-but-rights-watchdog-says-not-so-fast/?fbclid=iwar2_ba_3eddfpm0shzqjpnht6fmhw0yjfualjugjrnxczcvi_70gfwadqla https://www.inbrampton.com/no-mask-no-service-businesses-have-the-right-to-require-masks-on-customers?fbclid=IwAR2UMCjwOtyIXU898j_EwIn8r1nuqiM7TJxJDs6ECz5tACPAHFMipGiHB7c

[35] https://toronto.citynews.ca/2020/05/08/ford-cottage-coronavirus/

[36] https://www.cbc.ca/news/canada/toronto/ford-physical-distancing-daughters-1.5564756

[37] Retrieved from: https://www.cbc.ca/news/canada/toronto/toronto-salutes-health-care-workers-covid19-1.5537982

(ii) May 23: Here is Tory violating social distancing rules and modeling counterproductive mask use at Trinity Bellwoods park , where **thousands** had gathered;[38]

157. The Plaintiffs state, and the fact is, that the various leaders are fast and loose with ignoring their own rules, contrary to law, and ignoring the actual rules implemented, because they know the measures are false and ineffective and that the virus is no more dangerous than a seasonal viral respiratory illness. This further holds true for Neil Ferguson who put out the false modeling early on, in March, 2020, and who had to resign his post in the UK for breaching the Rules. Other examples of such reckless behaviour and statements include:

(a) On April 25th FORD calls protestors opposing government lockdowns as "selfish" "irresponsible" "yahoos";

(b) Mayor John Tory agreed with Ford, saying the quickest way to end the shutdown is for people to stay home.

> "Gathering in a large group is to thumb your nose at **well accepted science and professional health advice**. It risks undoing the good we have all sacrificed to achieve together. In fact it runs the risk of making the shutdown longer,"

Tory said in a statement on Saturday.[39] The Plaintiff states, and fact is, that TORY has no clue, and is wholly unqualified, and has not, assessed the "well accepted science" and "advice", and same holds for FORD and TRUDEAU, all of whom simply follow one singular dogma from the WHO, while refusing to disclose the "science", its substance or source,

[38] retrieved at: https://www.cp24.com/video?clipId=1964623
[39] Retrieved at: https://www.cbc.ca/news/canada/toronto/ontario-shutdown-protesters-queens-park-yahoos-1.5545253

and what "advice" is being given by whom to them all-the-while ignore vast pool of experts who state that the measures are **NOT** warranted;

(c) Andrew Scheer and family, Elizabeth May, and Liberal Cabinet Minister ignore social distancing orders:

> "Parliamentarians packed onto a small nine-seat government jet last week — ignoring pandemic health guidelines to maintain a distance of two meters from others — in their haste to reach Ottawa for a vote on federal emergency economic legislation that passed on Saturday. Green Party Leader Elizabeth May, who lives in B.C., boarded the Challenger jet along with Liberal B.C. cabinet minister Carla Qualtrough, Conservative Opposition Leader Andrew Scheer, his wife and their five children last Friday — filling all seats on the aircraft."[40]

(d) Dr. Bonnie HenryBC Provincial Health Officer allows gatherings of 50 and when challenged on conflicting figures from across Canada confirm "None of these are based on scientific evidence."[41]

(e) Dr. Yaffe:Ontario's Associate Chief Officer of Health Dr. Yaffe caught blatantly violating the social-distancing rules, just minutes after the premier said that based on public-health officials' advice we'll have to stay on lock-down for an indefinite period.[42] No such indefinite "lock-down" was mandated by any law.

158. The Plaintiffs state, and the fact is, that the illegal actions, and decrees issued by Trudeau, Ford, Tory, and other public officials were done, in abuse and excess of their offices, knowingly to propagate a groundless and falsely-declared 'pandemic'', and generate fear and confusion on the ground, not only with

[40] Retrieved from: https://www.cbc.ca/news/politics/challenger-flight-may-scheer-qualtrough-1.5530542
[41] Retrieved at: https://www.1043thebreeze.ca/2020/04/01/bc-not-budging-on-50-person-limit-restirction/
[42] https://twitter.com/RosemaryFreiTO/status/1254908247322083331

citizens, but further, and moreover, with enforcement officials who are pursuing, detaining, ticketing for perfectly legal conduct, because of the contradictory laws, and conduct of these public officials. All the while, their own personal conduct clearly manifests a knowledge that the 'pandemic'' is false, and the measures phony, designed and implemented for improper and ulterior purposes, at the behest of the WHO, controlled and directed by Billionaire, Corporate, and Organizational Oligarchs.

C/ IGNORING AND NOT ADDRESSING THE MEDICAL EXPERTS' EVIDENCE

- **The Nature of Viral Respiratory Illness (or Disease) and COVID-19**

159. The Plaintiff Dr. Denis RANCOURT, Ph.D., and co-Plaintiffs state, and the fact is that, as is borne out by vast preponderance of medical and scientific study, that regardless of the novel viral specification ("strain"), viral strains which lead to Seasonal Viral Respiratory Illness (Diseases) annually follow the same pattern, namely:

(a) That classifying causes of death by "influenza" or "influenza-related", or "pneumonia" is unhelpful and unreliable in the face of under-lying chronic diseases, particularly in the elderly (co-morbidity");

(b) That what is of more and central relevance is simply the total number of excess deaths during a viral strain season;

(c) That the year-to-year winter-burden (excess) mortality in mid- latitude nations is robustly regular, with respect to Seasonal Viral Respiratory illness due to the following:

(i) The absolute humidity which directly controls the impact of the transmission of airborne, pathogen-laden aerosol particle droplets;

(ii) In mid-latitude countries, on either side of the Equator, "Flu-season" emerges in the late fall-winter months, owing to the dry, humidity-free, air which allows the pathogen-laden aerosol particles to travel freely and effectively to infect and be transmitted from person to person which phenomenon occurs on both sides of the Equator, at different times on the calendar year, given the reversal of the seasons on the opposite sides of the Equator;

(iii) As the temperature rises, and humidity content in the air increases, the incident of transmission is reduced.[43] In tropical year-round hot climates this phenomenon is not generally in play. Nor is it at play in extreme cold climates towards both North and South Poles.

160. The Plaintiffs further state, and the fact is, as reflected in the scientific and medical literature that:

(a) The above means that all the viral respiratory diseases that seasonally plague temporal-climate populations every year are extremely contagious for two reasons: (1) they are transmitted by small aerosol particles that are part of the fluid air and fill virtually all enclosed air spaces occupied by

[43] "All-Cause Mortality during COVID-19". Denis G. RANCOURT PhD., June 2nd, 2020, and all cited scientific and medical studies therein.

humans, and (2) a single such aerosol particle carries the minimal infective dose (MID) sufficient to cause infection in a person, if breathed into the lungs, where the infection is initiated.

(b) This is why the pattern of all-cause mortality is so robustly stable and distributed globally, if we admit that the majority of the burden is induced by viral respiratory diseases, while being relatively insensitive to the particular seasonal viral ecology for this operational class of viruses. This also explains why the pattern is inverted between the Northern and Southern hemispheres, irrespective of tourist and business air travel and so on.

(c) The data shows that there is a persistent and regular pattern of winter-burden mortality that is independent of the details, and that has a well constrained distribution of year to year number of excess deaths (approximately 8% to 11% of the total yearly mortality, in the USA, 1972 through 1993). Despite all the talk of epidemics and pandemics and novel viruses, the pattern is robustly constant.

(d) An anomaly worthy of panic, and of harmful global socio-economic engineering, would need to consist of a naturally caused yearly winter-burden mortality that is statistically greater than the norm. That has not occurred since the unique flu pandemic of 1918 (the "Spanish Influenza"). Covid-19 is no exception and no more virulent than all others apart from the influenza pandemic of 1918.

(e) Scientific studies show that the three recent epidemics assigned as pandemics, the H2N2 pandemic of 1957, the H3N2 pandemic of 1968, and the H1N1 pandemic of 2009, were not more virulent (in terms of yearly winter-burden mortality) than the regular seasonal epidemics . In fact, scientific studies further show that the epidemic of 1951 was concluded to be more deadly, on the basis of P&I data, in England, Wales and Canada, than the pandemics of 1957 and 1968).[44]

- **Contrary Views of the Experts to WHO protocol**

161. The Plaintiffs further state that the COVID-19 measures have in fact accelerated, and caused more than would be normal deaths, and in the elderly population, which has accounted for 81% of the deaths with respect to COVID-19, mostly in Long-Term Care facilities.[45]

162. The Plaintiffs state and fact is that these Defendants, while purportedly relying on "advice" from their medical officers, are not transparent as to what the advice was, nor the scientific/ medical basis was, and in fact suppressing it. In fact, to date, they refuse to disclose where they are ultimately getting this 'advice'', and from whom, based on what medical evidence. The fact is that they are simply parroting the "advice" and dictates of the WHO without any scrutiny whatsoever, and without ever addressing nor recognizing Canadian and international experts who took, and continue to take, a contrary view and criticism of those directives from the WHO.

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[44] "All-Cause Mortality during COVID-19". Denis G. RANCOURT PhD., June 2nd, 2020, and all cited scientific and medical studies therein.

[45] "All-Cause Mortality during COVID-19". Denis G. RANCOURT PhD., June 2nd, 2020, and all cited scientific and medical studies therein.

163. The Plaintiffs state that such experts include, but are not restricted to:

(a) **Dr Sucharit Bhakdi** , a specialist in microbiology. He was a professor at the Johannes Gutenberg University in Mainz, Germany, and head of the Institute for Medical Microbiology and Hygiene and one of the most cited research scientists in German history.

(b) **Dr Wolfgang Wodarg**, a German physician specializing in Pulmonology, politician and former chairman of the Parliamentary Assembly of the Council of Europe. In 2009 he called for an inquiry into alleged conflicts of interest surrounding the EU response to the Swine Flu pandemic.

(c) **Dr Joel Kettner** , a professor of Community Health Sciences and Surgery at Manitoba University, former Chief Public Health Officer for Manitoba province and Medical Director of the International Centre for Infectious Diseases.

(d) **Dr John Ioannidis**, a Professor of Medicine, of Health Research and Policy and of Biomedical Data Science, at Stanford University School of Medicine and a Professor of Statistics at Stanford University School of Humanities and Sciences. He is director of the Stanford Prevention Research Center, and co-director of the Meta-Research Innovation Center at Stanford (METRICS).

(e) **Dr Yoram Lass**, an Israeli physician, politician and former Director General of the Health Ministry. He also worked as Associate Dean of the Tel Aviv University Medical School and during the 1980s presented the science-based television show Tatzpit.

(f) **Dr Pietro Vernazza** , a Swiss physician specializing in Infectious Diseases at the Cantonal Hospital St. Gallen and Professor of Health Policy.

(g) **Frank Ulrich Montgomery** ,a German radiologist, former President of the German Medical Association and Deputy Chairman of the World Medical Association.

(h) **Prof. Hendrik Streeck**, a German HIV researcher, epidemiologist and clinical trialist. He is professor of virology, and the director of the Institute of Virology and HIV Research, at Bonn University.

(i) **Dr Yanis Roussel et. al.** – A team of researchers from the Institut Hospitalo-universitaire Méditerranée Infection, Marseille and the Institut de Recherche pour le Développement, Assistance Publique-Hôpitaux de Marseille, conducting a peer-reviewed study on Coronavirus mortality for the government of France under the 'Investments for the Future' programme.

(j) **Dr. David Katz** , an American physician and founding director of the Yale University Prevention Research Center.

(k) **Michael T. Osterholm**, a regents professor and director of the Center for Infectious Disease Research and Policy at the University of Minnesota.

(l) **Dr Peter Goetzsche** , a Professor of Clinical Research Design and Analysis at the University of Copenhagen and founder of the Cochrane Medical Collaboration.[46]

[46] https://www.fort-russ.com/2020/03/coronavirus-skepticism-these-12-leading-medical-experts-contradict-the-official-government-media-narrative/

And the Plaintiffs state, and fact is, that the above-noted experts are not alone in their contrary views and criticisms, but merely examples of a much bigger body of experts who take the same views, which contradict and criticize the WHO and current measures adopted by Canada, Ontario and Toronto.

164. These experts have expressed, in summary, for example, the following opinions:

(a) By **Dr. Sucharit Bhakdi**:

> "**[that The government's anti-COVID19 measures] are grotesque, absurd and very dangerous [...] The life expectancy of millions is being shortened.** The horrifying impact on the world economy threatens the existence of countless people. The consequences on medical care are profound. Already services to patients in need are reduced, operations cancelled, practices empty, hospital personnel dwindling. All this will impact profoundly on our whole society. All these measures are leading to self-destruction and collective suicide based on nothing but a spook."

(b) By **Dr Wolfgang Wodarg** that:

> "what is missing right now is a rational way of looking at things. We should be asking questions like "How did you find out this virus was dangerous?", "How was it before?", "Didn't we have the same thing last year?", "Is it even something new?" That's missing."

(c) By **Dr Joel Kettner** that:

> "I have never seen anything like this. I'm not talking about the pandemic, because I've seen 30 of them, one every year. It is called influenza. And other respiratory illness viruses, we don't always know what they are. But I've never seen this reaction, and I'm trying to understand why. . . I worry about the message to the public, about the fear of coming into contact with people, being in the same space as people, shaking their hands, having meetings

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https://off-guardian.org/2020/03/24/12-experts-questioning-the-coronavirus-panic/?__c?_chl_jschl_tk__=337111ad6d6d902b24b4e099f5281c65e3e4b9f4-1585388282-0-Af0o_edKyUgbHvh1VcWNkI9pmmKmNDpIe3t8p8AzOfNSL3KMq2f_1tyTqyj4i1RlgmD_uDh8P8ulAs_zAhps_nKe8fMclO8scdWTV4Jf5xpZtzHt3Hg5mrz4twlZSnTJ3tojWZUi6Vu4pAcnuDnaZ4WVv7Da0oCcEh38A0GuO5trR0zZOfPrwpXW5P7QlRjcNju5ST6yX4Fv7A09GNLFQRibRl8X1HgEpCzf5fPlQtOchyiX9wWUG-oM4wlgZqVvKDyUdHNQO1ZpMAXQFtOaEb9VeapKfqawhowADQDFU00X9yL8VLExpR33YwWjprrD7_zYCdPsl6xlOAZ06Js3baiu9t35M7s2F9IrPgzUR0W5&fbclid=IwAR0ZWy2bg8_HioqtuJ-5xuOP8zKS-ds2-OqPxNL3MArzYJbwwEhrKImvnkA

with people. I worry about many, many consequences related to that. . . In Hubei, in the province of Hubei, where there has been the most cases and deaths by far, the actual number of cases reported is 1 per 1000 people and the actual rate of deaths reported is 1 per 20,000. So maybe that would help to put things into perspective."

(d) **By Dr John Ioannidis** that:

"Patients who have been tested for SARS-CoV-2 are disproportionately those with severe symptoms and bad outcomes. As most health systems have limited testing capacity, selection bias may even worsen in the near future. . . The one situation where an entire, closed population was tested was the Diamond Princess cruise ship and its quarantine passengers. The **case fatality rate there was 1.0%**, but this was a largely elderly population, in which the death rate from Covid-19 is much higher. . . .Could the Covid-19 case fatality rate be that low? No, some say, pointing to the high rate in elderly people. However, even some so-called mild or common-cold-type coronaviruses that have been known for decades can have case fatality rates as high as 8% when they infect elderly people in nursing homes. If we had not known about a new virus out there, and had not checked individuals with PCR tests, the number of total deaths due to "influenza-like illness" would not seem unusual this year. At most, we might have casually noted that flu this season seems to be a bit worse than average. . . ."A fiasco in the making? As the coronavirus pandemic takes hold, we are making decisions without reliable data", *Stat News*, 17th March 2020."

(e) **By Dr Yoram Lass** that:

"Italy is known for its enormous morbidity in respiratory problems, more than three times any other European country. In the US about 40,000 people die in a regular flu season. . . .In every country, more people die from regular flu compared with we all forget: the swine flu in 2009. That was a virus that reached the world from Mexico and until today there is no vaccination against it. But what? At that time there was no Facebook or there maybe was but it was still in its infancy. The coronavirus, in contrast, is a virus with public relations. . . .Whoever thinks that governments end viruses is wrong. – Interview in *Globes*, March 22nd 2020."

(f) **By Dr Pietro Vernazza** that:

> "We have reliable figures from Italy and a work by epidemiologists, which has been published in the renowned science journal ‹Science›, which examined the spread in China. This makes it clear that around 85 percent of all infections have occurred without anyone noticing the infection. 90 percent of the deceased patients are verifiably over 70 years old, 50 percent over 80 years. . . .In Italy, one in ten people diagnosed die, according to the findings of the *Science* publication, that is statistically one of every 1,000 people infected. Each individual case is tragic, but often – similar to the flu season – it affects people who are at the end of their lives. . . . **If we close the schools, we will prevent the children from quickly becoming immune. . . .We should better integrate the scientific facts into the political decisions.** – Interview in *St. Galler Tagblatt*, 22nd March 2020 ."

(g) **By Frank Ulrich Montgomery** that:

> "I'm not a fan of lockdown. Anyone who imposes something like this must also say when and how to pick it up again. Since we have to assume that the virus will be with us for a long time, I wonder when we will return to normal? You can't keep schools and daycare centers closed until the end of the year. Because it will take at least that long until we have a vaccine. Italy has imposed a lockdown and has the opposite effect. They quickly reached their capacity limits, but did not slow down the virus spread within the lockdown. – Interview in *General Anzeiger*, 18th March 2020."

(h) **By Prof. Hendrik Streeck** that:

> "The new pathogen is not that dangerous, it is even less dangerous than Sars-1. The special thing is that Sars-CoV-2 replicates in the upper throat area and is therefore much more infectious because the virus jumps from throat to throat, so to speak. But that is also an advantage: Because Sars-1 replicates in the deep lungs, it is not so infectious, but it definitely gets on the lungs, which makes it more dangerous. . . .You also have to take into account that the Sars-CoV-2 deaths in Germany were exclusively old people. In Heinsberg, for example, a 78-year-old man with previous illnesses died of heart failure, and that without Sars-2 lung involvement. Since he was infected, he naturally appears in the Covid 19 statistics. But the question is whether he would not have died anyway, even without Sars-2. – Interview in *Frankfurter Allgemeine*, 16th March 2020".

(i) **By Dr Yanis Roussel** et. al. that:

> "The problem of SARS-CoV-2 is probably overestimated, as 2.6 million people die of respiratory infections each year compared with less than 4000 deaths for SARS-CoV-2 at the time of writing. . . .This study compared the mortality rate of SARS-CoV-2 in OECD countries (1.3%) with the mortality rate of common coronaviruses identified in AP-HM patients (0.8%) from 1 January 2013 to 2 March 2020. Chi-squared test was performed, and the P-value was 0.11 (not significant)....it should be noted that systematic studies of other coronaviruses (but not yet for SARS-CoV-2) have found that the percentage of asymptomatic carriers is equal to or even higher than the percentage of symptomatic patients. The same data for SARS-CoV-2 may soon be available, which will further reduce the relative risk associated with this specific pathology. – "SARS-CoV-2: fear versus data", *International Journal of Antimicrobial Agents*, 19th March 2020."

(j) **By Dr. David Katz** that:

> "I am deeply concerned that the social, economic and public health consequences of this near-total meltdown of normal life — schools and businesses closed, gatherings banned — **will be long-lasting and calamitous, possibly graver than the direct toll of the virus itself**. The stock market will bounce back in time, but many businesses never will. The unemployment, impoverishment and despair likely to result will be public health scourges of the first order. – "Is Our Fight Against Coronavirus Worse Than the Disease?", *New York Times* 20th March 2020."

(k) **By Michael T. Osterholm** that:

> "Consider the effect of shutting down offices, schools, transportation systems, restaurants, hotels, stores, theaters, concert halls, sporting events and other venues indefinitely and leaving all of their workers unemployed and on the public dole. The likely result would be not just a depression but a complete economic breakdown, with countless permanently lost jobs, long before a vaccine is ready or natural immunity takes hold. . . [T]he best alternative will probably **entail letting those at low risk for serious disease continue to work, keep business and manufacturing operating**, and "run" society, while at the same time advising higher-risk individuals to protect themselves through physical distancing and ramping up our health-care capacity as aggressively as possible. With this battle plan, we could gradually

build up immunity without destroying the financial structure on which our lives are based.
– "Facing covid-19 reality: A national lockdown is no"

cure", *Washington Post* 21st March 2020

(l) **By Dr Peter Goetzsche** that:

> "Our main problem is that no one will ever get in trouble for measures that are too draconian. They will only get in trouble if they do too little. So, our politicians and those working with public health do much more than they should do. . . .No such draconian measures were applied during the 2009 influenza pandemic, and they obviously cannot be applied every winter, which is all year round, as it is always winter somewhere. We cannot close down the whole world permanently. . . .Should it turn out that the epidemic wanes before long, there will be a queue of people wanting to take credit for this. And we can be damned sure draconian measures will be applied again next time. But remember the joke about tigers. "Why do you blow the horn?" "To keep the tigers away." "But there are no tigers here." "There you see!"[47]
> "Corona: an epidemic of mass panic", blog post on *Deadly Medicines* 21st March 2020

165. Expert criticism has also been levelled by Canadian experts, including:

(a) **By Dr Denis Rancourt, Ph.D.,** expert in public health and Researcher,

In stating that:

> "Federal and provincial Canadian government responses to and communications about COVID-19 have been irresponsible.""The approach being followed by governments is reckless.""Justification for the early panic-response is not corroborated.""Faith in epidemic-modelling of catastrophe-scenarios and mitigation strategies is not justified."[48]

(b) **Dr. Richard Schabas,** Ontario's former Chief Medical Officer who is of

the opinion that:

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[47] Another 10 experts have been added to this link. Total is 22 experts.
https://www.europereloaded.com/twenty-two-experts-questioning-the-coronavirus-panic-videos-scientific-common-sense/

[48] http://ocla.ca/wp-content/uploads/2014/01/OCLA-Report-2020-1-Criticism-of-Government-Response-to-COVID19.pdf

- "We have **fundamentally over-reacted and misjudged the magnitude of the problem**."
- "lockdown measures are unsustainable"
- "the virus isn't going anywhere"
- "In no country, including Italy, has the death toll come anywhere close to what we would expect in an average influenza year."(CBC News, March 22, 2020)[49]

(c) Based on Dr. Richard Schabas' study of SARS and quarantine[50] Schabas states:

> "far more cases are out there than are being reported. This is because many cases have no symptoms and testing capacity has been limited. There have been about 100,000 cases reported to date, but, if we extrapolate from the number of reported deaths and **a presumed case-fatality rate of 0.5 per cent**, the real number is probably closer to two million – the vast majority mild or asymptomatic."
>
> " **the number of deaths was comparable to an average influenza season**. That's not nothing, but it's not catastrophic, either, and it isn't likely to overwhelm a competent health-care system. Not even close." "Quarantine belongs back in the Middle Ages. Save your masks for robbing banks. Stay calm and carry on. **Let's not make our attempted cures worse than the disease**."[51]

(d) **Dr Joel Kettner** - former Chief Public Health Officer for Manitoba province; professor of Community Health Sciences and Surgery at Manitoba University; Medical Director of the International Centre for Infectious Diseases. In a phone interview on CBC Radio he stated:

> "in 30 years of public health medicine **I have never seen anything like this**, anything anywhere near like this. I'm not talking about the pandemic, because I've seen 30 of them, one every year. It is called influenza. . . . But I've never seen this reaction, and I'm trying to understand why.

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[49] https://www.youtube.com/watch?v=sm9alyH8x
https://ca.news.yahoo.com/virus-isnt-going-anywhere-says-121720522.html

[50] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2094974/

[51] https://www.theglobeandmail.com/opinion/article-strictly-by-the-numbers-the-coronavirus-does-not-register-as-a-dire/

> . . . **the data they are getting is incomplete to really make sense of the size of the threat**. We are getting very crude numbers of cases and deaths, very little information about testing rates, contagious analysis, severity rates, who is being hospitalised, who is in intensive care, who is dying, what are the definitions to decide if someone died of the coronavirus or just died with the coronavirus. There is so much important data that is very hard to get to guide the decisions on how serious a threat this is.
>
> The other part is **we actually do not have that much good evidence for the social distancing** methods. It was just a couple of review in the CDC emerging infectious disease journal, which showed that although some of them might work, we really don't know to what degree and the evidence is pretty weak.
> The third part is the pressure that is being put on public health doctors and public health leaders. And that **pressure is coming from various places**. The first place it came from was the Director-General of the World Health Organization (WHO) when he said *"This is a grave threat and a public enemy number one"*, I have never heard a Director-General of WHO use terms like that."[52]

166. Other pointed criticism and opposite views include:

(a) **Stanford University Team**—to the effect that the Evidence of Covid 19 mortality rate is low;[53]

(b) **By Thomas Stavola**, Rutgers University Law School Relaxation of Lockdown via Quarantine of Symptomatics and Digital Contact Tracing, Experts Agree, indicating that:

> "The latest scientific data indicates that mild and asymptomatic prevalence is much higher than previously thought, thus, **the true**

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[52] https://off-guardian.org/2020/03/17/listen-cbc-radio-cuts-off-expert-when-he-questions-covid19-narrative/?__cf_chl_jschl_tk__=d3faf8dfba5018289da87f791a612c2495a7f86d-1585163840-0-AcjXr346mVjSnluV8YDpGpd_VknFDStnK_liia4dphot9-E3ukKrgN7snq4BA4LggYPkDzlCQ8JXC7G-hqZtf0BZ0LJgFi5mB5Wv34UJsPHJy6UbROLM35V1nV98oiPR7t8pfCObZ75WWrgS4NCn6vwzBMXAlZw0UMU32u_sijPnsW53IpHqSEwCnDdx9dfpJokTen28kaf0Is4UoNQMtfCxCbBpmxmdeFwYj6XWo-XQXWC4rA57a_cBCLR54bfmC1mS1vPBIsHHqljjCg5N2joO9spQJUCbF80INdWsmat8SOzlb2pDrfNdA9dCUdG2tRszCWgTBrVxRFu7zjPABr3Jj0hvjtLlkniXq3AnMs1lCU0rIhPAGzHmXAsEvsRUw

[53] https://www.greenmedinfo.com/blog/stanford-team-finds-evidence-covid-19-mortality-rate-low-2-17-times-lower-whos-esta?utm_campaign=Daily%20Newsletter%3A%20Personal%20update%20%28VVNwgr%29&utm_medium=email&utm_source=Daily%20Newsletter&_ke=eyJrbF9lbWFpbCI6ICJqb2huZnJvbW91dHdlc3RAZ21haWwuY29tIiwgImtsX2NvbXBhbnlfaWQiOiAiSzI2WEF5In0%3D

fatality rate is closer to 0.4%, or possibly even lower. While SARS-CoV-2 can be severe in very small subset, these values indicate that the population-based severity burden is much lower than initially considered months ago. Studies indicate that asymptomatic transmission is negligible[1]. Maria Van Kerkhove, who heads the World Health Organization's emerging diseases and zoonoses unit, stated that asymptomatic cases are definitely not a major driver of transmission."[54]

(c) **By Knut Wittkowski** - German epidemiologist. **Mass Isolation Preventing Herd Immunity** , and conluding that:

"The lockdown prevents the normal progression of natural immunity that is key to protecting the wellbeing of the most vulnerable. The extended lockdown will increase the harm already done many fold including deaths.

Dr. Wittkowski said we must protect and quarantine the frail, sick and very elderly 10% of our population, while allowing the other 90% to acquire the virus with mild to no symptoms, thereby gaining true NATURAL herd immunity. He estimated this to be a 4 week process.

When people are allowed to go about their daily lives in a community setting, he argued, the elderly could eventually – sooner rather than later – come into contact with the rest of the population in "about four weeks" because the virus at this point would be "vanquished."

"With all respiratory diseases, the only thing that stops the disease is 'herd immunity,'" [55]

(d) **By Martin Dubravec, MD** - Allergist/Clinical Immunologist Allergy and Asthma Specialists of Cadillac Cadillac, MI, conducting that:**The Answer is Herd Immunity**[56]**;**

[54] https://medium.com/@tomstavola/latest-science-on-covid-19-and-digital-contract-tracing-f58ee55b3b9b

[55] https://www.aier.org/article/stand-up-for-your-rights-says-professor-knut-m-wittkowski/?fbclid=IwAR2ZuYv6CbCsjiln2UJHXOk84KOjbSOWoxceTSiaNZdl_eZuhadppi25PnE https://ratical.org/PerspectivesOnPandemic-II.html

[56] https://aapsonline.org/coronavirus-covid-19-public-health-apocalypse-or-anti-american/

(e) **By Dr. Dubravec's** whose advice on how to end this epidemic is:

> "What can be done to end this epidemic? **The answer is herd immunity**. Let those who will not die nor become seriously ill from the disease get infected and immune to the disease. Don't close schools – open them up! Don't close universities – reopen them! Let those under the age of 65 with no significant health problems go to work. Their risk of death is very close to zero. They become the wall that stops the virus.
>
> **Our current strategy of isolating these healthy people from the virus: a. is not working** – the virus is still spreading and b. for those who theoretically may be shielded from the virus, they will get exposed later. **Our current strategy is actually leading to a prolonged COVID-19 season!** Herd immunity works and despite our current efforts to mess it up, **herd immunity will be the ultimate reason the virus dies down**. We should promote the concept, not try to stop it. Unlike the influenza epidemics of the past, this virus is not attacking young people. We can use herd immunity to our collective advantage."
>
> **The bottom line is that herd immunity is what will stop the virus from spreading. Not containment. Not a vaccine. Not staying locked in our homes.** It's time we had an honest conversation on how to move beyond containment.

(f) By **Professor Peter C. Gøtzsche** that: "**The Coronavirus mass panic is not justified."**[57]

(g) **By the Wall Street Journalin "Rethinking the Coronavirus Shutdown", that :**

> No society can safeguard public health for long at the cost of its economic health.[58]

[57] https://www.deadlymedicines.dk/wp-content/uploads/G%C3%B8tzsche-The-Coronavirus-mass-panic-is-not-justified.pdf

[58] https://www.wsj.com/articles/rethinking-the-coronavirus-shutdown-11584659154

(h) **By the Professor Yitzhak Ben Israel** of Tel Aviv University, who plotted the rates of new coronavirus infections of the U.S., U.K., Sweden, Italy, Israel, Switzerland, France, Germany, and Spain, concluding that:

> "The numbers told a shocking story: irrespective of whether the country quarantined like Israel, or went about business as usual like Sweden, **coronavirus peaked and subsided in the exact same way**. The professor believes this evidence - **actual evidence and data, not the projections of some model - indicate that there is no need for either quarantines or economic closures."**[59]

(i) **By Professor Stefano Montanari that: "The Virus Vaccine is a Scam"**[60]**;**

(j) **By Virologist Hendrick Streeck that: "There is no danger of infecting someone else while shopping"**[61]**;**

(k) **By:**

(i) **Sucharit Bakhdi:**[62]

(ii) **John Ioannidis, Stanford:**[63]

(iii) **John Lee:**[64]

(iv) **Perspectives on the Pandemic | Professor Knut Wittkowski | Episode 2.**[65]

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[59] https://www.afa.net/the-stand/culture/2020/04/shutdowns-were-pointless-all-along/#.XpnwkkhO_ZA.facebook

[60] https://europeansworldwide.wordpress.com/2020/04/02/the-virus-vaccine-is-a-scam/

[61] https://www.zuercher-presse.com/virologe-hendrick-streeck-gibt-keine-gefahr-beim-einkaufen-jemand-anderen-zu-infizieren/?cn-reloaded=1

[62] https://www.youtube.com/watch?v=JBB9bA-gXL4&fbclid=IwAR1XMZJdTEpe-9woCk7YlMd5WShxUms_loYZYLKVBR8CQlCkGVjD63ZSSY

[63] https://www.youtube.com/watch?v=d6MZy-2fcBw&fbclid=IwAR1LCsQoUVv3dmZzn_2Uwzl85XgFofld0tnn8iSMTMAODv5N9_Dwsi7f3K4

[64] https://www.spectator.co.uk/article/how-to-understand-and-report-figures-for-covid-19-deaths-/amp

[65] https://www.youtube.com/watch?v=lGC5sGdz4kg

(v) **"Medical Doctor Blows C Vi Rus Scamdemic Wide Open" Andrew Kaufman M D in (Nederlands ondertiteld);**[66]

All indicating that the "pandemic" is **not** a pandemic and the modeling and measures unwarranted;

(l) **French researchers**: in COVID FEAR vs. DATA :

> "Under these [first world] conditions, there does not seem to be a significant difference between the mortality rate of SARS-CoV-2 in OECD countries and that of common coronaviruses " which are responsible for 10 to 20 percent of all respiratory infections, including colds, worldwide."[67]

(m) **In :Coronavirus COVID-19: Public Health Apocalypse or Panic, Hoax, and Anti-American?**[68]**;**

(n) **In :Stanford doctor says Fauci doesn't have the evidence to back up his claims;**[69]

(o) **In :Questioning Conventional Wisdom in the COVID-19 Crisis, with Dr. Jay Bhattacharya;**[70]

(p) **By Dr M. I. Adil , Corona Virus is a Hoax;**[71]

(q) **In Resp therapist blowing the whistle on covid -19.**[72]

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[66] https://www.youtube.com/watch?v=S8JBg9H725E

[67] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7102597/?fbclid=IwAR29vpTe-Dk-_xoVzVRbuAgVhil1k0DcZkGqyYsak6lC0BvjZcBRPGcyjc

[68] https://aapsonline.org/coronavirus-covid-19-public-health-apocalypse-or-panic-hoax-and-anti-american/

[69] https://www.youtube.com/watch?v=-UO3Wd5urg0

[70] https://www.youtube.com/watch?v=J04YzligPyU

[71] https://www.youtube.com/watch?v=y9WelOX1UuQ&feature=youtu.be

[72] https://www.youtube.com/watch?v=R0aDAM5LzWA

- **COVID- Measures Worse than Virus**

167. Another thematic point of sound scientific and medical criticism is that the COVID - measures are worse than the virus as reflected in, **inter alia**, the following:

(a) At least one study suggests the ultimate changes in contact patterns triggered by social distancing measures **could end up having a negative effect on the population** and, in some cases, even worsen the outcome of the epidemic.[73]

(b) **Cost of Coronavirus cure could be deadlier than the disease.**[74], by Carpay who is president of the Justice Centre for Constitutional Freedoms;

(c) **California ER Physicians: Sheltering in Place Does More Harm than Good - Lowers Our Immune System.**

(d) Doctors Dan Erickson and Artin Massihi of Accelerated Urgent Care in Kern County, California say the longer people stay inside, the more their immune system drops. The secondary effects, the child abuse, alcoholism, loss of revenue – all of these are, in our opinion, significantly more detrimental thing to society than a virus that has proven similar in nature to the seasonal flu that we have every year.[75]

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[73] J R Soc Interface. 2018 Aug; 15(145): 20180296.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6127185/pdf/rsif20180296.pdf
https://www.greenmedinfo.com/blog/social-distancing-may-worsen-epidemic-outcomes

[74] https://www.jccf.ca/the-cost-of-the-coronavirus-cure-could-be-deadlier-than-the-disease/

[75] https://vaccineimpact.com/2020/california-er-physicians-sheltering-in-place-does-more-harm-than-good-lowers-our-immune-system/
https://prepforthat.com/kern-county-california-doctors-coronavirus-end-shutdown/

(e) **Economic Consequences of Lockdown:**

> "Our leaders must reopen our country immediately. We will survive this virus. We will not survive this economic lockdown."[76]

168. With respect to treatment measures, the Defendants further ignored, and continue to ignore, the following expert criticism and opposition;

(a) **Ventilators are not working and may be increasing harm.** New evidence reveals there is no 'pneumonia' nor ARDS with CV 19. Ventilators are not only the wrong solution, but high pressure intubation can actually wind up causing more damage than without. Ventilators are not working and may be increasing harm. Over 80% of individuals put on ventilators are dying. [77]

(b) **Managing the Flow.** The truth for any new virus is that most people will be exposed to it. If one's goal is to NEVER get COVID-19, one would pretty much need to live on lockdown for the rest of his/her life. The ONLY reason for the lockdown is to manage the flow of people through our hospitals so that those who have acute symptoms will get the care they need to hopefully not die. Is the desire to manage the flow of people through our hospitals worth shutting down our economy? Given most hospitals are operating at 50% or less of capacity, have we not over managed the flow?

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[75] https://www.facebook.com/groups/221945012378955/

[77] https://web.archive.org/web/20200405061401/https://medium.com/@agaiziunas/covid-19-had-us-all-fooled-but-now-we-might-have-finally-found-its-secret-91182386efcb

(c) **No Evidence Masks Work.** No RCT study with verified outcome shows a benefit for HCW or community members in households to wearing a mask or respirator. There is no such study. Likewise, no study exists that shows a benefit from a broad policy to wear masks in public. Furthermore, if there were any benefit to wearing a mask, because of the blocking power against droplets and aerosol particles, then there should be more benefit from wearing a respirator (N95) compared to a surgical mask, yet several large meta-analyses, and all the RCT, prove that there is no such relative benefit.

(d) **Ineffectiveness of Masks & Respirators** - D. G. Rancourt.[78]

(e) **Conflicting Advice About Face Masks to Prevent CV 19.** There is currently no evidence that wearing a mask (whether medical or other types) by healthy persons in the wider community setting, including universal community masking, can prevent them from infection with respiratory viruses, including COVID-19.[79]

(f) **The surgeon general said not to wear a mask.**[80]

(g) **Over 3 times the risk of contracting influenza like illness if cloth mask is used versus no mask at all;**[81]

(h) "Penetration of cloth masks by particles was almost 97% compared to medicalmaskswith44%";[82]

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[78] https://www.researchgate.net/publication/340570735_Masks_Don't_Work_A_review_of_science_relevant_to_COVID-19_social_policy?fbclid=IwAR3xOsnDOC2oRHau1k8F8_rA6CmfTvca6eZY1lS_8H0GRc5uHhKYPoWEmfk

[79] https://thevaccinereaction.org/2020/04/face-masks-to-prevent-covid-19-conflicting-facts-advice/#_edn5

[80] https://www.businessinsider.com/who-no-need-for-healthy-people-to-wear-face-masks-2020-4

[81] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4420971/

(i) **Report on surgical mask induced deoxygenation during major surgery"**[83] ;

(j) **Co-Factors:** Not everyone is at equal risk of dying from COVID 19. CV 19 has spread unevenly around the world, clustered in several hot pockets, while leaving other areas with scant outbreaks. What other factors are contributing to the COVID 19 virus mortality?;

(k) **Link Between Air Pollution and CV 19;**[84]

(l) **Underlying Disease and COVID- 19.**[85]

169. The Plaintiffs state, and the fact is, that the evidence is that far many, more people have died as result of the "pandemic" measures themselves, than purportedly from the "COVID- deaths", even if one takes the deaths "caused" by COVID as a given, through the following consequences of the measures:

(a) Spikes in suicide rates resulting in intense clinical depression from the measures;

(b) Spikes in drug over-dose attributable to measures;

(c) Spikes in domestic violence and murder as a direct result of the measures;

(d) Deaths resulting from the cancellation of over 170,000 medical surgeries;

(e) Deaths from persons afraid to leave their homes to obtain medical diagnosis and treatments; and

[82] https://www.sciencedaily.com/releases/2015/04/150422121724.htm
[83] https://www.ncbi.nlm.nih.gov/pubmed/18500410
[84] https://thevaccinereaction.org/2020/04/study-shows-link-between-fine-particle-air-pollution-and-covid-19-mortality/
[85] https://thevaccinereaction.org/2020/04/covid-19-hospitalized-patients-and-underlying-chronic-disease/

(f) Sub-space spikes in starvation, given the UN World- Food Bank warning that 130 Million additional people will be on the brink of starvation by end of 2020 due to disruption of supply chains due to COVID Measures.

170. It is to be noted that the above-noted criticism was early on in the outbreak which criticism has now intensified both in volume and accuracy, that the COVOD-measures are unwarranted, extreme, and not based on science and medicine.

171. Another pointed area of disagreement and criticism, which continues, along with the above-noted, which the Defendants refuse to acknowledge, ignore, and not respond to, is the questioning of this as a "pandemic" rather than a typical seasonal viral respiratory illness, as reflected, inter alia, by the following:

(a) **California has a 0.0003% Chance of Death from Covid 19**":

> "Initial models were woefully inadequate. They predicted millions of cases of death. Not of prevalence or incidence but deaths. This is not materializing. What is materializing in California is 12% positives... This equates to 4.7 million cases in California. This is the good news.... We have seen 1,227 deaths. California has 0.0003% chance of death from Covid-19. Is this enough to justify a lock-down?"
>
> **"COVID-19 Antibody Seroprevalence in Santa Clara County, California"**Conclusion: "The population prevalence of SARS-CoV-2 antibodies in Santa Clara County implies that the infection is much more widespread than indicated by the number of confirmed cases. Population prevalence estimates can now be used to calibrate epidemic and mortality projections." [86]

[86] https://www.medrxiv.org/content/10.1101/2020.04.14.20062463v1

(b) The above research, in (a) above, is ground-breaking and provides foundational support for narratives such as :

(i) the initial models were incorrect;

(ii) conflicts of interest (Gates/Fauci/Democrats) contributed to an over-hyped response and failure to revisit despite availability of new data (confirmation bias);

(iii) we need to be rational here as the lock-down is hurting normal citizens - the 99% ;

(iv) no evidence exists to justify forceful solutions like mandatory Covid-19 vaccinations, community immunity passwords, contact tracing, or increased domestic surveillance;

(v) we need to root out and remove all conflicts of interests in our public health institutions, both CDC and WHO; again

(vi) **Annual Influenza Deaths vs. CV 19 deaths.** It is claimed that 7 to 8,000+ Canadians die from season viral respiratory illness each year. The number of Canadians who have died from Covid-19 does not stray from annual season viral respiratory illness death total,[87] notwithstanding the inflated, false " covid-deaths";

(c) In 2009-2010, the world experienced the swine flu pandemic (H1N1). During that pandemic it is claimed that 203,000 people were killed world-

[87] https://www.worldometers.info/coronavirus/?nsukey=8gR2B80EUvHglg1gz%2FFrRbGWu%2BhOoChcVMEV2tcidO%2Fguhc nKlUP2 6Oevxq86h8W7SYtAC%2FYsoVycvKvhtVZgT%2FvREx1TON%2BcUTJ6uKZDsLJ4QDUYN0QG2n2IfAPsDuLBJZryuEWbYH3BsYmR4hwzTa azvCLjqZsbV0YQAANZ46gHbo7Sf%2Beyzk1c3WND68j

wide by the virus. There was not a need to shut down our entire way of life in 2009. It is still unclear why this is the strategy being implemented today;

(d) The CDC has tracked the total number of Americans who die every week from pneumonia. For the last few weeks, that number has come in far lower than at the same moment in previous years. How could that be? **It seems that doctors are classifying conventional pneumonia deaths as COVID-19 deaths.** That would mean this epidemic is being credited for thousands of deaths that would have occurred if the virus never appeared here.

(e) **Number of influenza cases and deaths according to WHO every year.**[88]

(f) **Are the numbers of CV deaths accurate?**[89]

(g) **Montana physician Dr. Annie Bukacek discusses how COVID 19 death certificates are being manipulated;**[90]

(h) **Italy: 99% who died from virus had other illness;**[91] The Key Points being that :

- The cases and deaths of this new disease COVID19 are being described as "flu-like symptoms with pneumonia" but **there is NO data that shows SARSCov2 is present in all of these cases/deaths.** Only coronavirus of which there are many strains.

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[88] http://www.euro.who.int/en/health-topics/communicable-diseases/influenza/seasonal-influenza/burden-of-influenza?fbclid=IwAR0ZDNTwTXKGve_oJVmtZsGKFAi44JYSo6IAf4GkA47EYD88O5b6FS-8Rkw

[89] https://www.ctvnews.ca/health/coronavirus/why-the-exact-death-toll-for-covid-19-may-never-be-known-1.4881619

[90] https://www.youtube.com/watch?v=CnmMNdiCz_s

[91] https://www.bloomberg.com/news/articles/2020-03-18/99-of-those-who-died-from-virus-had-other-illness-italy-says?utm_campaign=pol&utm_medium=bd&utm_source=applenews&fbclid=IwAR0qN9k2HVrnAghrK-Wrl72I7oBoNY1vFAGY3dI-M7GWKirK6cfUeAI16yg

- This is because **the PCR test is not reliable enough** to identify the new strain - laboratory testing is only identifying coronavirus. This is the flaw in the CDC/WHO theory of causality for this "new" disease "COVID19". They haven't provided any data about the presence of this new strain (SARSCov2) in COVID19 and it is known that many influenza viruses and bacteria cause "flu-like symptoms with pneumonia".

- Until you have evidence to prove the causality of COVID19 disease as being to SARsCov2 by showing that it is present in every case of the disease then there is no new disease. Koch's postulates need to be used to provide proof of causality.

- **Mathematical Modeling Flawed**
In March, UK epidemiologist Neil Ferguson from the Imperial College of London issued a mathematical "model" that predicted that as many as 500,000 in the UK would die from Covid-19. On March 24th Ferguson revised his modeling projections to read 20,000 deaths, and "likely far fewer." On April 2nd Ferguson revised it again to read 5,700 deaths. The problem was that many world leaders used Ferguson's original number to shut down most of the planet.[92]

(i) The Canadian government implemented the lockdown on the basis of Neil Ferguson's Imperial College mathematical modeling that was grossly flawed. Ferguson has drastically backtracked on his predictions which begs the question why is Canada now doubling down on the lockdown that will not be lifted until a vaccine is ready?

(j) **UK Decides CV 19 No Longer A 'High Consequence Infectious Disease'** As of March 19, 2020, COVID-19 is no longer considered to be a high consequence infectious diseases (HCID) in the UK.[93]

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[92] https://prepforthat.com/fear-mongering-covid-19-epidemiologist-says-he-was-wrong/

[93] https://prepforthat.com/uk-officials-covid-19-no-longer-high-consequence-infectious-disease/

(k) High Consequence Infectious Disease Public Health England, have provided current information and regarding COVID-19 mortality rates as low. The Advisory Committee on Dangerous Pathogens (ACDP) in the UK and is also of the opinion that COVID-19 should no longer be classified as an HCID (High Consequence Infectious Disease).[94]

(l) **Our World in Data researchers announced this week that they had stopped relying on World Health Organization data for their models.**[95]

(m) **New Oxford study suggests millions have already built up coronavirus immunity.**[96]

(n) **Lack of Good Data. If you are going to do something as draconian as shut down an economy, you better be right, and you better have good data.** The government has neither.[97]

(o) **Dr Teresa Tam's incompetent virus response.**[98]

(p) **BC health officer Dr Bonnie Henry admits They did not use science to impose restrictions.**[99]

172. The measures have been also heavily criticized, on a legal basis, in Canada and abroad. Early on in the declaration, on March 26th, 2020 the UN Commissioner

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[94] https://www.gov.uk/topic/health-protection/infectious-diseases

[95] https://fee.org/articles/oxford-based-group-stops-using-who-data-for-coronavirus-reporting-citing-errors/?fbclid=IwAR1okWvqn-qe7zvbHxoUY_U-4Nlqe6A8mOVwGqw4_N3gk9TXsfs_P6eEMJA

[96] https://news.yahoo.com/oxford-study-suggests-millions-people-221100162.html?soc_src=hl-viewer&soc_trk=fb

[97] https://www.foxnews.com/opinion/tucker-carlson-we-must-ask-the-experts-how-they-screwed-up-the-coronavirus-models-so-badly?fbclid=IwAR0xrpFytibdv5IJLOR2fveTjvpj5b23tn7JFn2uemrXeu27GDFRpeuDLoI

[98] https://www.spencerfernando.com/2020/03/29/devastating-timeline-reveals-total-incompetence-of-theresa-tams-virus-response/

[99] https://www.youtube.com/watch?v=SY8fcICOG4c&feature=youtu.be&fbclid=IwAR0BmcUm4qk7BB3VuJRqvaJpyuB0VfyIkymVM0ILmF-uOKiKJbD_cdKQIIs&app=desktop

for Human Rights, Michelle Bachelet, took an opposite view to that of Dr. Teresa Tam, whose view is that it is appropriate to run rough-shod over these rights and worry about it later, where Bachelet early declared that:

> "Lockdowns, quarantines and other such measures to contain and combat the spread of COVID-19 should always be carried out in strict accordance with human rights standards and in a way that is necessary and proportionate to the evaluated risk."

173. Former UK Supreme Court Justice Lord Sumpton was an early opponent to the lock-down measures. In a BBC interview of May18th, 2020, he re-iterated and stated, **inter alia**, as follows:

> JS: because they seem to me to have no real purpose in continuing the lockdown other than to spare themselves public criticism. now one does understand why politicians don't want to be criticized but it's the mark of a statesman that you're prepared to stand up for the national interest and not simply to run away before public opinion. especially when you have in a sense created that public opinion yourself by frightening the daylights out of people over the over the last eight weeks and trying to persuade them that this is a much more virulent epidemic than it actually is.
> ....
> LS: what i'm advocating now is that the lockdown should become entirely voluntary. it is up to us, not the state, to decide what risks we are going to take with our own bodies. now, the traditional answer that people give to that is: "well, but by going out or in the streets and in shops and things you are infecting other people". but you don't have to take that risk you can voluntarily self-isolate. you don't have to go into the streets. you don't have to go to the shops. people who feel vulnerable can self-isolate, and the rest of us can then get on with our lives.
>
> ....
>
> we have never lived in a risk-free world and we're never going to live in a risk-free world.
>
> ...
>
> we are entitled to take risks with our own lives especially when basically life is only worth living if you are prepared to engage in social activities. which inevitably involve risk. that is part of life.

174. The Plaintiffs state, and fact is, that the above-noted **scientific and medical expert opinions,** against and in severe criticism of the "pandemic" declaration, and its draconian and un-necessary measures, are not exhaustive, but examples. The Plaintiffs state, and fact is, that the Defendants have never acknowledged, addressed, spoken to, nor responded to these contrary expert views, and further state that the Defendants, including the mega-social media, such as YouTube, Facebook, Amazon, Google, Yahoo and like, as well as CBC, have intentionally suppressed, censored, belittled and removed the publication of any such contrary views, contrary to the principles and methodology of science and medicine, with the acquiescence and actual support of the Canadian Federal government, which government threatens to add criminal sanctions to assist these media for what they irrationally, arbitrarily and unscientifically deem "misinformation" , and further violate the Plaintiffs' rights to freedom of speech, expression, and the media, contrary to s.2 of the **Charter**, by the government's acts and omissions in making threats of criminalizing speech, and doing absolutely nothing, by omission, to regulate this type of "Stalinist censorship".

D/ THE SCIENCE & MEDICINE OF COVID-19

- **Summary (Overview)**

175. The Plaintiffs state, and the fact is, that the World Health Organization,("WHO"), our federal, provincial and municipal governments, and the mainstream media, propagate that we are facing the biggest threat to humanity in our lifetime. This is false.

176. The fact is that, false and baseless predictions of wide-spread infection with high rates of mortality persuaded governments that unprecedented containment measures were necessary to save us from certain peril.

177. The fact is that, while there is more about the SARS-CoV-2("COVID-19") coronavirus that needs to be understood, the scientific and medical evidence clearly demonstrates that the mathematical modeling used to justify extreme containment measures were invalid. Further, that the vast majority of the population is not at serious risk of complications or mortality as a result of exposure to COVID-19.

178. The fact is that, the mass and indiscriminate containment of citizens, the restriction of access to our economy, courts, parliament and livelihoods, medical and therapeutic care, and the imposition of physical distancing and other restrictions are measures that have never before been implemented nor tested, nor have a scientific or medical basis.

179. The fact is that, the impact of these measures on physical, emotional, psychological, and economic well-being is profoundly destructive, unwarranted, and clearly not sustainable.

180. The fact is that, these drastic isolation measures are not supported by scientific or medical evidence. There is considerable agreement in the scientific community that such drastic measures are not sustainable nor warranted or justified, and while these measures may delay viral spread, they are unlikely to impact overall morbidity.

181. The fact is that, this over-hyped COVID-19 pandemic narrative is creating unnecessary panic and being used to justify systemic governmental violations of the rights and freedoms that form the basis of our society, including our constitutional rights, sovereignty, privacy, rule of law, financial security, and even our very democracy.

182. The fact is that, it is clear that significant violations of the Plaintiffs' rights and freedoms are being perpetrated by the federal, provincial and municipal governments and health authorities.

183. The fact is that, as a result of all of the above, the Plaintiffs have suffered and continue to suffer, severe violations of their constitutional rights which are justified on any measurement, including s. 1 of the **Charter.**

- **The Covid -Measures Unscientific, Non-Medical, Ineffective, and Extreme**

184. The Plaintiffs state and the fact is, that the Measures implemented lack scientific and medical evidence to support containment measures in that:

(a) Mass and indiscriminate lockdown of the general population has not been previously attempted in modern history, and has no scientific nor medical basis. In fact, Dr. Bonnie Henry, BC Chief Medical Officer, has flatly stated that the measures are not based on science or medicine.

(b) A 2011 review of the literature to evaluate the effectiveness of social distancing measures such as school closures, travel restrictions, and restrictions on mass gatherings to address an influenza pandemic concluded that *"such drastic restrictions are not economically feasible*

and are predicted to delay viral spread but not impact overall morbidity" [100]

(c) There are no realistic and contextual studies of the negative social, family, psychological, and individual health consequences of extended general population lockdowns, nor the impact on the national economy.

(d) The long-term impact of the broadly applied infringements of civil rights and freedoms is not known, including any permanent structural erosion of democracy itself due to increased authoritarianism and heightened regulatory or penal consequences for violating government directives.

(e) The measures enacted by the federal, provincial and municipal governments are unprecedented.

(f) The government has acted in diametrical opposition to the precautionary principle: *"Government shall not act with insufficient scientific knowledge, if the action has any likelihood of causing more harm than good".*

(g) Justification for the early panic response has not been corroborated. [101]

(h) Faith in epidemic-modeling and the resulting mitigation strategies are not justified.

(i) Physicians globally are expressing alarm over the exponentially growing negative health consequences of the national shutdown. [102] [103]

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[100] Social Distancing as a Pandemic Influenza Prevention Measure https://nccid.ca/wp-content/uploads/sites/2/2015/04/H1N1_3_final.pdf

101 http://ocla.ca/wp-content/uploads/2014/01/OCLA-Report-2020-1-Criticism-of-Government-Response-to-COVID19.pdf

[102] https://www.scribd.com/document/462319362/A-Doctor-a-Day-Letter-Signed#from_embed

[103] https://www.forbes.com/sites/gracemarieturner/2020/05/22/600-physicians-say-lockdowns-are-a-mass-casualty-incident/#20248e5250fa

(j) Despite the importance given to physical distancing as a containment measure, there is a lack of scientific evidence on the effectiveness of such intervention on the long-term health of citizens. [104] [105]

(k) There is no scientific evidence to substantiate the effectiveness of two meter 'physical distancing' as an intervention to reduce SARS-CoV-2 transmission and infection and to improve overall health. [106]

(l) Dr. Martin Dubravec, MD, a Clinical Immunologist states: *"The bottom line is that herd immunity is what will stop the virus from spreading. Not containment. Not a vaccine. Not staying locked in our homes. It's time we had an honest conversation on how to move beyond containment."* [107]

(m) A review of the scientific literature with regards to the use of masking concluded there is no scientific evidence to substantiate the effectiveness of masking of the general public to prevent viral infection and transmission. [108]

(n) Denis Rancourt, Ph.D. has identified the many unknowns regarding the potential harm from a broad public policy of masking. Rancourt concludes: "In an absence of knowledge, governments should not make policies that have a hypothetical potential to cause harm. The government

[104] Benjamin E Berkman. Mitigating pandemic influenza: the ethics of implementing a school closure policy. Journal of Public Health Management and Practice: JPHMP, 14(4):372–378, August 2008. PMID: 18552649.
[105] https://nccid.ca/wp-content/uploads/sites/2/2015/04/H1N1_3_final.pdf
[106] https://www.zuercher-presse.com/virologe-hendrick-streeck-gibt-keine-gefahr-beim-einkaufen-jemand-anderen-zu-infizieren/?cn-reloaded=1
[107] https://aapsonline.org/coronavirus-covid-19-public-health-apocalypse-or-anti-american/
[108] https://www.researchgate.net/publication/340570735_Masks_Don't_Work_A_review_of_science_relevant_to_COVID-19_social_policy

has an onus barrier before it instigates a broad social-engineering intervention or allows corporations to exploit fear-based sentiments." [109]

(o) A study of cloth masks cautions against the use of cloth masks. The study concludes: "As a precautionary measure, cloth masks should not be recommended." [110]

(p) According to Dr. Richard Schabas, former Chief Medical Officer for Ontario -*"Quarantine belongs back in the Middle Ages. Save your masks for robbing banks. Stay calm and carry on. Let's not make our attempted cures worse than the disease."* [111]

(q) On May 20, 2020, Dr. Teresa Tam, Canada's Chief Medical Officer, publicly advised the use of non-medical masks for the general public to provide an *"added layer of protection"* that could help prevent asymptomatic or pre-symptomatic Covid-19 patients from unknowingly infecting others. Dr. Tam's advice is not supported by scientific evidence. [112]

(r) It would appear that any advice/requirement to use masks is for a purpose/agenda other than the prevention of viral infection and transmission.

(s) A paper published on January 30, 2020 in *The New England Journal of Medicine* (*NEJM*) which appeared to confirm that individuals who are

[109] https://www.researchgate.net/publication/340570735_Masks_Don't_Work_A_review_of_science_relevant_to_COVID-19_social_policy
[110] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4420971/
[111] https://www.theglobeandmail.com/opinion/article-strictly-by-the-numbers-the-coronavirus-does-not-
[112] https://www.politico.com/news/2020/05/20/canada-non-medical-masks-provinces-reopen-271008

asymptomatic can transmit SARS-CoV-2 to others has subsequently proven to contain major flaws and errors.[113]

(t) The imposition of mass and indiscriminate self-isolation measures prevents the development of natural immunity necessary to secure herd immunity and end the epidemic. [114]

(u) On April 6, 2020, German epidemiologist, Knut Wittkowski, released a statement warning that artificially suppressing the virus among low risk people like school children may *"increase the number of new infections"* as it keeps the virus circulating much longer than it normally would.[115]

(v) On March 24, 2020 global medical experts declared that efforts to contain the virus through self-isolation measures would negatively impact population immunity, maintain a high proportion of susceptible individuals in the population, prolong the outbreak putting more lives at risk, damage our economy and the mental stability and health of the more vulnerable. [116] [117]

(w) A review of recent literature pertaining to social distancing measures conducted by David Roth and Dr. Bonnie Henry of the BC Centre for Disease Control concluded the following: a) widespread proactive school closures are likely not an effective prevention measure during an influenza

[113] https://www.sciencemag.org/news/2020/02/paper-non-symptomatic-patient-transmitting-coronavirus-wrong
[114] https://www.aier.org/article/herd-immunity-is-misleading/
[115] Stand Up for Your Rights, says Bio-Statistician Knut M. Wittkowski. American Institute for Economic Research. April 6, 2020
https://www.aier.org/article/stand-up-for-your-rights-says-professor-knut-m-wittkowski/
[116] https://off-guardian.org/2020/03/24/12-experts-questioning-the-coronavirus-panic/
[117] https://www.europereloaded.com/twenty-two-experts-questioning-the-coronavirus-panic-videos-scientific-common-sense/

pandemic; b) stringent travel restrictions and border control may briefly delay imminent pandemics, these approaches are neither economically nor socially feasible; and c) there is no recent evidence outlining the effectiveness of the prohibition of mass gatherings. [118]

(x) According to a public statement issued by the BC Ministry of Health: a) COVID-19 virus has a very low infection rate in children and youth; b) In BC, less than 1% of children and youth tested have been COVID-19 positive; c) There is no conclusive evidence that children who are asymptomatic pose a risk to other children or to adults, and d) Schools and childcare facility closures have significant negative mental health and socioeconomic impacts on vulnerable children and youth. [119]

(y) According to a May 21, 2020 letter from Dr. Mark Lysyshyn, MD, Deputy Chief Medical Health Officer with Vancouver Coastal Health: *"Although children are often at increased risk for viral respiratory illnesses, that is not the case with COVID-19. Compared to adults, children are less likely to become infected with COVID-19, less likely to develop severe illness as a result of infection and less likely to transmit the infection to others."* Dr. Lysyshyn further states: *"Non-medical masks are not needed or recommended. Personal protective equipment such as medical masks and gloves are not recommended in the school environment."* [120]

(z) On May 21, 2020, British Columbia's Chief Health Officer, Dr. Bonnie Henry stated: *"We're encouraging people [to wear masks] as a mark of*

[118] https://nccid.ca/wp-content/uploads/sites/2/2015/04/H1N1_3_final.pdf
[119] https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/covid-19/covid-19-pho-guidance-k-12-schools.pdf
[120] http://www.vch.ca/Documents/COVID-VCH-Schools-May-21-2020.pdf

respect, as a mark of politeness, and paying attention to the welfare of others." The recommendation to mask no longer is on the basis of effectiveness but instead is being promoted as a social grace. [121]

(aa) British Columbia's Chief Health Officer, Dr. Bonnie Henry, when addressing a question regarding the inconsistency among the provinces of Canada on COVID-19 restrictions placed on Canadians stated: *"None of this is based on science."* [122]

(bb) The reported number of deaths attributed to SARS-CoV-2 is demonstrably unreliable given the inclusion of "*presumptive*" deaths, and the failure of the medical establishment to differentiate between individuals dying *from* COVID 19 and those with co-morbidities dying *with* COVID 19. [123] [124]

(cc) The failure to differentiate between individuals dying *from* COVID 19 and those with co-morbidities dying *with* COVID 19 inflates the risk of mortality from SARS-CoV-2 and undermines confidence in any response strategy based on mortality statistics. [125]

(dd) Doctors globally are being pressured to issue death certificates that identify COVID 19 as the cause of death even when other co-morbidity issues are the more likely cause of death.

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[121] https://www.straight.com/covid-19-pandemic/may-21-coronavirus-update-bc-resistance-health-measures-regional-restrictions-gender-differences-second-wave

[122] https://www.youtube.com/watch?v=SY8fclCOG4c&feature=youtu.be&fbclid=IwAR0BmcUm4qk7BB3VuJRqvaJpyuB0Vfyfkvm VM6HLmF-u0KiKJbD_cdKQIIs&app=desktop

[123] Why the exact death toll for COVID-19 may never be known. CTV News, April 3, 2020 https://www.ctvnews.ca/health/coronavirus/why-the-exact-death-toll-for-covid-19-may-never-be-known-1.4881619

[124] https://www.cpsbc.ca/for-physicians/college-connector/2020-V08-02/04

[125] https://www.bloomberg.com/news/articles/2020-03-18/99-of-those-who-died-from-virus-had-other-illness-italy-says

(ee) The presentation of mortality data, expressed as a percentage of deaths of *tested and confirmed cases*, is distorting the risk and creating undue panic. This data fails to include a significant percentage of the population who contracted the virus but were not tested nor confirmed and who recovered without medical intervention.

(ff) To date, the number of reported deaths attributed to SARS-CoV-2 is not out of "normal" range when compared to the annual mortality from influenza and pneumonia (seasonal viral respiratory illness) recorded through the last decade. [126] [127] [128]

(gg) According to Dr. Richard Schabas, former Chief Medical Officer of Ontario, strictly by the numbers, the coronavirus does not register as a dire global crisis.

(hh) No data has been provided by the Government of Canada nor Ontario to indicate that the total mortality in Canada has increased substantially from previous years.

(ii) Mortality modeling by the World Health Organization, Imperial College of London, and the US Institute for Health Metrics and

[126] Strictly by the numbers, the coronavirus does not register as a dire global crisis. Richard Schabas. The Globe and Mail. March 9, 2020
https://www.theglobeandmail.com/opinion/article-strictly-by-the-numbers-the-coronavirus-does-not-register-as-a-dire

[127] New Data Suggest the Coronavirus Isn't as Deadly as We Thought. WDJ/Opinion. April 17, 2020
https://www.greenmedinfo.com/blog/stanford-team-finds-evidence-covid-19-mortality-rate-low-2-17-times-lower-whos-esta
https://www.medrxiv.org/content/10.1101/2020.04.14.20062463v2

[128] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7102597/?fbclid=IwAR29vpTe-Dk-xoVzVRbuAgVhil1k0DcZkGqyYsak6lC-OByjZcBRP6cyjc

Evaluation have all been drastically "downgraded". Strategies and measures based on these original predictions are invalid.[129] [130]

(jj) As of March 19, 2020, the status of COVID-19 in the United Kingdom was downgraded. COVID-19 is no longer considered a high consequence infectious disease (HCID). The Advisory Committee on Dangerous Pathogens (ACDP) in the UK is also of the opinion that COVID-19 should no longer be classified as an HCID (High Consequence Infectious Disease). [131] [132]

(kk) **On March 26, 2020,** Dr. Anthony Fauci published an editorial in the *New England Journal of Medicine* stating that *"the overall clinical consequences of Covid-19 may ultimately be more akin to those of a severe seasonal influenza with a case fatality rate of perhaps 0.1%."* [133]

(ll) On April 9, 2020, Canadian public health officials stated: "In a best-case scenario, Canada's total COVID-19 deaths can range from 11,000 to 22,000." And "In the bad scenarios, deaths go well over 300,000." As of May 21, 2020, the total reported deaths from COVID 19 in Canada was 6,145. As of July 2, 2020, the total deaths attributed to COVID 19 in Canada was 8,642. In 2018, the mortality rate of the 2018 influenza/pneumonia in Canada which

[129] How One Model Simulated 2.2 Million U.S. Deaths from COVID-19. Cato Institute. April 21, 2020 https://www.cato.org/blog/how-one-model-simulated-22-million-us-deaths-covid-19
[130] https://prepforthat.com/fear-mongering-covid-19-epidemiologist-says-he-was-wrong/
[131] https://www.gov.uk/topic/health-protection/infectious-diseases
[132] https://prepforthat.com/uk-officials-covid-19-no-longer-high-consequence-infectious-disease/
[133] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7121221/

was **23 per 100,000**. [134] In a population of 37.7 M, this equates to approximately 8,671 deaths. This is the mortality even though a vaccine exists for both influenza and pneumonia and there is a high uptake rate in the senior population.

(mm) The World Health Organization knew as early as February 28, 2020 that most people will have mild illness from SARS-CoV-2 infection and get better without needing any special care. [135]

(nn) The Canadian government has implemented a re-start strategy that continues to maintain the unsubstantiated narrative that the SARS-CoV-2 virus is extra-ordinarily dangerous and requires extra-ordinary social distancing measures never before implemented.

(oo) The re-start strategy recommended by the federal and various provincial governments is based on 'sector' rather than 'risk'. There is no evidence that a re-start based on sector has scientific merit.

(pp) According to a number of infectious disease experts, hospital capacity, rather than the number of infections should be the metric of choice for relaxing restrictions. [136]

(qq) There is no evidence that harms caused by the mass and indiscriminate containment of citizens was calculated and

[134] https://www.statista.com/statistics/434445/death-rate-for-influenza-and-pneumonia-in-canada/
[135] WHO Director-General's opening remarks at the media briefing on COVID-19 - 28 February 2020 https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---28-february-2020
[136] https://nationalpost.com/opinion/opinion-we-are-infectious-disease-experts-its-time-to-lift-the-covid-19-lockdowns

considered in the modeling and strategic planning response to SARS-CoV-2. [137]

(rr) SARS (2003), Swine Flu/H1N1 (2009), and MERS (2012) were all considered pandemics by the World Health Organization. Each of these pandemics were effectively contained without lockdowns, economic ruin, violations of privacy, and the indefinite loss of the right to work and personal freedoms. SARS and MERS dissipated on their own naturally without any vaccine intervention. [138]

(ss) Academic studies of media coverage during the 2003 Canadian SARS outbreak concluded that the media coverage was excessive, sensationalist, and sometimes inaccurate. Government health agencies were criticized for lacking a unified message and communications strategy, resulting in confusion and panic about the disease. [139] These same criticisms hold even more true for media and government response to SARS-CoV-2.

(tt) The suspension of our civil liberties is not justified by the known risk posed by SARS-CoV-2.

(uu) In a statement released on March 24, 2020, professor Peter Gotzche states: *"The coronavirus mass panic is not justified."* The suspension of our right to liberty, to work, to travel, and to conduct

[137] Rethinking the Coronavirus Shutdown. WSJ/Opinion. March 19, 2020
https://www.wsj.com/articles/rethinking-the-coronavirus-shutdown-11584659154
[138] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2094974/
[139] https://www.thecanadianencyclopedia.ca/en/article/sars-severe-acute-respiratory-syndrome

commerce is not justified by the known risk posed by SARS-CoV-2. [140]

(vv) There is no independent human rights oversight committee to track human rights violations associated with SARS-CoV-2 response measures in Canada.

(ww) Communications about SARS-CoV-2 by the Government of Canada and mainstream media have been exaggerated, distorted, irresponsible, and appear to have been purposely designed to evoke fear and panic. The fear is out of proportion to the actual risk of mortality.

(xx) Governments and media have repeatedly failed to properly distinguish between the 'risk of infection' and 'the risk of mortality'. For the vast majority of the population the risk of mortality is extremely low.

(yy) Prevalence of SARS-CoV-2 in the entire Canadian population is very low. Extreme social controls should never be used in low prevalence epidemics.

(zz) As presented by PHAC, the modelling techniques used to establish probabilities of the epidemic trends and thus "inform" policy decisions have no basis in evidence, are completely inflated, and essentially amount to statistical chicanery.

[140] The Coronavirus mass panic is not justified. Professor Peter C. Gøtzsche24 March 2020
https://www.deadlymedicines.dk/wp-content/uploads/G%C3%B8tzsche-The-Coronavirus-mass-panic-is-not-justified.pdf

(aaa) Using total case numbers as though they represent the risk of being infected with SARS-CoV-2 is perception management. While these numbers may be of interest for epidemiological study, they have little bearing on the true risk facing citizens.

(bbb) Severity of SARS-CoV-2 is estimated by infection fatality rates. Infection fatality rates cannot be established until the total number of cases, both symptomatic and asymptomatic, in the entire population can be estimated.

(ccc) The Canadian government failed to perform a national random sample test to establish a SARS-CoV-2 baseline across the entire population to justify the restrictions and violations of rights and freedoms.

(ddd) Exaggerated claims and distorted messages have contributed to an atmosphere of fear and uncertainty that is destructive to the well-being of Canadians. It would appear that the real epidemic is an epidemic of fear.

(eee) The evoked fear and panic is so entrenched amongst a large proportion of Canadians that it is extremely difficult to reverse that message even when the scientific data does not support such panic.

(fff) As recent as May 22, 2020 Prime Minister Justin Trudeau told reporters that contact tracing needs to be ramped up across the county. Trudeau stated that he "strongly recommends" provinces use cell phone apps when they become available, and that this use

would likely be mandated. Use of surveillance technologies to monitor citizens constitutes a clear violation of our right to privacy.

(ggg) As of May 24, 2020, the Prime Minister of Canada has not invoked the *Emergencies Act*. Therefore, emergency measures announced by the Prime Minister and his public statements to Canadians to "just stay home" have no legal basis or authority, are an abuse of power, and is resulting in confusing, dangerous and unlawful messaging.

(hhh) The Prime Minister of Canada and Ontario Premier Doug Ford have repeatedly stated that *"life will not return to normal until a vaccine is found"*. It is irresponsible to base a return to normal upon a vaccine when there is no guarantee that an effective and safe vaccine can be developed.

(iii) There are significant risks to both individuals and to confidence in the health care system by accelerating the development of a SARS-CoV-2 vaccine by relaxing normal and prudent safety testing measures.

(jjj) Health Canada has approved human trials of a SARS-CoV-2 vaccine (May 19, 2020) without clear evidence that prior animal testing to identify the potential risk of pathogenic priming (immune enhancement) has been conducted. Pathogenic priming

has prevented the development of an effective and safe coronavirus vaccine to date.

(kkk) Dr. Peter Hotez of Baylor College (who has previously tried to develop a SARS vaccine) told a US Congressional Committee on March 5, 2020 that coronavirus vaccines have always had a "unique potential safety problem" — a "kind of paradoxical immune enhancement phenomenon." [141]

(lll) To impose through influence, mandate, or coercion an inadequately tested SARS-CoV-2 vaccine product upon all Canadians when 99% of the population is not at risk of mortality is reckless, irresponsible and immoral.

(mmm) A SARS-CoV-2 vaccine ought to be targeted at the less than 1% of the population that is at risk of mortality, rather than the more than 99% that is not at risk.

(nnn) There is no moral, medical or ethical justification to ignore prudent safety protocols and to suggest that the use of this yet to be developed medical product is necessary for life to return to normal.

(ooo) Dr. Allan S. Cunningham, a retired pediatrician, has raised the possibility that a potential contributor to the current coronavirus outbreak is the seasonal influenza vaccine. A randomized placebo-controlled trial in children showed that the influenza vaccine

[141] https://www.c-span.org/video/?470035-1/house-science-space-technology-committee-hearing-coronavirus&start=1380

increased fivefold the risk of acute respiratory infections caused by a group of non influenza viruses, including coronaviruses. [142] [143]

(ppp) A study of US military personnel confirms that those who received an influenza vaccine had an increased susceptibility to coronavirus infection. [144]

(qqq) EU numbers show correlation between influenza vaccine and coronavirus deaths. The countries with highest death rates (Belgium, Spain, Italy, UK, France, Netherlands, Sweden, Ireland and USA) had all vaccinated at least half of their elderly population against influenza. [145]

(rrr) Canada continues to be one of only two G20 Nations which fails to compensate citizens who are injured and killed by government approved and recommended vaccine products. The other is Russia.

(sss) The unwillingness of the Government of Canada to provide compensation for vaccine injury, while at the same time imposing vaccine products upon its citizens, is unconscionable.

(ttt) To rely on a vaccine as the required strategy to returning life to normal is reckless, irresponsible and unwarranted.

(uuu) Jonathan Kimmelman, director of McGill University's biomedical ethics unit stated: "Outbreaks and national emergencies often

[142] https://www.bmj.com/content/368/bmj.m810/rr-0
[143] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3404712/
[144] https://www.sciencedirect.com/science/article/pii/S0264410X19313647
[145] https://www.thegatewaypundit.com/2020/05/niall-mccrae-david-kurten-eu-numbers-show-correlation-flu-vaccine-coronavirus-deaths/

create pressure to suspend rights, standards and/or normal rules of ethical conduct. Often our decision to do so seems unwise in retrospect."

(vvv) On June 8th , 2020 the WHO publicly announced that the risk of symptomatic spreading of the virus was "**very rare**". This statement removed by Facebook as "fake News", given its very early, prior contrary assessment, the WHO, the next day partially retroacted this this June 8th, 2020 statement by qualifying without details or explanation that modeling suggested Asymptomatic transmission is possibly as high as 40%: NO evidence or study was provided, nor the basis of the previous day's release. On July 4th, 2020 the WHO re-re paddled back to its original June 8th, 2020 position.

185. The Plaintiff, VCC, had posted on its website, a CNBC report announcing the June 8th, 2020 WHO release, on Facebook, with respect that Asymptomatic transmission was very rare, which was immediately removed by Facebook as "Fake News" for, contradicting earlier WHO releases.

E/ HYPER – INFLATED, DISTORDETED TOTAL NUMBER OF CV-19 "CASES" & "DEATHS"

186. The Plaintiffs state that the total number of Covid-19 cases is the basis for almost all of the Covid-19 data including deaths in those cases, recovery from those cases, hospitalizations and ICU admissions of those cases and total active cases.[146] Total case numbers are also used for other epidemiological metrics (e.g., virulence and transmission rates of Covid-19).

187. Yet the total case numbers are inflated by both RT-PRC testing and WHO coding definitions.

188. The Plaintiffs state that the WHO coding of cases allows 'virus not identified', i.e., probable cases to be counted as Covid-19 cases.[147] WHO coding also inflates death data numbers by requiring **all cases** where Covid-19 is "probable or confirmed" to be certified as a death due to Covid-19 regardless of comorbidities. Admonishing physicians to "always apply these instructions, whether they can be considered medically correct or not."[148]

189. RT-PCR was never intended as a diagnostic tool[149] and is not an antigen test[150].

190. The Plaintiffs state that the PCR tests are based on an arbitrary cycling number (Ct) that is not consistent among testing laboratories.[151] "Cycling too much

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[146] Public Health Agency of Canada, https://www.canada.ca/en/public- health/services/diseases/2019-novel-coronavirus-infection/health-professionals/national-case-definition.html"Confirmed:A person with laboratory confirmation of infection with the virus that causes COVID-19 performed at a community, hospital or reference laboratory (NML or a provincial public health laboratory) running a validated assay. This consists of detection of at least one specific gene target by a NAAT assay (e.g. real-time PCR or nucleic acid sequencing).

[147] WHO ICD-10 Coding https://www.who.int/classifications/icd/COVID-19-coding-icd10.pdf?ua=1]

[148] WHO Cause of Death Guidelines https://www.who.int/classifications/icd/Guidelines_Cause_of_Death_COVID-19-20200420-EN.pdf?ua=1

[149] Dr. Judy Mikowitz https://articles.mercola.com/sites/articles/archive/2020/05/03/is-the-new-coronavirus-created-in-a-lab.aspx "Epidemiology is not done with PCR. In fact, Kary Mullis who invented PCR, Nobel Laureate, and others, said PCR was never intended for diagnostic testing."

[150] Not an Antigen Test: Prof Eleanor Riley, Professor of Immunology and Infectious Disease, University of Edinburgh and Dr Colin Butter, Associate Professor and Programme Leader in Bioveterinary Science, University of Lincoln https://www.sciencemediacentre.org/expert-comment-on-different-types-of-testing-for-covid-19/

could result in false positives as background fluorescence builds up in the PCR reaction." Tests can show positive for minute amounts of RNA that are not causing illness and for non-infectious fragments of RNA.[152] RT-PCR tests cannot prove the pathogenic nature of the RNA.

191. RT-PCR tests have a specificity of 80-85%.[153] This means 15-20% of the time a positive test does not indicate the presence of RNA of SARS-CoV-2, but of some other RNA source. RT-PCR testing is not reliable for SARS-CoV-2 testing.[154]

192. RT-PCR tests are more likely to be false positive than false negative.[155] In low prevalence countries like Canada: "Such [false positive] rates would have large impacts on test data when prevalence is low. Inclusion of such rates significantly alters four published analyses of population prevalence and asymptomatic ratio. The high false discovery rate that results, when prevalence is low, from false positive rates typical of RT-PCR assays of RNA viruses raises questions about the usefulness of mass testing…"[10]

193. The Plaintiffs state that the implications of false positive tests include the following: "There are myriad clinical and case management implications. Failure to appreciate the potential frequency of false positives and the

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[151] Issues with the RT-PCR Coronavirus Test, David Crowe and Dr. Stephen Bustin, April 23, 2020 https://theinfectiousmyth.com/coronavirus/RT-PCR_Test_Issues.php]

[152] https://www.independent.co.uk/news/world/asia/coronavirus-south-korea-patients-infected-twice-test-a9491986.html

[153] RT-PCR Test 80–85% specificity per Dr. James Gill, Warwick Medical School, England https://www.sciencemediacentre.org/expert-comment-on-different-types-of-testing-for-covid-19/]

[154] Stability Issues of RT-PCR Testing of SARS-CoV-2, March 10, 2020 Abstract: https://pubmed.ncbi.nlm.nih.gov/32219885/ Full text: https://onlinelibrary.wiley.com/doi/full/10.1002/jmv.25786 "In our study, we found a potentially high false negative rate of RT-PCR testing for SARS-CoV-2 in hospitalized patients in Wuhan clinically diagnosed with COVID-19. Furthermore, the RT-PCR results showed a fluctuating trend. These may be caused by insufficient viral material in the specimen, laboratory error during sampling, or restrictions on sample transportation."]

[155] . 10 False positives in reverse transcription PCR testing for SARS-CoV-2 https://www.medrxiv.org/content/10.1101/2020.04.26.20080911v1.full.pdf]

consequent unreliability of positive test results across a range of scenarios could unnecessarily remove critical workers from service, expose uninfected individuals to greater risk of infection, delay or impede appropriate medical treatment, lead to inappropriate treatment, degrade patient care, waste personal protective equipment, waste human resources in unnecessary contact tracing, hinder the development of clinical improvements, and weaken clinical trials."[156]

194. A Chinese study[157] found, "In the close contacts of COVID-19 patients, nearly half or even more of the 'asymptomatic infected individuals' reported in the active nucleic acid test screening might be false positives."[158]

195. The Public Health Agency of Canada reports more than 1.4 million people have had PCR tests.[159] Considering the false positive rate, especially for contact tracing, this is not a good use of our resources (both dollars and testing staff).

196. As of June 15th, 2020 the COVID "statistics" are as follows:

(a) Population of Canada 2020--- 37,742,154;

(b) Total number of confirmed or probable cases as of June 15th -- 99,147:

(c) Therefore, 0.0026% of Canadians are testing positive;

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156 https://www.medrxiv.org/content/10.1101/2020.04.26.20080911v2 <https://www.medrxiv.org/content/10.1101/2020.04.26.20080911v2>

157 Potential false-positive rate among the 'asymptomatic infected individuals' in close contacts of COVID-19 patients, March 23, 2020
http://html.rhhz.net/zhlxbx/017.htm
Full translation: https://theinfectiousmyth.com/articles/ZhuangFalsePositives.pdf

158 https://www.reddit.com/r/COVID19/comments/fik54b/false_positives_among_asymptomatic/ <https://www.reddit.com/r/COVID19/comments/fik54b/false_positives_among_asymptomatic/>

159 PHAC Daily Update, May 25: 1,454,966 total people tested
https://www.canada.ca/content/dam/phac-aspc/documents/services/diseases/2019-novel-coronavirus-infection/surv-covid19-epi-update-eng.pdf

(d) 0.00021% of Canadians are dying ''with'' or ''of COVID'' (there is no current differentiation between death " with" or "from" COVID statistically speaking). As of June 15,2020 the national death count from covid stands at 8,175, a completely inflated and distorted number, due to levels of gross mismanagement of patient care in institutions where outbreaks are reported, and death certificate mislabelling of dying ''with'' covid, as opposed to dying ''from'' covid. Meanwhile, the statistics (2018) for other causes of death, according to statistics Canada, in Canada were as follows:

(i) Suicides--- 3,811;
(ii) influenza and pneumonia (seasonal viral respiratory illness) --- 8,511*;
(iii) accidents (unintentional injuries) ---13,290;
(iv) medical error (including medications)--- 28,000;
(v) heart disease--- 53,134;
(vi) cancer--- 79,536.

197. The Plaintiffs state, and fact is that the US, UK, and Italy, through their public health officials have publicly admitted that a COVID death is tallied as such, simply where the COVID virus is found, **albeit** inactive, and regardless of whether the patient died from another **primary** cause of death, such as from cancer in palliative care. Thus a senior US Health official, on April 19th,2020, Dr. Ezike, Director of Public Health, put it this way:

> That means, that if you were in hospice and had already be given a few weeks to live, and then you also were found to have COVID, that would be counted as a COVID death.

> ''It means technically if you died of a clear alternate cause but you had COVID at the same time, its still listed as a COVID death.
>
> Everyone who is listed as a COVID death doesn't mean that was the cause of the death, but they had COVID at the time of death.

The Plaintiffs state, and the fact is, that Canada uses the same system, mandated by the WHO, because the WHO collapsed three different ways of certifying and classifying death into one, in order to grossly inflate the number of deaths "attributable" to covid-19.

198. This includes someone like George Floyd who was killed (murdered) by four (4) Minneapolis police officers, who have been charged with murder, in that the official autopsy report stipulated that he had tested positive for COVID months earlier. (Why George would be tested for COVID, in the circumstances, is beyond baffling).

199. The Plaintiffs state, and the fact is, that in many jurisdictions, such as New York City, a hospital is paid much more to deal with a "COVID-death", than a non-COVID death.

200. The Plaintiff states, and the facts is, that the false and faulty manner and method of determining a ''COVID-death'', is wholly and exclusively dictated by WHO guidelines and parroted by Chief Medical Officers in Canada, in furtherance of the WHO's false ''pandemic'', to instill baseless fears, in the WHO's non-medical agenda, at the control and instigation of Billionaire, Corporate, and Organizational Oligarchs, who actually control the agenda of the WHO, to effect their plan to install a New World (Economic) Order by means of

economic shut-down and mandatory vaccinations and surveillance of the planet's population.

F/ GLOBAL POLITICAL, ECONOMIC AGENDA BEHIND UNWARRANTED MEASURES

- **The Non-Medical measures and Aims of The Declared Pandemic- The Global Agenda**

201. The Plaintiffs state, and the fact is that the WHO is not, nor ever has been, an objective, independent **medical** body, but is riddled with over-reaching socio-economic and political dictates of its funders who, inexplicably over and above the nation-states who fund-it, is heavily funded, and directed, through its "WHO Foundation", and **GAVI,** by international Billionaire Oligarchs, and Oligarch organizations such as Bill Gates, GAVI, the World Economic Forum ("WEF"). The Plaintiff states, and the fact is, that WHO vaccination programs, funded by the Bill Gates and Melinda Foundation, have been accused, by the governments of various sub-Saharan African countries, as well as Nicaragua, India, Mexico and Pakistan, the Philippines, of conducting unsafe, damaging vaccine experiments on their children. In India, the Courts are investigating these vaccination experiments on children. The WHO has recently, in the context of the COVID-19, been expelled from various countries for lack of confidence, corruption, and attempted bribery of their officials, up to, and including, head(s) of state. The Plaintiffs further state, and fact is:

(a) There is a declared agenda to impose global mandatory vaccination, ID chipping, testing and immunity certification on all citizens. This global agenda has been in the works for decades. [160]

(b) Bill Gates, through his Foundation and Organization(s), is the largest private funder to the World Health Organization, is a leading proponent of keeping the economy locked down until a vaccine is developed. Gates is also a major advocate behind the contact tracing initiative. [161] Gates is a major investor in developing a SARS-CoV-2(COVID-19) vaccine and in tracking technology. Gates has a clear financial conflict of interest in advocating for a vaccine and contact tracing.

(c) Bill Gates has no medical or scientific training or credentials and holds no elected office. He should not be determining the fate of mankind. [162]

(d) The Gates Foundation (along with other partners) helped launch the Global Alliance for Vaccines and Immunization (GAVI). The foundation has given $4.1 billion to GAVI over the past 20 years;[163]

(e) These self-propelling agenda personally benefit Gates and other Billionaires, Corporations, and Organizations, particularly vaccines and computer and wireless technology, in his pharmaceutical (vaccine) holdings and agenda, as well as IT and internet holdings and concerns in that, overnight , a vast majority of socio-economic activity has been dislocated to a "virtual", "new normal" whereby everything from

[160] https://childrenshealthdefense.org/news/a-timeline-pandemic-and-erosion-of-freedoms-have-been-decades-in-the-making/
[161] https://www.lifesitenews.com/news/bill-gates-life-wont-go-back-to-normal-until-population-widely-vaccinated
[162] https://childrenshealthdefense.org/news/government-corruption/gates-globalist-vaccine-agenda-a-win-win-for-pharma-and-mandatory-vaccination/
[163] https://www.vox.com/future-perfect/2020/4/14/21215592/bill-gates-coronavirus-vaccines-treatments-billionaires

commerce, schools, Parliament, Courts, are converting to "virtual", not to mention the electronic surveillance through cellphone applications for contract tracing;

(f) The Gates Foundation project to develop at-home testing evolved from a two-year-old research project from the University of Washington that was intended to track the spread of diseases like influenza. All told, the Gates Foundation has poured about $20 Million into the effort. A project funded by the Gates Foundation will soon begin issuing at-home specimen collection kits for the novel coronavirus, COVID-19, according to a report in the Seattle Times.[164]

(g) Dr. Joel Kettner, former Chief Medical Officer revealed that pressure is being put on public health doctors and public health leaders by the Director-General of the World Health Organization (WHO) when he said, *"This is a grave threat and a public enemy number one"*. Kettner states – "I have never heard a Director-General of WHO use terms like that."[165]

(h) While these initiatives are presented as measures to address health, they significantly increase control by governments over their citizens, violate privacy, and are part of an agenda to impose vaccination by mandates and other forms of coercion.

(i) Contact tracing applications are being installed in cell phone software upgrades without the express knowledge or permission of consumers;

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[164] https://www.seattletimes.com/seattle-news/health/gates-funded-program-will-soon-offer-home-testing-kits-for-new-coronavirus/

[165] https://off-guardian.org/2020/03/17/listen-cbc-radio-cuts-off-expert-when-he-questions-covid19-narrative/

(j) The Centre for Disease Control in the United States is actively lobbying for increased masking and physical distancing measures, without substantive evidence to justify these measures., while in Canada compulsory masking has also emerged;

(k) Alan Dershowitz, a Harvard Law school professor has declared: *"If a safe vaccine is to be developed for Covid-19, I hope it's mandated, and I will defend it, and we'll argue that in the Supreme Court of the United States."* [166]

(l) Social media platforms such as Facebook, Pinterest, Instagram, Twitter, YouTube and others, under the direction of governments, are actively censoring information that challenges the SARS-CoV-2(COVID-19) pandemic narrative. Public debate on this topic is not being permitted, where Canada is no exception, and even worse, with the Canadian government threatening to enact **Criminal Code** provisions for those who utter or publish ''misinformation'' on COVID-19, including expert opinion;

(m) The voices of highly credentialed and respected scientists and medical doctors have been censored by the government and media, preventing them from providing critical information from their decades long experience in dealing with infectious diseases and epidemics. Even our own public health experts' experience and advice, gathered over many decades has been ignored. This includes Dr. Joel Kettner, former Chief

[166] https://www.forbes.com/sites/christopherrim/2020/05/20/more-than-stimulus-checks-how-covid-19-relief-might-include-mandated-vaccines/?fbclid=IwAR2nrvg0WDTdv_KwjL_wedTNWBe3pxbqQeQAvQIK4m8OfSctLGFhAU9rGYE#1d19b0d57992

Medical Officer of Manitoba and Dr. Richard Schabas, former Chief Medical Officer of Ontario.

(n) Scientists have been involved in "gain-of-function" (GOF) research since 2002 that seeks to generate viruses *"with properties that do not exist in nature"* and to *"alter a pathogen to make it more transmissible (to humans) or deadly."* [167] [168]

(o) Rather than instruct people on how to improve their overall health or boost their immunity with healthy foods, quality supplements, and physical activity, governments are telling citizens that the only way to survive the coronavirus crisis is to rush the development of a vaccine and then inject all seven billion humans on the planet.

(p) Many scientists and doctors have expressed confidence in high dose Vitamin C, Vitamin D supplementation, and other generic, inexpensive, and readily available medications and treatments to assist recovery. To state that there is no cure to SARS-CoV-2 (COVID-19) is dishonest.

(q) The "no cure" agenda devolves directly from the pharmaceutical industry, which is receiving billions of dollars from governments to develop expensive and, so far, unproven as safe and effective "cures". Yet safe, effective and inexpensive remedies that help with recovery from Covid-19 already exist.

[167] https://www.ncbi.nlm.nih.gov/books/NBK285579/
[168] https://www.sciencemag.org/news/2014/10/us-halts-funding-new-risky-virus-studies-calls-voluntary-moratorium

(r) Research in 2005 demonstrated that Chloroquine is a potent inhibitor of SARS coronavirus infection and spread, thus negating the urgent need for a vaccine. [169]

(s) Some governments are actively restricting access to treatments that have been proven to alleviate the symptoms of SARS-CoV-2(COVID-19) including VITAMIN C and D, zinc, HCQ, GTH precursors, and oxygen treatments, including hyperbaric chambers.

(t) The decision by governments globally to institute social controls and severe containment measures will prolong the epidemic and guarantee successive waves of infection. As social controls are lifted, susceptible individuals previously cocooned from infection will become exposed. Successive waves of infection is a certainty as a result of severe containment measures that prevented the development of natural immunity.

(u) Prime Minister Trudeau and Ontario Premier Ford have stated that "life will not return to normal until we have a vaccine", parroting Bill Gates and Gates' agenda, and has failed to take "mandatory vaccination" off the table as a potential action of the government.[170] It would appear that the Prime Minister and Premier are not considering any alternative plan to ending this lockdown.

[169] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1232869/
[170] https://nationalpost.com/news/canada/coronavirus-live-updates-covid-19-covid19

(v) The Government of Canada has not assumed legal and financial liability for any injury or death resulting from containment measures or the use of any vaccine.

(w) When a government uses its power to force ordinary citizens to give up their freedoms, that nation is in great danger of moral and economic collapse. [171]

202. The Plaintiffs state, and the fact is, that the non-medical aims and objectives to declare the "pandemic", for something it is not beyond one of many annual seasonal viral respiratory illnesses, was to, **inter alia,** effect the following non-medical agendas, by using the COVID- 19" as a cover and a pretext:

(a) To effect a massive bank and stock market bail-out needed because the banking system was poised to again collapse since the last collapse of 2008 in that the World debt had gone from $147 Trillion dollars in 2008 to $321 Trillion dollars in January, 2020 and that;

(i) With 10 days of the declared pandemic European and North American banks were given $2.3 Trillion dollars and further amounts to hold up stuck markets and corporations, for a total of approximately $5 Trillion dollars, largely going un-noticed in the face of the "pandemic", with this number progressively climbing ;

(ii) The shutting of virtually **all** , small independent businesses, with the bizarre, **but intended** consequence that a local, street-level clothing-store, or hardware store, or any store not selling food or medicine, is forced shut down but a Walmart or Costco could sell

[171] https://www.chp.ca/commentary/free-injections-or-mandatory-vaccinations

anything and everything in its stores because one section of the store sold food (an essential service);

(iii) Other stores unable to sell , had to close with the consequence that all small hardware shops, and the like, were closed but the large corporations such as Home Depot, and the like, were equipped to take o-line orders and have drive-by pick up;

(b) The fact is that the pandemic pretense is there to establish a "new normal"; of the New (Economic) World Order, with a concurrent neutering of the Democratic and Judicial institutions and an increase and dominance of the police state;

(c) A massive and concentrated push for mandatory vaccines of every human on the planet earth with concurrent electronic surveillance by means of proposed:

(i) Vaccine "chips", bracelets", and "immunity passports";

(ii) Contract- tracing via cell-phones;

(iii) Surveillance with the increased 5G capacity;

(d) The elimination of cash- currency and the installation of strictly digital currency to better-effect surveillance;

(e) The near-complete revamping of the educational system through "virtual" learning and closure of schools, particularly at the University levels.

203. The Plaintiffs state, and the fact is, that the benefactors of these goals and agendas are the global oligarchs who control and profit from vaccines and the technical infrastructure of information and communication such as Bill Gates,

and his companies and Organizations, who pursues global vaccination and profits from a global shift to "virtual economy" along with the other corporate oligarchs and their "on-line" sale and distribution infrastructure of globalization, and by-passing of effective national governance of nation-states under their own respective Constitutions, including Canada.

204. The Plaintiffs state, and the facts is, that this agenda is well on its way to "virtualizing", "corporatizing", and "isolating" even Parliament and the Courts to an embarrassing and debilitating degree as reflected by:

(a) Virtual Parliamentary Committers and sittings become the "new normal" because a declared "pandemic", is available every year, with projected "2nd and 3rd waves;

(b) The Supreme Court of Canada, on June 3rd,2020 announced virtual, "Zoom" hearing of its appeals with its first virtual appeal hearing on or about June 10th, 2020;

(c) The Chief Justice of the Ontario Superior Court, Justice Justice Geoffrey Morawetz, embarrassingly declared, on May 29th, 2020 that :

> "there is no real return to full-scale, what I will call normal operations, to pre-March operations, until such time that there's a vaccine available".

Whether the Chief Justice is aware, or not aware, that he was echoing a mantra originated by Bill Gates, and an agenda Gates has been pursuing for decades, which serves Bill Gates and his associates, is unknown.

205. The Plaintiffs further state, and the fact is, that this agenda executed under the pretext of the COVID-19 has been long in the planning and making, as reflected and borne out by, **inter alia** the following facts and documents:

(a) (i) "decade of vaccines" declared by Bill Gates, and its funding with the full support of the Canadian government, under a Memorandum of Understanding in 2020 up to including PM Trudeau, and further, on or about May 18th, 2020, gifting Bill Gates another $800 Million dollars of Canadian Taxpayer dollars in addition to prior millions already gifted;

(ii) The public statements made by Bill Gates and others for mandatory vaccination of the globe, with vaccine-chips, chip-bracelets, smart-phone tracing, covid-testing, and surveillance of everyone;

(iii) The criminal vaccine experiments causing horrific damage to innocent children in India, Pakistan, Africa and other developing countries;

(b) The Rockefeller Foundation Report, issued on May 2010, and leaked, in which report a hypothetical scenario and hypothetical is laid out with the effect of " how to obtain global governance during a pandemic", and which report, posits an unknown virus escaping Wuhan, China;

(c) **The 2010** Canadian Film Board documentary in which Dr. Theresa Tam, an ex-WHO committee member, is featured and quoted to have stated, with respect to a potential pandemic;

Transcript (of Film Documentary):

1:25 – 1:32 - "Large epidemics and pandemics occur on a regular basis through-out history, and it will occur again. It definitely will."

57:00 - 58:00 - "If there are people who are non-compliant, there are definitely laws and public health powers that can quarantine people in mandatory settings."

"It's potential you could track people, put bracelets on their arms, have Police and other set-ups to ensure quarantine is undertaken."

"It is better to be pre-emptive and pre-cautionary and take the heat of people thinking you might be overreacting, get ahead of the curve, and then think about whether you've over-reacted later. It's such a serious situation that I think decisive early action is the key."

Narrator Colm Feore states: "Police checkpoints are set up on all the bridges and everyone leaving the city is required to show proof of vaccination. Those who refuse to cooperate are taken away to temporary detention centers."

1:22 – "What is certain is an epidemic or pandemic is coming."[172]

(d) Gates, through the Bill and Melinda Gates Foundation, between 2003 and 2017,vaccine program killing thousands of children and severely injuring 486,000-plus in India, Pakistan, and Africa in administrating vaccines, as exposed by Robert Kennedy Junior and his Defense of Children Foundation, and others, and the fact that in India the Courts are investigating this conduct, and an unsuccessful motion brought in the Italian Parliament to have

[172] NFB Website: http://onf-nfb.gc.ca/en/our-collection/?idfilm=55974
Toronto Sun article: https://torontosun.com/news/national/warmington-tam-talked-of-tracking-bracelets-in-2010-epidemic-film

Gates indicted and extradited for crimes against humanity , and further that developing nation states declaring that they have been "guinea pigs", mostly children, in furtherance of global vaccination;

(e) A study by Dr. Peter Aaby in Africa, **DTP Vaccine Increases Mortality 5-Fold, In Study Without Healthy User Bias** concluded: **"DTP was associated with 5-fold higher mortality than being unvaccinated.** *No prospective study has shown beneficial survival effects of DTP.* **All currently available evidence suggests that DTP vaccine may kill more children from other causes than it saves from diphtheria, tetanus or pertussis."**[173] DTP while discontinued North America is still administered in the developing World.

(f) All the facts pleaded, in the above statement of claim with respect to Bill Gates, the Gates Foundation, GAVI, the WEF, Gates'entrenchment in vaccinating, mandatorily the entire planet, and his vaccine-chip pursuits with smart-phone surveillance, covid-testing, acquisition of 5G companies for maximum contact tracing and surveillance, his relationship with the WHO and its funding;

(g) A UN report, commissioned and released, in September, 2019, prepared by the "Global Preparedness Ministry Board", in which

[173] http://vaccinepapers.org/high-mortality-dtp-vaccine/

an "Apotyliptic Pandemic" is predicted killing as many as 80 million people;

(h) "Event 201", an exercise, simulating a pandemic, prior to October 18th, 2019, organized by Gates, GAVI, which included the "World Economic Forum", on invitation only;

(i) The Government of Canada's, minutely detailed 67- page Report, entitled" Government of Canada Response Plan COVID-19", final version 3.1", with previous versions unavailable, which could not have been researched and written a mere couple of weeks prior to the declaration of lock-downs and emergency in Canada;

(j) The heavily censored UK "Sage Report" of late-May, 2020;

(k) The International Lobby, spear-headed by Bill Gates and others as set out in the within Statement of Claim;

(l) The Suppressed German government 93-page, May, 2020, report which was eventually and recently leaked, which clearly and conclusively determined that the "pandemic" and measures are unjustified. The salient summary of which reads:

cs. KM4 – 51000/29#2

KM4 Analysis of Crisis Management (Brief Version)

Remarks: It is the task and aim of crisis management groups and any crisis management to recognize **extraordinary threats** and to fight them until the **normal state** is re-established/regained.
A normal state cannot therefore be a crisis.

Summary of the results of this analysis

1. In the past the crisis management did not (unfortunately against better institutional knowledge) build up adequate instruments for danger analysis. The situational reports, in which all information relevant for decision-making should be summarized in the continuing/current crisis, today still only cover a small excerpt of the looming spectrum of danger. An assessment of danger is in principle not possible on the basis of incomplete and inappropriate information. Without a correctly carried out assessment of danger, no appropriate and effective planning of measures is possible. The deficient methodology has an effect on a higher plane with each transformation; politics so far has had a strongly reduced chance to make factually correct decisions.

2. The observable effects of COVID-19 do not provide sufficient evidence that there is – in relation to the health consequences of all of society – any more than a **false alarm. At no point in time, it is suspected, was there a danger as a result of this new virus for the population (comparison is the usual death rate in Germany).** Those who die of corona are essentially those who statistically die this year, because they have arrived at the end of their lives and their weakened bodies cannot any longer fight coincidental everyday challenges (including the approximately 150 circulating viruses). **The danger of COVID-19 was overestimated. (In a quarter of a year worldwide no more than 250,000 deaths with COVID-19, as opposed to 1.5 million deaths during the 2017/18 influenza season). The danger is obviously no larger than that of many other viruses. We are dealing with a global false alarm which has been unrecognized over a longer period of time. - This analysis was reviewed by KM4 for scientific plausibility and does not fundamentally oppose the data and risk assessments provided by the RKI [Robert Koch Institute].**

3. A fundamental reason for not discovering the suspected false alarm is that the existing policies for the actions of the crisis management group and the crisis management during a pandemic do not contain appropriate instruments for detection which would automatically triger an alarm and the immediate cancellation/abandonment of measures, as soon as either a pandemic proves to be a false alarm or it is foreseeable that the collateral damage – and among these especially the parts that destroy human lives – threatens to become larger than the health effects of and especially the deadly potential of the illness under consideration.

4. In the meantime, the collateral damage is higher than the recognizable benefit. The basis of this assessment is not a comparison of material damages with damage to persons (human lives). Alone a comparison of deaths so far due to the virus with deaths due to the measures decreed by the state (both without certain data). Attached below is an overview-type summary of collateral health damages (incl. Deaths), reviewed by scientists as to plausibility.

5. The (completely useless) collateral damage of the corona crisis is, in the meantime, gigantic. A large part of this damage will only manifest in the nearer and more distant future. This cannot be avoided anymore, only minimized.

6. Critical infrastructures are the lifelines necessary for the survival of modern societies. As a result of the protective measures, the current security of supply is no longer a given as it usually is (so far gradual reduction of the basic security of supply, which could result in a fallout in future challenging situations). The resilience of the highly complex and strongly interdependent complete system of critical infrastructure has been reduced. Our society lives, from now on, with increased vulnerability and a higher risk of failure of infrastructures necessary for life. This can have fatal consequences, if on the in the meantime reduced level of resilience of KRITIS a truly dangerous pandemic or other danger should occur.

Four weeks ago, UN-general Secretary Antonio Guterres of a fundamental risk. Guterres said (according to a report in the Tagesschau on April 4, 2020): "The weaknesses and insufficient preparation which are becoming apparent through this pandemic give insight into how a bioterrorist attack could look – and these weaknesses possibly increase a risk thereof." According to our analysis, in Germany a grave deficiency is the lack of an adequate system for the analysis and assessment of danger.

7. the protective measures decreed by the state, as well as the manifold societal activities and initiatives which, as initial protective measures cause the collateral damage, but have in the meantime lost any purpose, are largely still in effect. It is urgently recommended to abolish these immediately, to avert damage to the population – especially unnecessary additional deaths -, and to stabilize the situation around critical infrastructure, which is possibly becoming precarious.

8. The deficits and failures in crisis management consequently lead to communication of information that was not well-founded. (A reproach could be: The state showed itself to be one of the biggest fake-news-producers in the corona crisis).

From these insights it follows:

a) The proportionality of interference with the rights of eg. Citizens is currently not given, since the state did not carry out an appropriate consideration with the consequences. The German constitutional court demands an appropriate balancing of measures with negative consequences. (PSPP judgement of May 5, 2020).

b) The situational reports of the crisis management group BMI-BMG and the communications from the state to the provinces regarding the situation must there fore henceforth
-conduct an appropriate analysis and assessment of dangerous
-contain an additional section with meaningful, sound data regarding collateral damage (see remarks in the long version)
-be freed of irrelevant data and information which are not required for the assessment of danger, because they make it difficult to see what is going on
-an index should be formed and added at the beginning

c) An appropriate analysis and assessment of danger is to be performed immediately. Otherwise the state could be liable for damages that have arisen.[174]

206. The Plaintiffs further state, and fact is, that in a study issued by Stefan Homburg, Christof Kuhbandner, at the Leibniz University Hannover, Germany, **post-June 8th, 2020,** these authors soundly concluded in their study that the lock-down measures as modelled and executed were Not effective, globally comparing countries following the WHO protocols and countries that did not.[175]

207. The Plaintiffs state, and the fact is, that this agenda includes the "World Economic Forum ("WEF")". The Plaintiffs state and fact is that the WEF;

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[174] https://human-synthesis.ghost.io/2020/05/31/km4-analysis-of-crisis-management-short-v...
<https://human-synthesis.ghost.io/2020/05/31/km4-analysis-of-crisis-management-short-ver
[175] http://diskussionspapiere.wiwi.uni-hannover.de/pdf_bib/dp-671.pdf

(a) Consistently promotes a "New Economic World Order" ,which is a vision in the process of being rolled out under the auspices of the World Economic Forum, of which one of the main sponsors is **The Bill & Melinda Gates Foundation.**

(b) The World Economic Forum is the International Organization for Public-Private Cooperation. **The Forum engages the foremost political, business, cultural and other leaders of society to shape** global, regional and industry agendas.

(c) The World Economic Forum is committed "to the launch of the Great Reset - a project to bring the world's best minds together to seek a better, fairer, greener, healthier planet as we rebuild from the pandemic." "The COVID-19 crisis has shown us that our old systems are not fit any more for the 21st century," said World Economic Forum Executive Chairman Klaus Schwab. "In short, we need a great reset."[176]

(d) Since its launch on March 11th, 2020, the Forum's COVID Action Platform has brought together 1,667 stakeholders from 1,106 businesses and organizations to mitigate the risk and impact of the unprecedented global health emergency that is COVID-19. The platform is created with the support of the **World Health Organization.**[177]

[176] https://www.weforum.org/agenda/2020/06/the-great-reset-this-weeks-world-vs-virus-podcast/
[177] https://cepi.net/about/whoweare/

(e) **The WEF sponsors have big plans**:"…the world must act jointly and swiftly to revamp all aspects of our societies and economies, from education to social contracts and working conditions. Every country, from the United States to China, must participate, and every industry, from oil and gas to tech, must be transformed. In short, we need a **"Great Reset" of capitalism." "The World Economic Forum is launching a new Davos Manifesto**, which states that companies should pay their fair share not taxes, show zero tolerance for corruption, uphold human rights throughout their global supply chains, and advocate for a competitive, level playing field." Klaus Schwab, Founder and Executive Chairman, World Economic Forum.[178]

(f) In 2017 Germany, India, Japan, Norway, the Bill & Melinda Gates Foundation, the Welcome Trust and the World Economic Forum founded the Coalition for Epidemic Preparedness Innovations (CEPI) to facilitate **focused support for vaccine development to combat major health epidemic/pandemic threats.** As an organization, the Forum has a track record of supporting efforts to contain epidemics. In 2017, at the Annual Meeting, the Coalition for Epidemic Preparedness Innovations (CEPI) was launched – bringing together experts from government, business, health, academia and civil society to accelerate the development of

[178] https://www.weforum.org/the-davos-manifesto

vaccines. CEPI is currently supporting the race to develop a vaccine against this strand of the coronavirus.[179]

(g) Event 201, the pandemic exercise in October 2019, was co-sponsored by the World Economic Forum and the Gates Foundation.[180]

208. Further with respect to global vaccination, in the context of Covid, the WEF has stated:

(a) That :

> "The COVID-19 crisis is affecting every facet of people's lives in every corner of the world. But tragedy need not be its only legacy. On the contrary, the pandemic represents a rare but narrow window of opportunity to reflect, reimagine, and reset our world to create a healthier, more equitable, and more prosperous future. Interactive diagram."[181]

(b) And that:

> "The changes that are underway today are not isolated to a particular country, industry, or issue. They are universal, and thus require a global response. Failing to adopt a new cooperative approach would be a tragedy for humankind. **To draft a blueprint for a shared global-governance architecture,** we must avoid becoming mired in the current moment of crisis management.
>
> Specifically, this task will require two things of the international community: wider engagement and heightened imagination. The engagement of all stakeholders in sustained dialogue will be crucial, as will the imagination to think systemically, and **beyond one's own short-term institutional and national considerations."**[182]

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[179] https://cepi.net/about/whoweare/ https://apps.who.int/gpmb/assets/annual_report/GPMB_annualreport_2019.pdf pg 19

[180] https://www.centerforhealthsecurity.org/event201/

[181] https://www.weforum.org/agenda/2020/06/now-is-the-time-for-a-great-reset

[182] https://intelligence.weforum.org/topics/a1G0X000006OLciUAG?tab=publications https://www.weforum.org/agenda/2018/11/globalization-4-what-does-it-mean-how-it-will-benefit-everyone/

209. In early July, 2020, Trudeau announced the massive expenditure of post-COVID-19 infrastructure spending to re-align the economy, in concert with the WEF agenda, in tandem with private sector partnership whereby the anticipated privatization of public assets is a given.

210. The Plaintiffs state, and the fact is, that:

(a) This agenda, conspiracy, is spear-headed by Bill Gates, and other Billionaire, Corporate, and Organizational Oligarchs, include vaccine, Pharmaceutical, and Technology Oligarchs, through the WHO, GAVI, and the WEF, whom they fund and effectively direct and control;

(b) National and Regional Leaders who are simply, knowingly and/ or unknowingly, as duped c-conspirators, partaking in this conspiracy by simply declaring a "pandemic", "emergency", and delegating decisions to their Chief medical officers who are simply following the dictates and guidelines without question nor concern for the world expert opinions against such measures, of the WHO;

(c) In effect there are less than a hand-full of people dictating the virtual fate of the planet whereby sovereign Parliaments, Courts, and Constitutions are by-passed;

(d) The "social media", such as Google, Facebook, YouTube, Amazon owned and operated by the likes of Bill Gates, Mark Zukerberg, and, in Canada, the CBC,funded and controlled by the Federal Government, are knowingly

playing in concert with this over-arching conspiracy, and in fact over-lapping conspiracies.

208. The Plaintiffs further state that through their conduct, communication, agreement, and functions of their intertwined respective public and private offices, the Defendants, knowingly and unknowingly, intentionally and unintentionally, as outlined, ***inter alia***, by the Supreme Court of Canada in the test set out in ***Hunt v. Carey*** and jurisprudence cited therein, have and to continue to:

(a) engage in an agreement for the use of lawful and unlawful means, and conduct, the predominant purpose of which is to cause injury to the Plaintiffs, through the declaration of a false pandemic and implementation of coercive and damaging measures including the infliction of a violation of their constitutional rights as set out above in the within statement of claim; and/or

(b) to engage, in an agreement, to use unlawful means and conduct, whose predominant purpose and conduct directed at the Plaintiffs, is to cause injury to the Plaintiffs, through the declaration of a false pandemic and implementation of coercive and damaging measures including the infliction of a violation of their constitutional rights as set out above in the within statement of claim, that Defendants and officials and employees, should know, in the circumstances, that injury to the Plaintiffs , is likely to. and does result.

211. The Plaintiffs state, and the fact is, that Canada's , and Trudeau's, connection to Gates, Gates' foundation, and various companies , and the global vaccine industry, is **inter alia,** as follows:

(a) PM Trudeau has echoed Bill Gates' sentiments that mass mandatory vaccination of people is necessary for any sense of normalcy to return.

(b) Gates uses proxies to successfully lobby the Canadian Government.

(c) The Gates Foundation founded GAVI, the Global Vaccine Alliance in 1999 with $750 million and continues to run it and fund it. The Global Vaccine Alliance, is an organization devoted to pushing vaccinations on the public all across the world.

(d) GAVI hired a lobbying firm called Crestview Strategy, a public affairs agency. Their Mission Statement is: "We make, change, & mobilize opinion."

(e) Canada has gifted Bill Gates, and his related Foundation and companies well over $1 Billion dollars in pursuit of his agenda, $800 Million recently by Justin Trudeau;

(f) Crestview has lobbied the Canadian Government on at least 19 occasions since2018 on various "health" matters, all on behalf of GAVI.

- **Bill Gates- Vaccines, Pharmaceuticals & Technology**

212. The Plaintiffs state, and the fact is, as set out in the within Statement of Claim. that Bill Gate's companies, and associates, manifest a clear agenda, for himself and his associates in the vaccine, pharmaceutical and technology, industries,

through the **de facto** control of the WHO, influencing and dictating its agenda, to:

(a) Effect a mandatory, global, vaccine policy and laws, which would net an approximately $1.3 Trillion per year, in which vaccine industry he is major proponent and investor;

(b) To effect surveillance, through his vaccination agenda, as outlined in their public statement, and the MIT developed smart-phone application to embed nannocrystal beneath the skin which can be read by a smart-phone through smart-phones, and 5-G capacity, in which industries Gates is a major stake-holder and investor;

(c) Using the above to "virtualize" and globalize the World economy , in which virtual and global New World (Economic) Order in which Gates further sits in the centre, along with the other Billionaire and corporate oligarchs;

(d) All of which is being effected and accelerated through the false pronouncement of a COVID-19 'pandemic'', and implementation of baseless and false, draconian measures.

213. The Plaintiffs state, and the fact is, that Bill Gates' statements, and conduct, in the above-noted facts, has been documented, as reflected in the within Statement of Claim, namely at paragraphs 63, 68, 69, 72, 75, 78, 81, 85, 93, 100, 107, 112, 118, 121, 124, 199, 200, 201, 202, 203, 205, of the within Statement of Claim, with respect to his agenda and conspiracy with others, including the Defandants.

- **The WHO / Gates/ Trudeau and Dr. Teresa Tam**

214. The Plaintiffs state and fact is, that the connection and common agreement between Gates-Trudeau-Tam, in addition to their statements and actions in furthermore of that agreement as outlined above in the within Statement of Claim, is further manifested by the following:

(a) On April 9, 2020 just before Easter, Trudeau announced that:

> *"We will not be coming back to our former normal situation; we can't do that until we have developed a vaccine and that could take 12 to 18 months..... [and]....This will be the new normal until a vaccine is developed."*[183]

(b) Trudeau's statement is a script lifted straight from Bill Gates' echoing almost word for word, the message Gates has been pushing since the coronavirus in North America earlier this winter. The April 9th **Highwire video clip at 2:07** captures Gates stating:

> "Things won't go back to truly normal until we have a vaccine that we've gotten out basically to the entire world."[184]

(c) Instead of following the recommendations of leading scientists, doctors and epidemiologists, Trudeau is foisting the Gates/WHO/ GAVI/ WEF globalist agenda which he knows or ought to know, will result in financial ruin for millions of Canadians including the Plaintiffs.

(d) Despite the prevailing global consensus on natural herd immunity, Bill Gates is determined however, to prevent natural immunity so he can

[183] https://nationalpost.com/news/canada/coronavirus-live-updates-covid-19covid19
[184] Blowing the Whistle on Covid-19, April 9, 2020: https://www.youtube.com/watch?v=5g4u1LJQ7_k

mandate his new vaccine(s) for everyone. Noted scientist and journalist, Rosemary Frei, shows Bill Gates does not want people to acquire immunity to COVID-19. Rather, Bill Gates prefers that we suffer the 'economic pain' of lockdown in order to prevent us from acquiring natural immunity as Gates has stated:

> "We don't want to have a lot of recovered people [...] To be clear, we're trying – through the shut-down in the United States – to not get to one percent of the population infected. We're well below that today, but with exponentiation, you could get past that three million [people or approximately one percent of the U.S. population being infected with COVID-19 and the vast majority recovering]. I believe we will be able to avoid that with having this economic pain."[185]

(e) In her latest compelling article, **Covid-19 Meltdown and Pharmas' Big Money Win,** Barbara Loe Fisher delves into the many disturbing angles of this epic viral/political war unleashed on humanity, the havoc caused by the Gates & Fauci lockdown policy and the economic spinoffs spawned by the pandemic.[186]

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[185] Did Bill Gates Just Reveal the Reason for the Lockdowns: By Rosemary Frei, Off-Guardian, April 4, 2020 https://off-guardian.org/2020/04/04/did-bill-gates-just-reveal-the-reason-behind-the-lockdowns/?__cf_chl_jschl_tk__=8a31c96b7b831b06c6631d2d800e39e274fdb4c5-1593827339-0AbbQnElw4gYMqoe14KfV-9sVWpJ8_IO6ZguVbep6dVylwrKGMbqfHkxidxl_3uCK08NImuk8B5fJzKB4cL3viT1qQYvV8722SeZLNTHOWUovzpclffZQcDifxvg3QQ6jPmp
ZkNGtNIwGs874a0MhuRY9_17yNj8TyeXmeBXidqKFHOtCmuLJEmS9ZGcLDsNGb5WKidfnHO7DSzlQ110eNBgHMLXcrbjPrKsESdGlhwd3LjoY6FiHbJu4U1bTEJMbsKQFlq5XIlOtoLGY2e7fThzjnbUBrcjpv76AL5aOYmAQAllCC3ttqOt_k21mLMgHNFafl2gWSIla4a2SUAI8IzoKXLcbkuTr0lpvKrbjkF8B4ij3p8MdQOK0DZHcW

[186] Covid-19 Meltdown and Pharma's Big Money Win: https://thevaccinereaction.org/2020/04/covid19-meltdown-and-pharmas-big-money-win/

(f) Covid-19 has sparked the hottest new market in town – vaccine development. A staggering number of coronavirus vaccines are under development right now with astronomical piles of money being thrown at it. Gates is in the thick of it along with Tony Fauci, director of the National Institute for Allergy and Infectious Diseases (NIAID). Both are on record stating they don't want people developing natural immunity, in stating:

> "Now, I hope we don't have so many people infected that we actually have that herd immunity, but I think it would have to be different than it is right now", says Fauci.[187]

(g) Natural immunity would disrupt Bill Gates expressed intension to "vaccinate everything that moves". In a video interview Gates says:

> "Eventually, what we'll have to have is certificates of who is a recovered person, who's a vaccinated person, because you don't want people moving around the world where you'll have some countries that won't have it under control…"[188]

(h) The Gates foundation has invested tens of $billions in vaccine development which includes a decades long vicious propaganda war against anyone questioning vaccine safety. Gates' *'decade of vaccines'* from 2010-20 captured the global media and social media giants that have demonized and ruthlessly censored the 'vaccine risk aware' movement comprised mostly of vaccine injured families trying to protect their children and the basic human right to informed consent and exemption

[187] Covid-19 Meltdown and Pharma's Big Money Win: https://thevaccinereaction.org/2020/04/covid19-meltdown-and-pharmas-big-money-win/

[188] 6 How we must respond to the coronavirus epidemic, Youtube video March 25, 2020:https://www.youtube.com/watch?v=Xe8fljxicoo#t=33m45s

rights. This has been documented by various publications, which explore the massive influence and control with which the Gates' empire manipulates global health and vaccine policies.[189]

(i) In one article Canadian medical journalist, Celeste McGovern investigates the upcoming vaccine and microchip technologies Gates is funding.[190]

(j) In another, Robert F. Kennedy Jr. exposes the Gates/WHO agenda listing their deadly vaccine experiments in the developing world. Kennedy explains:

> "In 2010, when Gates committed $10 billion to the WHO, he said "We must make this the decade of vaccines." A month later, Gates said in a TED Talk that new vaccines "could reduce population." And, four years later, in 2014, Kenya's Catholic Doctors Association accused the WHO of chemically sterilizing millions of unwilling Kenyan women with a "tetanus" vaccine campaign.[191]

(k) Another expose is that of Vera Sharav, a Holocaust survivor and founder of the Alliance for Human Research Protection. She examines how Gates table top 'Event 201' pandemic exercise in October, 2019, set the stage for how the coronavirus pandemic would be handled. It predicted the pandemic would end ONLY after an effective vaccine had been brought to market. It is no coincidence that the coronavirus pandemic was unleashed just weeks after Gates' pandemic 'war games' rehearsal and is now

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[189] Bill Gates search-Covid -19 Global Pandemic, Vaccine Impact News: https://vaccineimpact.com/?find=bill+gates

[190] Bill Gates and Intellectual Ventures Funds Microchip Implant Technology, By Celeste McGovern, April 14, 2020 https://www.greenmedinfo.com/blog/bill-gates-and-intellectual-ventures-funds-microchipimplant-vaccine technology1?utm_campaign=Daily%20Newsletter%3A%20Bill%20Gates%20and%20Intellectual%20Ventures%20Funds%20Microchip%20Implant%20Vaccine%20Technology%20%28TCCz3V%29&utm_medium=email&utm_source=Daily%20Newsletter&_ke=eyJrbF9lbWFpbCI6ICJjLm1jZ292ZXJuQGhvdG1haWwuY29tIiwgImtsX2NvbXBhbnlfaWQiOiAiSzJ2WEF5In0%3D

[191] Bill Gates' Globalist Agenda: A Win-Win for Pharma and Mandatory Vaccination by Robert F. Kennedy Jr. April 9, 2020, Children's Health Defense:https://childrenshealthdefense.org/news/governmentcorruption/gates-globalist-vaccine-agenda-a-win-win-for-pharma-and-mandatory-vaccination/

playing out, as lockdown scenario threatens to continue until the new vaccine arrives?[192]

(l) Sharav also delves into Gates' vast business ventures related to enhancing pharmaceutical products and vaccines. His ID2020 is a digital ID program aimed at identifying 1 billion + people lacking identity documents. Also in development are several ID devices that people could be forced to have implanted into their body to identify their vaccine and birth-control status.[193]

215. With respect to the Defendants Trudeau and Tam, the Plaintiffs state, and the fact is that:

(a) Theresa Tam, Canada's chief public health officer and longtime loyal servant of the WHO, serves on multiple international committees and related organizations that dictate global health policies. Her main job is to make sure that Trudeau follows the WHO/Gates lockdown policy until the new Covid-19 vaccine arrives in 18 months.

[192]Bill Gates & Intellectual Ventures Funds Microchip Implant Vaccine Technology by Celetes McGovern, April 14, 2020: https://www.greenmedinfo.com/blog/bill-gates-and-intellectual-ventures-fundsmicrochip-implant-vaccinetechnology1?utm_campaign=Daily%20Newsletter%3A%20Bill%20Gates%20and%20Intellectual%20Ventures%20Funds%20Microchip%20Implant%20Vaccine%20Technology%20%28TCCz3V%29&utm_medium=email&utm_source=Daily%20Newsletter&_ke=eyJrbF9lbWFpbCI6ICJjLm1jZ292ZXJuQGhvdG1haWwuY29tIiwgImtsX2NvbXBhbnlfaWQiOiAiSzJ2WEF5In0%3D

[193] Coronavirus provides dictators and oligarchs with a dream come true, By Vera Sharav, Alliance for Human Research Protection March 26, 2020: https://ahrp.org/coronavirus-provides-oligarchs-with-adream-come-true/

(b) Molly Chan, author of a **probing analysis** of Dr. Tam's career thinks it's evident from her background that:

> "Theresa Tam works with the world's most powerful globalist entities that have tremendous say in how the world deals with disease and immunization. This power enables them to have a grip on the entire planet, and to decide which measures are put into place to control the behaviour of people in any event they choose to cause a panic over. With COVID-19, we have a perfect example of how the decisions of this small group of people can lead to global hysteria and unprecedented societal changes."[194]

(c) Molly Chan asks important questions on Tam's career and extensive influence:

> "Does this make Theresa Tam a puppet or master? How is it possible to not follow WHO recommendations, when you're the one making them? She is on powerful committees!"

(d) Considering the multiple numerous high-level positions Dr. Tam holds on the international stage, Tam's first loyalty is not to the wellbeing of Canadians , or the Plaintiffs, but to the globalist policies so generously funded by Gates and Big Pharma.

[194] Dr. Theresa Tam, Queen of the Vaccine by Molly Chan, Civilian Intelligence Network, March 31, 2020 https://civilianintelligencenetwork.ca/2020/03/30/dr-teresa-tam-queen-of-the-vaccine/

(e) Chan dubs Tam as the *'Queen of Vaccine'* and explains:

> "convened public health leaders and parents to collaborate on the effort to shut down any hint of anti-vaccine thought. Governments, including Canada and the U.S. are also working with social media companies to remove vaccine misinformation and promote scientific literacy. She wants to make sure that people are not allowed to publicly say anything against vaccinations, and establish them as just a normal part of life, no questions asked."[195]

(f) While flexing her expansive influences, it seems a 'no brainer' Theresa Tam has been instrumental in controlling the CBC's narrative about the need to snuff out *'vaccine hesitancy'* which includes the ruthless censorship of any voices that would question vaccine safety in mainstream media.

(g) Tam is accused of **"total incompetence"** in having botched the Canadian response to the COVID-19 pandemic:

> "Tam has failed miserably, putting political correctness, and virtue-signalling lecturing ahead of doing her job. She couldn't grasp the situation in time, and when she grasped the seriousness of it was far too late to stop it."[196]

(h) The Toronto Sun's **cutting review** of Theresa Tam's incompetence says:

> "Our country is now run by 'healthcrats'. Dr. Theresa Tam is the Healthcrat who runs the federal government. **Her record on being wrong is spotless.**"[197]

(i) In a **recent interview** in Chatelaine magazine, Tam bashes vaccine resistors and accuses them of causing measles outbreaks. Her cryptic

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[195] Dr. Theresa Tam, Queen of the Vaccine by Molly Chan, Civilian Intelligence Network, March 31, 2020: https://civilianintelligencenetwork.ca/2020/03/30/dr-teresa-tam-queen-of-the-vaccine/

[196] Devastating timeline reveals complete incompetence of Theresa Tam's Virus Response https://spencerfernando.com/2020/03/29/devastating-timeline-reveals-total-incompetence-of-theresatams-virus-response/

[197] The healthcrats cure is proving worse than the disease, Toronto Sun, April 10, 2020: https://torontosun.com/opinion/columnists/snobelen-the-healthcrats-cure-is-proving-worse-than-thedisease

statement, ***"I always think we do a really good job, when no one knows what we're doing"***, reveals the federal health agency's lack of transparency and inability to provide crucial epidemiological data during this crisis.

G/ CONSEQUENCES OF MEASURES TO THE PLAINTIFFS AND OTHER CITIZENS, AND VIOLATION OF CONSTITUTIONAL RIGHTS

216. The Plaintiffs state, and the facts is, that the impact of containment measures to Plaintiffs is, **inter alia** that:

(a) Mass containment measures negatively impacts the development of herd immunity, artificially prolongs the epidemic, extends the period of confinement, and contributes to maintaining a high proportion of susceptible individuals in the population.

(b) California emergency room physicians stated that *"sheltering in place does more harm than good and lowers our immune system."* [198]

(c) The measures employed to achieve the objective of *"flattening the curve"* so as not to overwhelm the health care system were disproportionate to the objective. Our health care system has consistently operated at 40 – 50% **below** capacity since the introduction of these measures.

(d) The suspensions of rights to participate in community and in commerce has caused substantial and irreparable harm to the economy, livelihoods, communities, families, and the physical and psychological well-being of Canadians and the Plaintiffs. These include:

[198] https://vaccineimpact.com/2020/california-er-physicians-sheltering-in-place-does-more-harm-than-good-lowers-our-immune-system/

(i) A dramatic increase in reports of domestic violence (30%).

(ii) Over six million Canadians have applied for unemployment benefits and 7.8 million Canadians required emergency income support from the Federal government (as of May 2020). [199]

(iii) The deepest and most rapid loss of jobs, savings and income in the history of Canada. [200]

(iv) Numerous citizens have been forced into unemployment and poverty, the loss of their business, and bankruptcy.

(v) Estimates of the Federal deficit resulting from their response to SARS-CoV-2 ranges up to $400 billion (May 2020). [201]

(vi) Leading Economic Indicators show the Canadian economy is now in "*freefall*". [202]

(vii) Illnesses and conditions not related to SARS-CoV-2 have gone untreated and undiagnosed.

(viii) Dramatic increase in number of individuals dying at home due to lack of medical care and for fear of visiting emergency wards despite the fact that most hospitals have capacity.

(ix) Denial of access to health care professionals including doctors, dentists, chiropractors, physiotherapists, naturopaths, homeopaths, physiotherapists, massage therapists, optometrist, and osteopaths.

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[199] https://www.macdonaldlaurier.ca/beyond-lockdown-canadians-can-have-both-health-and-prosperity-an-open-letter-to-the-prime-minister/
[200] https://www.macdonaldlaurier.ca/beyond-lockdown-canadians-can-have-both-health-and-prosperity-an-open-letter-to-the-prime-minister/
[201] https://www.macdonaldlaurier.ca/beyond-lockdown-canadians-can-have-both-health-and-prosperity-an-open-letter-to-the-prime-minister/
[202] https://www.macdonaldlaurier.ca/beyond-lockdown-canadians-can-have-both-health-and-prosperity-an-open-letter-to-the-prime-minister/

(x) Denial of access to health care services including cancer treatments, elective surgeries, testing, diagnosing, and treatment.

(xi) Regulated health care practitioners, including chiropractors, Naturopaths, and Homeopaths have been directed to refrain from providing health care knowledge to individuals concerned about SARS-CoV-2. This is an unwarranted infringement on the right to therapeutic choice.

(xii) Dramatic Increase in mental health challenges including suicide.

(xiii) The significant potential for the traumatizing children due to the disproportionate fear of contracting a virus for which the risk of death is virtually zero.

(xiv) Significant increase in alcohol consumption and drug use.

(xv) Denial of access to healthy recreation including parks, beaches, camping, cottages, and activities as golf, tennis, swimming, etc.

(xvi) Denial of a public education for children.

(xvii) Denial of access to consumer goods and services.

(xviii) Individuals dying alone in hospital and extended care facilities without the support of family and friends. [203]

(xix) Fathers denied access to be present for the birth of their child.

(xx) Elderly parents in supportive care are denied access to the support of their family and friends.

[203] https://globalnews.ca/news/6866586/bc-woman-disability-dies-covid-19/

(xxi) The effective closure of Courts of Law is unprecedented, illegal, unconstitutional, undemocratic, unnecessary, and impedes the ability of Canadians to hold our governments accountable.

(xxii) The effective closure of Parliaments is unprecedented, illegal, unconstitutional, undemocratic, unnecessary, and impedes the ability of Canadians, including the Plaintiffs, to hold governments accountable.

217. The Plaintiffs further state, and fact is, that:

(a) To combat COVID-19, "Canada's federal government has committed to measures totaling around $400 billion, of which about two-fifths constitutes direct spending." Currently, the deficit for 2019-2020 is expected to be well over $180-$200 Billion. This is seven times larger than the previous year's deficit. It is expected the interest alone, even at the very low current interest rates will cost $1B each year. [204]

(b) There is no evidence that the impact of these negative consequences were calculated, much less fully considered in the government's response to SARS-CoV-2.

(c) John Carpay, president of the Justice Centre for Constitutional Freedoms in Canada has stated there is reason to conclude that the government's response to the virus is deadlier than the disease itself. [205]

[204] https://www.huffingtonpost.ca/entry/canada-budget-deficit-covid19_ca_5e85f6bcc5b60bbd735085f4
[205] https://www.jccf.ca/the-cost-of-the-coronavirus-cure-could-be-deadlier-than-the-disease/

(d) The cost of combatting SARS-CoV-2 is placed disproportionately on the young and blue collar and service workers who cannot work from home, as opposed to white collar workers who often can.

(e) The results from Sweden, and other countries that did not engage in mass and indiscriminate lockdowns, demonstrates that other more limited measures were equally effective in preventing the overwhelming of the health care system, and much more effective in avoiding severe economic and individual health consequences.

(f) The Ontario government took the "extraordinary step" to release a database to police with a list of everyone who has tested positive for COVID-19 in the province.[206]

218. Furthermore, while upon the declaration of the pandemic, based on a totally erroneous modeling, postulated that, as opposed to regular 650, 000 deaths every year form seasonal viral respiratory illness , world-wide, that 3.5 Million may or would die, the erroneous COVID implemented measures have proven to be more devastating than the "pandemic" at its posited worse in that:

(a) In Canada, as elsewhere, 170,000+ medical, surgical, operations are canceled, with the numbers climbing, as well as closure of other medical services at hospital, which have caused deaths;

(b) With the fear of lock-downs and self-isolation, patients have not accessed their doctor for diagnosis of medical problems;

(c) Documented spikes of domestic violence and suicides have been recorded;

[206] https://toronto.ctvnews.ca/mobile/ontario-takes-extraordinary-step-to-give-police-list-of-all-covid-19-patients-1.4910950?fbclid=IwAR10jfu_5OYq5BPZJKMyyoiN2P47dK_wbZzFMqC8WEpFxilhEFt81cGnfqc

(d) Inordinate spike in alcoholism, drug use, and clinical depression;

(e) Moreover, and most-shocking, the UN through an official of the World Food Bank, on April 22nd,2020, had published a document stating that, because of COVID-19 (measures)and the disruption of supply chain, it estimates that 130 **Million "additional people"** "on the planet could be on the brink of **starvation by end of year 2020** which, begs the question: why is it justifiable to add 130 Million deaths to purportedly save 3.5 Million?

219. The Plaintiffs state, and the facts is, that the purported, and false, goals of the WHO measures and its purveyors, such as the Defendants, are a perpetual moving target, and purposely shift to an unattainable goals, in that:

(a) The initial rationale for the mass lockdown of Canadian society was to "flatten the curve" to avoid overwhelming health care services. It was never about preventing the coronavirus from spreading altogether, but rather to render its spread manageable.

(b) It appears now that the goal has changed. Government appears to have shifted the goal to preventing the virus from infecting any and all Canadians. If so, this ought to be made clear, as should the justification for the change. [207]

(c) Yoram Lass, the former director-general of Israel's Ministry of Health is of the opinion that "lockdown cannot change the final number of infected people. It can only change the *rate* of infection." [208]

[207] https://nationalpost.com/opinion/raymond-j-de-souza-on-covid-19-a-lockdown-without-a-clear-goal
[208] https://www.spiked-online.com/2020/05/22/nothing-can-justify-this-destruction-of-peoples-lives/#.XsgqiN6D0uQ.facebook

(d) There are warnings of an imminent "second wave." But if the "first wave" has been flattened, planked or buried to the extent that in vast areas of the country very few people have been exposed to the virus at all, then the "second wave" is not really a second wave at all, but a delayed first wave

(e) Minimizing the total spread of the coronavirus until a vaccine is available will be the most expensive goal in the history of human governance.

(f) There is no scientific evidence to substantiate that the elimination of the virus through self-isolation and physical distancing is achievable or medically indicated.

(g) According to four Canadian infectious disease experts, Neil Rau, Susan Richardson, Martha Fulford and Dominik Mertz - *"The virus is unlikely to disappear from Canada or the world any time soon"* and *"It is unlikely that zero infections can be achieved for COVID-19."* [209]

(h) There is no compelling reason to conclude that the general-population lockdown measures (first requested by the Trudeau government on 17 March) had a detectable effect in Canada. The lockdown measures may have been implemented after "peak prevalence" of actual infections, which renders mitigation measures entirely without effect.

(i) The Government of Canada has been slow to endorse the re-opening of the economy even as hospitals remain well below capacity – the metric that was initially used to justify the restrictions.

[209] https://nationalpost.com/opinion/opinion-we-are-infectious-disease-experts-its-time-to-lift-the-covid-19-lockdowns

H/ THE PROPOSED COVID-19 VACCINE- "WE DO NOT GET BACK TO NORMAL UNTIL WE HAVE A VACCINE"

220. The Plaintiffs state, and the fact is, that the narrative and mantra created and propagated by Bill Gates that "we do not get back to normal until we have a vaccine" has been accelerated by a falsely declared "pandemic" to what has been a persistent push for **mandatory** vaccination of every human being on the planet, along with "global governance" as propagated by Bill Gates, Henry Kissinger, the Rockefeller Foundation, GAVI, the WEF, and their likes.

221. With respect to (mandatory) vaccines and the COVID-19, the Defendants, in addition to pushing the ultimate aim of mandatory vaccines, spear-headed by Bill Gates, and others, have also ignored and refuse to address the issues in the context of COVID-19, let alone vaccines at large, as reflected in, inter alia, the following:

(a) **Intention to Create Vaccine Dependency:** Is it ethical to deny children, young people and most of the population who are at low risk of mortality the opportunity to develop natural immunity when we know natural immunity is lifelong in most cases? Are we going to create another condition where we become 'vaccine dependent' or will we recognize the value of natural herd immunity? Advocates of the natural herd immunity model are of the opinion that rather than the mass isolation of billions of people, only the most at-risk people and their close associates should be isolated. The forced mass quarantine of an entire, mostly low-risk

population is disproportionate and unnecessary. This is the position being utilized by Sweden.[210]

(b) **Will A COVID 19 Vaccine Be Safe?**

(i) **Dr. Anthony Fauci** – is the director of the National Institute of Allergy and Infectious Diseases in the United States. Fauci has stated: *"We need at least around a year and a half to make sure any new vaccine is safe and effective."* [1]

(ii) **Dr. Paul Offit** - Offit warns, *"Right now you could probably get everyone in this country to get this (CV) vaccine because they are so scared of this virus. I think we should keep remembering that most people who would be getting this vaccine are very unlikely to be killed by this virus."*

(iii) **Dr. Peter Hotez** - dean of the National School of Tropical Medicine at Baylor College of Medicine, told Reuters, *"I understand the importance of accelerating timelines for vaccines in general, but from everything I know, this is not the vaccine to be doing it with."*

(iv) **Pathogenic Priming**[211]**;**

[210] https://vaccinechoicecanada.com/in-the-news/will-a-covid-19-vaccine-save-us/
[211] https://www.sciencedirect.com/science/article/pii/S2589909020300186?via%3Dihub=&amp=1

(c) **Jonathan Kimmelman**, a biomedical ethics professor at McGill University in Montreal, is watching how both scientific and ethical standards are maintained while the pandemic vaccine trials progress at breakneck speed.

> "My concern is that, in the fear and in the haste to develop a vaccine, we may be tempted to tolerate less than optimal science," Kimmelman said. "That to me seems unacceptable. The stakes are just as high right now in a pandemic as they are in non-pandemic settings. "To show how long the process can take, Kimmelman points to the example of the ongoing search for an effective HIV vaccine that began in the 1990s. Before healthy people worldwide receive a vaccine against SARS-CoV-2, the risk/benefit balance needs to tip in favor of the vaccine's efficacy in offering protection over the potential risks, he said. The balance still exists even in the face of a virus wreaking an incalculable toll on human health and society." [212]

(d) CBC News March 24, 2020 reported by Amina Zafar;[213]

(e) Moderna's vaccine uses genetic material from the virus in the form of **nucleic acid.** That tells the human body how to make proteins that mimic viral proteins and this should provoke an immune response. Denis Leclerc, an infectious diseases researcher at Laval University in Quebec City, said the advantage of nucleic acid vaccines like Moderna's is that they're much faster to produce than other types. While relatively safe, **nucleic acid vaccines are generally not the preferred strategy**, Leclerc said, because they **don't have the same safety record** as the traditional approach.

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[212] https://www.cbc.ca/news/canada/coronavirus-covid19-april16-canada-world-1.5534020

[213] https://www.cbc.ca/news/health/covid-19-vaccine-research-1.5497697

(f) **Will a COVID 19 vaccine be effective?Ian Frazer** - Immunologist Ian Frazer has downplayed the role of a vaccine in overcoming the coronavirus pandemic, saying it may "not stop the spread of the virus in the community". That's if a vaccine can be developed at all. Frazer, a University of Queensland scientist who was recognized as Australian of the Year in 2006 for his contribution to developing HPV vaccines, said a COVID-19 vaccine may not be the end-all to the current crisis. [214]

(g) **Role of Influenza Vaccination to Current Outbreak - Allan S. Cunningham**, Retired pediatrician The possibility that **seasonal flu shots are potential contributors** to the current outbreak. A randomized placebo-controlled trial in children showed that flu shots increased fivefold the risk of acute respiratory infections caused by a group of non influenza viruses, including coronaviruses.[215]

(h) **Mandatory Vaccination**

(i) **Diane Doucet** – Message to New Brunswick Committee on Law Amendments"Mandatory vaccination may soon be imposed on the entire population. Eventually, every person will have to decide between attending school, keeping their job, their home and their ability to participate in society and their so-called freedom to choose. People will also be at risk of losing their jobs if they speak out against mandatory vaccinations.

We are not talking about quarantining individuals infected by a disease. We are talking about the segregation of healthy children and adults from participating in society. Their crime is that they do not consent to handing over their bodies to the tyrannical will of a vaccine cartel which is accountable to no one.

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[214] https://7news.com.au/lifestyle/health-wellbeing/coronavirus-australia-immunologist-ian-frazer-expresses-doubt-around-role-of-vaccine-in-pandemic-c-983647

[215] https://www.bmj.com/content/368/bmj.m810/rr-0

> The policy makers look down upon the citizenry with arrogance. We live in a system that views the common people as being too ignorant to decide what's best for themselves and their children. When corporations, health agencies and government institutions treat people like chattel and punish those who do not submit, you have slavery. If an institution can take it upon itself and do what it wants to people's bodies against their will, then you live in a slave system. We find ourselves here today, wondering how we managed to slip this low."

- **Microchipping /Immunity Passports/ Social Contact Vaccine Surveillance & 5G**

222. The Plaintiffs state that, and fact is, this global vaccination scheme which is being propelled and pushed by the Defendants, is with the concurrent aim of total and absolute surveillance of the Plaintiffs and all citizens.

223. In addition to the facts, pleaded with respect to Gates' vaccine-chip, nannocrystal "app" already developed, in late June, 2020, cell-phone companies, at the request of Justin Trudeau that the 30-Million eligible Canadians "voluntarily" load up "contract-tracing apps" now available from the phone-tech giants. These companies began dumping the apps on to customers without **informed** consent.

224. On June 30th, 2020, Canada announced that it was participating, to be included, as one of an initial fifteen (15) countries, to require "immunity passport", a cell-phone application disclosing medical vaccination history.[216] Canada is one of an initial fifteen (15) countries to enter into a contract to deploy "immunity

[216] https://www.mintpressnews.com/mass-tracking-covi-pass-immunity-passports-slated-roll-15-countries/269006/

passport" technology. The technology would utilize a cell-phone application to disclose medical vaccination history. [217]

225. The Plaintiffs further state, and the fact is, that above and beyond what is set out above in the within Statement of Claim, mandatory vaccination, for any disease, let alone a **virus**, is a flagrant violation of the Plaintiffs' **Charter** , and written constitutional rights, under s. 2 and 7 of the **Charter,** to freedom of belief, conscience, religion, and life liberty and security of the person as a violation of physical and psychological integrity, where informed medical consent is absent in a mandatory scheme.

- **Vaccines in General**

226. The Plaintiffs state, and the fact is that:

(a) it is undisputed that vaccines cause severe, permanent injury up to and including death in a certain percentage of those who are vaccinated, including physical, neurological, speech, and other disabilities;

(b) that, as a result of this reality, risk, and severe injury, certain North American jurisdictions, such as the USA, and Quebec, as well as all G-7 countries except Canada, have established compensation schemes for those injured and killed by vaccines;

(c) that Ontario has no such compensation scheme;

(d) that there is no individual pre-screening, to attempt to pre-determine, which individual may have a propensity to be so injured, even in cases where older siblings, in the same family have been injured, no

[217] https://www.mintpressnews.com/mass-tracking-covi-pass-immunity-passports-slated-roll-15-countries/269006/

investigation is undertaken or weighed with respect to the risks of their younger siblings being vaccinated;

(e) the Plaintiffs state, and the fact is, that while peanuts and other nuts, as an absolute proposition, do not injure or kill, they do injure or kill those who are allergic to them. While schools have taken saturated and heightened steps to make their spaces "nut-free", the risks of vaccines to children, particularly those who are pre-disposed to injury and death from them, are completely ignored.

227. The individual, biological Plaintiffs state that they further rely on the facts set out below under the Plaintiff heading "Vaccine Choice Canada (VCC)".

228. The individual, biological Plaintiffs state that the compulsory vaccination , and or testing, schemes violates their rights, by act and omission. Mandatory vaccination removes the right to weigh the "risks" of vaccinating or not vaccinating, to allow for informed choice, in that vaccines can cause injury or death, is a violation of their rights as follows:

(a) an ***in limine*** compulsory vaccination scheme violates s.2(a) and (b) of the ***Charter*** in infringing the rights to freedom of conscience, religion, thought and belief, as well as infringing the rights to liberty and security of the person, in interfering with the physical and psychological integrity of the person and the right to make choices as to that integrity and autonomy, pursuant to s.7 of the ***Charter***;

(c) that the failure and omissions of the Defendants, their officials and delegees, in the vaccination scheme, to transparently and honestly present the

risks of vaccination, pro and con, and the failure and omissions to make individual assessments to pre-determine and pre-screen those children who may have a propensity and pre-disposed to being vaccine injured, constitutes a violation of the same ***Charter*** cited above, in depriving the right to an informed consent before medical treatment through vaccine is compulsorily administered, by way of omission as set out by the Supreme Court of Canada in, ***inter alia, Vriend*** in unnecessarily exposing children and adults, to injury up to and including death, by an overly-broad, untailored, indiscriminate and blind vaccination scheme, notwithstanding the dire and pointed warnings in the manufacturers' own very inserts and warnings as to the risks.

229. The Plaintiffs state that the violations of their ss. 2(a) and (b) ***Charter*** rights are not justified under s.1 of the ***Charter*** and puts the Defendants to their onus of justifying the violations. The Plaintiffs further state that the violations of their s.7 ***Charter*** rights, as set out above in the statement of claim, are not in accordance with the tenets of fundamental justice in that the scheme and provisions suffer from overbreadth and that the protection of overbreadth in legislation has been recognized, by the Supreme Court of Canada, as a tenet of fundamental justice, and that further they cannot be saved under s.1 of the ***Charter,*** the onus of which lies with Defendants.

- **Vaccine Choice Canada (VCC)**

230. Vaccine Choice Canada is a federally registered not-for-profit educational society. VCC is committed to protecting children's health by informing parents of the existing and emerging scientific literature evaluating the risks, side effects, and potential long-term health effects of artificial immunization. VCC works to protect the right of all people to make fully informed and voluntary vaccine decisions for themselves and their children. Vaccine Choice Canada was originally incorporated as the Vaccination Risk Awareness Network (VRAN) in 1982. It changed its name to Vaccine Choice Canada(VCC) in 2014.

231. In the 38 years that Vaccine Choice Canada, and its predecessor organization, has been involved in reviewing the vaccine safety literature, supporting families in their vaccine decisions, and developing educational materials related to vaccine safety, efficacy and necessity, so that individuals can make responsible and informed decisions, VCC has noted, uncovered, and researched certain established facts as set out below.

232. VCC states that, with respect to facts pertinent to product safety testing, the facts and medical literature sets out that:

(a) Vaccines do not undergo the same level of safety testing as is required for all other drugs and medical products.

(b) None of the vaccines licensed for use in Canada have been tested for safety using long-term, double blind, placebo-controlled studies.

(c) Vaccine products licensed for use in Canada are not evaluated for safety using a neutral placebo, [218] a requirement for all other pharmaceutical products.

(d) Vaccines are an invasive medical intervention whose safety is determined primarily by the amount of injury or death reported *after* vaccination.

(e) Pre-licensing safety monitoring of childhood vaccines, prior to the vaccines being administered, is not long enough to reveal whether vaccines cause autoimmune, neurological or developmental disorders. [219]

(f) Studies designed to examine the long-term effects of the cumulative number of vaccines or other aspects of the vaccination schedule have not been conducted. [220]

(g) There are too few scientifically sound studies published in the medical literature to determine how many serious brain and immune system problems are or are not caused by vaccines. [221]

(h) The design and reporting of safety outcomes in MMR vaccine studies, both pre- and post-marketing, is largely inadequate. [222]

(i) Vaccines have not been tested for carcinogenicity, toxicity, genotoxicity, mutagenicity, ability to impair fertility, or for long-term adverse reactions.

(j) Health Canada does not conduct its own independent clinical trials to determine vaccine safety and efficacy and instead relies on the data provided by the vaccine manufacturers.

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[218] https://www.icandecide.org/wp-content/uploads/2019/08/VaccineSafety-Version-1.0-October-2-2017-1.pdf
[219] https://icandev.wpengine.com/wp-content/uploads/2019/08/ICAN-Reply.pdf
[220] https://www.nap.edu/catalog/13563/the-childhood-immunization-schedule-and-safety-stakeholder-concerns-scientific-evidence.
[221] https://www.nvic.org/PDFs/IOM/2013researchgaps-IOMchildhoodimmunizationschedulea.aspx
[222] https://www.cochrane.org/CD004407/ARI_using-combined-vaccine-protection-children-against-measles-mumps-and-rubella

(k) Studies comparing the overall health of vaccinated and unvaccinated children reveal that vaccinated children are significantly more likely to have neuro-developmental disorders and chronic illness. [223]

(l) There is evidence that vaccines are contaminated with unintended ingredients and that the health impact of injecting these ingredients is unknown. [224]

(m) Canada is the only G7 Nation without a national program to compensate those injured or killed by vaccination, and one(1) of two(2) G-20 Nations without a vaccine injury compensation program. The other nation being Russia.

(n) The United States Vaccine Injury Compensation Program has awarded more than $4.1 billion in compensation since 1989.

(o) The published medical literature recognizes that vaccines can cause permanent injury including death.

(p) The US government has acknowledged that vaccination can cause brain damage resulting in symptoms of autism in genetically susceptible children. [225]

(q) The US Centre for Disease Control (CDC)has acknowledged that every domestic case of polio that occurred after 1979 was caused by the vaccine strain of polio. [226]

[223] https://antivakcina.org/files/MawsonStudyHealthOutcomes5.8.2017.pdf

[224] https://www.corvelva.it/it/speciale-corvelva/vaccinegate-en.html

[225] https://www.jeremyrhammond.com/wp-content/uploads/2019/10/080226-Vaccine-Autism-Court-Document-Kirby-HuffPost.pdf.

[226] https://web.archive.org/web/20150103130229/http://www.cdc.gov/vaccines/vpd-vac/polio/dis-faqs.htm

(r) Vaccines include ingredients that are classified as poisons, carcinogens, toxins, neurotoxins, immune-and-nervous-system disruptors, allergens, fertility inhibitors, and sterilizing agents.

(s) Health Canada exposed children to cumulative levels of mercury and aluminum, in the incubation of the vaccines that exceeded the US FDA's safety guidelines.

233. VCC states that, with respect to the facts pertinent to screening for susceptibility to vaccine injury, that:

(a) Pre-screening to identify individuals who may be at increased susceptibility to vaccine injury and death does not occur in Canada.

(b) Health Canada has not committed resources to identify those individuals who may have increased susceptibility to experience vaccine injury or death.

(c) Policies to administer vaccines to "Mature Minors", often without the knowledge and consent of the parents and without the informed consent of the "Mature Minor",, in schools and medical settings without the knowledge or consent of the parents has inadequate safety protocols to fully consider the personal and family medical history prior to vaccination.

(d) This failure to fully consider personal and family medical history puts these youth at increased risk of vaccine injury.

234. VCC states that, with respect to the facts pertinent to monitoring of adverse effects of vaccination, that:

(a) Doctors and health care workers are not trained to recognize and diagnose vaccine injury.

(b) There are no legal consequences when medical professionals fail to report vaccine injury.

(c) Parents' observations of health and behavioral changes following vaccination are routinely ignored and denied by doctors and rarely captured in adverse events reporting systems.

(d) It is recognized that fewer than 1% of vaccine adverse reactions are reported. [227]

(e) Ontario's AEFI reporting system has lower reporting rates than other provinces. [228]

(f) The medical industry has failed to fully consider the combined toxicology of vaccine ingredients and the synergistic effect of combining vaccine ingredients.

230. VCC states that, with respect to the facts pertinent to safeguarding policy over patient health, that:

(a) The primary metric used by Health Canada to measure the success of the vaccine program appears to be how many vaccines are delivered.

(b) The goal of public health vaccine policy is to persuade parents to comply with the full vaccine schedule. [229]

(c) The pursuit of the goal of persuading parents to comply with vaccination recommendations is incompatible with the goal of allowing parents to possess the knowledge they need to exercise their right to informed consent, and act in their child's best interests.

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[227] https://healthit.ahrq.gov/sites/default/files/docs/publication/r18hs017045-lazarus-final-report-2011.pdf

[228] https://www.myhealthunit.ca/en/health-professionals-partners/resources/Health-Care-Professionals/adverse-events/Annual_Report_Vaccine_Safet.pdf

[229] https://cic-cci.ca/

(d) The right to informed consent has been recognized as one of the most fundamental ethics in medicine.

(e) Public health professionals routinely fail to inform citizens of their legal right to personal, religious and medical exemptions where they exist.

(f) Health Canada, with respect to vaccines, places public policy over individual health considerations.

(g) Government policy makers have refused to consider the fact that the risks of the target diseases are not the same for every child and that some children are at greater risk of being harmed by vaccines due to genetic or environmentally caused predispositions.

(h) Government policymakers ignore that the fact that for informed consent to happen, the risk-benefit analysis must be conducted for *each* vaccine and *individually for each child*.

(i) Antibody titre testing is rarely conducted in an effort to avoid unnecessary vaccination.

(j) An increasing number of parents are choosing not to vaccinate because they recognize that public health vaccine policy poses a serious threat to both their health and liberty.

235. VCC states that, with respect to the facts pertinent to lack of accountability for vaccine Injury, that:

(a) Vaccine manufacturers and medical professionals are not held legally and financially accountable when vaccine injury and death occurs.

(b) A consequence of this legal immunity is that there is no legal or financial incentive for the vaccine industry to make their products safer, even when there is clear evidence that vaccines *can* be made safer.

(c) Systemic corruption within the medical establishment is well recognized within the scientific community. [230] [231]

(d) Conflicts of interest in biomedical research are "very common". [232]

236. VCC states that, with respect to the facts pertinent to informed consent, that Consumers are rarely informed that:

(a) vaccines do not confer life-long immunity;

(b) not all vaccines eliminate susceptibility to infection;

(c) not all vaccines are designed to prevent the transmission of infection;

(d) most vaccines do not alter the safety of public spaces; [233]

(e) Health Canada has acknowledged that vaccines are voluntary in Canada and cannot be made mandatory due to the Canadian Charter of Rights and Freedoms;

(f) there is no scientific evidence that herd immunity can be achieved using vaccines due to the temporary nature of the immunity offered nor that vaccine herd immunity is more effective that natural herd immunity;

(g) vaccine can and do cause permanent injury and death;

(h) there is no scientific evidence that vaccines are primarily responsible for reduced mortality over the last century as is often claimed;

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230 https://www.nybooks.com/articles/2009/01/15/drug-companies-doctorsa-story-of-corruption/

231 https://doi.org/10.1111/eci.12074

232 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1182327/.

233 https://childrenshealthdefense.org/news/why-you-cant-trust-the-cdc-on-vaccines/

(i) the human body has an innate capability to fight off infections and heal itself ;

(j) the pharmaceutical companies that produce almost all vaccines have been found guilty and paid billions of dollars in criminal penalties for research fraud, faking drug safety studies, failing to report safety problems, bribery, kickbacks and false advertising [234];

(k) Canadian children are among the most vaccinated children in the world

(l) there is no compensation available in Canada, except for Quebec, should vaccination result in injury or death;

(m) only two provinces in Canada (Ontario and New Brunswick) require exemptions to decline vaccination;

(n) recommended/required vaccines vary by province, by state, and by country.

237. Consumers are rarely provided with the product monograph (product information insert) by health care providers. Vaccines monographs warn of limitations to vaccine safety testing as well as recognized adverse events following vaccination which include severe and permanent injury and death.

238. Vaccine mandates violate the medical and legal ethic of informed consent.

239. Vaccine mandates violate *'The Universal Declaration of Bioethics and Human Rights'*, the *Nuremberg Code*, professional codes of ethics, and all provincial health Acts.

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[234] **GlaxoSmithKline Fined $3B After Bribing Doctors to Increase Drug Sales.** https://www.theguardian.com/business/2012/jul/03/glaxosmithkline-fined-bribing-doctors-pharmaceuticals?CMP=share_btn_fb
Merck: Corporate Rap Sheet http://www.corp-research.org/merck

240. A review of the transcripts of the vaccine education materials produced by the Ontario government reveal that the risk of vaccine injury is discussed superficially, and that consumers are given insufficient information to make an informed decision.

241. A review of Public Health Agency of Canada recommended curriculum for school children reveals that education on the risk of vaccine injury is absent, as is education on the right to informed consent. [235]

242. The vaccine risk information provided to consumers varies by health region.

243. Vaccines are routinely administered to youth in medical clinics and school settings without the knowledge or consent of their parents.

244. Youth vaccinated in school-based clinics routinely report being intimidated into vaccination and being threatened with expulsion if they refuse vaccination.

245. Public health presents as if all vaccines carry the exact same risk/benefit assessment for all individuals.

246. Individual benefit versus individual risk of vaccination is rarely considered.

247. Indigenous people are required to receive vaccines other than those required for non-Indigenous people based on assumed risk, not upon medical evidence of risk.

248. VCC states that, with respect to the facts pertinent to the ***Immunization of School Pupils Act*** (ISPA), that:

(a) Only school children are mandated to provide their medical records under ISPA. Adults are not required and are less likely to be 'up to date' with their vaccinations.

[235] https://kidsboostimmunity.com/sites/default/files/reusable_files/kbi_bc.pdf

(b) The forced disclosure of private medical records puts a child's medical privacy at risk.

(c) This disclosure often results in the child being ostracized by school staff and peers.

(d) The ISPA does not give the medical officer of health authority to suspend a student. Only a principal can suspend a student from school. The Education Act does not have any section that allows a principal to suspend for lack of medical records. Yet this is routinely done for those who do not, or refuse, to comply with the mandatory scheme.

(e) Parents who do not comply with unlawful suspension are threatened with child protection services.

(f) Children who are under vaccinated or without exemptions are intimidated, held in the office, and incorrectly told by school officials that they need to get their shots or they cannot come to school.

(g) The HSARB (Health Service Appeal and Review Board), which deals with appeals of suspensions, registration and expulsions, cannot rule on ***Charter*** challenge cases, as the enabling legislation specifically bars jurisdiction to adjudicate ***Charter*** issues.

(h) There is zero accountability for violations of rights by the medical officer of health. This has resulted in many cases of the Medical Officer of Health unlawfully suspending young children for 60 to 90 school days, contrary to the 20 days suspension as set out in the ISPA.

I/ THE MEDIA

249. The Plaintiff states that the Defendant CBC, and other mainstream media, is purposely suppressing valid, sound, and sober criticism of recognized experts with respect to the measures that amount to censorship and violation of freedom of speech, expression and the media.

250. The Plaintiffs state, and the fact is, that CBC, a completely publicly- funded news service, and national broadcaster, paid for by Canadian taxpayers, has been to the Trudeau government, and acted as, PRAVDA was and acted for the Soviet Union in the cold-war, with respect to coverage of the COVID- "pandemic", "emergency", and its draconian measures.

251. The Plaintiffs state that CBC, as the nationally and publicly-funded broadcaster under the public broadcasting policy for the Canadian public, under the **Broadcast Act,** owes:

(a) a Fiduciary duty to the Plaintiffs and all citizens; and

(b) a duty in Negligence (negligent investigation) to the Plaintiffs and all citizens;

To be independent, fair, balanced, and objective in its coverage of the "pandemic", declared "emergency", and the measures undertaken, which duties it has breached causing damages to the Plaintiffs.

- **Negligence**

252. The Plaintiff states that the Defendant, CBC, as a publicly-funded mandate to publicly broadcast on behalf of Canadians, owes a common-law, and statutory duty of care to the Plaintiffs, to fairly, independently, objectively report, and engage in responsible journalism, on the news and current affairs, and the Plaintiffs further state that:

(a) the CBC breached that duty of care; and

(b) as a result of the breach of that duty of care, the Plaintiffs suffered damages.

253. The Plaintiff states and the fact is, this duty was breached by the CBC's negligent acts and omissions, including **inter alia**, the following:

(a) The daily broadcasting of Trudeau's press-conferences, with absolutely no questions about the scientific and medical evidence behind the measures, and their source;

(b) Whether contrary expert views exist, to the secret advice being followed;

(c) If opposite, expert opinion exist, what is the government's response to it?;

(d) The CBC further dumps, on a daily basis, the government numbers on COVID-positive rates, and death rates, without any investigation or scrutiny as to the basis of compiling those numbers, and who and how the parameters are determined in complying those numbers nor any contextual analysis as to what they mean;

(e) The CBC has done **no** independent investigation, nor asked any questions, on the scientific or medical basis of the COVID- measures but simply

parrots the government line, and has not investigated, exposed, nor published the avalanche of Canadian and World experts who firmly hold an opposite view, and severe criticism of the measures, nor put those criticism to the Federal Defendants for response.

254. In short, the Plaintiffs state, and the fact is, that CBC has breached its duty of care to the Plaintiffs, and has not acted in a fair, independent, objective, and responsible manner, but has acted in a manner more akin to a propagandistic state news agency serving a dictatorial regime.

255. The Plaintiffs state, and the fact is, that CBC has actually gone far beyond the above in that, in the rare instance CBC pretends to tackle an opposite view, CBC irresponsibly belittles, and in fact intentionally misleads, the Plaintiffs and viewers. For example, in a story published May 21st, 2020, written by CBC's Andrea Bellemere, Katie Nicholson and Jason Ho entitled **"How a debunked COVID-19 video kept spreading after Facebook and YouTube took it down",** these "reporters" falsely and intentionally distort with respect to the video in question entitled **"Plandemic"**. In the story they refer, with a picture, to a person CBC describes as: "featuring controversial virologist Judy Mikovitz". In the story, these three "reporters" choose to:

(a) Delete the fact that it is **Dr. Judy Mikovitz, Ph. D.**, is a **recognized expert in virology** who worked at the Centre for Disease Control (CDC) with Anthony Fauci, with whom she had serious disagreement which she documented in her book entitled **"Plague Corruption";**

(b) That she continues to work in, and be recognized as an expert in virology;

(c) The "reporters" do not give a hint as to by whom, when, on what medical basis her expert views were "debunked";

(d) Nor do the "reporters" investigate, nor pose any questions, about why it is appropriate to remove from Facebook, or YouTube, the views of a recognized, working World expert, of virology, with respect to issues of COVID-19. This conduct by these "reporters" and CBC, is intentional at worst, and depraved and gross negligence at best.

- **Fiduciary Duty**

256. The Plaintiffs further state that the CBC further has a fiduciary relationship, and owed a corresponding fiduciary duty, to the Plaintiffs, as the national publicly-funded broadcaster to fairly, independently, objectively report, and engage in responsible journalism, on the news and current affairs for the following reasons:

(a) The Defendant CBC is in a position of power over the Plaintiffs, with respect to what it covers and reports; and was able to use this power so as to control and affect the Plaintiff's interests in their right to freedom of speech, expression, and the media for their national, publicly-funded broadcaster under the **Broadcast Act,** with respect to the covid - "pandemic', "emergency" and measures;.

(b) The Plaintiffs are in a corresponding position of vulnerability toward CBC in depending on CBC to put out fair, balanced, responsible, objective and responsible reports on the reality of the "pandemic", the declared "emergency" as well as measures undertaken;

(c) CBC impliedly and statutorily undertakes to so, to act in the best interests of the Plaintiffs', and the public, in its functions and work, in that:

(i) the Defendant CBC performs a public function, to operate as Canada's national publicly-funded broadcaster under statute;

(ii) the Defendant CBC impliedly and statutorily undertakes to so to act in the best interests of the Plaintiffs'.

257. The Plaintiffs state that the Defendants breached this fiduciary duty as set out above in this Statement of Claim.

258. The Plaintiffs state, and the fact is, that CBC, Facebook, YouTube , Google, and other social media are viciously censoring, and removing any and all content that criticizes or takes issue with the WHO, and governments that follow WHO guidelines, with respect to covid-19, as purported "misinformation" contrary to "community standards" even when that content is posted by a recognized expert.

259. The Plaintiffs further state, and the fact is, that the Defendant Federal Crown is by way of act and omission, under **inter alia,** the **Broadcast Act** , and its Agencies such the CRTC, legislatively and administratively violating the Plaintiffs' rights under s. 2 of the **Charter,** to freedom of expression and the press in doing nothing to halt what has been described by members of the scientific community as " Stalinist censorship", by government, along with media the likes of CBC, Facebook, and YouTube. In fact, the Federal Crown goes further, in following suit with these social media censors, to propose

criminal sanctions for posting such deemed and anointed "misinformation" by all, including experts.

260. On or about end of May, 2020 the UK " Scientific Advisory Group for Emergency (SAGE) –COVID-19 Response, in response to the unwarranted measures of redaction, and removing, all criticism in respect of COVID-Measures, from the Report, of this government advisory body, the body responsible for their SAGE report referred to the government redaction as "Stalinist Censorship".

261. The Plaintiffs state, and the fact is, that CBC, Facebook, and YouTube, and other major social media, in their coverage of the COVID-19, have acted in the same fashion, by knowingly and intentionally suppressing and removing expert opinion not in line with the official dogma of the WHO, which is being blindly and deafly parroted and incanted by the Defendant governments (leaders) and their officials, to the detriment of the Plaintiffs and citizens at large, in violation of their constitutional rights.

J/ SUMMARY

262. In summary, the Plaintiffs state that the COVID -19 Legislation, and Regulations By-Laws, and orders, violate, as follows, the Plaintiffs' statutory and constitutional rights in:

(a) That the conduct of Justin Trudeau and Doug Ford, constitute a dispensing of Parliament under the pretense of Royal prerogative contrary to the Plaintiffs' constitutional rights to a Parliament;

(b) That the declaration of an emergency by Doug Ford in Ontario, was **ultra vires** , and continues to be **ultra vires,** the **Act** in failing to meet the requisite criteria to declare an emergency;

(c) That the declared emergency, and measures implemented thereunder are:

(i) Not based on any scientific or medical basis;

(ii) Are ineffective , false, and extreme;

(iii) Contravene ss. 2, 7,8,9, and 15 of the **Charter** ;

(iv) Contravene the same parallel unwritten constitutional rights, enshrined through the Pre-Amble of the **Constitution Act, 1867;**

(v) Contravene the same rights fund in the international treaty, read in, as a minimal standard of protection, under s. 7 of the **Charter,** as ruled by the Supreme Court of Canada, in, **inter alia,** the **Hape** decision;

(d) That the ''COVID- pandemic'' was pre-planned, and executed, as a false pandemic, through the WHO, by Billionaire, Corporate, and Organizational Oligarchs the likes of Bill Gates, GAVI, the WHO, the WEF, and others, in order to install a New World (Economic) Order with:

(i) **De facto** elimination of small businesses;

(ii) Concentration of wealth and the power to control economic activity in large global corporations;

(iii) To disguise a massive bank and corporate bail-out;

(iv) To effect global, **mandatory** vaccination with chip technology, to effect total surveillance and testing of any and all citizens, including the Plaintiffs;

(v) To shift society, in all aspects into a virtual'' world at the control of these vaccine, pharmaceutical, technological, globalized oligarchs, whereby the Plaintiffs, and all others, cannot organize nor congregate.

(vi) To effectively immobilize resistance to ths agenda by neutering Parliaments and the Courts, and by extension the Constitution and Constitutional Democracy and Sovereignty, in short to obtain "global governance".

263. The Plaintiffs rely on:

(a) the Statutory Schemes set out in the within statement of claim;

(b) The Pre-Amble to the **Constitution Act, 1867** and jurisprudence thereunder;

(c) ss. 2, 7,8,9, 15, and 24(1) of the ***Charter;***

(d) s. 52(1) of the ***Constitution Act, 1982;***

(d) the ***Common Law***;

(e) such further statutory or constitutional provisions as counsel may advise.

264. The Plaintiffs therefore request:

(a) The relief set out in paragraphs 1 to 5 of the within the Statement of Claim;

(b) Costs of this action on full indemnity basis;

(c) Such other or further relief as counsel for the Plaintiff may advise and this Honourable Court grant.

265. The Plaintiff proposes that this action be tried in Toronto.

Dated at Toronto this 3rd day of July, 2020.

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Court File No:

VCC, et al -AND- Justin Trudeau, et al

Plaintiffs Defendants

(Short title of proceeding)

ONTARIO
SUPERIOR COURT OF JUSTICE

Proceeding Commenced at Toronto

STATEMENT OF CLAIM

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From: Cara Stapleton
To: Legislative Assistants
Subject: Mask bylaw
Date: Sunday, September 13, 2020 9:56:50 PM
Attachments: Efficacy of face masks .pdf

Hi,

I am hoping to submit this written piece to be shared at the council meeting tomorrow. I am not able to register to "present" at the meeting. Can I submit the written piece without registering to speak? If so, please see my written submission below:

Dear Council,
I wanted to take this opportunity to share with you my thoughts on the proposed bylaw re: masks. I would very much like to see masks made mandatory in indoor public places. There are many places in town where indoor spaces do not allow for physical distancing and in those where space allows for it, there are individuals that do not follow signage. Perhaps schools could be the exception — following current arrangements that are in place.

Despite many debates over the effectiveness of masks, we have seen that they do lower transmission rates. Nature Medicine (article attached) published a journal article on April 3, 2020, noting that masks could prevent the transmission of human coronavirus. According to Patient Care (a journal article out of University of California San Francisco) The Centres for Disease Control and Prevention (CDC) and World Health Organization didn't originally recommend masks, however those original recommendations were based on a false sense of security that occurred due to less testing taking place. Namely, they did not understand the prevalence of the Covid-19 pandemic. They understood there to be a low disease occurrence and culturally they did not believe that people were prepared to wear masks. Additionally there was concern that there would not be enough masks available for the health-care workers. Now, they have changed tune and recommend cloth masks for the general population. They note that the evidence is clear that masks can help prevent the spread of Covid-19. That the more people wearing them the better. They state that even 80 percent of the population wearing masks would do more to prevent Covid-19 spread than another lockdown. https://www.ucsf.edu/news/2020/06/417906/still-confused-about-masks-heres-science-behind-how-face-masks-prevent

As a small business owner, I know how important preventing another lock-down will be. Mental health will be impacted, people will be more isolated, children more at risk of hunger and domestic violence and small restaurants and local specialty shops won't likely survive. We are a small community and need to protect our population as best we can from the detriment that could occur if our health needs surpass the local capacity to address those needs.

Again, please consider implementing the bylaw.

Thanks for your time and energy in this matter,

Cara Stapleton
Section 17 (1) FOIP

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Respiratory virus shedding in exhaled breath and efficacy of face masks

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We identified seasonal human coronaviruses, influenza viruses and rhinoviruses in exhaled breath and coughs of children and adults with acute respiratory illness. Surgical face masks significantly reduced detection of influenza virus RNA in respiratory droplets and coronavirus RNA in aerosols, with a trend toward reduced detection of coronavirus RNA in respiratory droplets. Our results indicate that surgical face masks could prevent transmission of human coronaviruses and influenza viruses from symptomatic individuals.

Respiratory virus infections cause a broad and overlapping spectrum of symptoms collectively referred to as acute respiratory virus illnesses (ARIs) or more commonly the 'common cold'. Although mostly mild, these ARIs can sometimes cause severe disease and death[1]. These viruses spread between humans through direct or indirect contact, respiratory droplets (including larger droplets that fall rapidly near the source as well as coarse aerosols with aerodynamic diameter >5 μm) and fine-particle aerosols (droplets and droplet nuclei with aerodynamic diameter ≤5 μm)[2,3]. Although hand hygiene and use of face masks, primarily targeting contact and respiratory droplet transmission, have been suggested as important mitigation strategies against influenza virus transmission[4], little is known about the relative importance of these modes in the transmission of other common respiratory viruses[2,3,5]. Uncertainties similarly apply to the modes of transmission of COVID-19 (refs. [6,7]).

Some health authorities recommend that masks be worn by ill individuals to prevent onward transmission (source control)[4,8]. Surgical face masks were originally introduced to protect patients from wound infection and contamination from surgeons (the wearer) during surgical procedures, and were later adopted to protect healthcare workers against acquiring infection from their patients. However, most of the existing evidence on the filtering efficacy of face masks and respirators comes from in vitro experiments with nonbiological particles[9,10], which may not be generalizable to infectious respiratory virus droplets. There is little information on the efficacy of face masks in filtering respiratory viruses and reducing viral release from an individual with respiratory infections[8], and most research has focused on influenza[11,12].

Here we aimed to explore the importance of respiratory droplet and aerosol routes of transmission with a particular focus on coronaviruses, influenza viruses and rhinoviruses, by quantifying the amount of respiratory virus in exhaled breath of participants with medically attended ARIs and determining the potential efficacy of surgical face masks to prevent respiratory virus transmission.

Results

We screened 3,363 individuals in two study phases, ultimately enrolling 246 individuals who provided exhaled breath samples (Extended Data Fig. 1). Among these 246 participants, 122 (50%) participants were randomized to not wearing a face mask during the first exhaled breath collection and 124 (50%) participants were randomized to wearing a face mask. Overall, 49 (20%) voluntarily provided a second exhaled breath collection of the alternate type.

Infections by at least one respiratory virus were confirmed by reverse transcription PCR (RT–PCR) in 123 of 246 (50%) participants. Of these 123 participants, 111 (90%) were infected by human (seasonal) coronavirus ($n=17$), influenza virus ($n=43$) or rhinovirus ($n=54$) (Extended Data Figs. 1 and 2), including one participant co-infected by both coronavirus and influenza virus and another two participants co-infected by both rhinovirus and influenza virus. These 111 participants were the focus of our analyses.

There were some minor differences in characteristics of the 111 participants with the different viruses (Table 1a). Overall, 24% of participants had a measured fever ≥37.8 °C, with patients with influenza more than twice as likely than patients infected with coronavirus and rhinovirus to have a measured fever. Coronavirus-infected participants coughed the most with an average of 17 (s.d. = 30) coughs during the 30-min exhaled breath collection. The profiles of the participants randomized to with-mask versus without-mask groups were similar (Supplementary Table 1).

We tested viral shedding (in terms of viral copies per sample) in nasal swabs, throat swabs, respiratory droplet samples and aerosol samples and compared the latter two between samples collected with or without a face mask (Fig. 1). On average, viral shedding was higher in nasal swabs than in throat swabs for each of coronavirus (median 8.1 $\log_{10}$ virus copies per sample versus 3.9), influenza virus (6.7 versus 4.0) and rhinovirus (6.8 versus 3.3), respectively. Viral RNA was identified from respiratory droplets and aerosols for all three viruses, including 30%, 26% and 28% of respiratory droplets and 40%, 35% and 56% of aerosols collected while not wearing a face mask, from coronavirus, influenza virus and rhinovirus-infected participants, respectively (Table 1b). In particular for coronavirus, we identified OC43 and HKU1 from both respiratory

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Table 1a | Characteristics of individuals with symptomatic coronavirus, influenza virus or rhinovirus infection

	All who provided exhaled breath	Coronavirus	Influenza virus	Rhinovirus
	(*n* = 246)	(*n* = 17)	(*n* = 43)	(*n* = 54)
	n (%)	*n* (%)	*n* (%)	*n* (%)
Female	144 (59)	13 (76)	22 (51)	30 (56)
Age group, years				
11–17	12 (5)	0 (0)	8 (19)	4 (7)
18–34	114 (46)	10 (59)	11 (26)	24 (44)
35–50	79 (32)	2 (12)	16 (37)	18 (33)
51–64	35 (14)	4 (24)	8 (19)	5 (9)
≥ 65	6 (2)	1 (6)	0 (0)	3 (6)
Chronic medical conditions				
Any	49 (20)	5 (29)	5 (12)	10 (19)
Respiratory	18 (7)	0 (0)	4 (9)	3 (6)
Influenza vaccination				
Ever	94 (38)	6 (35)	15 (35)	20 (37)
Current season	23 (9)	2 (12)	1 (2)	4 (7)
Previous season only	71 (29)	4 (24)	14 (33)	16 (30)
Ever smoker	31 (13)	1 (6)	6 (14)	6 (11)
Time since illness onset, h				
<24	22 (9)	0 (0)	5 (12)	2 (4)
24–48	100 (41)	9 (53)	13 (30)	25 (46)
48–72	85 (35)	8 (47)	18 (42)	20 (37)
72–96	39 (16)	0 (0)	7 (16)	7 (13)
History of measured fever ≥37.8 °C	58 (24)	3 (18)	17 (40)	8 (15)
Measured fever ≥37.8 °C at presentation	36 (15)	2 (12)	18 (42)	2 (4)
Measured body temperature (˚C) at enrollment (mean, s.d.)	36.8 (0.8)	36.9 (0.8)	37.4 (0.9)	36.6 (0.7)
Symptoms at presentation				
Fever	111 (45)	10 (59)	27 (63)	16 (30)
Cough	198 (80)	15 (88)	40 (93)	44 (81)
Sore throat	211 (86)	15 (88)	31 (72)	49 (91)
Runny nose	200 (81)	17 (100)	36 (84)	48 (89)
Headache	186 (76)	13 (76)	30 (70)	38 (70)
Myalgia	176 (72)	12 (71)	31 (72)	34 (63)
Phlegm	176 (72)	9 (53)	34 (79)	41 (76)
Chest tightness	64 (26)	3 (18)	12 (28)	9 (17)
Shortness of breath	103 (42)	6 (35)	14 (33)	25 (46)
Chills	100 (41)	8 (47)	29 (67)	16 (30)
Sweating	95 (39)	5 (29)	18 (42)	20 (37)
Fatigue	218 (89)	16 (94)	38 (88)	48 (89)
Vomiting	19 (8)	2 (12)	5 (12)	2 (4)
Diarrhea	17 (7)	2 (12)	1 (2)	6 (11)
Number of coughs during exhaled breath collection (mean, s.d.)	8 (14)	17 (30)	8 (11)	5 (9)

Seasonal coronavirus (*n* = 17), seasonal influenza virus (*n* = 43) and rhinovirus (*n* = 54) infections were confirmed in individuals with acute respiratory symptoms by RT-PCR in any samples (nasal swab, throat swab, respiratory droplets and aerosols) collected.

droplets and aerosols, but only identified NL63 from aerosols and not from respiratory droplets (Supplementary Table 2 and Extended Data Fig. 3).

We detected coronavirus in respiratory droplets and aerosols in 3 of 10 (30%) and 4 of 10 (40%) of the samples collected without face masks, respectively, but did not detect any virus in respiratory droplets or aerosols collected from participants wearing face masks, this difference was significant in aerosols and showed a trend toward reduced detection in respiratory droplets (Table 1b). For influenza virus, we detected virus in 6 of 23 (26%) and 8 of 23 (35%) of the

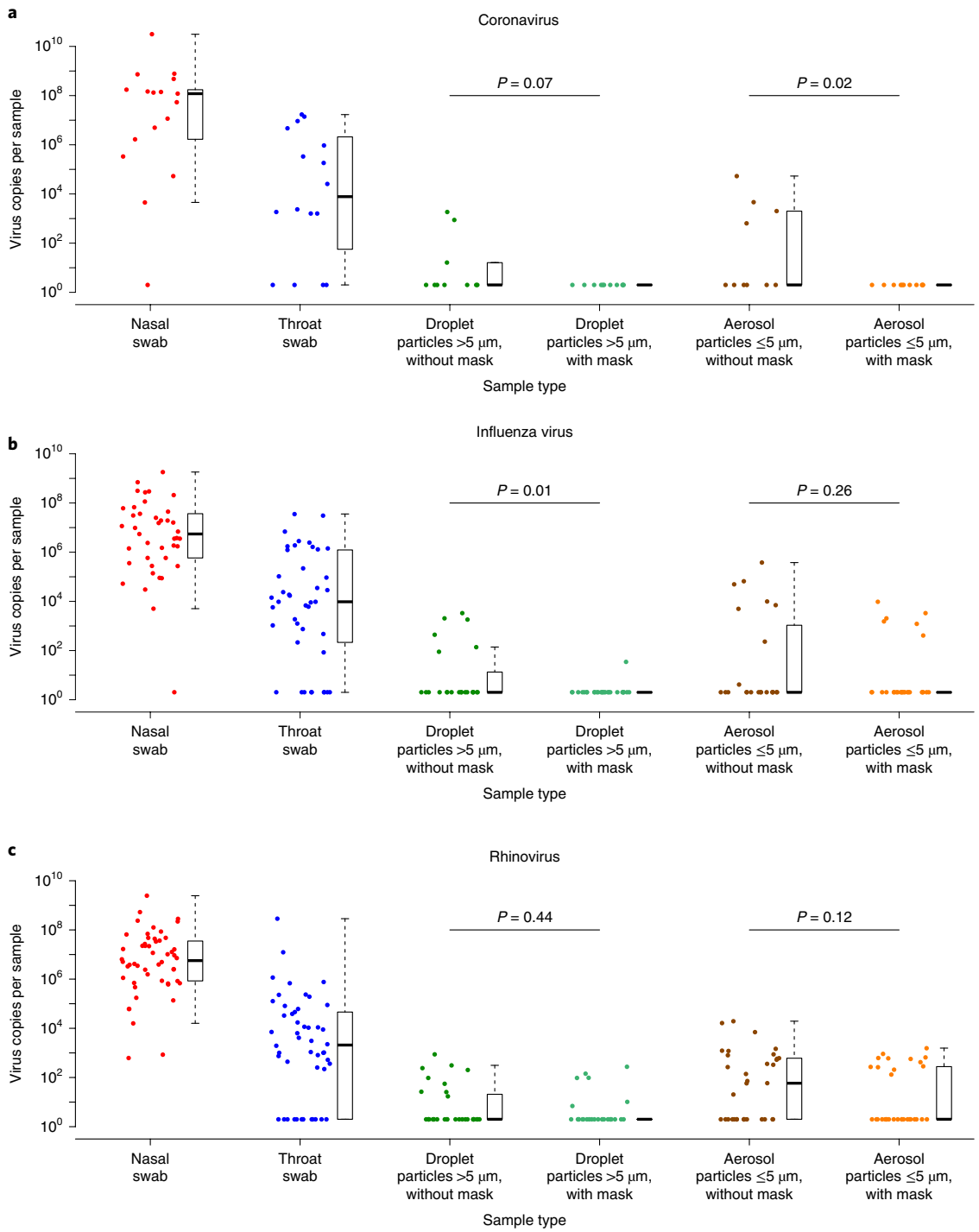

Fig. 1 | Efficacy of surgical face masks in reducing respiratory virus shedding in respiratory droplets and aerosols of symptomatic individuals with coronavirus, influenza virus or rhinovirus infection. a–c, Virus copies per sample collected in nasal swab (red), throat swab (blue) and respiratory droplets collected for 30min while not wearing (dark green) or wearing (light green) a surgical face mask, and aerosols collected for 30min while not wearing (brown) or wearing (orange) a face mask, collected from individuals with acute respiratory symptoms who were positive for coronavirus (**a**), influenza virus (**b**) and rhinovirus (**c**), as determined by RT–PCR in any samples. *P* values for mask intervention as predictor of $\log_{10}$ virus copies per sample in an unadjusted univariate Tobit regression model which allowed for censoring at the lower limit of detection of the RT–PCR assay are shown, with significant differences in bold. For nasal swabs and throat swabs, all infected individuals were included (coronavirus, *n*=17; influenza virus, *n*=43; rhinovirus, *n*=54). For respiratory droplets and aerosols, numbers of infected individuals who provided exhaled breath samples while not wearing or wearing a surgical face mask, respectively were: coronavirus (*n*=10 and 11), influenza virus (*n*=23 and 28) and rhinovirus (*n*=36 and 32). A subset of participants provided exhaled breath samples for both mask interventions (coronavirus, *n*=4; influenza virus, *n*=8; rhinovirus, *n*=14). The box plots indicate the median with the interquartile range (lower and upper hinge) and ±1.5×interquartile range from the first and third quartile (lower and upper whiskers).

Table 1b | Efficacy of surgical face masks in reducing respiratory virus frequency of detection and viral shedding in respiratory droplets and aerosols of symptomatic individuals with coronavirus, influenza virus or rhinovirus infection

	Droplet particles >5 µm			Aerosol particles ≤5 µm		
Virus type	**Without surgical face mask**	**With surgical face mask**	***P***	**Without surgical face mask**	**With surgical face mask**	***P***
	Detection of virus					
	No. positive/no. total (%)	**No. positive/no. total (%)**		**No. positive/no. total (%)**	**No. positive/no. total (%)**	
Coronavirus	3 of 10 (30)	0 of 11 (0)	0.09	**4 of 10 (40)**	**0 of 11 (0)**	**0.04**
Influenza virus	**6 of 23 (26)**	**1 of 27 (4)**	**0.04**	8 of 23 (35)	6 of 27 (22)	0.36
Rhinovirus	9 of 32 (28)	6 of 27 (22)	0.77	19 of 34 (56)	12 of 32 (38)	0.15
	Viral load (log_{10} virus copies per sample)					
	Median (IQR)	**Median (IQR)**		**Median (IQR)**	**Median (IQR)**	
Coronavirus	0.3 (0.3, 1.2)	0.3 (0.3, 0.3)	0.07	**0.3 (0.3, 3.3)**	**0.3 (0.3, 0.3)**	**0.02**
Influenza virus	**0.3 (0.3, 1.1)**	**0.3 (0.3, 0.3)**	**0.01**	0.3 (0.3, 3.0)	0.3 (0.3, 0.3)	0.26
Rhinovirus	0.3 (0.3, 1.3)	0.3 (0.3, 0.3)	0.44	1.8 (0.3, 2.8)	0.3 (0.3, 2.4)	0.12

P values for comparing the frequency of respiratory virus detection between the mask intervention were obtained by two-sided Fisher's exact test and (two-sided) *P* values for mask intervention as predictor of log_{10} virus copies per sample were obtained by an unadjusted univariate Tobit regression model, which allowed for censoring at the lower limit of detection of the RT-PCR assay, with significant differences in bold. Undetectable values were imputed as 0.3 log_{10} virus copies per sample. IQR, interquartile range.

respiratory droplet and aerosol samples collected without face masks, respectively. There was a significant reduction by wearing face masks to 1 of 27 (4%) in detection of influenza virus in respiratory droplets, but no significant reduction in detection in aerosols (Table 1b). Moreover, among the eight participants who had influenza virus detected by RT–PCR from without-mask aerosols, five were tested by viral culture and four were culture-positive. Among the six participants who had influenza virus detected by RT–PCR from with-mask aerosols, four were tested by viral culture and two were culture-positive. For rhinovirus, there were no significant differences between detection of virus with or without face masks, both in respiratory droplets and in aerosols (Table 1b). Conclusions were similar in comparisons of viral shedding (Table 1b). In addition, we found a significant reduction in viral shedding (Supplementary Table 2) in respiratory droplets for OC43 (Extended Data Fig. 4) and influenza B virus (Extended Data Fig. 5) and in aerosols for NL63 (Extended Data Fig. 4).

We identified correlations between viral loads in different samples (Extended Data Figs. 6–8) and some evidence of declines in viral shedding by time since onset for influenza virus but not for coronavirus or rhinovirus (Extended Data Fig. 9). In univariable analyses of factors associated with detection of respiratory viruses in various sample types, we did not identify significant association in viral shedding with days since symptom onset (Supplementary Table 3) for respiratory droplets or aerosols (Supplementary Tables 4–6).

A subset of participants (72 of 246, 29%) did not cough at all during at least one exhaled breath collection, including 37 of 147 (25%) during the without-mask and 42 of 148 (28%) during the with-mask breath collection. In the subset for coronavirus ($n=4$), we did not detect any virus in respiratory droplets or aerosols from any participants. In the subset for influenza virus ($n=9$), we detected virus in aerosols but not respiratory droplets from one participant. In the subset for rhinovirus ($n=17$), we detected virus in respiratory droplets from three participants, and we detected virus in aerosols in five participants.

Discussion

Our results indicate that aerosol transmission is a potential mode of transmission for coronaviruses as well as influenza viruses and rhinoviruses. Published studies detected respiratory viruses[13,14] such as influenza[12,15] and rhinovirus[16] from exhaled breath, and the detection of SARS-CoV[17] and MERS-CoV[18] from air samples (without size fractionation) collected from hospitals treating patients with severe acute respiratory syndrome and Middle East respiratory syndrome, but ours demonstrates detection of human seasonal coronaviruses in exhaled breath, including the detection of OC43 and HKU1 from respiratory droplets and NL63, OC43 and HKU1 from aerosols.

Our findings indicate that surgical masks can efficaciously reduce the emission of influenza virus particles into the environment in respiratory droplets, but not in aerosols[12]. Both the previous and current study used a bioaerosol collecting device, the Gesundheit-II (G-II)[12,15,19], to capture exhaled breath particles and differentiated them into two size fractions, where exhaled breath coarse particles >5 µm (respiratory droplets) were collected by impaction with a 5-µm slit inertial Teflon impactor and the remaining fine particles ≤5 µm (aerosols) were collected by condensation in buffer. We also demonstrated the efficacy of surgical masks to reduce coronavirus detection and viral copies in large respiratory droplets and in aerosols (Table 1b). This has important implications for control of COVID-19, suggesting that surgical face masks could be used by ill people to reduce onward transmission.

Among the samples collected without a face mask, we found that the majority of participants with influenza virus and coronavirus infection did not shed detectable virus in respiratory droplets or aerosols, whereas for rhinovirus we detected virus in aerosols in 19 of 34 (56%) participants (compared to 4 of 10 (40%) for coronavirus and 8 of 23 (35%) for influenza). For those who did shed virus in respiratory droplets and aerosols, viral load in both tended to be low (Fig. 1). Given the high collection efficiency of the G-II (ref. [19]) and given that each exhaled breath collection was conducted for 30 min, this might imply that prolonged close contact would be required for transmission to occur, even if transmission was primarily via aerosols, as has been described for rhinovirus colds[20]. Our results also indicate that there could be considerable heterogeneity in contagiousness of individuals with coronavirus and influenza virus infections.

The major limitation of our study was the large proportion of participants with undetectable viral shedding in exhaled breath for each of the viruses studied. We could have increased the sampling duration beyond 30 min to increase the viral shedding being captured, at the cost of acceptability in some participants. An alternative approach would be to invite participants to perform forced coughs during exhaled breath collection[12]. However, it was the aim of our present study to focus on recovering respiratory

virus in exhaled breath in a real-life situation and we expected that some individuals during an acute respiratory illness would not cough much or at all. Indeed, we identified virus RNA in a small number of participants who did not cough at all during the 30-min exhaled breath collection, which would suggest droplet and aerosol routes of transmission are possible from individuals with no obvious signs or symptoms. Another limitation is that we did not confirm the infectivity of coronavirus or rhinovirus detected in exhaled breath. While the G-II was designed to preserve viability of viruses in aerosols, and in the present study we were able to identify infectious influenza virus in aerosols, we did not attempt to culture coronavirus or rhinovirus from the corresponding aerosol samples.

Online content

Any methods, additional references, Nature Research reporting summaries, source data, extended data, supplementary information, acknowledgements, peer review information; details of author contributions and competing interests; and statements of data and code availability are available at https://doi.org/10.1038/s41591-020-0843-2.

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References

1. Nichols, W. G., Peck Campbell, A. J. & Boeckh, M. Respiratory viruses other than influenza virus: impact and therapeutic advances. *Clin. Microbiol. Rev.* **21**, 274–290 (2008).
2. Shiu, E. Y. C., Leung, N. H. L. & Cowling, B. J. Controversy around airborne versus droplet transmission of respiratory viruses: implication for infection prevention. *Curr. Opin. Infect. Dis.* **32**, 372–379 (2019).
3. Tellier, R., Li, Y., Cowling, B. J. & Tang, J. W. Recognition of aerosol transmission of infectious agents: a commentary. *BMC Infect. Dis.* **19**, 101 (2019).
4. Xiao, J. et al. Nonpharmaceutical measures for pandemic influenza in nonhealthcare settings-personal protective and environmental measures. *Emerg. Infect. Dis.* https://doi.org/10.3201/eid2605.190994 (2020).
5. Kutter, J. S., Spronken, M. I., Fraaij, P. L., Fouchier, R. A. M. & Herfst, S. Transmission routes of respiratory viruses among humans. *Curr. Opin. Virol.* **28**, 142–151 (2018).
6. Cowling, B. J. & Leung, G. M. Epidemiological research priorities for public health control of the ongoing global novel coronavirus (2019-nCoV) outbreak. *Euro Surveill.* https://doi.org/10.2807/1560-7917.ES.2020.25.6.2000110 (2020).
7. Han, Q., Lin, Q., Ni, Z. & You, L. Uncertainties about the transmission routes of 2019 novel coronavirus. *Influenza Other Respir. Viruses* https://doi.org/10.1111/irv.12735 (2020).
8. MacIntyre, C. R. & Chughtai, A. A. Facemasks for the prevention of infection in healthcare and community settings. *BMJ* **350**, h694 (2015).
9. Ha'eri, G. B. & Wiley, A. M. The efficacy of standard surgical face masks: an investigation using "tracer particles". *Clin. Orthop. Relat. Res.* **148**, 160–162 (1980).
10. Patel, R. B., Skaria, S. D., Mansour, M. M. & Smaldone, G. C. Respiratory source control using a surgical mask: an in vitro study. *J. Occup. Environ. Hyg.* **13**, 569–576 (2016).
11. Johnson, D. F., Druce, J. D., Birch, C. & Grayson, M. L. A quantitative assessment of the efficacy of surgical and N95 masks to filter influenza virus in patients with acute influenza infection. *Clin. Infect. Dis.* **49**, 275–277 (2009).
12. Milton, D. K., Fabian, M. P., Cowling, B. J., Grantham, M. L. & McDevitt, J. J. Influenza virus aerosols in human exhaled breath: particle size, culturability, and effect of surgical masks. *PLoS Pathog.* **9**, e1003205 (2013).
13. Huynh, K. N., Oliver, B. G., Stelzer, S., Rawlinson, W. D. & Tovey, E. R. A new method for sampling and detection of exhaled respiratory virus aerosols. *Clin. Infect. Dis.* **46**, 93–95 (2008).
14. Stelzer-Braid, S. et al. Exhalation of respiratory viruses by breathing, coughing and talking. *J. Med. Virol.* **81**, 1674–1679 (2009).
15. Yan, J. et al. Infectious virus in exhaled breath of symptomatic seasonal influenza cases from a college community. *Proc. Natl Acad. Sci. USA* **115**, 1081–1086 (2018).
16. Tovey, E. R. et al. Rhinoviruses significantly affect day-to-day respiratory symptoms of children with asthma. *J. Allergy Clin. Immunol.* **135**, 663–669 (2015).
17. Booth, T. F. et al. Detection of airborne severe acute respiratory syndrome (SARS) coronavirus and environmental contamination in SARS outbreak units. *J. Infect. Dis.* **191**, 1472–1477 (2005).
18. Kim, S. H. et al. Extensive viable Middle East respiratory syndrome (MERS) coronavirus contamination in air and surrounding environment in MERS isolation wards. *Clin. Infect. Dis.* **63**, 363–369 (2016).
19. McDevitt, J. J. et al. Development and performance evaluation of an exhaled-breath bioaerosol collector for influenza virus. *Aerosol Sci. Technol.* **47**, 444–451 (2013).
20. Jennings, L. C. & Dick, E. C. Transmission and control of rhinovirus colds. *Eur. J. Epidemiol.* **3**, 327–335 (1987).

Methods

Study design. Participants were recruited year-round from March 2013 through May 2016 in a general outpatient clinic of a private hospital in Hong Kong. As routine practice, clinic staff screened all individuals attending the clinics for respiratory and any other symptoms regardless of the purpose of the visit at triage. Study staff then approached immediately those who reported at least one of the following symptoms of ARI for further screening: fever ≥37.8 °C, cough, sore throat, runny nose, headache, myalgia and phlegm. Individuals who reported ≥2 ARI symptoms, within 3 d of illness onset and ≥11 years of age were eligible to participate. After explaining the study to and obtaining informed consent from the participants, a rapid influenza diagnostic test, the Sofia Influenza A + B Fluorescent Immunoassay Analyzer (cat. no. 20218, Quidel), was used to identify influenza A or B virus infection as an incentive to participate. All participants provided a nasal swab for the rapid test and an additional nasal swab and a separate throat swab for subsequent virologic confirmation at the laboratory. All participants also completed a questionnaire to record basic information including age, sex, symptom severity, medication, medical conditions and smoking history. In the first phase of the study from March 2013 to February 2014 ('Influenza Study'), the result of the rapid test was used to determine eligibility for further participation in the study and exhaled breath collection, whereas in the second phase of the study from March 2014 to May 2016 ('Respiratory Virus Study'), the rapid test did not affect eligibility. Eligible participants were then invited to provide an exhaled breath sample for 30 min in the same clinic visit.

Before exhaled breath collection, each participant was randomly allocated in a 1:1 ratio to either wearing a surgical face mask (cat. no. 62356, Kimberly-Clark) or not during the collection. To mimic the real-life situation, under observation by the study staff, participants were asked to attach the surgical mask themselves, but instruction on how to wear the mask properly was given when the participant wore the mask incorrectly. Participants were instructed to breathe as normal during the collection, but (natural) coughing was allowed and the number of coughs was recorded by study staff. Participants were then invited to provide a second exhaled breath sample of the alternate type (for example if the participant was first assigned to wearing a mask they would then provide a second sample without a mask), but most participants did not agree to stay for a second measurement because of time constraints. Participants were compensated for each 30-min exhaled breath collection with a supermarket coupon worth approximately US$30 and all participants were gifted a tympanic thermometer worth approximately US$20.

Ethical approval. Written informed consent was obtained from all participants ≥18 years of age and written informed consent was obtained from parents or legal guardians of participants 11–17 years of age in addition to their own written informed consent. The study protocol was approved by the Institutional Review Board of The University of Hong Kong and the Clinical and Research Ethics Committee of Hong Kong Baptist Hospital.

Collection of swabs and exhaled breath particles. Nasal swabs and throat swabs were collected separately, placed in virus transport medium, stored and transported to the laboratory at 2–8 °C and the virus transport medium was aliquoted and stored at −70 °C until further analysis. Exhaled breath particles were captured and differentiated into two size fractions, the coarse fraction containing particles with aerodynamic diameter >5 µm (referred to here as 'respiratory droplets'), which included droplets up to approximately 100 µm in diameter and the fine fraction with particles ≤5 µm (referred to here as 'aerosols') by the G-II bioaerosol collecting device[12,15,19]. In the G-II device, exhaled breath coarse particles >5 µm were collected by a 5-µm slit inertial Teflon impactor and the remaining fine particles ≤5 µm were condensed and collected into approximately 170 ml of 0.1% BSA/PBS. Both the impactor and the condensate were stored and transported to the laboratory at 2–8 °C. The virus on the impactor was recovered into 1 ml and the condensate was concentrated into 2 ml of 0.1% BSA/PBS, aliquoted and stored at −70 °C until further analysis. In a validation study, the G-II was able to recover over 85% of fine particles >0.05 µm in size and had comparable collection efficiency of influenza virus as the SKC BioSampler[19].

Laboratory testing. Samples collected from the two studies were tested at the same time. Nasal swab samples were first tested by a diagnostic-use viral panel, xTAG Respiratory Viral Panel (Abbott Molecular) to qualitatively detect 12 common respiratory viruses and subtypes including coronaviruses (NL63, OC43, 229E and HKU1), influenza A (nonspecific, H1 and H3) and B viruses, respiratory syncytial virus, parainfluenza virus (types 1–4), adenovirus, human metapneumovirus and enterovirus/rhinovirus. After one or more of the candidate respiratory viruses was detected by the viral panel from the nasal swab, all the samples from the same participant (nasal swab, throat swab, respiratory droplets and aerosols) were then tested with RT–PCR specific for the candidate virus(es) for determination of virus concentration in the samples. Infectious influenza virus was identified by viral culture using MDCK cells as described previously[21], whereas viral culture was not performed for coronavirus and rhinovirus.

Statistical analyses. The primary outcome of the study was virus generation rate in tidal breathing of participants infected by different respiratory viruses and the efficacy of face masks in preventing virus dissemination in exhaled breath, separately considering the respiratory droplets and aerosols. The secondary outcomes were correlation between viral shedding in nose swabs, throat swabs, respiratory droplets and aerosols and factors affecting viral shedding in respiratory droplets and aerosols.

We identified three groups of respiratory viruses with the highest frequency of infection as identified by RT–PCR, namely coronavirus (including NL63, OC43, HKU1 and 229E), influenza virus and rhinovirus, for further statistical analyses. We defined viral shedding as $\log_{10}$ virus copies per sample and plotted viral shedding in each sample (nasal swab, throat swab, respiratory droplets and aerosols); the latter two were stratified by mask intervention. As a proxy for the efficacy of face masks in preventing transmission of respiratory viruses via respiratory droplet and aerosol routes, we compared the respiratory virus viral shedding in respiratory droplet and aerosol samples between participants wearing face masks or not, by comparing the frequency of detection with a two-sided Fisher's exact test and by comparing viral load (defined as $\log_{10}$ virus copies per sample) by an unadjusted univariate Tobit regression model, which allowed for censoring at the lower limit of detection of the RT–PCR assay. We also used the unadjusted univariate Tobit regression to investigate factors affecting viral shedding in respiratory droplets and aerosols without mask use, for example age, days since symptom onset, previous influenza vaccination, current medication and number of coughs during exhaled breath collection. We investigated correlations between viral shedding in nasal swab, throat swab, respiratory droplets and aerosols with scatter-plots and calculated the Spearman's rank correlation coefficient between any two types of samples. We imputed 0.3 $\log_{10}$ virus copies ml^{-1} for undetectable values before transformation to $\log_{10}$ virus copies per sample. All analyses were conducted with R v.3.6.0 (ref. [22]) and the VGAM package v.1.1.1 (ref. [23]).

Reporting Summary. Further information on research design is available in the Nature Research Reporting Summary linked to this article.

Data availability

Anonymized raw data and R syntax to reproduce all the analyses, figures, tables and supplementary tables in the published article are available at: https://doi.org/10.5061/dryad.w9ghx3fkt.

References

21. Chan, K. H., Peiris, J. S., Lim, W., Nicholls, J. M. & Chiu, S. S. Comparison of nasopharyngeal flocked swabs and aspirates for rapid diagnosis of respiratory viruses in children. *J. Clin. Virol.* **42**, 65–69 (2008).
22. R: a language and environment for statistical computing (R Foundation for Statistical Computing, Vienna, Austria, 2019).
23. Yee, T. W. *Vector Generalized Linear and Additive Models: with an Implementation in R* (Springer, 2016).

Acknowledgements

This work was supported by the General Research Fund of the University Grants Committee (grant no. 765811), the Health and Medical Research Fund (grant no. 13120592) and a commissioned grant of the Food and Health Bureau and the Theme-based Research Scheme (project no. T11-705/14-N) of the Research Grants Council of the Hong Kong SAR Government. We acknowledge colleagues including R. O. P. Fung, A. K. W. Li, T. W. Y. Ng, T. H. C. So, P. Wu and Y. Xie for technical support in preparing and conducting this study and enrolling participants; J. K. M. Chan, S. Y. Ho, Y. Z. Liu and A. Yu for laboratory support; S. Ferguson, W. K. Leung, J. Pantelic, J. Wei and M. Wolfson for technical support in constructing and maintaining the G-II device; V. J. Fang, L. M. Ho and T. T. K. Lui for setting up the database; and C. W. Y. Cheung, L. F. K. Cheung, P. T. Y. Ching, A. C. H. Lai, D. W. Y. Lam, S. S. Y. Lo, A. S. K. Luk and other colleagues at the Outpatient Center and Infection Control Team of Hong Kong Baptist Hospital for facilitating this study.

Author contributions

All authors meet the International Committee of Medical Journal Editors criteria for authorship. The study protocol was drafted by N.H.L.L. and B.J.C. Data were collected by N.H.L.L., E.Y.C.S. and B.J.P.H. Laboratory testing was performed by D.K.W.C. and K.-H.C. Statistical analyses were conducted by N.H.L.L. N.H.L.L. and B.J.C. wrote the first draft of the manuscript, and all authors provided critical review and revision of the text and approved the final version.

Competing interests

B.J.C. consults for Roche and Sanofi Pasteur. The authors declare no other competing interests.

Additional information

Extended data is available for this paper at https://doi.org/10.1038/s41591-020-0843-2.

Supplementary information is available for this paper at https://doi.org/10.1038/s41591-020-0843-2.

Correspondence and requests for materials should be addressed to B.J.C.

Peer review information Alison Farrell was the primary editor on this article and managed its editorial process and peer review in collaboration with the rest of the editorial team.

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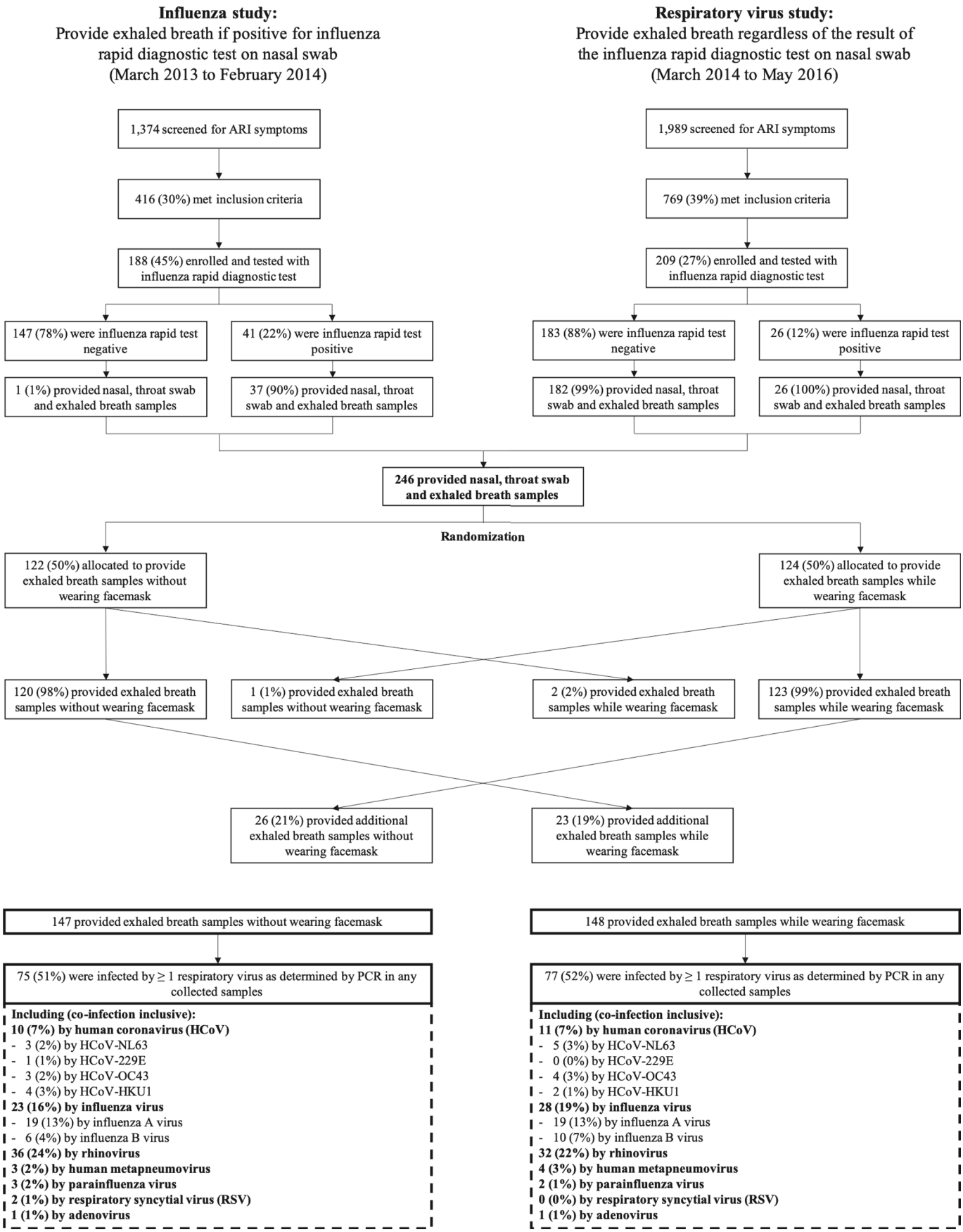
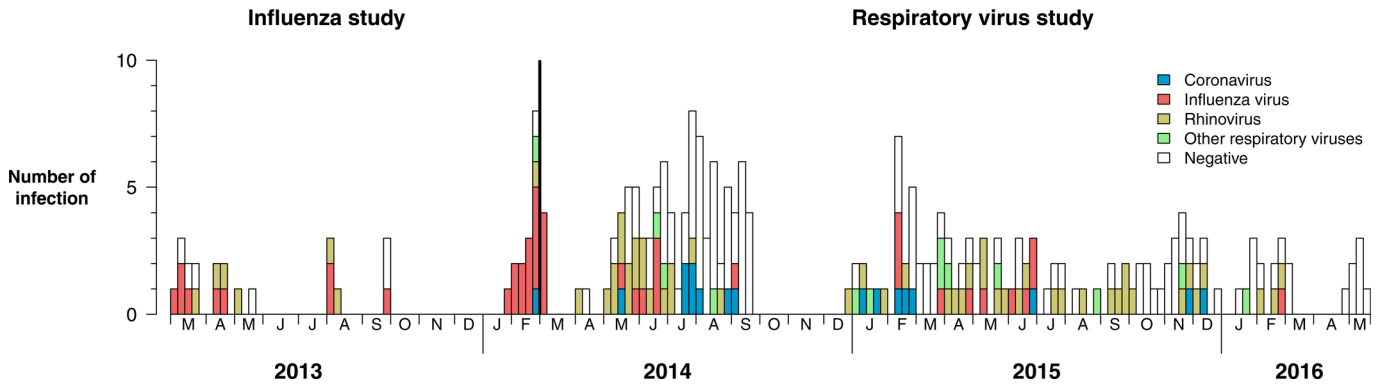
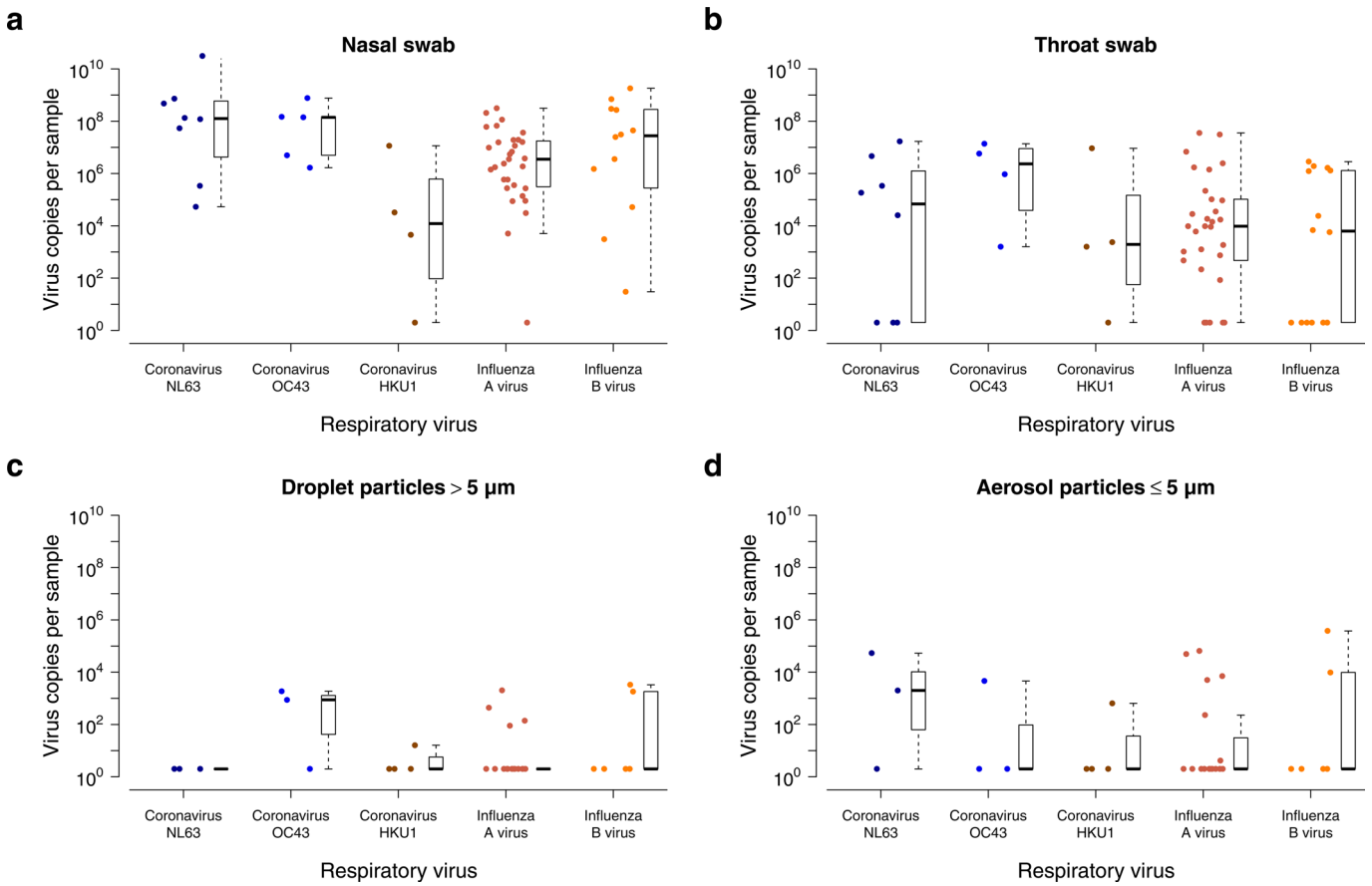


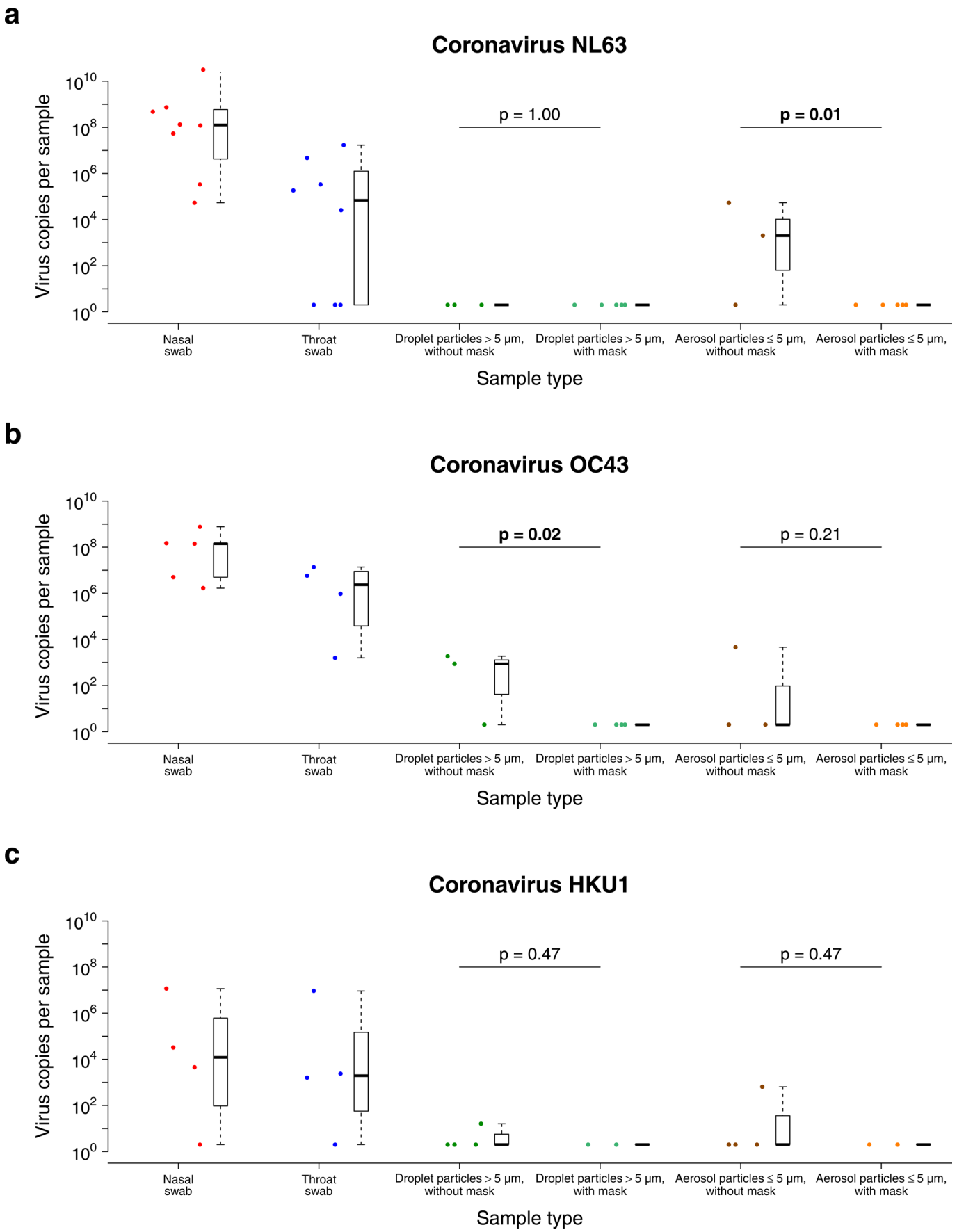
Extended Data Fig. 1 | Participant enrolment, randomization of mask intervention and identification of respiratory virus infection.



Extended Data Fig. 2 | Weekly number of respiratory virus infections identified by RT-PCR in symptomatic individuals who had provided exhaled breath samples (respiratory droplets and aerosols) during the study period. Blue, coronavirus; red, influenza virus; yellow, rhinovirus; green, other respiratory viruses including human metapneumovirus, parainfluenza virus, respiratory syncytial virus and adenovirus; white, no respiratory virus infection identified.

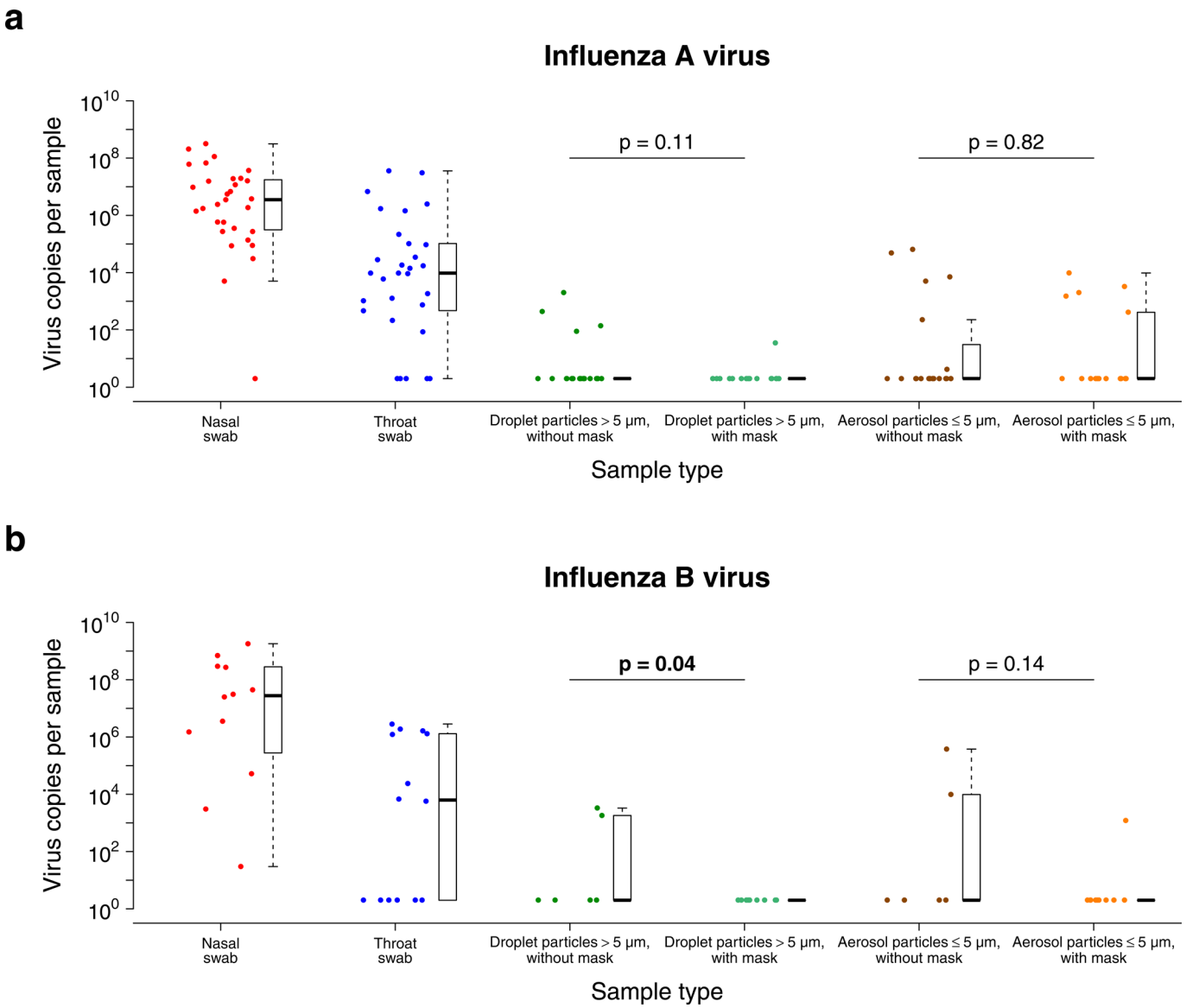


Extended Data Fig. 3 | Respiratory virus shedding in (a) nasal swab, (b) throat swab, (c) respiratory droplets and (d) aerosols in symptomatic individuals with coronavirus NL63, coronavirus OC43, coronavirus HKU1, influenza A and influenza B virus infection. For nasal swabs and throat swabs, all infected individuals identified by RT-PCR in any collected samples were included: coronavirus NL63 (n = 8), coronavirus OC43 (n = 5), coronavirus HKU1 (n = 4), influenza A virus (n = 31) and influenza B virus (n = 14). For respiratory droplets and aerosols, only infected individuals who provided exhaled breath samples while not wearing a surgical face mask were included: coronavirus NL63 (n = 3), coronavirus OC43 (n = 3), coronavirus HKU1 (n = 4), influenza A virus (n = 19) and influenza B virus (n = 6). The box plots indicate the median with the interquartile range (lower and upper hinge) and ±1.5 × interquartile range from the first and third quartile (lower and upper whisker). Dark blue, coronavirus NL63; light blue, coronavirus OC43; brown, coronavirus HKU1; red, influenza A virus; orange, influenza B virus.

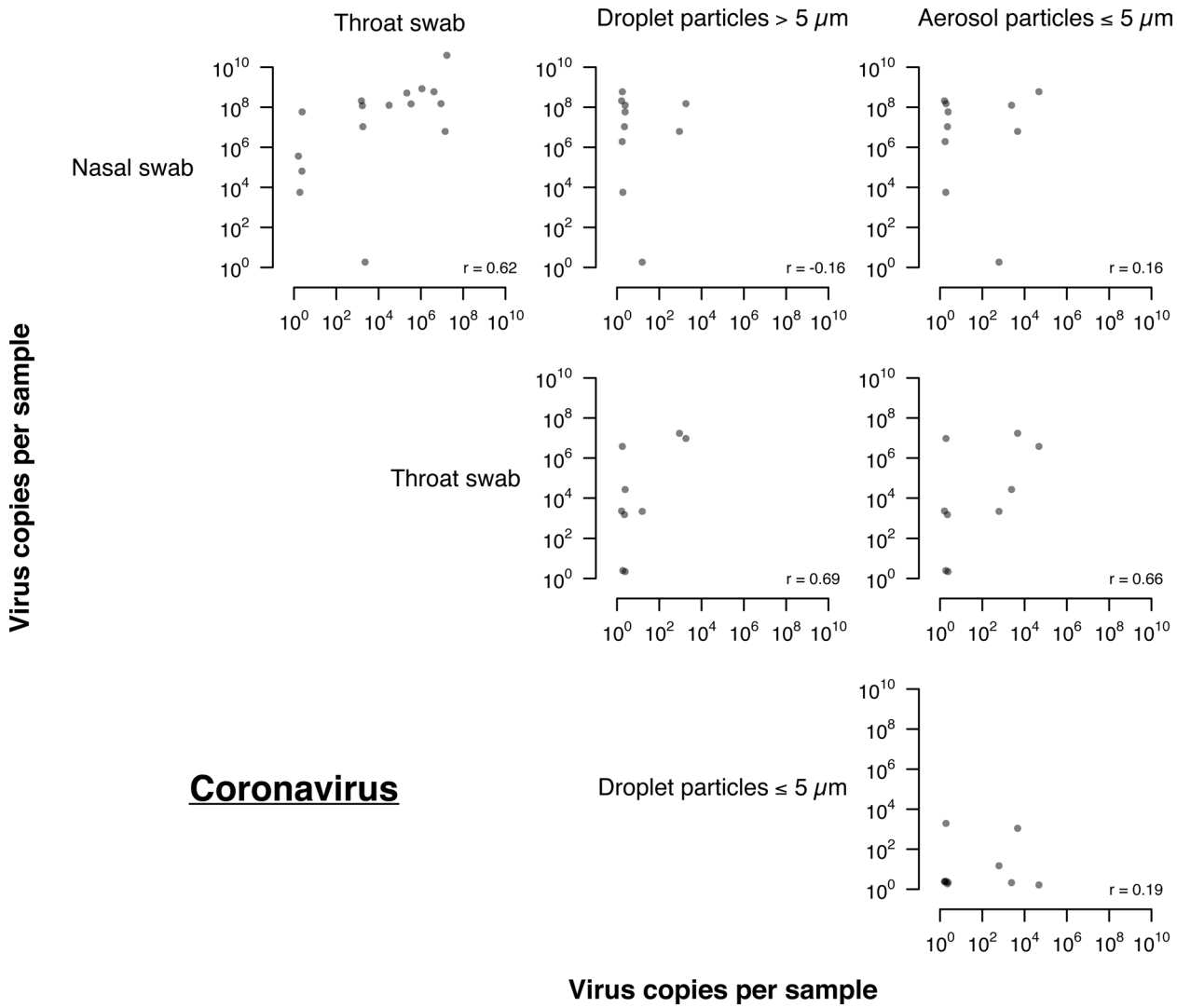


Extended Data Fig. 4 | See next page for caption.

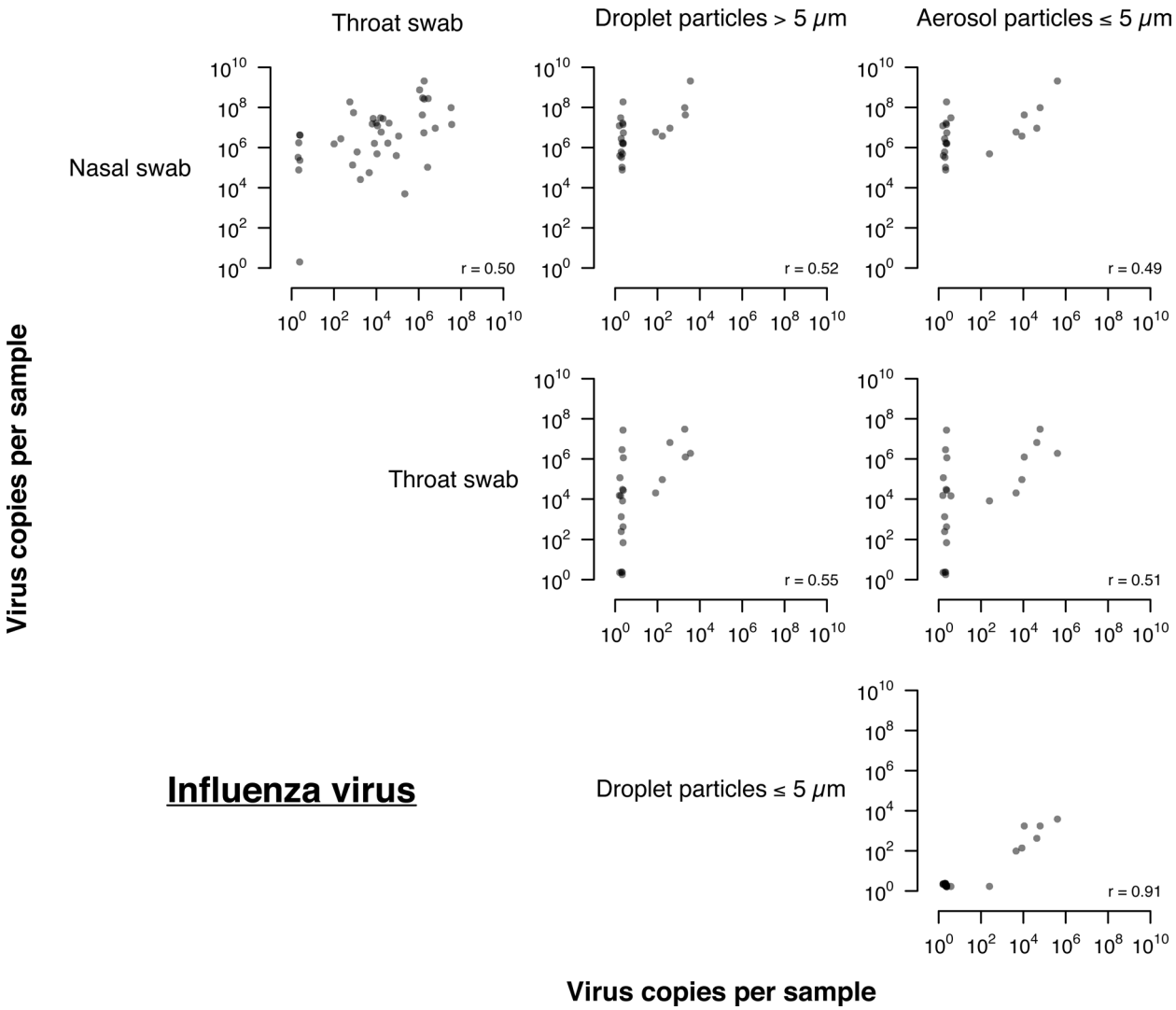
Extended Data Fig. 4 | Efficacy of surgical face masks in reducing respiratory virus shedding in respiratory droplets and aerosols of symptomatic individuals with seasonal coronaviruses including (a) coronavirus NL63, (b) coronavirus OC43 and (c) coronavirus HKU1. The figure shows the virus copies per sample collected in nasal swab (red), throat swab (blue), respiratory droplets collected for 30 min while not wearing (dark green) or wearing (light green) a surgical face mask and aerosols collected for 30 min while not wearing (brown) or wearing (orange) a face mask, collected from individuals with acute respiratory symptoms who were positive for coronavirus NL63, coronavirus OC43 and coronavirus HKU1 as determined by RT-PCR in any samples. *P* values for mask intervention as predictor of $\log_{10}$ virus copies per sample in an unadjusted univariate Tobit regression model which allowed for censoring at the lower limit of detection of the RT-PCR assay are shown, with significant differences in bold. For nasal swabs and throat swabs, all infected individuals were included (coronavirus NL63, n = 8; coronavirus OC43, n = 5; coronavirus HKU1, n = 4). For respiratory droplets and aerosols, numbers of infected individuals who provided exhaled breath samples while not wearing or wearing a surgical face mask, respectively were: coronavirus NL63 (n = 3 and 5), coronavirus OC43 (n = 3 and 4), coronavirus HKU1 (n = 4 and 2). A subset of participants provided exhaled breath samples for both mask interventions (coronavirus NL63, n = 0; coronavirus OC43, n = 2; coronavirus HKU1, n = 2).



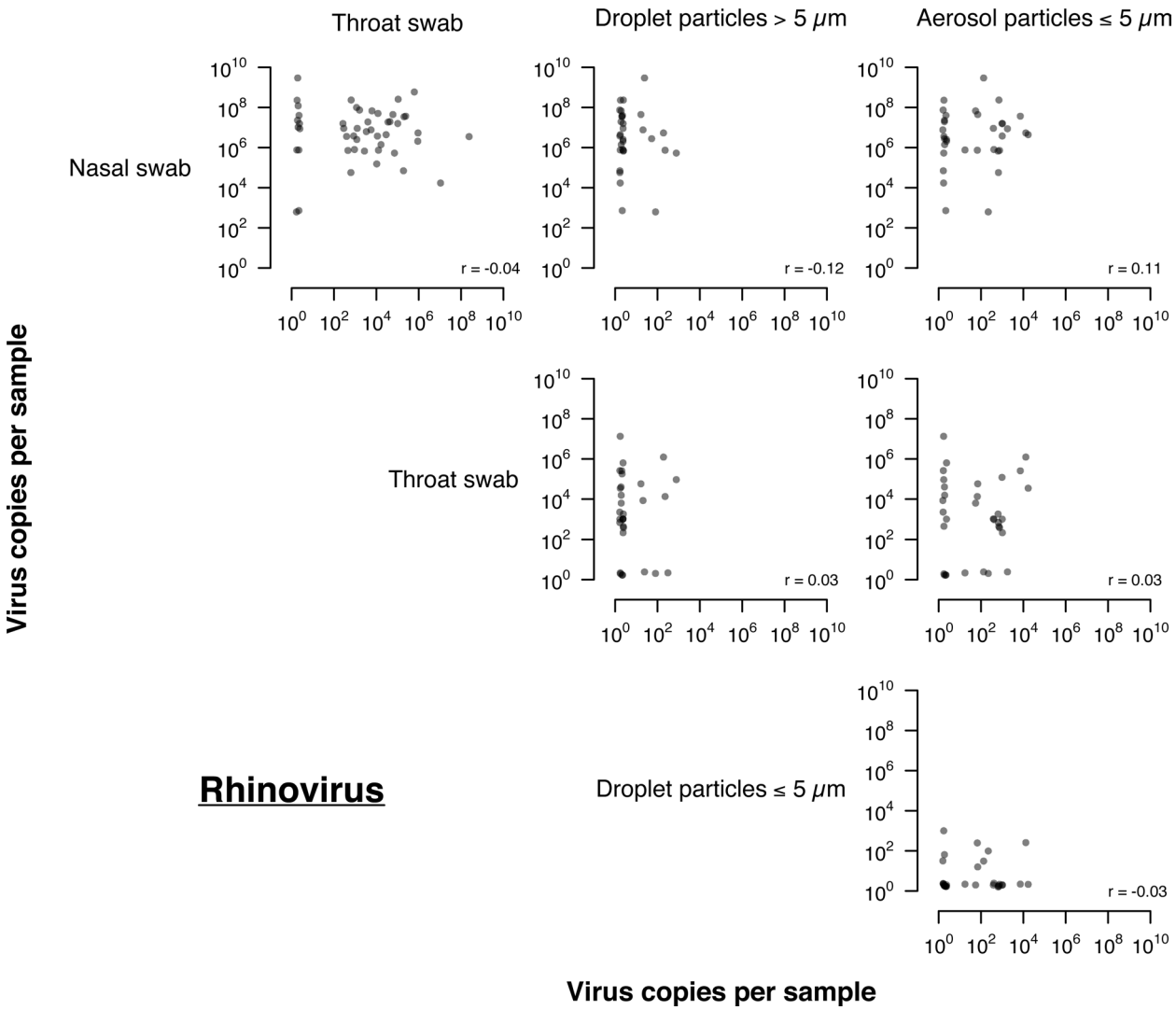
Extended Data Fig. 5 | Efficacy of surgical face masks in reducing respiratory virus shedding in respiratory droplets and aerosols of symptomatic individuals with seasonal influenza viruses including (a) influenza A and (b) influenza B virus. The figure shows the virus copies per sample collected in nasal swab (red), throat swab (blue), respiratory droplets collected for 30 min while not wearing (dark green) or wearing (light green) a surgical face mask and aerosols collected for 30 min while not wearing (brown) or wearing (orange) a face mask, collected from individuals with acute respiratory symptoms who were positive for influenza A and influenza B virus as determined by RT-PCR in any samples. *P* values for mask intervention as predictor of $\log_{10}$ virus copies per sample in an unadjusted univariate Tobit regression model which allowed for censoring at the lower limit of detection of the RT-PCR assay are shown, with significant differences in bold. For nasal swabs and throat swabs, all infected individuals were included (influenza A virus, n = 31; influenza B virus, n = 14). For respiratory droplets and aerosols, numbers of infected individuals who provided exhaled breath samples while not wearing or wearing a surgical face mask, respectively were: influenza A virus (n = 19 and 19), influenza B virus (n = 6 and 10). A subset of participants provided exhaled breath samples for both mask interventions (influenza A virus, n = 7; influenza B virus, n = 2).



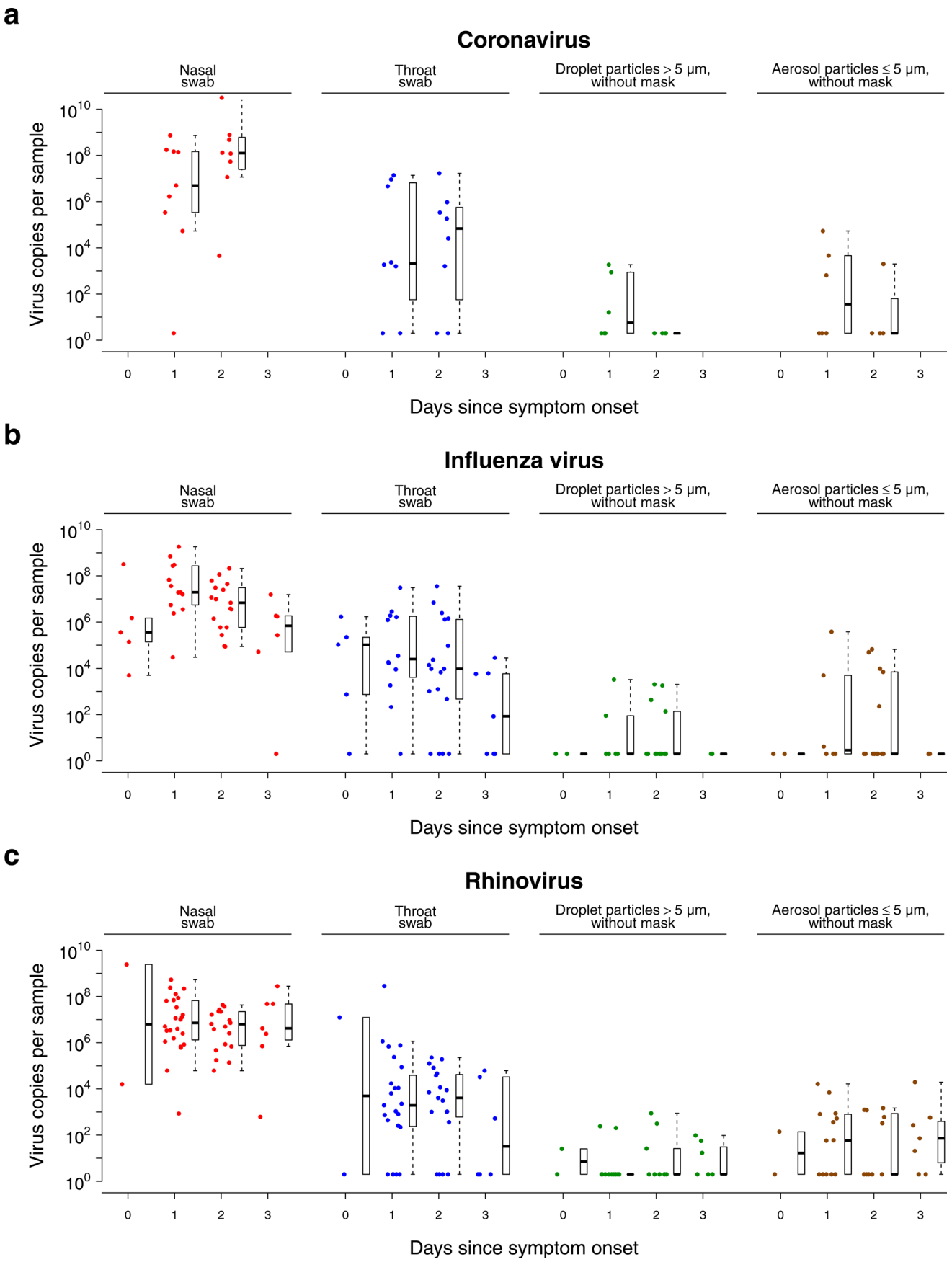
Extended Data Fig. 6 | Correlation of coronavirus viral shedding between different samples (nasal swab, throat swab, respiratory droplets and aerosols) in symptomatic individuals with seasonal coronavirus infection. For nasal swabs and throat swabs, all infected individuals were included (n = 17). For respiratory droplets and aerosols, only infected individuals who provided exhaled breath samples while not wearing a surgical face mask were included (n = 10). r, the Spearman's rank correlation coefficient.



Extended Data Fig. 7 | Correlation of influenza viral shedding between different samples (nasal swab, throat swab, respiratory droplets and aerosols) in symptomatic individuals with seasonal influenza infection. For nasal swabs and throat swabs, all infected individuals were included (n = 43). For respiratory droplets and aerosols, only infected individuals who provided exhaled breath samples while not wearing a surgical face mask were included (n = 23). r, the Spearman's rank correlation coefficient.



Extended Data Fig. 8 | Correlation of rhinovirus viral shedding between different samples (nasal swab, throat swab, respiratory droplets and aerosols) in symptomatic individuals with rhinovirus infection. For nasal swabs and throat swabs, all infected individuals were included (n = 54). For respiratory droplets and aerosols, only infected individuals who provided exhaled breath samples while not wearing a surgical face mask were included (n = 36). r, the Spearman's rank correlation coefficient.



Extended Data Fig. 9 | See next page for caption.

Extended Data Fig. 9 | Respiratory virus shedding in respiratory droplets and aerosols stratified by days from symptom onset for (a) coronavirus, (b) influenza virus or (c) rhinovirus. The figures shows the virus copies per sample collected in nasal swab (red), throat swab (blue), respiratory droplets (dark green) and aerosols (brown) collected for 30 min while not wearing a surgical face mask, stratified by the number of days from symptom onset on which the respiratory droplets and aerosols were collected. For nasal swabs and throat swabs, all infected individuals were included (coronavirus, n = 17; influenza virus, n = 43; rhinovirus, n = 54). For respiratory droplets and aerosols, numbers of infected individuals who provided exhaled breath samples while not wearing or wearing a surgical face mask, respectively were: coronavirus (n = 10 and 11), influenza virus (n = 23 and 28), rhinovirus (n = 36 and 32). A subset of participants provided exhaled breath samples for both mask interventions (coronavirus, n = 4; influenza virus, n = 8; rhinovirus, n = 14). The box plots indicate the median with the interquartile range (lower and upper hinge) and ±1.5 × interquartile range from the first and third quartile (lower and upper whisker).

nature research

Corresponding author(s): Benjamin John Cowling

Last updated by author(s): Mar 4, 2020

Reporting Summary

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Statistics

For all statistical analyses, confirm that the following items are present in the figure legend, table legend, main text, or Methods section.

n/a	Confirmed
☐	☒ The exact sample size (*n*) for each experimental group/condition, given as a discrete number and unit of measurement
☐	☒ A statement on whether measurements were taken from distinct samples or whether the same sample was measured repeatedly
☐	☒ The statistical test(s) used AND whether they are one- or two-sided *Only common tests should be described solely by name; describe more complex techniques in the Methods section.*
☐	☒ A description of all covariates tested
☐	☒ A description of any assumptions or corrections, such as tests of normality and adjustment for multiple comparisons
☐	☒ A full description of the statistical parameters including central tendency (e.g. means) or other basic estimates (e.g. regression coefficient) AND variation (e.g. standard deviation) or associated estimates of uncertainty (e.g. confidence intervals)
☐	☒ For null hypothesis testing, the test statistic (e.g. *F*, *t*, *r*) with confidence intervals, effect sizes, degrees of freedom and *P* value noted *Give P values as exact values whenever suitable.*
☒	☐ For Bayesian analysis, information on the choice of priors and Markov chain Monte Carlo settings
☒	☐ For hierarchical and complex designs, identification of the appropriate level for tests and full reporting of outcomes
☐	☒ Estimates of effect sizes (e.g. Cohen's *d*, Pearson's *r*), indicating how they were calculated

Our web collection on statistics for biologists contains articles on many of the points above.

Software and code

Policy information about availability of computer code

Data collection	No software was used.
Data analysis	All analyses were conducted with R version 3.6.0 and the VGAM package 1.1.1.

For manuscripts utilizing custom algorithms or software that are central to the research but not yet described in published literature, software must be made available to editors/reviewers. We strongly encourage code deposition in a community repository (e.g. GitHub). See the Nature Research guidelines for submitting code & software for further information.

Data

Policy information about availability of data

All manuscripts must include a data availability statement. This statement should provide the following information, where applicable:

- Accession codes, unique identifiers, or web links for publicly available datasets
- A list of figures that have associated raw data
- A description of any restrictions on data availability

Anonymized raw data and R syntax to reproduce all the analyses, figures, tables and supplementary tables in the published article are available at: [Dryad link pending].

Field-specific reporting

Please select the one below that is the best fit for your research. If you are not sure, read the appropriate sections before making your selection.

☒ Life sciences ☐ Behavioural & social sciences ☐ Ecological, evolutionary & environmental sciences

Life sciences study design

All studies must disclose on these points even when the disclosure is negative.

Sample size	We estimated a priori the sample size to be 300 participants. The primary outcome of the study was the reduction in the exhaled virus concentration of normal tidal breathing by wearing face mask in terms of total virus by RT-PCR as a proxy for infectious virus particle. We expected that a 1-log reduction in exhaled virus particle by face mask intervention would have a clinically relevant effect in reducing the probability of transmission. Except for influenza, there was no quantitative data available from exhaled breath samples from respiratory virus-infected individuals before the present study. If the standard deviation of exhaled virus concentration was 1 log copies/ml (Milton et al., PLoS Pathog 2013), we would detect a difference of >1 log copies/ml in the mask vs control group as long as we have >15 participants with a specific respiratory virus. For example, if our study included 23 participants with rhinovirus detectable in exhaled breath without a mask, we will have 80% power and 0.05 significance level to identify differences in viral shedding in aerosols of 1.28 log10 copies associated with the use of face masks, assuming a standard deviation of 1.54 log10 copies based on data from nasal and throat swab (Lu et al., J Clin Microbiol 2008). We expected from 300 individuals with ARI, at least 150 to have a respiratory virus, and at least 20-30 to have each of rhinovirus, coronavirus, adenovirus and parainfluenza plus small numbers of other respiratory viruses, assuming the Viral Panel would detect respiratory viruses in 60% of participants including 10% by influenza (since we partly recruited during the influenza seasons) and the other 50% made up of rhinovirus, coronavirus, adenovirus and parainfluenza virus.
Data exclusions	As described in the Results section and Supplementary Figure 1, only participants who provided exhaled breath samples and randomized to mask intervention were included; and final analyses were performed only for participants with either coronavirus, influenza virus or rhinovirus infection, which had sufficient sample size for comparison between mask intervention.
Replication	Samples from a subset of participants identified with a coronavirus, influenza or rhinovirus infection were re-tested by RT-PCR with consistent results. R syntax is available to reproduce all the analyses, figures, tables and supplementary tables in the published article.
Randomization	Prior to the exhaled breath collection, each participant was randomly allocated in a 1:1 ratio to either wearing a surgical face mask or not during the exhaled breath collection using a computer-generated sequence. The allocation was concealed to the study stuff performing the exhaled breath collection before allocation of the mask intervention.
Blinding	Blinding to the participant and the study stuff for the mask intervention was not possible. The study staff performing the statistical analyses was also involved in the data collection. We expected there would be minimal bias due to unblinding since data collection for questionnaires was done before randomization to mask intervention, and viral load from a sample measured by RT-PCR is an objective measurement.

Reporting for specific materials, systems and methods

We require information from authors about some types of materials, experimental systems and methods used in many studies. Here, indicate whether each material, system or method listed is relevant to your study. If you are not sure if a list item applies to your research, read the appropriate section before selecting a response.

Materials & experimental systems

n/a	Involved in the study
☒	☐ Antibodies
☐	☒ Eukaryotic cell lines
☒	☐ Palaeontology
☒	☐ Animals and other organisms
☐	☒ Human research participants
☐	☒ Clinical data

Methods

n/a	Involved in the study
☒	☐ ChIP-seq
☒	☐ Flow cytometry
☒	☐ MRI-based neuroimaging

Eukaryotic cell lines

Policy information about cell lines

Cell line source(s)	Madin-Darby Canine Kidney (MDCK) cells
Authentication	European Collection of Authenticated Cell Cultures.
Mycoplasma contamination	We confirm that all cell lines tested negative for mycoplasma contamination.
Commonly misidentified lines (See ICLAC register)	Nil

Human research participants

Policy information about studies involving human research participants

Population characteristics	As described in the Results section, Table 1a and Supplementary Table 1, there were some differences in characteristics of participants with the different viruses. Overall, most participants were younger adults and 5% were age 11-17 years, but there were more children with influenza virus and no children in the subgroup with coronavirus infection. Overall, 59% were female, but there were more females among the subgroup with coronavirus infection. The majority of participants did not have underlying medical conditions and overall 9% had received influenza vaccination for the current season but only 2% among those with influenza virus infection. The majority of participants were sampled within 24–48 or 48–72 hours of illness onset. 24% of participants had a measured fever ≥37.8ºC, with influenza patients more than twice as likely than coronavirus and rhinovirus-infected patients to have a measured fever. Coronavirus-infected participants coughed the most with an average of 17 (SD 30) coughs during the 30-minute exhaled breath collection. The profile of the participants randomized to with-mask vs without-mask groups were similar.
Recruitment	As described in the Methods section, participants were recruited year-round from March 2013 through May 2016 in a general outpatient clinic of a private hospital in Hong Kong. As routine practice, clinic staff screened all individuals attending the clinics for respiratory and any other symptoms regardless of the purpose of the visit at the triage. Study staff then approached immediately those who reported at least one of the following symptoms of acute respiratory illness (ARI) for further screening: fever≥37.8ºC, cough, sore throat, runny nose, headache, myalgia and phlegm. Individuals who reported ≥2 ARI symptoms, within 3 days of illness onset and ≥11 years of age were eligible to participate.
Ethics oversight	As described in the Methods section, the study protocol was approved by the Institutional Review Board of The University of Hong Kong and the Clinical and Research Ethics Committee of Hong Kong Baptist Hospital.

Note that full information on the approval of the study protocol must also be provided in the manuscript.

Clinical data

Policy information about clinical studies

All manuscripts should comply with the ICMJE guidelines for publication of clinical research and a completed CONSORT checklist must be included with all submissions.

Clinical trial registration	The present study was not registered in clinical trials registries, as it was a laboratory-based study of detection of viruses in exhaled breath and the effect of wearing surgical facemasks on virus detection. It was not a Phase II/III clinical trial.
Study protocol	Not available in clinical trials registries (as above). Study protocol will be made available to editors and peer reviewers if requested.
Data collection	As described in the Methods section, participants were recruited year-round from March 2013 through March 2016 in a general outpatient clinic of a private hospital in Hong Kong. Data collection for questionnaires and exhaled breath sample collection was done face-to-face with the participant by trained study staff at the same clinic on the day of participant enrolment.
Outcomes	As pre-specified in the study protocol, the primary outcomes of the study were the virus generation rate in the tidal breathing of participants infected by different respiratory viruses, and the efficacy of face mask in preventing virus dissemination in exhaled breath especially at the aerosol fraction. As pre-specified in the study protocol, one of the secondary outcomes was to provide indirect evidence for relative importance of different transmission routes of influenza and other respiratory viruses. In this regard, in the present manuscript we examined the correlation between viral shedding in nose swabs, throat swabs, respiratory droplets and aerosols, and factors affecting viral shedding in respiratory droplets and aerosols. As described in the Discussion section in the present manuscript about the limitation of our study, there was large proportion of participants with undetectable viral shedding in exhaled breath for each of the viruses studied, and therefore we were unable to examine the exhaled respiratory virus reduction proportion by chi-squared test, nor the exhaled respiratory virus reduction volume (i.e. viral load) by t-test and linear regression as pre-specified in the study protocol. Instead, we have used Fisher's exact test and Tobit regression for the same purposes respectively.

From: St-Pierre, Johanie
To: Legislative Assistants
Subject: No for the marsk
Date: Sunday, September 13, 2020 8:32:56 AM

Me and my familly dont want the mask.

Get Outlook for iOS

From: Sharon Stuve Mitchelmore
To: Legislative Assistants
Subject: Please vote No to Mandatory Masks
Date: Saturday, September 12, 2020 12:54:05 AM

This City has suffered enough with the destruction of the oil sector while we buy foreign oil, the 2016 fire without any federal support and the flood.
People are leaving this beautiful city as their hopes and dreams slowly die.

Now with covid19, small businesses are closing shop one by one. They will never be able to return. Fort MCMurray is quickly becoming a ghost town and we look to you to represent the citizens today with equal consideration by leaving each to choose whether they mask or not.
Do not make it mandatory removing freedom of choice and further destroy this city as there isn't room for more despair.

The fear mongering must stop in order for recovery to begin and before healthy people succumb to bacterial infections which will undoubtedly be caused by extensive wearing of masks.
When that occurs, the hospitals will be overrun but it will not be from covid itself but by the mismanaging of it.

People are losing their homes because they are not permitted to work. Suicides are up and people are delaying health issues because they fear that they will be placed in isolation if by chance they have to go into the hospital and test positive. It's scary to know people are afraid of hospitals now And putting off addressing other health issues because of a virus that kills less than 1%. The quarantine rules will force many to quarantine multiple times without ever catching the virus simply by knowing someone who did.

Locking down This City is not in the best interests of this city nor its citizens. It simply takes away freedom of choice, creates division and trust issues; and risks the healthy getting sick from masks.

The argument that medical folks wear masks all day holds no water because we all know they have access to masks that are changed out frequently.

I'm retired, healthy and fortunately don't have anyone in the school system so wearing a mask or not won't make a personal difference to me.
I will never have to wear it extensively and I'm capable as an adult to ensure a mask must be changed frequently. Kids won't have that advantage.

So my request is two-fold:
1) freedom of choice
2) do not create environment for bacterial infections to make our citizens ill unnecessarily as our little hospital here do not have the capacity to handle it. Those at the highest risk will be the children.

Vote with logic and be brave enough to acknowledge that this virus is here to stay. We must learn to live with it. Creating an environment that compromises immune systems is irresponsible.

Sunni-Page Swyers

From:
To: Legislative Assistants
Subject: Read before mask debate
Date: Sunday, September 13, 2020 6:52:52 AM

I am writing in today to say I am NOT in favour of mandatory masks. Please do your due diligence and thoroughly read full content prior to the Sept 14th 2020 debate. Thank you in advance.

Fort McMurray has done very well in dealing with cases and the continued amount of recoveries are proof. Even with the increase of cases we are seeing a rapid amount of recoveries at 10-14 days after infection due to the 99.9% recovery rate.

We need to understand that we are doing a massive amount of testing and for those reasons alone there are more positive cases. I have a huge concern for the test accuracy due to the amount of published articles on false positives and the fact that they have not even isolated the virus itself. This should be very worrisome that we do not have accurate and reliable resources.

WHO and studies have indicated that the spread of Asymptomatic carries is low if not rare. A few of the cited papers explicitly examined population-level asymptomatic transmission rates. One, a preprint (i.e., not-yet peer-reviewed) research review posted to the site MedRxiv on June 4, analyzed four previous studies (two published and two preprint) that estimated asymptomatic transmission rates. The highest estimate was a transmission rate of 2.2%, suggesting “asymptomatic spread is unlikely to be a major driver of clusters or community transmission of infection.

Dr Hinshaw has said and I quote
“What we know from best available evidence is that Face masks are really effective when someone who is sick is wearing them to prevent spread to others and we know that in workplace settings when someone is needing to provide close care especially in health care to someone who is sick, a face mask when it is combined with all the other appropriate personal protective equipment and measures that limit the spread of infections from one person to another that is also effective. But what we have seen from studies in previous occasions like the previous pandemic in 2009 or in SARS is that if you wear a face mask alone while you are well and just out and about it doesn’t seem to add a great deal of protection over and above regular hand washing and avoiding touching your face with unwashed hands and in fact if people are wearing face masks in a way that is not correct, so say they are putting their face mask on with unwashed hands or taking it off with unwashed hands they can actually contaminate themselves potentially causing more risk. So really depends on how face masks are worn and again, the recommendation is that people who are sick should wear those to prevent spread to others and in healthcare or workplace settings again with personal protective equipment not the mask alone the entire sweep of precautions is necessary.”

Masks have not been effectively proven to prevent the spread. They may prevent how far it can travel outwards but the virus size is 40x the width of a hair strand and it can still travel through any gaps in the masks and directly through the covering of your mouth. If in fact someone was infected it would STILL transmitted even if everyone was masked. Watching Cities like Edmonton, Calgary, Toronto who have mandatory masks and are still having increase cases is proof they are not the saving grace. Wearing a mask at this point is causing more harm to the one wearing it, restricting their oxygen source and creating moisture and a breeding ground for bacteria to grow. The WHO and CDC recommends changing out a mask when it become damp/dirty or worn for 30mins. This is not feasible and surely not happening. The system has been very flip flop in the direction from the top since the beginning and I have no faith according to the publish studies that they are effective. It is purely symbolic.

Jason Kenney has stated and I quote “I think at this point, Alberta has done a very good job of preventing the spread,” he said. “The average age of COVID-19 related fatalities in Alberta is 84. The average life expectancy in the province is 83. And the vast majority of those who we have lost to COVID-19 were not only the average age of 84, but they had one or more chronic health conditions or comorbidities.” he does not want to micromanage Albertans.

Mandating overrides people’s rights to make decisions for their own health. Anxiety, panic attacks, asthma,claustrophobia and pregnancies are just a few reasons why one may not be fit to wear a mask for any length of time. Residents of the RMWB should not be belittled, harassed every time they enter a store or refused service because of these conditions and forced or fined into wearing one. Children who do not have the intellectual ability to understand why or how to wear them should never be forced to cover their mouths and should not be jeopardized for not doing so. I am extremely fearful on the long term mental heath effects this pandemic will have on our children. Studies have shown how the wild fires crisis has effected those who went through it along with those who were and became pregnant afterwards. Highly intrusive measures have already and will continue to have a negative toll on ones mental health. There is a terrifying evidence showing the increase in children suicides due to the isolations and lockdown measures that can’t be ignored.

We got through the peak of this pandemic with minimal restrictions and no masks. The curve is flattened. Yes more cases will happen but this is a good thing with achieving herd immunity. I know Fort McMurray can get through this pandemic without harsh restrictions, laws, fines and orders. Please consider the livelihood and the long term effects on the residences in the RMWB.

I ask you to consider these points when choosing to take the freedom rights away from the people of Fort McMurray.

Resources:

ALBERTA

March 17, 2020 – Alberta declared a public health emergency under section 52.1 of Alberta's Public Health Act.
State of Public Health Emergency
52.1(1) Where, on the advice of the Chief Medical Officer, the
Lieutenant Governor in Council is satisfied that
(a) a "public health emergency exists" or" may exist"

SUMMARY and CONCLUSION

Total covid-19 "related" deaths Canada-wide at time of declarations in March 2020 was 750
Current covid-19 "related" deaths as of September 11, 2020 Canada-wide is 9,163
Canada's total population is nearly 38,000,000
Alberta covid-19 "related" deaths as of September 11, 2020 = 253
Alberta population as of 2020 = 4,428,247

Children suicide rate 2020
https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-canada-infographic.html

Justice Centre for Constitutional Freedoms
https://www.jccf.ca/making-face-masks-mandatory-is-not-backed-by-science-or-law/

Jason Kenney briefing
https://globalnews.ca/news/7324554/kenney-restrictions-september-covid-19-b-c/

Virus has not been isolated
https://standupcanada.ca/wp-content/uploads/2020/09/Isolation-Virus-UK-1.pdf

Additional Ontario Canada form.

"Meanwhile.... Christine Massey from Brampton, Ontario has submitted Freedom of Information requests to various Canadian institutions, including Health Canada, seeking records that describe the isolation of a SARS-COV-2 virus from any unadulterated sample taken from a diseased patient. Here is what she describes in her posting:
"Thus far (August 21, 2020) 6 Canadian institutions have provided me their final response to my request: Health Canada, the National Research Council of Canada, the University of Toronto, Sunnybrook Health Sciences Centre, McMaster University, and the Region of Peel (Ontario). Every institution has indicated the same: that they searched and could locate NO record describing the isolation of any "COVID-19 virus"."

- Garry Lowney

Recent False positive testing

https://www.nbcnews.com/news/us-news/coronavirus-testing-boston-lab-suspended-after-nearly-400-false-positives-n1239656?fbclid=IwAR2Jz3AM1jWVZ399PyDF4ux2GUXNaLd4AjjstmnLDLUJQINTtRKAb6FCVjc

Get Outlook for iOS

From: Amy Thibodeau
To: Legislative Assistants
Subject: No to the mandatory mask/face covering bylaw
Date: Sunday, September 13, 2020 7:34:15 PM

It is my expressed wish that the RMWB Council does NOT implement a mandatory mask or face covering bylaw for indoor spaces. Those who wish to mask may do so, those who wish to not mask may choose to do so, equal rights. I trust you will not take my rights away.
Amy Thibodeau
Fort Mcmurray

Sent from my iPhone

From: Shauna Thompson
To: Legislative Assistants
Subject: Regarding potential Mandatory Mask Bylaw
Date: Saturday, September 12, 2020 6:23:13 AM

Hello,
Because of my job as a real estate agent, I really need to stay out of political discussions, however I would still like to have my voice heard.
I don't believe we should have a mandatory mask bylaw. I don't feel our economy can handle it. Businesses and individuals should be allowed to make whatever decision is best for themselves and the business.
Thank you.

--
Sincerely, Shauna Thompson Section 17 (1) FOIP [redacted]

From: April Tollman
To: Legislative Assistants
Subject: Fort McMurray Mandatory Mask Bylaw - Opposed
Date: Saturday, September 12, 2020 8:35:39 AM
Attachments: Open Letter to RMWB.pdf

Good Day,

Please see attached my open letter opposing a mandatory mask bylaw in Fort McMurray.

Two other major points I'd like to make are:

- Why don't the people that want to wear them so badly just wear them and let everyone make their own choices to either wear them or not

- How about we all just respect each other and allow everyone to make their own decision and be done with it and stop the fighting

The above comments I've made on the RMWB's facebook post debating this bylaw and I believe in freedom of choice. Mandatory masks have not brought the numbers of new cases down in cities that have implemented a similar bylaw so please don't take away our freedom of choice.

Regards,

April Tollman
Fort McMurray, Ab

Open Letter

September 9, 2020.

Dear Councillors of the Regional Municipality of Woodbuffalo,

With the upcoming debate to be held on September 14, 2020, I write to you as a concerned citizen of Fort McMurray. I am asking that you strongly consider not making masks a mandated bylaw.

By **John Carpay** "The curve is flat, and has been for months. COVID-19 deaths peaked in March or April (depending on which jurisdiction) and now continue to decline, even while increased testing exposes more "cases." If masks were not required to flatten the curve, why should they be required now?

Many leading doctors and public health officials from around the world support mandatory mask-wearing. But this does not mean that the science is settled.

One study states that cloth masks pose a 13 percent increased risk of influenza-like illness infection to those wearing them, noting that "moisture retention, reuse of cloth masks, and poor filtration may result in an increased risk of infection." This past April, the World Health Organization (WHO) also confirmed that masks "offer a false sense of security, leading to potentially less adherence to other preventive measures."

The same WHO document points to problems with self-contamination that can occur by touching and reusing contaminated masks, and potential breathing difficulties due to decreases in oxygen levels.

Health professionals observe rampant misuse of masks in the community. Contamination by the incorrect removal of masks is a persistent problem, even among trained medical personnel. England's deputy chief medical officer, Dr. Jenny Harries notes that one "can actually trap the virus in the mask and start breathing it in" and that "people can adversely put themselves at more risk than less."

The New England Journal of Medicine explained recently that "wearing a mask outside health care facilities offers little, if any, protection from infection," and that masks "serve symbolic roles" as "talismans" that may help increase a "perceived sense of safety" and do more to reduce anxiety than to reduce the transmission of Covid-19. Likewise, Dr. Anthony Fauci, member of the U.S. White House's coronavirus task force, recently said that masks are symbolic of being a responsible citizen rather than a dependable infection-control measure.

A WHO guideline from June 5, 2020 states: "At present, there is no direct evidence (from studies on COVID-19 and in healthy people in the community) on the effectiveness of universal masking of healthy people in the community to prevent infection with respiratory viruses, including COVID-19. … At the present time, the widespread use of masks by healthy people in the community setting is not yet supported by high quality or direct scientific evidence and there are potential benefits and harms to consider."

Masks impair communication, harshly impacting vulnerable people with mental-health disorders and developmental disabilities; the deaf and hard of hearing; those with cognitive impairments; and children. Dangerous miscommunications can result when those who suffer from hearing loss are not able to hear someone who is wearing a mask. These risks are even greater in multicultural settings, where a person often needs to see the speaker's mouth and face to fully understand what is being said.

Assuming for a moment that the spread of COVID-19 is actually reduced by forcing the public to wear non-medical masks, this still does not address the violation of personal autonomy and human dignity, which are protected by the *Canadian Charter of Rights and Freedoms*.

Faces are the glue that holds us together, giving us our identity. Recognizing a face is vital to our social lives. By seeing each other's faces, we discern emotional expressions such as joy, fear or anger. As the Czech-and-French author Milan Kundera wrote in his 1988 book *Immortality*: "The serial number of a human specimen is the face, that accidental and unrepeatable combination of features."

The significance of the uncovered face was underscored not long ago by the heated debate over Quebec's law banning face-coverings. Quebec Premier Philippe Couillard argued: "We are just saying that for reasons linked to communication, identification and safety, public services should be given and received with an open face… We are in a free and democratic society. You speak to me, I should see your face, and you should see mine. It's as simple as that."

Opponents of this Quebec law argue that living in a free society means being able to choose what to wear, and what not to wear. To cover or expose one's face is a profoundly personal choice that carries with it political, cultural, psychological and spiritual implications.

Few would disagree that an "open face" helps with communication, identification and safety. Antifa thugs and criminals wear masks for a reason.

The *Charter* requires politicians to justify laws that diminish the realm of personal choice. Even if mask-wearing really does reduce the spread of COVID, it's necessary to distinguish the fearmongering of this past March from the facts we now know in July. In March, the politicians relied on claims by Dr. Neil Ferguson of Imperial College that COVID-19 would kill 510,000 people in the UK and 2.2 million Americans. We were told in March that COVID threatened everyone, including children and healthy adults.

Today we know that what politicians and chief medical officers said in March was not just false, but demonstrably false. Alberta Premier Jason Kenney and Chief Medical Officer Deena Hinshaw claimed that as many as 32,000 Albertans could die of COVID. As of July 23, the number was 176 (not 32,000) and 97 percent of deaths were amongst people over 60.

Today, government data tells us that COVID poses very little threat to children or youth. Like other viruses, it threatens elderly people with one or more serious health conditions. We now know that four fifths of COVID deaths occurred in nursing homes, amongst elderly people who were already very sick. As a cause of death, the impact of COVID on healthy adults under 60 has

been negligible in comparison to so many other causes of death. Statistically speaking, healthy adults have more to fear from driving than they do of dying of COVID.

On a global scale, COVID deaths are a small fraction of the number of lives claimed by the Asian Flu (1957-58) and the Hong Kong Flu (1968-69). In Alberta and other jurisdictions, the average age of death from COVID is higher than the average life expectancy; COVID has little if any impact on life expectancy.

Yet government policies are still based on the panic of March, rather than on the facts known in July. The media continue to speak about COVID as though death is not a natural part of life, and as though no person has ever died (whether wholly or partly) from a virus. Government policy seems to be predicated on the notion that we can somehow make people live forever (or for a very long time) even when they are already very elderly and very sick.

What is "unprecedented" in 2020 is not COVID but a new social and political experiment of locking up an entire population of millions of healthy people, pushing many of them into unemployment, poverty, depression and loneliness, all of which significantly reduce overall health. This is completely different from quarantine: the ages-old practice of isolating the sick.

Another "unprecedented" feature of 2020 is politicians and chief medical officers who ignore settled medical opinion that the best way to vanquish a virus (and to protect the vulnerable from it) is to allow it to spread amongst people who are younger, stronger and healthier. Once "population immunity" ("herd immunity") is established, the virus cannot easily spread further, and therefore has far less chance of harming the vulnerable. If wearing a mask truly works to reduce the spread of a virus, then mask-wearing will hurt the vulnerable by delaying the acquisition of population immunity.

Settled medical opinion about herd immunity cannot simply be disregarded or dismissed. Those who believe that we can and should try to stop the spread of a virus amongst healthy and invulnerable people must prove and justify their novel approach."

Again, I write this letter and beg you not to pass the mask bylaw.

Sincerely,

A Concerned Citizen

https://www.jccf.ca/making-face-masks-mandatory-is-not-backed-by-science-or-law/

https://apps.who.int/iris/bitstream/handle/10665/331693/WHO-2019-nCov-IPC_Masks-2020.3-eng.pdf?sequence=1&isAllowed=y

https://www.independent.co.uk/news/health/coronavirus-news-face-masks-increase-risk-infection-doctor-jenny-harries-a9396811.html

https://www.nejm.org/doi/full/10.1056/NEJMp2006372?query=TOC

https://apps.who.int/iris/handle/10665/332293

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4420971/

https://www.educateadvocateca.com/face-masks-and-social-distancing/

https://www.acpjournals.org/doi/10.7326/M20-1342

https://www.realclearpolitics.com/video/2020/05/12/flashback_march_2020_fauci_says_theres_no_reason_to_be_walking_around_with_a_mask.html

From: alisa unruh
To: Legislative Assistants
Subject: Mask bylaw
Date: Monday, September 14, 2020 10:46:50 AM

I disagree with the mask bylaw. They are proven to not be an effective way to prevent virus transmission. The covid 19 virus has been grossly exaggerated by the government by propaganda. I will not wear and mask to every public place. Businesses should have the choice to decide so and should every person.

Alisa Unruh
Section 17 (1) FOIP

From: Christine Unruh
To: Legislative Assistants
Cc: Mike Allen; Krista Balsom; Keith McGrath; Phil Meagher; Verna Murphy; Sheila Lalonde; Claris Voyageur; Jeff Peddle; Don Scott; Bruce Inglis; Jane Stroud
Subject: Att: Mask Bylaw
Date: Saturday, September 12, 2020 2:00:38 PM

RMWB City Counsel Members,

I have seen other letters that more eloquently & factually describe many of the reasons I am against a mandatory mask bylaw. But, in my own words I would like to put emphasis on my personal reasons for not being in support of your proposed bylaw. I urge you to remove your own bias & at least consider our point of view. It has been suggested on social media you having your mind made up prior to being publicly urged to invite residents to voice their opinion, your scheduled vote being a matter of process. This is not YOUR city, it is OURS, my opinion has merit just as yours. You will find in closing I have positive & compromising starter suggestions for your consideration where you may have jurisdiction to do so.

A) 55% of communication is non-verbal through a combination of facial expression & body language. Mandatory masks take this away which is especially essential for special needs, children, hearing impairments, where English isn't first language, or there is an accent.

B) Requiring me to wear a mask is against my constitutional rights (so is closing churches, my right to peacefully congregate, but we will save that rabbit trail for another day). Some argue that a mask does not interfere with my ability to express myself or communicate, I then again refer you to point 'A'. Our government is already being sued with infringing on our rights.

C) Personal responsibility: if the government had the right to control our actions for the benefit of our health and others, then cigarettes would be banned. 13-15% of Albertans smoke, intentionally & knowingly slowly killing & damaging themselves. This is also proven to be damaging to unborn babies & effects of secondhand smoke Is well documented. Yet, our government allows smokers the free choice to knowingly and intentionally cause harm to their unborn child by smoking when pregnant and/or smoking in their own home which is detrimental to the health of their

family.

D) Due to our nature, difficulty communicating (Muffled, too quiet, accent, etc), habits (face touching, adjusting glasses, scratching an itch, moving hair out of face, smokers), and adjusting the face mask (moving it down as it interferes with line of vision, ear discomfort, Improperly fitted mask) the vast majority of wearers are unable to adhere to recommended mask wearing guidelines. This effectively makes the point of the mask moot. Don't believe me, go to the mall or walmart and people watch for an hour Or look across the boardroom and take a mental note of how many times your fellow counsel members touched their face during this meeting. Not to mention the wearers that only cover their mouth, and not their nose.

E) Exactly how slow do you want this to spread? Should we expect to live with restrictions such as mandatory masks for a hundred years? There are just over 15,000 total cases in Alberta in approximately 7 months. We were given the impression the goal was to slow the spread so that our health system isn't overloaded. I press you to produce a single instance where our hospitals were unable to manage the hospitalized covid-19 cases. 4.4+million people in our province. Based on those stats and the current rate of spread we as Albertans will be under restrictions for 171 years or until you force me to take a vaccine. I am not willing to accept that when I have a greater chance of dying from cardiovascular disease. This impending no-light-at-the-end-of-the-tunnel weighs on our mental health as we contemplate the never ending restrictions that affect/have affected our access to health/justice system, increased rates of substance abuse/suicides/domestic abuse & access to supports such as wellness/physical activity/sports/Support groups/art classes/etc. All of which have affected my family personally. Contributing & encouraging mass ongoing restrictions directly affects our economy, our children's education, & our health, in endless ways.

F) In places that already have Mandatory mask requirements there have been reports of discrimination, interrogation, & bullying. This has been occurring both to minors & Adults, even to those who are exempt. Making masks mandatory is going to increase this & as a result increased mental health issues & abuse. In addition, some exempt individuals are reporting being refused access To facilities & services, including students. Examples include;
- Forced mask wearing on an infant on west jet flight which led to the infant screaming to the point of vomiting into the mask as the mother tried to force her beloved child to wear it in compliance,
- threats on today's local protest,

- Alberta children been turned away from their school despite having documented exemptions,
I have seen many more that have made the news, and some that have not, but instead shared on social media. I put responsibility onto you, the RMWB. You encourage discrimination against those who share my opinion in your recent 'show kindness by wearing a mask' post, as if to imply I am unkind if I do not agree with wearing one. As a result, giving those that share a different opinion permission to treat me with disgust, insult & make derogatory comments. This is just the beginning of a very slippery slope.

G) The suggestion that everyone should wear any non-medical, dust or homemade mask not only is scientifically unsound, but is potentially dangerous as there are other factors to consider:
- the way in which the reusable masks are cleaned, material of the mask & the potentially hazardous/toxic/carcinogenic laundering products used to clean.
- reduction in oxygen & increased resistance forces the lungs to work harder. The degree of which would be dependant on the type/thickness of material used. Not only can this cause fainting, but suppose an individual does not yet know they have a cardiovascular disease, COPD, or any other physical illness that would exempt them from wearing a mask. Restricting oxygen to your lungs should only be done if advised by a health professional For athletic purposes. (AHS knows this, which is why they have advised you not to wear a mask if you are doing physical activity or exerting yourself, see return-to-work guidelines for gyms)
- we already have on record our government telling us that it is not advised that healthy people wear masks
- every single package of these masks have a disclaimer that they do not protect against covid, that they are non-medical, or they stand to be sued.
- identification: both for identifying criminals & missing children, I do not feel comfortable masking my toddlers identity particularly in consideration with today's #savethechildren climate
- disposal: city of Edmonton is already being sued for this. If this virus is so hazardous, our government would have made consideration for proper disposal of contaminated masks, gloves & other PPE. Particularly if you consider when an 'outbreak' occurs, businesses shut their doors to do a full disinfect, yet there are masks already all over the city.

IN CLOSING, I have many other points but I will end at that. I can speak from personal experience being forced to wear a mask at work. As a seasoned registered massage therapist & athlete not only am I more fatigued after work then usual, some brands of masks make my nose run, some days I have to stifle a panic as my mental health cant handle it, &

headaches from the ear straps as well as using my jaw to prevent the mask from riding into my eyes have a negative impact on my wellbeing. I have been professionally trained to not touch my face when working with clients. This took years of practice & creating good habits, something That cannot realistically be expected of the general public In the short term.
It was stated by our government that it is unrealistic to expect us to be able to eradicate this virus, so in all likelihood, the general public will all get it. Why put our country, our province, our city into mass depression & economic crisis by delaying the inevitable if our health system can handle the hospitalized cases as it spreads?

I do support:
- taking measures to Directly protect our high risk as some countries have done,
- everyone making the free choice to wear a mask if you want. Your mask tells me to back off! I respect your decision & acknowledge your fear.
- I support privately owned businesses/individuals making the free choice to limit capacity or ask their customers to wear a mask. It's your property, your business. I may, as a result, not make that business my first choice, but I support your decision. Just the same as some restaurants/clubs have a dress code. I have clients that refuse to make an appointment because they don't want to wear a mask, despite it not my rules but my association/GOA. This will allow residents who prefer mask wearing to choose those businesses first, and individuals like myself to find an alternative if we don't want to wear a mask or if my son is with me (whom I will not mask).
- society as a whole being more forgiving for students/employees calling in sick if they have symptoms. Whereas pre-covid it was frowned upon to call in over the sniffles. However, I do not agree with prisoning us to our homes. Just because my son has a runny nose doesn't mean I shouldn't be able to take him for a walk or a drive for example. Currently regulations prison & alienate us to our tiny apartment without permission to take the garbage out, do laundry, or even enter the hallway.

Fort McMurray is my home, let us continue to lead by example as the world already has us on their radar. We have been through fire, flood & economic downturn. A flood where we did not see an influx of cases despite breaking lockdown protocol to come to our neighbours aid. Allow our city to consider a compromising alternative solution, continuing to be a leader in our Province & Country.

Thank you for your consideration,

Christine Unruh

From: Allan Waldner
To: Legislative Assistants
Subject: Submission to Council regarding proposed mandatory mask bylaw
Date: Sunday, September 13, 2020 8:35:02 PM

Good day,

I'm writing today to express my disgust with the proposed mandatory mask bylaw being proposed by Council. As a lifelong resident of this town, I'm shocked that Council would consider such a draconian and ineffective way to try and make people believe that this step will be effective at reducing COVID infections in our community.

Masks have not been proven to be effective in preventing COVID transmission. Multiple studies have confirmed this fact and not one study has proven that masks work. CIDRAP (The Center for Infectious Disease Research and Policy) posted a perspective here https://www.cidrap.umn.edu/news-perspective/2020/04/commentary-masks-all-covid-19-not-based-sound-data . In this posting they summarized their thoughts as follows.

In summary, though we support mask wearing by the general public, we continue to conclude that cloth masks and face coverings are likely to have limited impact on lowering COVID-19 transmission, because they have minimal ability to prevent the emission of small particles, offer limited personal protection with respect to small particle inhalation, and should not be recommended as a replacement for physical distancing or reducing time in enclosed spaces with many potentially infectious people. We are very concerned about messaging that suggests cloth masks or face coverings can replace physical distancing. We also worry that the public doesn't understand the limitations of cloth masks and face coverings when we observe how many people wear their mask under their nose or even under their mouth, remove their masks when talking to someone nearby, or fail to practice physical distancing when wearing a mask.

The New England Journal of Medicine concurs. In their perspective found here: https://www.nejm.org/doi/full/10.1056/NEJMp2006372?query=TOC they found masks to be not effective. They say:

"We know that wearing a mask outside health care facilities offers little, if any, protection from infection. Public health authorities define a significant exposure to Covid-19 as face-to-face contact within 6 feet with a patient with symptomatic Covid-19 that is sustained for at least a few minutes (and some say more than 10 minutes or even 30 minutes). The chance of catching Covid-19 from a passing interaction in a public space is therefore minimal. In many cases, the desire for widespread masking is a reflexive reaction to anxiety over the pandemic"

Why are we entertaining a draconian solution that's of questionable effectiveness, especially an indefinite one with no set end date or reauthorization required? If mask wearing was an effective solution, there would be many many certified scientific studies done that

would prove this conclusively, and this would be done for each mask material type. To say a bandana will protect you is laughable at best and devious at worst. A universal mask mandate may instill in people a sense of false protection, causing them to be less diligent in regards to proper distancing and practicing appropriate hand hygiene. The proposed bylaw is simply "health theatre"...an attempt to delude people into thinking that a mask will protect them. It's a proven fact that masks cannot filter out the virus, as even high quality medical grade surgical masks only filter out particles that are 2-10 microns in size). The COVID virus itself is 0.12 microns in size, which makes arguments that they offer transmission protection a patent impossibility.

If people feel anxious over COVID and want wear a mask to allieviate their anxiety, then they can feel free to wear a mask and should he able to do so freely without issue. Continue to isolate the sick and vulnerable (the elderly, those with compromised immune systems, those who have co-morbidities), but to demand that healthy people wear a mask that results in their continually inhaling their own bacteria is unconscionable to say the least. I can say with absolute certainty that this formerly politically ambivalent citizen will definitely be voting against anyone on Council who votes in favour of this absolutely ridiculous bylaw in the next municipal election amd many people I know will be doing likewise.

Most sincerely,

Allan Waldner

September 13, 2020

By email only: legislative.assistants@rmwb.ca; mayor@rmwb.ca; mike.allen@rmwb.ca; krista.balsom@rmwb.ca; keith.mcgrath@rmwb.ca; phil.meagher@rmwb.ca; verna.murphy@rmwb.ca; jeff.peddle@rmwb.ca; bruce.inglis@rmwb.ca; claris.voyageur@rmwb.ca; shelia.lalonde@rmwb.ca; jane.stroud@rmwb.ca

Attention: Regional Municipality of Wood Buffalo, Mayor and Members of Council

RE: Letter of Support for Bylaw No. 20/024 - Face Covering Bylaw

To whom this may concern:

Why do I support the proposed RMWB Face Covering Bylaw?

- I want to slow the spread of COVID-19.
- I want schools and businesses to remain open.
- I want to reduce the risk to community members who are at higher risk of catching COVID-19 and/or at higher risk of complications from COVID-19; so that they are able to more safely enter indoor public places during the pandemic.
- The bylaw will provide some protection from community members that aren't following any other public health guidelines, specifically while they are riding city transit and inside public places.

My husband and I both work full time in the oil sands mining industry and although I am able to work remotely from home, my husband is a heavy equipment operator and needs to be on site to do his job. My children have recently returned to school and because of their varying ages, they have different risks for exposure to COVID-19, as well as other common cold and flu viruses. My youngest son (4) just started EEP, where face coverings aren't required; my middle son (9) is in grade 5, where face coverings are required; and my eldest son (11) just started grade 7 (at a different school), where face coverings are required, but he takes the city transit to/from school which currently doesn't require face coverings.

Further to this, my mother (76) has Multiple Myeloma, my father (79) has atrial fibrillation and a pacemaker, and my father in-law (65) has COPD. We value our parents/grandparents lives and the roles they play in our lives/our children's lives and we want to be able to visit with them during the course of the pandemic (which is expected to go on for at least another year). The proposed face covering bylaw would help minimize the risk of transmission of COVID-19 to our vulnerable elders and community members, so that they can hopefully live as long as their ages and medical ailments will allow them, and so that they can still enjoy their quality of life during the COVID-19 pandemic.

Although my family doesn't need schools to remain open for childcare reasons (because we have a live-in caregiver), we strongly value the importance of in-person learning and social interaction, as much as possible. My youngest is a bright spark who loves to learn and interact and he hasn't had many opportunities yet to help him grow and develop. My middle child has some social/learning challenges that

require some extra support from professionals who are properly educated in this area. My eldest son is entering into his first year of junior high, which is a critical year in his physical, social and mental development. Neither my husband, our live-in caregiver, nor I have the time or skills to effectively educate and socialize our three children whilst still doing our jobs, etc.

My family was recently in Edmonton for back to school shopping where we spent most of our time at South Edmonton Commons. There was a face covering bylaw in place while we were there and it was great to see so many people out and about living their lives with face coverings on, without it being a big deal. Businesses and restaurants were respecting maximum occupancy limits and they didn't have to worry about having to tell customers to wear face coverings because everyone was already doing it. We were only there for 2 days, but my family (including my children) all adjusted quickly. For us it wasn't fearful to have to wear face coverings in public, rather it was refreshing to see the community taking the situation seriously while still getting as close to normalcy as possible.

Many citizens in the RMWB are already required to wear face coverings at work and school and it seems to be going very well from what I've heard through my employer and children's schools. But, those who are already following the public health guidelines at work and school are also entering public places where it seems that most community members aren't wearing face coverings or following public health guidelines. As a result, the risk of exposure to COVID-19 in public places remains higher than necessary.

It is my belief that we need to work together as a community to slow the spread of COVID-19 and that the proposed Face Covering Bylaw (20/024) is a reasonable risk mitigation measure that will help schools and businesses remain open, in support of the continued success of Alberta's COVID-19 relaunch strategy.

Regards,

Rochelle Young
Fort McMurray resident since 1984

From: JoAnne Zelmer
To: Boards Committees
Subject: Mask By-law
Date: Sunday, September 13, 2020 3:28:07 PM

Hi,

My name is JoAnne Zelmer, and I have been a resident of Fort McMurray for over 5 years now. I'm not sure if I am sending this to the right email address. I had just read that the council had only received around 23 emails on what their position was, regarding making masks mandatory for indoor buildings and transit. I just wanted to say that I fully support making masks mandatory.

As this virus is still very new, and new information is being discovered about the long-term effects, I would much rather err on the side of caution.

Thank you for your time.
JoAnne

Bylaw No.20/024 Face Covering Bylaw

Intake 3: Written Submissions

1. Karen Savoie
2. Greg De Haan
3. Ismay O'Neil
4. Ty Andres
5. KC Hutchins
6. Wendy Lucas
7. Sara Doyle

From: Karen Savoie
To: Legislative Assistants
Subject: NO to Mask Mandate By-law council meeting September 14
Date: Monday, September 14, 2020 2:39:50 PM

Fort McMurray Mask Mandate By-law - An Open Letter
September 14, 2020

Good evening Councillors,

I would like to add my voice to others voicing their concerns about a mask by-law.

It should be a personal choice to wear one or not and the Municipal council should not mandate something that AHS is not advocating for. Quote from AHS "While COVID-19 can cause serious illness, many people have only mild symptoms. It appears the illness caused by COVID-19 tends to be less severe than some other coronaviruses like the one that caused SARS." Did we need to wear a mask during the SARS pandemic NO

We are far from government projections made in the beginning of this pandemic to justify keeping the public in panic.

If the Municipality wants to force people by enforcing a bylaw and finning individuals for choosing the best path for their own health, mental and physical.

Karen Savoie

From: Greg De Haan
To: Legislative Assistants
Subject: Face covering bylaw
Date: Monday, September 14, 2020 4:29:40 PM

Hello,

I am writing to express that I do not support a face covering bylaw in our community.

I understand that there is now also pressure from industry within the community, but I would remind the council that they are elected by their constituents, not industry.

If the highest of medical officials of both our province and our nation are not pushing this directive I do not believe it is the place of our, or any municipal council to try to say they know better.

There is no science to back up the efficacy of face coverings. I would ask council members that are considering supporting this to keep digging into it and I would request that they look into the dispute between Ontario Nurses Association & Toronto Acedemic Health Science Network. "Vaccinate or mask policy is illogical and makes no sense" and "is the exact opposite of being resonable" These are quotes from the arbitrators decision which is available in its entirety online.

This is not a decision to be made by small business people of municipal councils. This is a decision to be made by Dr. Hinshaw, Dr. Tam & their counterparts. Like it or not, they have made the decision.

Stick to municipal level politics folks, you're punching above your weight class on this one.

Greg de Haan

Sent from my Samsung Galaxy smartphone.

Submitted by: Ismay O'Neill

From: Gallagher Gulley Section 17 (1) FOIP
Sent: Monday, September 14, 2020 12:00 PM
To: Legislative Assistants <Legislative.Assistants@rmwb.ca>
Subject: Mandatory mask use bylaw

Dear council members,

Please make mask use mandatory. It is impossible to remain 6 feet apart in almost all enclosed business headquarters, particularly from people who refuse to cooperate. I personally have to go into the post office frequently for work and I have panic attacks before I go into the store each and every time now. It is impossible to social distance in there. I have to gently remind people not wearing masks to please keep their space from me each time and it gets ugly quickly. My mental state should not be compromised weekly when I simply need to drop off a parcel for work. I also have a lot of relatives who live here who are older and who have underlying illnesses which puts them a high risk for Covid-19. I just want to see them safe and not afraid to go about their daily lives running regular and necessary errands. Please help us.

From: Ty Andres
To: Legislative Assistants
Subject: Mask bylaw
Date: Monday, September 14, 2020 5:26:55 PM

Hello,

I am a citizen living in Parson's Creek. I believe that mask use should be required in all public spaces until such time that the Covid-19 pandemic is over. The mask argument is extremely simple (outside of the occasional cases of legitimate health issues preventing mask use): wearing a mask is putting the community ahead of yourself, and helping to protect others from contracting the virus if you are a carrier; arguments against wearing masks are self oriented, and focused on individual liberty. This is a public health issue, and in the interest of public health, masks should be required in all public spaces.

Thanks for your time,

Ty Andres

From: KC Hutchins
To: Legislative Assistants
Subject: Masks should be optional
Date: Monday, September 14, 2020 3:02:42 PM

Dear Council,

I am writing in today to express my opinion that wearing masks should be a personal choice.

It has been brought into Edmonton, Calgary, Canmore & Banff with their high tourist population for in public places, and still people choose not to wear them. The spread may be limited by the masks but as we've seen in conflicting research, it's precautionary and not actually proven to not be hard on our lungs / scientifically we need to dispel carbon dioxide & sneeze/cough particulates away from our body to not get sick. The mask would not only keep some C02 but would also prevent our natural mechanism of ridding our body of particulates that could make us sick.

The waste of disposable masks are becoming a litter problem around our city. It is currently mandatory for people to wear a mask to shop at Superstore grocery store & still some people don't wear them... and in hard economic times are we going to start fining people for not wearing them?

I struggle to wear one because it's hard to breath & my kids are made to wear theirs at school even if they get head aches!

I enjoy being on trails & going to the parks without masks.

Just as an example, in Canmore we did wear our mask to go into a building to dine, but then if we're all sitting and not wearing our masks (to eat and drink) in the same room (6 feet apart) but all breathing the same air in that building does it actually help or is it just the easier thing to do.

All the site workers have mandatory masks and I have heard many people feel fatigued after 8 hours of wearing them. They struggle to breath and the moisture is also not good. At what point is this Covid-19 going to be gone? There is no unknown answer.

What if research showed that many people may have already had this virus in Nov. /Dec. /Jan. 2019/2020 and we're just being careful.

KC Hutchins

From: Wendy Lucus
To: Legislative Assistants
Subject: Masks
Date: Monday, September 14, 2020 5:51:48 PM

To Whom It May Concern,

I am writing to voice my opinion about wearing masks in public.

I do not believe we should be made to wear masks, and I believe it is a personal choice to do so! Personally, I don't believe that masks help stop the spread of covid. Many people don't even wear their masks correctly, causing more problems. I have seen so many masks and gloves on the ground around town, it is shameful! People are getting throat infections and lung infections from wearing masks all day long! Infections on their faces! Cloth masks are useless, disposable masks say right on the box, does not prevent the spread of the covid 19 virus! People with medical problems and mental health issues have a very hard time with masks! My husband has a hard time breathing sometimes, when it is just hot and humid, not alone with a mask on! And no, he doesn't smoke, but has a lung disease. Take a look at cancer deaths each year, deaths from the flu, deaths from all the other diseases, where is all the panic from them? Where are the numbers being posted? Its time to take a stand, against the fear!

I believe, our bodies, our choice!

The best for me is, our children are in school, yet this town meeting is online, because council won't sit together, and the government won't sit together! How does any of this make sense?

A Concerned Citizen,
Wendy

Sent from my iPad

From: Sara Doyle
To: Legislative Assistants
Subject: Masks
Date: Monday, September 14, 2020 4:58:00 PM

My name is Sara Doyle.

I am writing in hopes that you think of me and my children during your votes concerning mandatory masks.

I have two auto immune diseases. I also have severe asthma.

I want you to know that I am aware of how contagious Covid-19 is. I am also aware of the current recovery statistics. I am also aware that should I catch covid-19, it could take me longer to recover than most.

I have severe asthma attacks when I wear a mask. So when I try to go grocery shopping for my family, it's always a catch 22. My family needs to eat, but I need to breathe. This is beyond stressful. Not just for me, but for my children. Watching their mom struggle to breathe is causing major anxiety for them when I need to shop. I look pretty healthy, asthma is not really a disease you can "see" and I am afraid that if you make masks mandatory, people will take it upon themselves to enforce the bylaw by way of violence for not wearing a mask. I also have Crohn's disease, which is highly triggered by stress. It's debilitating and I cannot function during flare ups. The stress of masks cause major stress on my body, given that I have severe asthma attacks when I wear one. Going grocery shopping to feed my children is essential, so is not being sick from stress, Crohn's disease and asthma attacks.

I know I am not the only family in our community with issues like mine. Please consider making mask wearing optional in town. Think of families like mine when you vote. You are the only voice we have.

Thank you for your time,
Sara Doyle