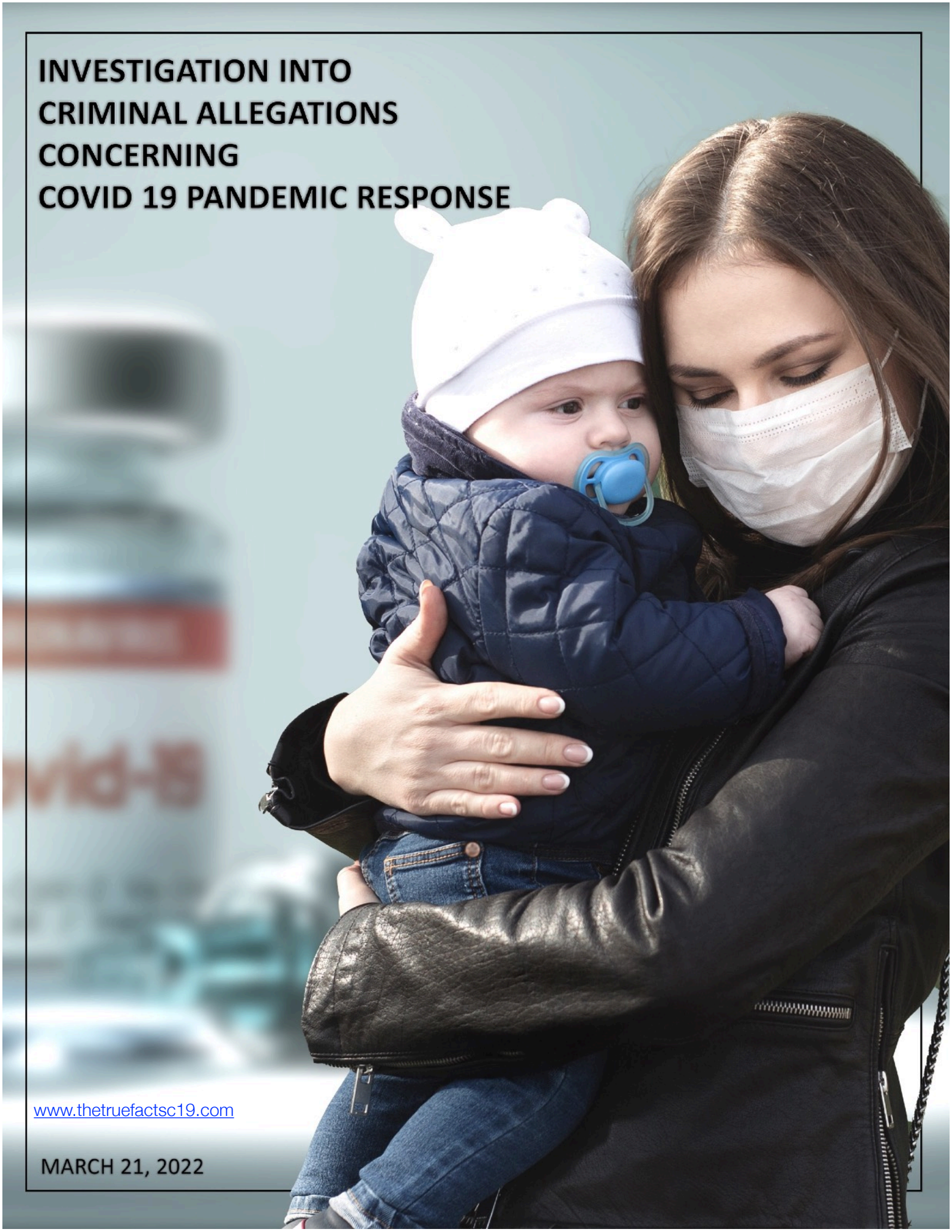
INVESTIGATION INTO CRIMINAL ALLEGATIONS CONCERNING COVID 19 PANDEMIC RESPONSE



www.thetruefactsc19.com

MARCH 21, 2022

1.0 INTRODUCTION 4

2.0 REQUIREMENT FOR POLICE TO ACT 8

3.0 ALLEGED CRIMES 9

4.0 ALLEGED PERPETRATORS 14

5.0 TIMING OF CRIMES 17

6.0 BASIS FOR ALLEGING ILLEGAL ACTS 18

6.1 Statistics Canada Data Available as of May 2020 21

6.1.1 Statistical Trends on Population & Deaths 21

6.1.2 Morbidity Rates and Recovery Rates Reported for 2020 25

6.1.3 Perspective on Risk 31

6.1.3.1 Odds in Various Age Groups 32

6.1.4 Detailed Review of Causes of Death in Various Age Groups 2020 36

6.1.4.1 Analysis of Deaths 14 Years of Age and Less for 2020 38

6.1.4.2 Analysis of Deaths Of Women In Child Bearing Years 40

6.2 Statistics Infographics 48

6.3 Harm Caused by Mitigative Measures 52

6.3.1 Forced Masking 53

6.3.2 Forced or Mandated Vaccinations 60

6.3.3 Forced Closure of Businesses 74

6.3.4 Other Measures Implemented but Not Recommended 76

6.4 Criminal Mismanagement of the ICU 77

6.4.1 ICU Bed Infographics 83

7.0 CONCLUSIONS 86

List of Appendices 88

Appendix One: 88

Canadian Pandemic Influenza Plan for the Health Sector 2006 88

Appendix Two: 88

Pfizer 5.3.6 Cumulative Analysis of Post-authorization Adverse Event Report 88

Appendix Three: 88

Government of Manitoba Public Health Factsheet Information for Pregnant & Breast Feeding individuals 88

Appendix Four: 88

Government of Manitoba Public Health Factsheet Covid-19 mRNA Vaccines for Individuals Aged 12 Years and Older 88

Appendix Five: 88

Government of Manitoba Public Health Covid-19 Vaccine for Children 5 to 11 Years Old 88

Appendix Six: 88

Government of Manitoba Important Notice for Manitobans Aged 30+ 88

Appendix Seven: 88

Pfizer Canada - Comirnaty Product Monograph Date of Revision November 19, 2021 88

Appendix Eight: 89

United States Senate - Office of Senator Ron Johnson February 1, 2022 89

Appendix Nine: 89

John Hopkins Institute for Applied Economics - A Literature Review and Meta-Analysis of the Effects of Lockdowns on Covid-19 Mortality January 2022 89

Appendix Ten: 89

May 18, 2021 Covid-19 Report - A Citizen's Perspective 89

Appendix Eleven: 89

Appendix Twelve: 89

The Epidemiology and Outcomes of Critical Illness in Manitoba, April 2021 89

Appendix Thirteen: 89

Intracellular Reverse Transcription of Pfizer BioNTech Covid 19 mRNA Vaccine in Vitro In Human Liver Cells February 25, 2022 89

Investigation into Criminal Allegations Concerning Covid 19 Response

1.0 INTRODUCTION

We, the authors of this report, are citizens of Canada, and as citizens have the benefit of the full protection of the laws of Canada, including the Rights as set out in the Canadian Constitution and the Canadian Charter of Rights and Freedoms.

Since 2020, we have borne witness to the systematic degradation and elimination of the most basic rights and freedoms as guaranteed to citizens. Furthermore, we have witnessed how serious alleged crimes against Canadian Citizens have been committed without consequence to those who have perpetrated these alleged crimes.

We as citizens of Canada, believe it is our duty to document some of these crimes and present evidence of them to Law Enforcement, so that an appropriate unbiased criminal investigation can be initiated.

It is **not** our intention to complete the full investigation and analysis for Law Enforcement. It is our duty and intention to ensure that enough **indisputable evidence** of these alleged crimes is brought to the attention of Law Enforcement to ensure that they undertake their sworn duty to investigate and pursue criminal charges as required by the laws and statutes of Canada.

The Covid 19 Pandemic has been presented to the public in Canada and around the world as an emergency of such proportion that it justifies the suspension of civil liberties, the restriction of civil rights, and forced medical procedures on all individuals through mandates, coercion and threats of violence, loss of employment etc.

The facts presented in this report **prove** that the risk to the public from Covid 19 was and is being criminally exaggerated to first terrorize the public and then use that terror to coerce the public into accepting the illegal dictates of the government.

Lives have been destroyed in the process. People have died from or been injured from unsafe medical procedures. Suicides, crime, drug addiction, domestic violence and other social maladies have increased significantly, due to the illegal actions of the government.

Peoples lives have been disrupted with the closing of schools and businesses. The fundamental fabric of our nation has been shredded due to the intentional sowing of terror amongst the citizens.

And the closure of churches and other places of social interaction and community, has eliminated any support systems in place to assist Canadians.

The intent of this report is not to argue all the consequences of the illegal actions, ….that will be the responsibility of the police investigations.

This report **proves** that the unprecedented actions taken by the governments during the Covid 19 Pandemic were not based on supportable statistics. The statistics used in this report to prove these allegations were supplied by the Canadian Government themselves.

This report <u>does not</u> rely on "expert opinion" to assert a position. This report uses the actual numbers as presented by the Government, and these statistics prove that the pandemic narrative is false, and that the people who perpetrated the false narrative knew it was false.

As a few examples of our findings:

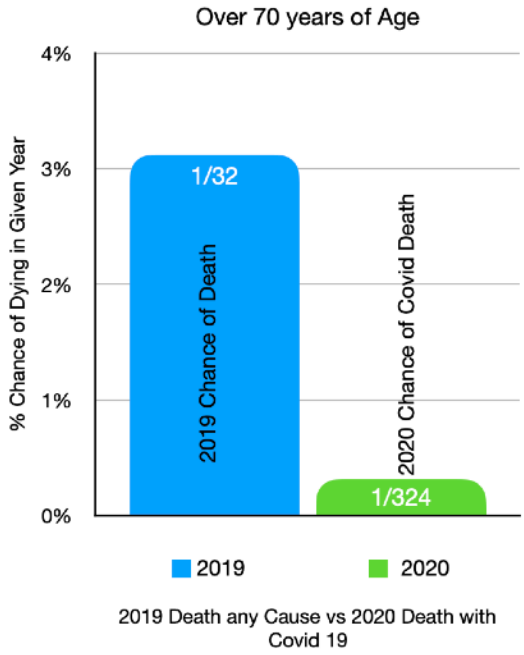
The government has claimed that people over the age of 70 had an unprecedented and unacceptable risk of dying from Covid 19. So much so that locking down and isolating these people from their loved ones was justified, many died in loneliness and despair. **According to Statistics Canada, this claim is untrue.** The table below indicates that in 2019, before Covid 19, if you were over 70 years of age, in Canada, the chances of dying for any reason was 1 in 32.

According to Statistic Canada, in 2020, in the age group of 70 years old and older, the risk of contracting and dying of Covid 19 was 1 in 324.

2019 Over 70 years Old - Odds of Dying

2019 Odds of Dying All Causes		
Number of People		4,668,591
Number Total Deaths		145,569
Percent Chance of Death Any Cause		**3%**
Odds of Death in 2019	**1 in**	**32**

2020 Odds of Dying With Covid 19		
Number of People		4,676,492
Number Covid Deaths		14,441
Percent Chance of Death From Covid 19		0.31%
Odds of Death in 2020 with Covid 19	**1 in**	**324**



2019 Death any Cause vs 2020 Death with Covid 19

So the risk of dying from Covid 19, at the age of 70 was ten times lower, 1000% lower than the chance of simply dying from other causes!

The age group 70 and higher was the group that was at most risk.

The above statistics do not even consider or debate the number of deaths in this group that were attributed to Covid 19. We point out, that in order to be counted as a Covid 19 death a patient only had to test positive for Covid 19 at the time of death, which does not mean that they actually died from Covid 19.

Furthermore, this analysis does not consider the fact that the testing procedures being used to detect Covid 19 have been found to be highly unreliable with a reported false incidence rate up to 45% or more.

Had these factors, and many others been included in the analysis, an already extremely low death count would have been further reduced.

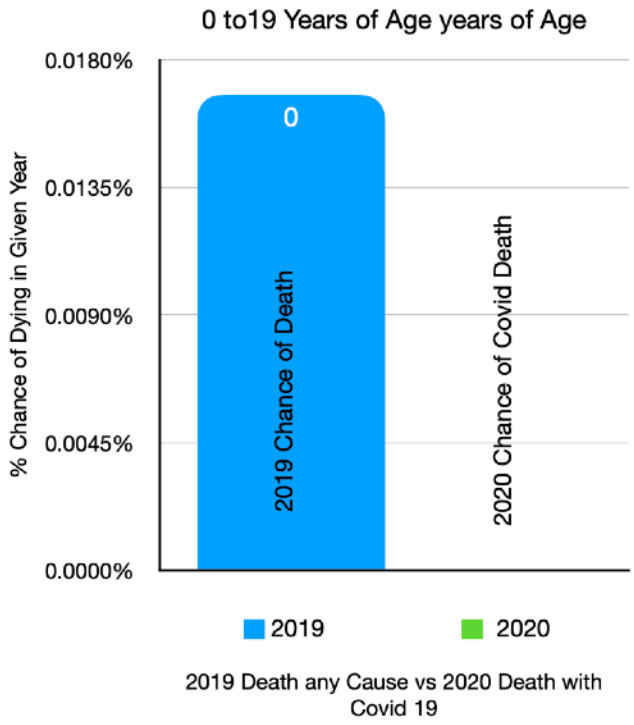
The numbers and risks reduce to statistically zero for other age groups.

A similar analysis for children under the age of 19 was carried out. Similarly the following table summarizes the risk from Covid to this group:

2019 Zero to 19 years Old - Odds of Dying

2019 Odds of Dying All Causes		
Number of People		8,139,512
Number Total Deaths		1,365
Percent Chance of Death Any Cause		**0.0168%**
Odds of Death in 2019	**1 in**	**5,963**

2020 Odds of Dying With Covid 19		
Number of People		8,144,135
Number Covid Deaths		2
Percent Chance of Death From Covid 19		0.0000%
Odds of Death in 2020 with Covid 19	**1 in**	**4,072,068**



2019 Death any Cause vs 2020 Death with Covid 19

In 2020, the odds of contracting and dying from Covid 19 in this age group was: 1 in 4,072,068.
In 2019, the odds of dying from any cause in this age group was: 1 in 5,963

So the odds of dying from any cause at all, in this age group was 683 times higher than the chance of a person contracting and dying from Covid 19.

Based on these statistics, and once again not considering the actual reporting issues related to the Covid 19 deaths, how could these risks be considered so severe that civil liberties had to be suspended?

This report examines death counts for a variety of age groups across Canada, and the statistics simply do not support the level of risk reported to the Canadian people. In fact, this report has found that the risk imposed on Canadians due to the mandated, coerced and forced vaccinations were many times higher than the risk of Covid 19 itself. And those risks do not consider the unknown longterm risks.

Once again, we have not questioned or disputed the number of Covid 19 vaccine injuries that have been reported by the government, despite the emerging data indicating much higher injury rates than have officially been reported. This new data concerning Vaccine risks were known to the government agencies prior to the current court ordered data releases.

Based on the number of injuries reported, it is inconceivable that the vaccine would have been used on population groups who were at greater risk from the vaccine itself, than from the disease.

We, as a society have not yet been able to come to grips with the full reality of the damage done by the measures undertaken by the government during the declared emergency.

THE STATISTICS AS REPORTED BY THE GOVERNMENT CLEARLY PROVE THAT THE EMERGENCY DECLARATIONS WERE UNWARRANTED.

THE STATISTICS AS REPORTED BY THE GOVERNMENT CLEARLY PROVE THAT THE RISK ASSOCIATED WITH THE NOVEL COVID 19 VACCINES WERE HIGHER, IN SOME AGE GROUPS, THAN THE RISKS ASSOCIATED WITH COVID 19 ITSELF.

We anticipate, it will be very difficult for many readers to absorb the information contained in this report, as it conclusively proves that they have been deceived, and that the deception has been used to strip them of their Charter Rights and Freedoms and to force them into taking a medical procedure, whose long term safety and efficacy is unknown.

We urge the reader to carefully consider the content of this report, and to verify the information contained in this report through the actual sources.

The crimes that are alleged to have been committed against the Canadian people are without precedence, and the damage will be with us for decades, action must be taken to bring the perpetrators to justice.

2.0 REQUIREMENT FOR POLICE TO ACT

We are a group of concerned Manitobans who have borne witness to numerous alleged serious criminal offences committed over the course of the past years against the People of Manitoba and Canada.

In accordance with the tenets set out in the Police Services Act:

> WHEREAS police services play a critical role in protecting the safety and security of Manitobans;
>
> AND WHEREAS co-operation between police services and the communities they serve will result in improved safety and security and better relations between police and citizens;
>
> AND WHEREAS civilian governance and oversight of police services will improve transparency and accountability in the delivery of policing services;
>
> AND WHEREAS it is desirable that policing services be provided in a manner that recognizes the pluralistic and multicultural character of Manitoba society, and in particular, First Nation, Metis and other aboriginal peoples;
>
> AND WHEREAS it is recognized that public safety is enhanced as police services become more representative of the communities they serve;
>
> AND WHEREAS it is important to recognize the rights of victims of crime and their needs in the delivery of policing services;
>
> AND WHEREAS the importance of safeguarding the fundamental rights protected by the Canadian Charter of Rights and Freedoms and The Human Rights Code is recognized by all;

Furthermore in accordance with the Police Services Act, a Police Officers duty include:

> (a) preserving the public peace;
> (b) preventing crime and offences against the laws in force in the municipality;
> (c) assisting victims of crime;
> (d) apprehending criminals and others who may lawfully be taken into custody;
> (e) executing warrants that are to be executed by peace officers, and performing related duties;
> (f) laying charges and participating in prosecutions;
> (g) enforcing municipal by-laws; and
> (h) performing other duties assigned by the police chief.

According to the Province of Manitoba Department of Justice:

> The police conduct criminal investigations. Investigations begin when police witness behaviour or **receive information about behaviour which may be a crime.**

It is on the basis of the above directives, and definitions we have brought forward this information of the alleged criminal activities, and expect the Police Services to execute their responsibility to undertake a detailed investigation into the allegations.

3.0 ALLEGED CRIMES

In the early part of 2020 the world was faced with the news of a Novel Coronavirus that may have originated in China in late 2019, and was now being detected in other parts of the world including Canada.

Expert opinions about the virus sprang up overnight and their dire and conflicting opinions filled every mass media program.

“Expert” predictions included millions, if not billions of deaths around the world, our leaders were in free fall panic mode. Government officials provided advice that was erratic and their opinions changed, on a weekly basis.

Although Canada had established The Canadian Pandemic Influenza Plan for the Health Sector 2006, many of the fundamental recommendations of that plan were never implemented. Additionally many activities that were specifically not recommended in the plan were implemented and formed some of the foundational principals of Canada’s response to the pandemic.

Some examples of recommendations and or mandates that **were** made and subsequently changed, or that made no sense follow:

Allow international travel, do not allow international travel; wear cloth masks, do not wear cloth masks; stay home do not stay home. You can sit in a restaurant without a mask, but you cannot sit at school without a mask. You cannot leave your home, if you do you are a murderer, but you can travel from China to Canada, and if you oppose that, you are a racist.

We could go on and on with the utter absurdity of the mandates and regulations being made when the Corona Virus was first announced.

Given this initial explosion of highly contradictory and spectacularly erroneous information, the Canadian Population became overwhelmed and terrified.

This was despite the fact that our own health officials and government departments had been planning for an event similar to Covid 19 for years, and had written emergency plans in place based on “corona like viruses”. These emergency plans were set in place by all major countries

and World Health Organizations (WHO) alike. The latest CDC emergency response plan was completed in 2017.

A copy of Canada's Emergency plan can be found here: The Canadian Pandemic Influenza Plan for the Health Sector 2006 (https://www.longwoods.com/articles/images/Canada_Pandemic_Influenza.pdf). One of the listed authors of this report is Dr. Teresa Tam. We were unable to determine whether or not the Canadian plan had been officially updated since 2006.

Although the Plan's description of the assumed Pandemic very closely matched what actually happened in Canada, the recommendations made in the Plan were never fully implemented.

During this same period of time, (2005 to 2006) many countries around the World developed very similar plans to combat the threat of a future Corona type Pandemic. The Centres for Disease Control (CDC) in the United States developed a plan in 2005, updated the plan in 2009 and the last update to that plan prior to the Covid 19 pandemic was in 2017.

A link to this CDC report is here: CDC 2017 Updated Pandemic Plan (https://www.cdc.gov/flu/pandemic-resources/pdf/pan-flu-report-2017v2.pdf)

The World Health Organization (WHO) also prepared similar influenza pandemic plans around the same time: WHO 2013 Pandemic Influenza Risk Management Intern Guide. (https://www.who.int/influenza/gisrs_laboratory/en/)

These plans were all very similar in scope and nature, the World Health Organization's plan appeared to be used as a basis for individual country plans around the World. Their plans all described what eventually happened with the Covid-19 Pandemic with great detail and accuracy. However, many of the main attributes of the plans were never implemented, why?

In addition, prior to and during the Covid 19 pandemic, the CDC in the United States issued a number of reports that dealt with the use of measures to combat the pandemic. In many cases, including in Canada, **the recommendations were not followed, and in fact, in a number of cases Health Officials in Canada implemented the opposite strategy, and ignored many long standing and proven techniques for preventing the spread of the disease and or mitigating the detrimental effects caused by their attempts at pandemic mitigation.**

We understand, at the outset of the pandemic, that combating uncertainty and fear would be one of the key issues at hand. In the words of the CDC in their 2017 Pandemic Plan:

> *"At the onset of an outbreak with pandemic potential, the uncertainty and complexity of the situation demand ways to assess the risk and potential public health impact posed by the emerging virus, understand the possible progression of the event, and evaluate its severity and transmissibility to enable informed public health interventions."*

It is arguable how much allowance should be made for this initial uncertainty, since the Health Community had been planning for just such a pandemic since 2005, and their plans accurately predicted the course and nature of the actual pandemic.

So the question that must be asked is "when did the Health Officials know, or when ought they have known how effective their orders were at mitigation, and what negative impacts were being caused by these mitigative measures.

We cannot know exactly when verifiable statistical information was made available to the Health Officials in Canada; however, we do know when these statistics were made available to the Canadian public by Statistics Canada.

In May 2021, Statistics Canada provided, to the general public, significant statistical information that could be used to understand the nature of the virus, the efficacy of our preventative efforts, guidance for treatment and the effects of the measures on the overall society. As of May 2021, the statistics of the impacts of the virus on the Canadian population were known. It is reasonable to assume that the official health department officers who were implementing the government's response to the pandemic would have had access to this information well in advance of when it was made available to the general public.

In regard to this, on page 4 of the Canadian Pandemic Plan 2006 it states:

> ***Mitigation/Response*** activities are directed at controlling the pandemic and repressing direct outcomes (mortality and morbidity due to influenza) and indirect associated effects (social disruption). Implementation of these activities would involve a series of escalating and potentially varying (but harmonized) responses as the pandemic unfolds across the country. Implementation also involves documenting activities and outcomes to determine if a more extensive response is required or if adjustments to the planned response are necessary.

So in the very plan, that was supposed to be used to guide Canada's pandemic response, it recognizes the principle of controlling the pandemic by continual monitoring of results including assessing the social disruption to society as a whole.

Although a key question is, when did health officials know or ought to have known, it is clear that they knew no later than May of 2021 what the actual nature of the pandemic was. These officials also knew which measures were effective and which were ineffective. Each mitigative measure should have been evaluated for both positive and negative effects. All of these factors should have been assessed on a cost benefit basis and as set out in the pandemic plan.

The authors have prepared this report to outline in broad and sometimes specific terms, how the Canadian Pandemic response was so seriously flawed, that it directly resulted in:

1. Unprecedented disruptions to our society as a whole, resulting in unnecessary deaths;
2. Unnecessary isolation of individuals resulting in many serious conditions including suicide, domestic abuse and mental disorders;
3. Medical apartheid;
4. Forced medical procedures on the general population including coercion, duress and threats;
5. Violations of the "Genetic Non-Discrimination Act 2017, as affirmed by the Supreme Court of Canada in July 10, 2020;
6. Violations of various sections of the Canadian Charter Rights and Freedoms;
7. Cruel and unusual punishment of "at risk" individuals though physical, mental and medical isolation;

8. Serious mental and physical damage to children through forced school closures, isolation and forced masks usage;
9. Denying of physical, social and business services to an identifiable segment of the Canadian Population;
10. Violation of sections of the Criminal Code of Canada 319(1) related to communicating statements in any public place, inciting hatred against any identifiable group;
11. Various other breaches of the laws of Canada and Manitoba that are to be determined by the police investigation.

Detailed statistical and testimonial evidence presented in this report is more than that required to initiate a detailed investigation by the appropriate policing services in Manitoba and Canada.

It is not the intent of this report to provide the totality of the information required in order to complete the investigation. Rather, the intent of the report is to provide the police with enough information to establish the requirement for a criminal investigation.

Further, as the actions of the various governments and government authorities are continuing and in some instances, these governmental actions are continuing to cause serious harm to various individuals throughout Canada, we anticipate and request the police obtain immediate injunctions against the government to suspend any of these ongoing activities that further harm both individuals and our society as a whole. The injunctions should remain in place until such time the investigation can be concluded.

Many citizens were coerced into taking the Covid-19 vaccine under penalty of loosing their jobs, or other Constitutionally guaranteed freedoms.

The broad definition of coercion is "the use of express or implied threats of violence or reprisal (as discharge from employment) or other intimidating behaviour that puts a person in immediate fear of the consequences in order to compel that person to act against his or her will." Actual violence, threats of violence, or other acts of pressure may constitute coercion if they're used to subvert an individual's free will or consent.

In legal terms, it's often said that someone who's been coerced was acting under duress. In fact, "duress" and "coercion" are often interchanged. Black's Law Dictionary defines duress as "any unlawful threat or coercion used... to induce another to act [or to refrain from acting] in a manner [they] otherwise would not [or would].

The Crimes we believe have been committed include the following:

- misfeasance in public office
- misconduct in public office
- conspiracy to commit grievous bodily harm
- conspiracy to administer a poisonous and harmful substance to cause severe injury & death
- gross negligence manslaughter
- corporate manslaughter
- corruption
- fraud
- blackmail
- murder
- conspiracy to commit murder
- terrorism
- genocide
- torture
- crimes against humanity
- false imprisonment
- multiple breaches of The Canadian Charter of Rights and Freedoms
- war crimes
- multiple violations of The Nuremberg Code 1947
- multiple violations of the Criminal Code of Canada
- other crimes which will be determined by the police investigation

4.0 ALLEGED PERPETRATORS

Those people that could be identified as either playing a direct role in or assisting in the commission of these offences include, but are not limited to, the following individuals and organizations:

Dr. Teresa Tam;
Dr. Joss Reimer;
Dr. Brent Roussin;
Dr. Jazz Atwal;
Johanu Botha;
Don Leitch;
Brian Pallister;
Heather Stefanson;
Scott Johnston
Sarah Guillemard
Audrey Gordon

Undisclosed Members of the following Manitoba Government Task Forces:
- Vaccine Task Force
- Vaccine Medical Advisory Table
- Collaboration Tables
- Covid-19 Coordinating Committee

Council Members of the College of Physicians and Surgeons of Manitoba (CPSM):
- Dr. Jacobi Elliot
- Dr. Nader Shenouda
- Dr. Brett Stacey
- Dr. Daniel Lindsay
- Dr. Chris Penner
- Dr. Kevin Convery
- Dr. Mary Jane Seager
- Dr. Norman McLean
- Dr. Wayne Manishen
- Dr. Ravi Kumbharathi
- Dr. Heather Smith
- Dr. Eric Sigurdson
- Dr. Roger Suss

CPSM's role is to protect the public as consumers of medical care and promote the safe and ethical delivery of quality medical care by physicians in Manitoba.

Along with other individuals or organizations that will be discovered during the course of the investigation.

For greater clarity, we have included the following section from the Criminal Code of Canada which sets out who are “Parties to Offences”:

Parties to Offences

Parties to offence

21 (1) Every one is a party to an offence who

(a) actually commits it;

(b) does or omits to do anything for the purpose of aiding any person to commit it; or

(c) abets any person in committing it.

Common intention

(2) Where two or more persons form an intention in common to carry out an unlawful purpose and to assist each other therein and any one of them, in carrying out the common purpose, commits an offence, each of them who knew or ought to have known that the commission of the offence would be a probable consequence of carrying out the common purpose is a party to that offence.

R.S., c. C-34, s. 21.

Person counselling offence

22 (1) Where a person counsels another person to be a party to an offence and that other person is afterwards a party to that offence, the person who counselled is a party to that offence, notwithstanding that the offence was committed in a way different from that which was counselled.

Idem

(2) Every one who counsels another person to be a party to an offence is a party to every offence that the other commits in consequence of the counselling that the person who counselled knew or ought to have known was likely to be committed in consequence of the counselling.

Definition of *counsel*

(3) For the purposes of this Act, ***counsel*** includes procure, solicit or incite.

R.S., 1985, c. C-46, s. 22; R.S., 1985, c. 27 (1st Supp.), s. 7.

Offences of negligence — organizations

22.1 In respect of an offence that requires the prosecution to prove negligence, an organization is a party to the offence if

(a) acting within the scope of their authority

(i) one of its representatives is a party to the offence, or

(ii) two or more of its representatives engage in conduct, whether by act or omission, such that, if it had been the conduct of only one representative, that representative would have been a party to the offence; and

(b) the senior officer who is responsible for the aspect of the organization’s activities that is relevant to the offence departs — or the senior officers, collectively, depart — markedly from the standard of care that, in the circumstances, could reasonably be expected to prevent a representative of the organization from being a party to the offence.

2003, c. 21, s. 2.

Other offences — organizations

22.2 In respect of an offence that requires the prosecution to prove fault — other than negligence — an organization is a party to the offence if, with the intent at least in part to benefit the organization, one of its senior officers

(a) acting within the scope of their authority, is a party to the offence;

(b) having the mental state required to be a party to the offence and acting within the scope of their authority, directs the work of other representatives of the organization so that they do the act or make the omission specified in the offence; or

(c) knowing that a representative of the organization is or is about to be a party to the offence, does not take all reasonable measures to stop them from being a party to the offence.

2003, c. 21, s. 2.

Accessory after the fact

23 (1) An accessory after the fact to an offence is one who, knowing that a person has been a party to the offence, receives, comforts or assists that person for the purpose of enabling that person to escape.

(2) [Repealed, 2000, c. 12, s. 92]

R.S., 1985, c. C-46, s. 23; 2000, c. 12, s. 92.

Where one party cannot be convicted

23.1 For greater certainty, sections 21 to 23 apply in respect of an accused notwithstanding the fact that the person whom the accused aids or abets, counsels or procures or receives, comforts or assists cannot be convicted of the offence.

R.S., 1985, c. 24 (2nd Supp.), s. 45.

Attempts

24 (1) Every one who, having an intent to commit an offence, does or omits to do anything for the purpose of carrying out the intention is guilty of an attempt to commit the offence whether or not it was possible under the circumstances to commit the offence.

Question of law

(2) The question whether an act or omission by a person who has an intent to commit an offence is or is not mere preparation to commit the offence, and too remote to constitute an attempt to commit the offence, is a question of law.

R.S., c. C-34, s. 24.

5.0 TIMING OF CRIMES

The crimes were committed during the period from December 2020 until the present time.

Criminal offences occurred when the accused knew or ought to have known that the actions being taken by them or as a result of their actions, or that the information provided by them to the public or any government agencies were false, misleading and were resulting in significant harm to the Public.

Based on the discussion presented in section 2.0 of this report, it is alleged that these actions became crimes when sufficient data was available to determine the direct and consequential results of the actions undertaken by Government officials and the Medical Community.

For the purposes of this report, we believe this occurred some time in late 2020 through to May of 2021, but the actual timing should be determined based on the criminal investigation of the activities of the specific persons involved.

6.0 BASIS FOR ALLEGING ILLEGAL ACTS

Since 2005/2006 the Canadian and Manitoba governments took steps to mitigate a potential for experiencing a catastrophic outcome due to a possible future pandemic event. Significant resources both in Canada and Worldwide were expended in their endeavour.

Many of the people responsible for the preparation of Canada's Pandemic Planning Document remain active and a part of the current Covid 19 pandemic response team. Most notable of those is Dr. Teresa Tam, who was listed on Page 1 of Section V of the report as the Director.

In addition to Dr. Tam, there are nine pages listing participants on this influenza planning committee located across Canada. Consequently the plan had broad national consensus and was widely distributed and understood by many senior health officials.

Many reports prepared by other national and international organizations were available, and should have been reviewed and understood by the medical community across Canada.

We have provided proof that despite this knowledge, those named, and more as yet to be identified by the police investigations, were aware of the requirements and recommendations of the established medical reports. Yet they took steps directly counter to those recommended in the various reports, and further, did not take reasonable steps to evaluate the effects the implemented measures were having on the public and to our overall society.

We have not tried to determine the motive, as we have no access into their individual reasons or motivation; however, we highly recommend these motives be examined in detail by means of a police investigation. The police investigation would further clarify how contradictory and harmful actions were not only perpetrated on the public but then maintained for an additional 18 to 20 months resulting in further harm.

Further, many of the same authorities and persons are currently engaged in the lifting of and cancellation of the very measures they previously put in place; however, the easing of illegal and criminal restrictions and actions, in no way protects those same individuals and organizations from their previously committed criminal acts.

Therefore, despite easing of the restrictions, the offences still require investigation and criminal proceedings must be initiated for the acts previously committed notwithstanding future acts of mitigation.

The basis of our preliminary investigation has included the review of various sources of information that were available to the alleged perpetrators of the criminal acts, and which should have led them to adjust or curtail their acts to mitigate harm being caused by those acts.

1. Statistics Canada Data for Years before the pandemic, up to including the present;
2. Manitoba Government Covid 19 Response Web Site
3. The Canadian Pandemic Influenza Plan 2006
4. CDC 2017 Update Pandemic Plan
5. WHO 2013 Pandemic Plan
6. Various CDC reports and Guidelines

The information we are referring to above are not merely expert opinions, or any opinion at all for that matter. Many "expert" opinions on almost any topic are now available to support almost any position one wishes. **Instead, we are offering hard evidence based on Government of Canada statistics, reports, and scientific evidence that is irrefutable, and it is these facts that we are providing to assist the Police in their investigations of the these alleged criminal acts.**

We do recognize and acknowledge, that the alleged criminal acts committed have had a very human and profound toll on the majority of Canadians. As a recognition of these human effects, we have included various recent articles, testimonials and expert medical opinions as an appendix to support of our direct evidence of wrong doing.

The statistical information for the year 2020 is uniquely significant when considering the effects of Covid 19.

The Covid 19 pandemic was reported to have started in late 2019, and was being widely reported throughout the World by early 2020. Considering its reported transmissibility and the number of cases being reported throughout 2020, it is reasonable to assume that 2020 would be the year that would result in the most serious outcomes, including deaths. This is based on the following facts:

1. In 2020, no therapeutic treatments were available;
2. In 2020, no one had any natural immunity to the virus as it was a "novel" corona virus;
3. In 2020, there were no vaccines available to fight the virus;
4. In 2020, many of the mitigative measures had not yet been implemented;
5. In 2020, the most vulnerable people had no protections against the virus;
6. In 2020, no deaths had yet occurred due to Covid 19 vaccines; therefore, those most at risk had not yet been affected

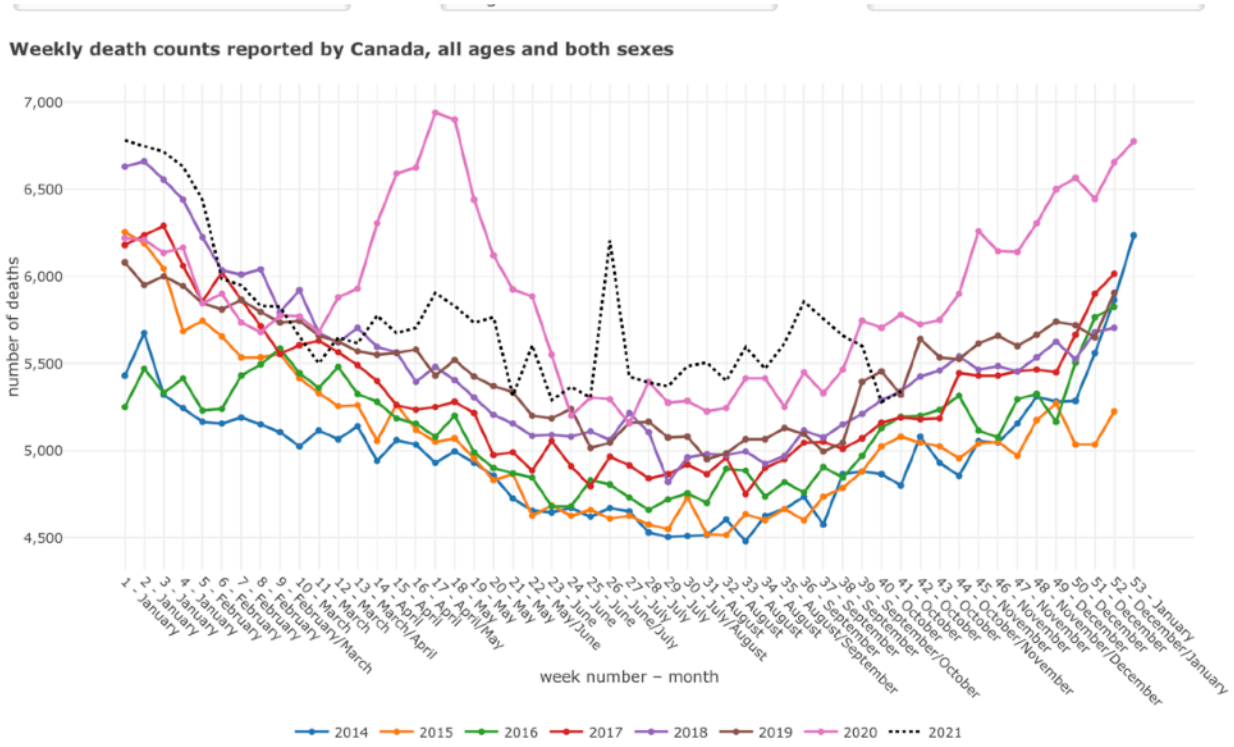
So 2020 would represent the year in which the general population would have been at most risk to Covid 19. In addition, since there were no vaccines available at the time, any injuries or deaths related to the new experimental vaccines could not have occurred.

Although not directly discussed in this presentation, there are many serious reports concerning adverse reactions and deaths that are alleged to be the direct result of the administration of the Covid-19 "genetic therapies". The data in 2020 is unaffected by this potential complicating factor.

The table below was obtained from Statistics Canada on March 7, 2022. It shows the Total Weekly Death Counts in Canada for the years 2014 through 2021.

The table directly compares the weekly death counts reported for the years 2014 through 2021.

The highest weekly death counts occurred in 2020.



6.1 Statistics Canada Data Available as of May 2020

Statistics Canada collects and distributes a wide variety of data that affects the daily lives of Canadians. The data is presented in many formats and becomes available to the general public at various times.

The Covid 19 pandemic was initially recognized in the early part of 2020 and public health orders began to be issued in or around March of 2020.

Since there was no direct and current information widely available at the time of the announcements, it would be reasonable to assume that those parties formulating and issuing the orders, would be basing their proclamations on established medical techniques and processes, plus any pandemic planning that had already been prepared, in addition to reviewing of any authoritative information that was available at that time.

A review of whether or not they followed any of the reasonable steps to mitigate the pandemic will be examined in subsequent sections of this report.

At the time of the recognition of the pandemic, certain detailed statistical information was available from Statistics Canada. Although this data predated the pandemic it was critical information from which a baseline could have been established. This baseline of information was critical to informing the medical community and the government on the efficacy of the steps there were taken. In fact, given the enormous scope and unprecedented nature of the proclamations being issued, these persons had a highest duty to constantly monitor and assess the situation as it related to the development of their understanding of the pandemic.

6.1.1 Statistical Trends on Population & Deaths

Below are data exerts from Statistics Canada Website collected on or about May 14, 2021.

Included in Appendix 10 is a copy of a report prepared in May 2021, analyzing the data available at that time.

We will not review that entire May 2021 report here, but a summary of some of the major conclusions are as follows:

TABLE 1
Population vs No. Of Deaths

Year	Total Actual Population	Total Deaths	Change in No of Deaths	Overall Change in Population
2020	38,048,738	300,310	12,850.0	724,252
2019	37,324,486	287,460	3,690.0	724,252
2018	36,600,234	283,770	9,530.0	724,253
2017	35,875,981	274,240	12,150.0	724,253
2016	35,151,728	262,090	-4,070.0	335,008
2015	34,816,720	266,160	13,110.0	335,008
2014	34,481,712	253,050	1,390.0	335,008
2013	34,146,704	251,660	9,250.0	335,008
2012	33,811,696	242,410	-3,090.0	335,008
2011	33,476,688	245,500	8,360.0	368,766
2010	33,107,922	237,140	-570.0	368,767
2009	32,739,155	237,710	1,180.0	368,766
2008	32,370,389	236,530	2,700.0	368,767
2007	32,001,622	233,830	8,340.0	368,766
2006	31,632,856	225,490		

The table to the left are the unadjusted raw data from Statistics Canada as of May 14, 2021.

No adjustments have been made to these numbers by the authors.

We note that the Total Number of Deaths are deaths for all causes.

We further point out that over the period of time from 2006 through 2020, the overall population of Canada increased from around 31 million in 2006 to around 38 million in 2020.

In order to understand the number of deaths as a proportion to the number of people in Canada, the number of deaths has to be adjusted or normalized to a common baseline. In that way it is possible to understand the trend in the number of deaths.

One could also adjust the numbers to reflect deaths per 1000 persons, but for our analysis we will adjust or normalize the population by adjusting each figure in direct proportion to reflect an overall population of 38 million persons.

TABLE 2
Adjusted Population vs No. Of Deaths

Year	Total Actual Population	Total Actual Deaths	Population Adjusted	Total Adjusted Deaths	Change in No of Adjusted Deaths
2020	38,048,738	304,760	38,048,738	304,760	15,166
2019	37,324,486	284,082	38,048,738	289,594	-5,339.7
2018	36,600,234	283,706	38,048,738	294,934	1,487.9
2017	35,875,981	276,689	38,048,738	293,446	4,210.9
2016	35,151,728	267,213	38,048,738	289,235	364.3
2015	34,816,720	264,333	38,048,738	288,871	3,275.7
2014	34,481,712	258,821	38,048,738	285,595	4,421.9
2013	34,146,704	252,338	38,048,738	281,173	3,675.7
2012	33,811,696	246,596	38,048,738	277,498	729.4
2011	33,476,688	243,511	38,048,738	276,768	866.0
2010	33,107,922	240,075	38,048,738	275,902	-1,182.0
2009	32,739,155	238,418	38,048,738	277,084	-3,390.5
2008	32,370,389	238,617	38,048,738	280,475	810.5
2007	32,001,622	235,217	38,048,738	279,664	5,325.5
2006	31,632,856	228,079	38,048,738	274,339	
		257,497.00	38,048,738.00		

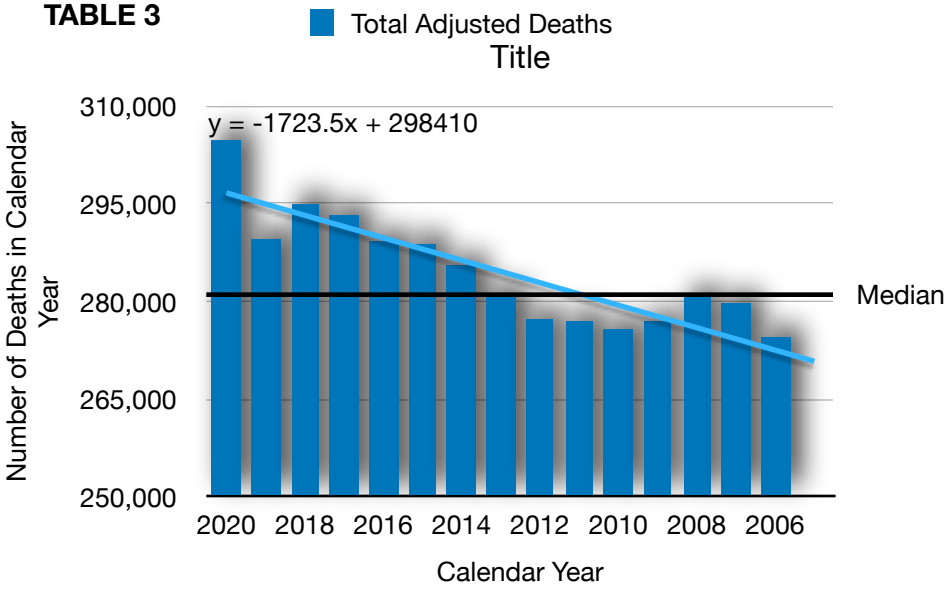
Table 1, has **not** been adjusted to take into account the changes in the total population that have occurred in Canada over the reporting years.

In other words, if the population is increasing then you would expect that the number of deaths would increase in direct proportion to the population growth. To compare one year to the next, one must adjust the death numbers in direct proportion to the reported population and **"normalize"** the numbers to a constant total population.

Table Two Adjusts the data reported in Table 1. We have set a base population for all the reported years in the table to the 2020 population numbers and adjusted each year's total death numbers proportionately.

When you plot the data from Table Two into a chart you get a visual indication of the total number of deaths in Canada over the period from 2006 through 2020.

TABLE 3



In **Table 3**, the median Value line has been added and a simple linear trend line has also been added.

The trend line is based on the data from all 14 years and predicts the trend in the number of deaths. This trend line can be used to estimate what the numbers of deaths would have been in 2020, had nothing unusual occurred.

The trend line predicted that in 2020 we could have expected somewhere around 298,500 deaths in Canada had nothing unusual occurred.

Statistics Canada reported a total number of deaths for 2020 at 304,760 which is approximately **6,260 more** than the linear trend line predicted.

Note how closely the trend line matches the data from 2014 thru 2018. In 2019 there is a significant drop in the number of deaths reported, compared to the trend line prediction.

We could find no data explaining the drop in death totals for 2019.

In 2019 the total number of deaths predicted by the linear trend line is 295,000.

In 2019 the number of adjusted deaths reported by Statistics Canada was 289,594.

The difference in the number of deaths reported in 2019 compared to the linear trend line prediction is: **5,406 less**.

In 2020 there was an increase in total death of 6,260. In 2019, there was a decrease in total death of 5,406.

Statistics Canada has reported a total number of deaths related to Covid 19 for the 2020 year as: **15,606**. This is according to an article from CTVNews January 5, 2021.

Taking the total number of deaths reported in 2020 as 304,760, and subtracting the number of "confirmed" Covid 19 deaths for the year (15,506), should provide the number of total deaths **excluding** Covid 19 in 2020. 304,760 - 15,606 = 289,154.

In 2020, based on this simple analysis, the anticipated total deaths in Canada was **289,154** deaths, if not for Covid 19.

The total number of deaths in Canada has not been this low since 2015.

Based on these reported numbers of deaths related to Covid 19, had it not been for the Covid 19 crisis, Canada would have reversed a five year trend of increasing death rates and achieved a death rate in 2020, that had not been seen in Canada since 2015.

Conclusion Regarding Total Deaths for 2020, as Reported May 2021

As of May 2021, based on the actual statistics that were available at the time, the various government agencies who were implementing the pandemic response should have known exactly how the Covid-19 pandemic was affecting the population.

The pandemic response should have been focused on those particular groups of people who were at most risk, and the level of hysteria that was being elevated in all parts of the population should have been reduced by focused and truthful messaging.

There were many instances where the reporting by both the government agencies and the press presented the data in such a way as to significantly exaggerate the number of deaths associated with Covid overall, and more specifically in the rates related to certain population groups.

This misinformation resulted in a drastic over reaction by authorities and significantly contributed to the terror being experience by the overall population.

Based on the misleading and sensational way that data was being presented to the public, it would have been impossible for the average citizen to draw coherent and reasonable conclusions necessary to take appropriate steps and to allow the average citizen to exercise an informed decision as to their treatment options.

6.1.2 Morbidity Rates and Recovery Rates Reported for 2020

As of May 2020 and until the present time, the governmental agencies and medical agencies were and still are reporting death and survival rates related to Covid 19.

The figures often reported to the public indicated that a person's chances from dying from Covid 19 are low and in the range of a 99.99 % survival rate.

Based on the actual numbers available from Statistics Canada as of May 2020, this statement is false and at the very best was misleading. The chance of contracting and dying of Covid 19 were actually much lower, and varied significantly across various identifiable population groups.

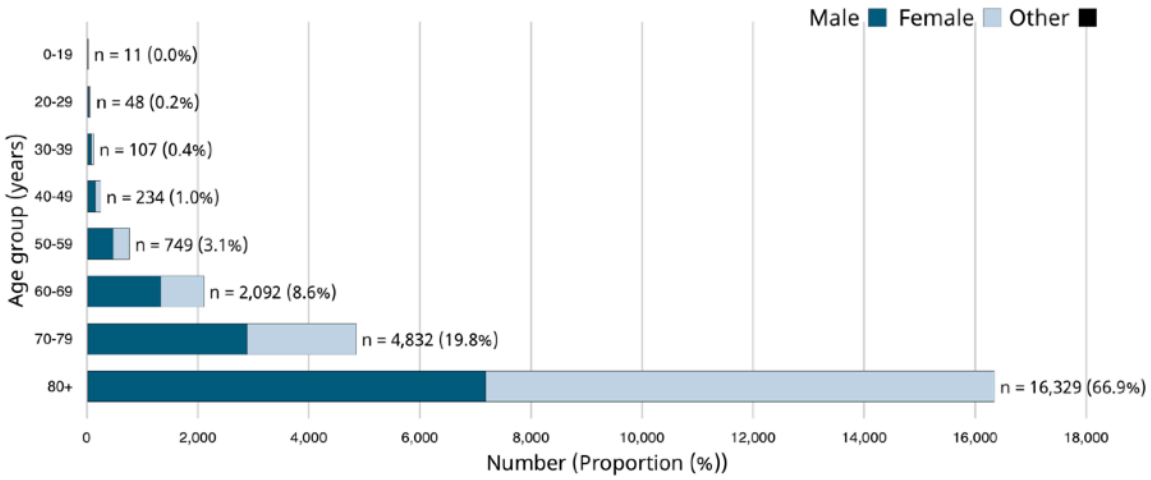
The truth is the death rate from Covid-19 is directly related to your age and any comorbidity that you might have.

In other words, if you are older or have a number of preconditions that become compounded with Covid 19, then your chances of getting very sick or actually dying are increased dramatically.

But what are the actual statistics, and how are they being reported?

TABLE 4

Figure 5. Age and gender [4] distribution of COVID-19 cases deceased in Canada as of May 7, 2021, 7 pm EST (n=24,402 [1])



Data note: Figure 5 includes COVID-19 cases hospitalized, admitted to ICU, and deceased for which age and gender information were available. Therefore, some COVID-19 hospitalizations, ICU admissions, and deaths may not be included in Figure 5.

The above figure was taken from Health Canada's Covid 19 website May 7, 2020.

Based on the information in **Table 4** we can see the extremely close relationship between age and reported death outcomes related to Covid 19.

86.7% of all deaths due to Covid 19 are in persons **over the age of 70**, despite the fact that people in this age group comprise **8.3% of the population**.

People under the age of 50 account for 1.6% of the reported Fatalities, and they account for 91.7% of the population.

The way the data has been reported, pertaining to a person's chances of dying from Covid-19, are extremely misleading, and do not take into account the statistics of age and numbers of population in a given age group or the relationship of co-morbidities.

Your chances of contracting and dying from Covid 19 depend on your age, condition of health, and the entire number of persons who are in your affected group.

For instance, below are the Statistics Canada numbers of persons in Canada in the various listed age groups.

The government and health officials and main stream media get their "survival rate" numbers by taking the overall number of reported Covid 19 deaths and dividing it by the total number of "confirmed" cases. As of May 14, 2021, Statistics Canada was reporting a total number of confirmed cases at 1,257,680, and Covid-19 deaths of 15,606. This produces the 98% survival rate that was being reported.

This reported statistic, does not take into account the actual unknown number of cases in Canada, and it does not take into account the chance of you contracting Covid in the first place. In addition it ignores the correlation between serious outcomes related to age and comorbidity.

This is like saying your chance of dying from getting run over by a bulldozer is 100% so you cannot go outside. Of course just about everyone who gets run over by a bulldozer dies; however, you have to take into account the chance of getting run over by a bulldozer in the first place.

Table 5, illustrates your actual **chances of contracting and then dying of Covid 19**, based on your specific age group. It is based on Statistics Canada data for May 14, 2021. The column headed "Odds of Death One in X" means this is your odds of dying from Covid 19.

As an example, if you are 0 - 19 Years of age, then your odds of contacting and dying of Covid 19 in Canada are 1 in 739,956. Or to put it another way, in this age group, your chance of contracting and dying from Covid 19 is 0.000135%. This takes into account all deaths reported from Covid 19 up to May 7, 2021.

We point out that these statistics are totals to date numbers, so they report the numbers from the beginning of the pandemic early 2020 to May of 2021, 17 plus or minus months.

TABLE 5 Covid Deaths Plotted to Age Range - May 7, 2021

Age Range	No. Of People	No. Of Deaths	Odds of Death One in X	% Odds Of Dying from Covid 19	% Odds of Not Dying from Covid 19
0 - 19	8,139,512	11	1 in 739,956	0.0001351%	99.9998649%
20 - 29	5,128,042	48	1 in 106,834	0.0009360%	99.9990640%
30 - 39	5,292,403	107	1 in 49,462	0.0020218%	99.9979782%
40 - 49	4,854,363	234	1 in 20,745	0.0048204%	99.9951796%
50 - 59	5,194,811	749	1 in 6,936	0.0144182%	99.9855818%
60 - 69	4,727,516	2,092	1 in 2,260	0.0442516%	99.9557484%
70 - 79	3,004,925	4,832	1 in 622	0.1608027%	99.8391973%
80 and Older	1,663,666	16,329	1 in 102	0.9815071%	99.0184929%
Total	38,005,238	24,402			
Median Age	40.9				

This extreme over reporting of the chances of dying from Covid-19 had the serious effect of both terrorizing the population while also being used to justify the lethal health orders that were being imposed on Canadians.

Had a proper analysis and presentation of the actual data been presented to the Canadian public, the mitigation steps taken could have been more focused on the population groups that needed it most and the terrible fear that developed in the Canadian population could have been mitigated.

Furthermore the efficacy of any mitigative measure would have been increased by focussing on the highest at risk groups and by not disrupting the lives of those who had little or no statistical risk from Covid 19.

There are currently some misleading statistics concerning the number of cases in a given age group in Canada. This is shown in **Table 6** below.

Assuming the data is correct, the table does not alert the reader to the fact that the numbers of people in each of the age categories varies greatly. The table only reports the overall number of cases in each age group.

Table 6 is taken from the Health Canada Covid Reporting Website.

Once again, the actual statistics present a very different story than what was being told to the public at the time, and the mitigative measures were being justified and enforced based on faulty and or misleading information.

TABLE 6

Figure 3. Age distribution of COVID-19 cases (n=1,257,680 [1]) in Canada as of May 7, 2021, 7 pm EST [4]

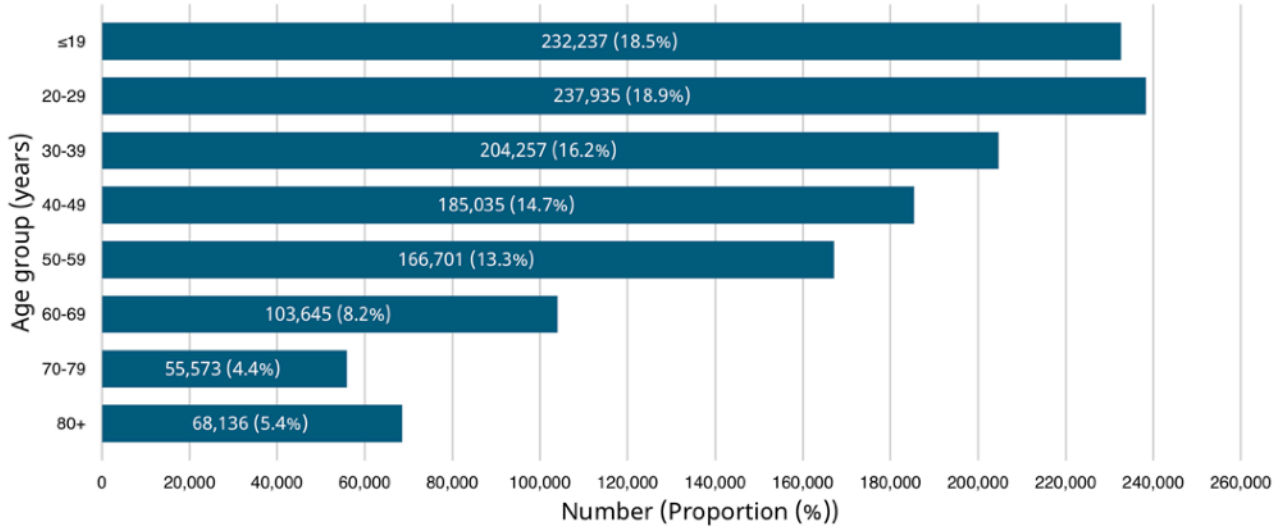


TABLE 7

Covid Infections Plotted to Age Range

Age Range	No. Of People	No. Infections	Rate of Infection One in X
0 - 19	8,139,512	232,237	1 in 35
20 - 29	5,128,042	237,935	1 in 22
30 - 39	5,292,403	204,257	1 in 26
40 - 49	4,854,363	185,035	1 in 26
50 - 59	5,194,811	166,701	1 in 31
60 - 69	4,727,516	103,645	1 in 46
70 - 79	3,004,925	55,573	1 in 54
80 and Older	1,663,666	68,136	1 in 24
Total	38,005,238		
Median Age	40.9		

Although **Table 6 (from Statistics Canada)** appears to show that the infection rate among people less than 19 years old, is extremely high, it does not take into account the numbers of people who are in this age group.

Table 7, shows the numbers of people in each age group that are infected, as well as the **total** number of people in that age group.

The “Rate of Infection One in X” illustrates that the actual age group with the lowest infection rate is the 60 to 79 year age group.

A cursory review of the data would lead one to believe the infection rate in younger people is much higher that in the older population. This is deceptive, since the number of people in each category must be taken into account to get a true picture of the infection rate.

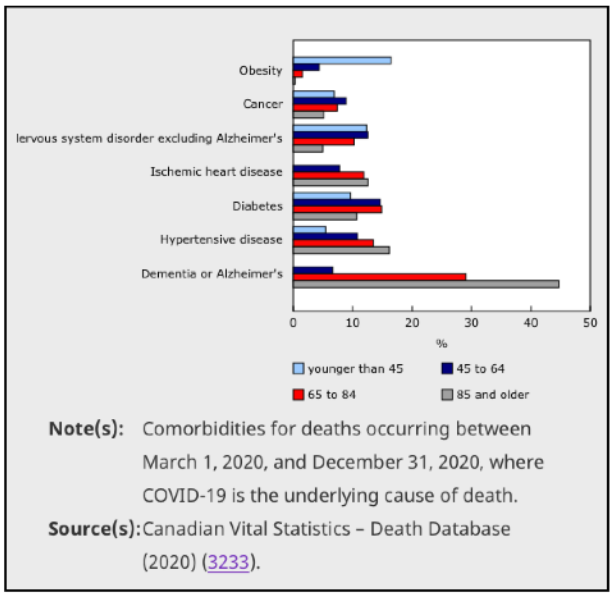
One can see from **Table 7** that the actual rate of infections are lowest in the 70-79 year old age group.

Another important consideration is that although the infection rate of the population who are 19 years of age and younger is at 1 infected person per 35, the death rate is the lowest. This further indicates that the chances of a person in this age group of actually dying from Covid 19 is actually even more remote than previously indicated since the infection rates per capita is actually higher.

The information that was available to government agencies clearly showed that while some particular populations were at some risk, the vast majority of healthy people in the minimally affected age groups were hardly at any risk of contracting and dying of Covid 19. Mandates which shut down schools, businesses, churches, and severely limited social interaction and business, were entirely unnecessary, given the information that the government had available to them. The mandates which severely impacted and damaged the very fabric of our society were unnecessary and the implementation of such measures, in the face of the actual data available at the time, rises to the level of criminal negligence. The continued mandating of vaccines to groups not at risk unnecessarily exposes people to an unevaluated level of risk.

Frequency of chronic conditions reported on death certificates where death is due to COVID-19

Back to main article | Interactive | Image | CSV (1 KB)



Note(s): Comorbidities for deaths occurring between March 1, 2020, and December 31, 2020, where COVID-19 is the underlying cause of death.

Source(s): Canadian Vital Statistics – Death Database (2020) (3233).

It is interesting to note the statistics on how many other chronic conditions were present in most people who are reported to have died **from** Covid-19.

Health Canada is reporting, in the article below, that 46% had **3 or more co-morbidities.**

How is it determined that the people did actually die **of** Covid-19, rather than **with** Covid-19 or that they died of a heart attack that was complicated by Covid-19.

Had it not been for Covid-19 would they have died? Had it not been for the other morbidities, would Covid-19 have killed them?

An answer to these questions has not been provided and explained in a rational manner.

It is certainly an important question.

Frequency of chronic conditions reported on death certificates where death is due to COVID-19, %

	younger than 45	45 to 64	65 to 84	85 and older
Obesity	16.44	4.38	1.57	0.28
Cancer	6.85	8.89	7.41	5.12
Nervous system disorder excluding Alzheimer's	12.33	12.52	10.25	4.93
Ischemic heart disease	0.00	7.76	11.90	12.53
Diabetes	9.59	14.64	14.90	10.65
Hypertensive disease	5.48	10.76	13.44	16.15
Dementia or Alzheimer's	0.00	6.63	29.07	44.67

Almost 90% of people who died of COVID-19 in 2020 had a least one other comorbidity

Of the nearly 15,300 people who died of COVID-19 between March and December 2020, 89% had one or more other conditions or complications reported on their death certificate. In fact, almost two-thirds (65%) had two or more comorbidities and almost half (46%) had three or more comorbidities reported. These results, along with the specific conditions listed on the death certificate, highlight some of the populations in Canada most vulnerable to severe outcomes of COVID-19. Although individuals had pre-existing conditions, it does not imply that they were at risk of dying if there had been no COVID-19 infection.

6.1.3 Perspective on Risk

Percentages, Numbers, Odds: What Does it all Mean?

It is an uncomfortable truth, but we all live with risk everyday. On any given day there is always the risk that something bad could happen to any one of us. Perhaps many of us do not think about it, but it is a fact of life.

It is impossible to eliminate 100% of the risk of someone contracting and dying from a disease. There are mitigative measures that can be taken to reduce risk, and these mitigative measures always have new or additional risks associated with them as well.

It is required that the benefits of any mitigation actions are weighed against the potential derived benefits so an informed decision can be made based on the Risk vs Benefit analysis.

Examples of risk to benefits include the following:

- Wearing Masks to Reduce Transmission vs. Masks Cause Infections, Damage Children Development
- Lock Downs to Reduce Transmission vs. Lock Downs Increase Violence, Suicide, Bankruptcy
- Vaccines to Prevent Infection vs. Costs, Efficacy, and Side Effects Both Long and Short Term

Every potential action has a potential negative reaction so it is absolutely critical there is a clear understanding of the risks.

Although decision making processes can be informed by “experts” in certain specialized fields, the actual decision as to whether or not to undertake a certain mitigative course of action must be taken by Leaders who can understand the entire spectrum of considerations and arrive at a political decision based on compromise and overall consideration of societies requirements.

6.1.3.1 Odds in Various Age Groups

The following is a discussion of the risks presented by Covid-19 based on the actual statistics reported by Statistics Canada as of May 2021 and as presented in the previous graphs and tables.

To put these odds in perspective:

If you are over the age of 70

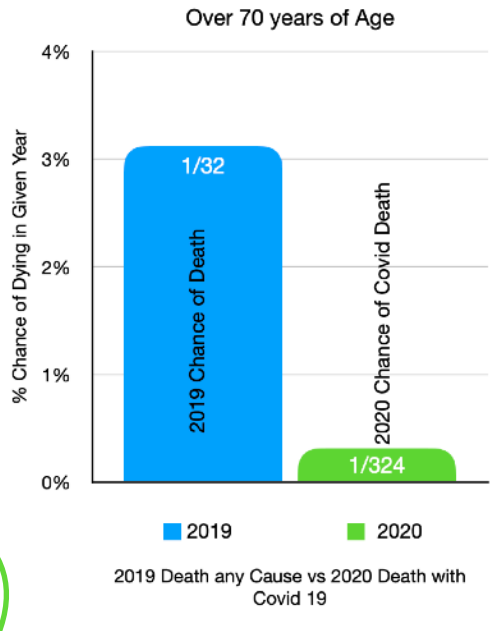
- In 2019, (prior to Covid 19) there were 4,668,591 people over the age of 70 in Canada.
- In 2019, there were a total of 145,569 deaths in this age group.
- In 2019, (prior to Covid 19) **your odds of dying** in a given year if you were over 70 years of age are: **1 in 32**.
- In 2020, your **odds of dying from Covid-19**, if you are over 70 year of age are: **1 in 324**

So your odds of simply dying for any reason in 2019 were ten times higher than your odds of dying with Covid 19, in 2020.

2019 Over 70 years Old - Odds of Dying

2019 Odds of Dying All Causes	
Number of People	4,668,591
Number Total Deaths	145,569
Percent Chance of Death Any Cause	**3%**
Odds of Death in 2019	**32**

2020 Odds of Dying With Covid 19	
Number of People	4,676,492
Number Covid Deaths	14,441
Percent Chance of Death From Covid 19	0.31%
Odds of Death in 2019	**324**



Odds of Death Defined:

32 means your chances of dying are 1 in 32.

324 means your chances of dying are 1 in 324.

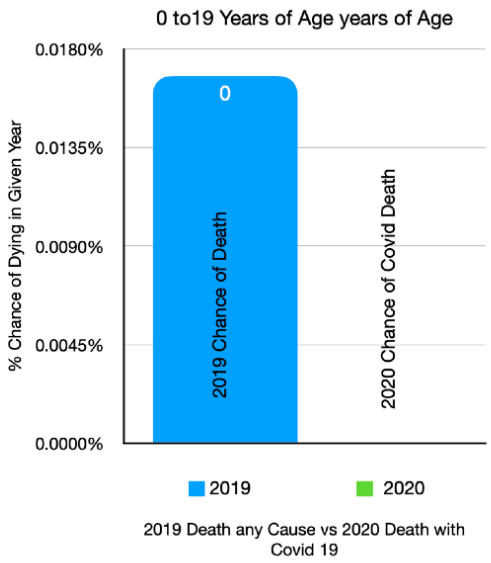
If you are under the age of 19
In 2020, Two Covid 19 Deaths Reported for this age group

- In 2019 (Prior to Covid 19) (12 months) there were:
  - 43 Murders
  - 232 Suicides
  - 316 Fatal Accidents
  - 20 Deaths from Influenza

2019 Zero to 19 years Old - Odds of Dying

2019 Odds of Dying All Causes		
Number of People		8,139,512
Number Total Deaths		1,365
Percent Chance of Death Any Cause		**0.0168%**
Odds of Death in 2019	**1 in**	**5,963**

2020 Odds of Dying With Covid 19		
Number of People		8,144,135
Number Covid Deaths		2
Percent Chance of Death From Covid 19		0.0000%
Odds of Death in 2020 with Covid 19	**1 in**	**4,072,068**

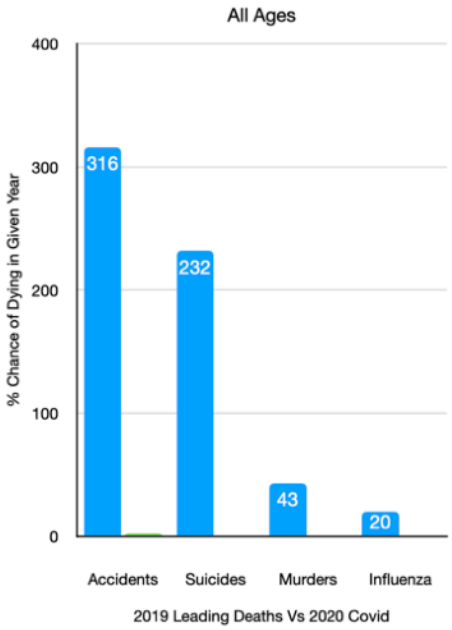


2019 Death any Cause vs 2020 Death with Covid 19

2019 Zero to 19 Years Old Leading Causes of Death

2019 Odds of Dying All Causes		
Number of People		8,139,512
Number Total Deaths		1,365
Murders		43
Suicides		232
Accidents		316
Influenza		20
Percent Chance of Death Any Cause		**0.0168%**
Odds of Death in 2019	**1 in**	**5,963**

2020 Odds of Dying With Covid 19		
Number of People		8,139,512
Covid		2
Percent Chance of Death From Covid 19		0.0000%
Odds of Death with Covid 19 in 2020	**1 in**	**4,069,756**



2019 Leading Deaths Vs 2020 Covid

At any age (in the General Population)

- By May 14, 2021, there has been a **Total of 15,606 reported deaths** from Covid 19
- In 2019 (Prior to Covid 19) there were:
  - 387 Murders
  - 4,012 Suicides
  - 13,746 Accidents
  - 6,893 Deaths from Influenza
  - 52,541 Deaths from Heart Disease
  - 80,152 Deaths from Cancer
  - 6,912 Deaths from Diabetes
  - 6,166 Deaths from Alzheimer's
  - 13,660 Deaths from Heart Attack

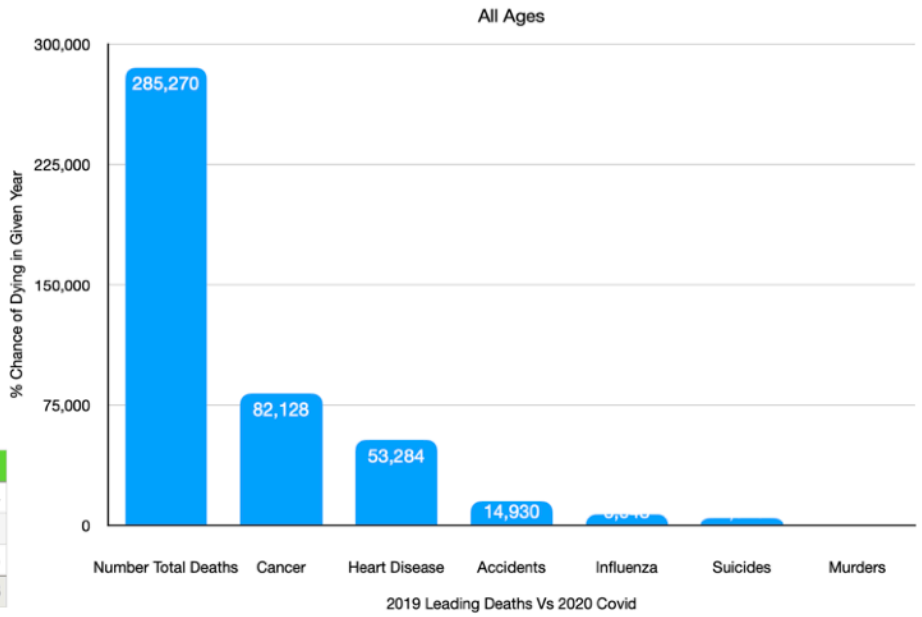
We note that in 2019 Statistics Canada reported a total of 59,664 deaths listed as "Other Causes". They define Other Causes as "Other causes of death" as a residual category, which includes all causes of death that are not part of the 50 leading causes of death list.

This is interesting as the Other Causes of death comprises 21% of the total deaths reported.

2019 All Ages Leading Causes of Death

2019 Odds of Dying All Causes		
Number of People		37,324,486
Number Total Deaths		285,270
Murders		501
Suicides		4,528
Accidents		14,930
Influenza		6,943
Cancer		82,128
Heart Disease		53,284
Percent Chance of Death Any Cause		**0.7643%**
Odds of Death in 2019	**1 in**	**131**

2020 Odds of Dying With Covid 19		
Number of People		38,037,204
Covid		16,151
Percent Chance of Death From Covid 19		0.0425%
Odds of Death with Covid 19 in 2020	**1 in**	**2,355**



Conclusion

As of May 2020, the officials knew or ought to have known what the real odds of dying from Covid-19 were. In the same way, they knew or ought to have known the actual effects of the application of the Covid-19 restrictions. They should also have observed the panic and fear that was being induced into the population as a result of their own inaccurate or misleading statistics.

Furthermore, as of May 2020, there were enough issues described in the data being reported that a detailed investigation of the actual issues should at least have been initiated.

6.1.4 Detailed Review of Causes of Death in Various Age Groups 2020

Like all things in life, perspective is one of the most important measures as to how much mitigative action a person should take when facing certain situations.

The following data is derived from Statistics Canada database reference:

https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=1310039401&pickMembers%5B0%5D=2.7&pickMembers%5B1%5D=3.1&cubeTimeFrame.startYear=2020&cubeTimeFrame.endYear=2020&referencePeriods=20200101%2C20200101

The data presented in the following table are unadjusted, except that Statistics Canada reports the specific causes of death as the “top 50 causes” despite some of the causes listed recording zero deaths in 2020. We have deleted the causes of death that were zero rated for 2020.

Also, it is interesting to note that 21% of the total deaths for 2020 were listed as “Other Causes”. In other words, no explanation for these deaths were provided in the statistics, except that they were not in the list of “top 50 causes of death”.

In this section we will review the “risk of death” in the year 2019, and compare it to the year 2020. Further, we will compare the risk of death from Covid 19 to the risk of death in various age groups from various causes reported by Statistics Canada.

According to Statistics Canada, here are various age groups and causes of death in Canada for the year 2020:

2020	Number of Deaths																
Age Range	**0 - 14**	**15-19**	**20-24**	**25-29**	**30-34**	**35-39**	**40-44**	**45-49**	**50-54**	**55-59**	**60-64**	**65-69**	**70-74**	**75-79**	**80-84**	**85 ++**	**Totals**
Total in Age Group	6,041,733	2,102,402	2,484,313	2,647,713	2,664,486	2,632,387	2,465,574	2,392,365	2,452,279	2,746,773	2,561,677	2,168,710	1,788,124	1,219,909	812,613	856,146	38,037,204
Total Deaths	616	733	1,552	2,229	2,596	2,995	3,638	4,886	7,511	13,281	18,931	24,277	31,089	35,372	41,334	114,543	305,583
Covid 19	1	1	9	7	11	25	38	65	124	247	425	757	1,212	1,813	2,592	8,824	16,151
Salmonella											1	2	1		2	3	9
Tuberculosis			3		1	3	2	6	2	4	10	4	7	15	12	27	96
Meningococcal infection	2					1				1		1	1		1		7
Sepsis	5	3	2		4	7	23	26	28	49	106	124	200	295	311	1,033	2,216
Syphilis												1	1	1		2	5
Viral hepatitis			2	1	2	3	3	8	17	46	53	50	22	16	11	14	248
HIV				2	8	7	14	15	19	19	13	15	11	8	2	2	135
Malignant neoplasms	112	68	64	134	191	403	718	1,183	2,275	4,842	7,813	10,036	12,257	12,098	11,278	17,493	80,965
neoplasms	9	4	1	3	5	7	10	14	27	51	96	130	197	272	333	697	1,856
Anaemias	3	3	1	2	3	4	3	1	5	10	12	19	44	44	73	392	619
Diabetes	6	6	9	16	48	63	72	115	196	387	558	708	914	1,017	1,143	2,308	7,566
Nutritional deficiencies					2	1	2	3	8	10	13	18	13	21	34	126	251
Meningitis	3		1	1	1	1	3	2	5	8	7	7	6	5	7	13	70
Parkinsons								3	1	12	52	132	313	603	814	1,501	3,431
Alzheimer's disease							2	2	5	20	39	102	253	510	899	3,911	5,743
Diseases of heart	12	15	28	51	108	170	302	591	1,063	2,071	3,178	4,018	5,133	5,819	7,259	23,868	53,686
Essential hypertension						3	3	6	15	38	71	91	134	151	239	1,196	1,947
Cerebrovascular	10	3	10	18	19	30	66	113	195	367	526	794	1,180	1,578	2,222	6,562	13,693
Atherosclerosis							3	1	6	10	22	43	55	55	83	258	536
Aortic aneurysm			1	3	6	8	11	34	30	68	91	116	181	242	233	491	1,515
Influenza and	16	5	8	14	31	15	49	56	87	135	211	300	436	563	775	3,238	5,939
Acute bronchitis													2	1	2	12	17
Chronic lower	2	4	6	5	7	10	19	36	103	289	2	1,121	1,594	1,885	1,980	3,959	11,022
Pneumoconioses						1	1	2		1		4	15	18	34	41	117
Pneumonitis			2	2		1	4	7	15	31	43	74	117	160	254	955	1,665
Peptic Ulcer					3	4	7	11	15	23	41	57	63	70	81	174	549
Diseases of appendix	1			1		1		1		3	4	3	4	3	3	24	48
Hernia			1		1	113	4	3	2	13	16	33	41	42	70	198	537
Chronic liver		2	5	28	55		162	241	382	587	553	653	505	375	262	250	4,060
Gall Blader				1	2		1	426	8	11	12	27	36	76	82	247	929
Nephritis	1		1	5	8	10	17	1	50	82	144	213	347	452	686	2,000	4,017
Infection of Kidney							1			7	4	18	12	18	25	85	170
Prostate									1		4	5	10	15	25	127	187
Female pelvic organs						1	1	1	1	2	3			5	3	9	26
Pregnancy		1	4	3	9	10	3										30
Perinatal period	1				1	1	1		1				1		1	2	9
Congenital	50	14	20	22	22	16	22	36	67	92	101	49	47	31	22	44	655
Acidents	127	208	520	741	792	776	772	676	754	856	745	682	716	949	1,303	4,871	15,488
Suicide	39	173	291	342	353	323	317	314	309	419	301	198	159	120	78	103	3,839
Homicide	13	27	61	66	40	45	35	23	18	26	10	9	12	5	1	5	396
Legal intervention				3	2	1	2	1	2	1	2		1				15
War																1	1
Complications of medical	1	1	2	2		1	2	2	3	6	15	16	24	21	16	54	166
Other causes		194	500	756	870	929	943	1,257	1,649	2,437	2,933	3,647	4,812	5,999	8,083	29,423	64,432
% 0f Other Causes to		26%	32%	34%	34%	31%	26%	26%	22%	18%	15%	15%	15%	17%	20%	26%	21%

The above death statistics are for Canada in the year 2020. The data has been broken down into age groups of 5 year intervals with the exception of the youngest interval which runs from birth to 14 years.

In order to truly understand the numbers, one has to consider the number of persons in each age group. This is an important parameter, because if you have one death in a group and that group only contains one person then you have a 100% death rate. If you have one death in a group and you have 10,000 people in the group, your death rate is only 0.1%.

We have provided these population numbers, but first it is very enlightening to simply look at the numbers of covid deaths for any age group and compare it to the total numbers of deaths in that age group and to the total number of deaths for any other single or combination of causes.

6.1.4.1 Analysis of Deaths 14 Years of Age and Less for 2020

In the age group 0 through 14 years of age there was 1 reported death due to Covid-19. Given the missing information about this death and the significant reports of errors in the data, it is interesting to compare Covid-19 deaths to other causes.

In this age group a person had the following other death risks:

FOR PERSONS 0 TO 14 YEARS OF AGE

COVID-19:	**1X**
SUICIDE:	**39X**
HOMICIDE:	**13X**
ACCIDENTS:	**127X**
INFLUENZA:	**16X**
CANCER:	**112X**

People in this age group had a statistically zero chance of dying from Covid 19. Despite this fact, the government mandated vaccines for children in this age range. Vaccines are still being administered to people in this age group.

It is important to consider that the mRNA vaccines had never been used on the general population and that no specific controlled peer reviewed testing on children had not been carried out. For more information on Vaccine risks see section **6.2.2. Forced or Mandated Vaccinations**

So a consideration of the risks of mandating a new vaccine to children is of paramount importance.

As of February 11, 2022, the number of serious adverse reactions reported for children in the age group 5 to 11 years of age is 263 per 100,000. Health Canada also states that at the time of the report, some 2,339,876 doses had been administered to 5 through 11 year olds. That means that they have caused some 6,153 "adverse reactions" in a group of children who **have a statistically zero chance of dying from Covid-19**.

More accurately, the chance of a person below the age of 14 dying of Covid-19 is **1 in 6 million** According to Stats Canada. The Chance of a 5 to 11 year of having a severe reaction to the vaccine is 263 in 100,000 or to make it easier to understand, **15,780 in 6 Million.**

Chance of Child 0 to 14 years dying of Covid: 1X
Chance of Child 0 to 14 years getting adverse reaction to vaccine: ... 15,780 X

These numbers are incredibly large numbers and hard to understand. Let us put this into perspective:

If you took 6 million children and linked them arm in arm, the line of these children would stretch from St. John's Newfoundland to Tofino British Columbia, and beyond…**AND** in that entire line of 6 million children, there would have been one "reported" death from Covid-19.

The following outlines some of the vaccine risk information listed on the Government of Manitoba's own website (February 2022). Manufacturer product monographs presented on the Manitoba Government Covid-19 Website state the following:

> ***Acute Allergic Reactions***
> *Anaphylaxis has been reported. As with all vaccines, training for immunizers, appropriate medical treatment and supervision after immunization should always be readily available in case of a rare anaphylactic event following the administration of this vaccine.*
>
> *Vaccine recipients should be kept under observation for at least 15 minutes after immunization; 30 minutes is a preferred interval when there is a specific concern about a possible vaccine reaction.*
>
> *A second dose of the vaccine should not be given to those who have experienced anaphylaxis to the first dose of COMIRNATY.*
>
> ***Cardiovascular***
> ***Myocarditis and Pericarditis***
> *Very rare cases of myocarditis and/or pericarditis following vaccination with COMIRNATY have been reported during post-authorization use. These cases occurred more commonly after the second dose and in adolescents and young adults. Typically, the onset of symptoms has been within a few days following receipt of COMIRNATY. Available short-term follow-up data suggest that the symptoms resolve in most individuals, but information on long-term sequelae is lacking. The decision to administer COMIRNATY to an individual with a history of myocarditis or pericarditis should take into account the individual's clinical circumstances.*
>
> *Healthcare professionals are advised to consider the possibility of myocarditis and/or pericarditis in their differential diagnosis if individuals present with chest pain, shortness of breath, palpitations or other signs and symptoms of myocarditis and/or pericarditis following immunization with a COVID-19 vaccine. This could allow for early diagnosis and treatment. Cardiology consultation for management and follow up should be considered.*

Driving and Operating Machinery
COMIRNATY has no or negligible influence on the ability to drive and use machines. However, some of the effects mentioned under 8 ADVERSE REACTIONS may temporarily affect the ability to drive or use machines.

Fertility
It is unknown whether COMIRNATY has an impact on fertility. Animal studies do not indicate direct or indirect harmful effects with respect to female fertility or reproductive toxicity (see 16 NON-CLINICAL TOXICOLOGY).

Hematologic
Individuals receiving anticoagulant therapy or those with a bleeding disorder that would contraindicate intramuscular injection should not be given the vaccine unless the potential benefit clearly outweighs the risk of administration.

Immune
Immunocompromised persons, including individuals receiving immunosuppressant therapy, may have a diminished immune response to the vaccine. In these individuals, a third dose may be considered as part of the primary series.

So, based on the statical numbers, administering the vaccine to anyone in the 0 to 14 years age group results in a 16,000 times greater chance of causing a reaction due to the Vaccine, and carries with it any number of unknown potential long term issues which the manufacturer and the government have no information about due to the absence of testing.

It has been widely reported that no healthy child has died of Covid 19 anywhere in North America.

How can health officials claim that locking children out of schools and forcing vaccinations against Covid-19 is justified when the risk to children of dying from common Flu is 16X higher, than it is for dying from Covid 19.

The statistical justification for undergoing a forced or coerced vaccination does not exist.

This is obvious on the face of the raw statistics.

In every age range (excluding 0 to 14) the levels of death by "**other causes**" is many times higher than the death toll reported for Covid-19 and the death tolls due to other preventable causes is also much higher than Covid 19.

6.1.4.2 Analysis of Deaths Of Women In Child Bearing Years

A similar analysis can be undertaken for a wide range of age groups, sexes and other demographics.

We have particularly chosen to highlight the Covid 19 risks in what we define as women in child bearing years because this age group is likely at highest risk from potential short term and long term effects of any Covid 19 Vaccine that may be developed.

There have been a significant number of historical disasters caused by the administration of various pharmaceutical products to this group of the people. In fact the extreme sensitivity of this group to both medical and toxicological issues is well known.

Historical major issues related to birth defects, development issues, miscarriages, etc., etc., dictate that extreme caution is to be exercised before prescribing any vaccine, drug or treatment regime to this group.

We point out that in the product monogram provided by Pfizer-Biontech, they specifically state the following:

> ***Fertility***
> *It is unknown whether COMIRNATY has an impact on fertility. Animal studies do not indicate direct or indirect harmful effects with respect to female fertility or reproductive toxicity (see 16 NON-CLINICAL TOXICOLOGY).*
>
> **7.1 Special Populations**
>
> **7.1.1 Pregnant Women**
>
> The safety and efficacy of COMIRNATY in pregnant women have not yet been established. Animal studies do not indicate direct or indirect harmful effects with respect to pregnancy, embryo/ fetal development, parturition, or post-natal development (see 16 NON-CLINICAL TOXICOLOGY). 7.1.2 Breast-feeding
>
> It is unknown whether COMIRNATY is excreted in human milk. A risk to the newborns/ infants cannot be excluded.
>
> The developmental and health benefits of breastfeeding should be considered along with the mother's clinical need for immunization against COVID-19.
>
> **7.1.3 Pediatrics**
>
> The safety and efficacy of COMIRNATY in children under 5 years of age have not yet been established.
>
> **16 NON-CLINICAL TOXICOLOGY**
>
> Non-clinical data reveal no special hazard for humans based on conventional studies of repeat dose toxicity.
>
> **General Toxicology:**
>
> In a repeat-dose toxicity study, rats were administered three once weekly doses of 30 mcg/ animal (0.06 mL of a vaccine formulation containing the same quantity of nucleoside-modified messenger ribonucleic acid (mRNA) and other ingredients included in a single human dose) of COMIRNATY by intramuscular injection. Vaccine administration resulted in transient erythema and edema at the site of injection, as well as increased cellularity in draining and inguinal lymph nodes, spleen, and bone marrow, along with transiently

increased body temperature, increased white blood counts, and decreased reticulocyte counts coupled with decreased red blood cell mass. Clinical chemistry changes (e.g., increased acute phase protein levels) indicated an acute phase response. These changes are consistent with an expected immunostimulatory response following intramuscular administration of a vaccine. Transient periportal hepatocyte vacuolation was also observed without evidence of liver injury. Full or partial recovery from all findings was observed following a 3-week recovery period.

Carcinogenicity:

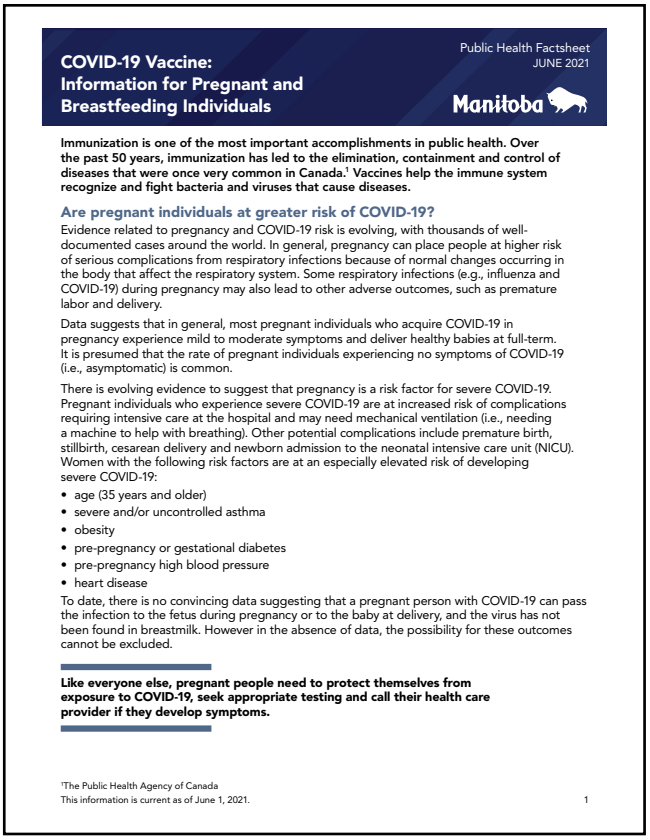
Carcinogenic potential was not assessed, as carcinogenicity studies were not considered relevant to this vaccine.

Genotoxicity:

Genotoxic potential was not assessed, as genotoxicity studies were not considered relevant to this vaccine.

Reproductive and Developmental Toxicology:

In a reproductive and developmental toxicity study, 30 mcg/animal (0.06 mL of a vaccine formulation containing the same quantity of nucleoside-modified messenger ribonucleic acid (mRNA) and other ingredients included in a single human dose) of COMIRNATY was administered to female rats by the intramuscular route on four occasions: 21 and 14 days prior to mating, and on gestation days 9 and 20. No vaccine-related adverse effects on female fertility, fetal development, or postnatal development were reported in the study.



COVID-19 Vaccine:
Information for Pregnant and Breastfeeding Individuals

Public Health Factsheet
JUNE 2021

Manitoba

Immunization is one of the most important accomplishments in public health. Over the past 50 years, immunization has led to the elimination, containment and control of diseases that were once very common in Canada.[1] Vaccines help the immune system recognize and fight bacteria and viruses that cause diseases.

Are pregnant individuals at greater risk of COVID-19?

Evidence related to pregnancy and COVID-19 risk is evolving, with thousands of well-documented cases around the world. In general, pregnancy can place people at higher risk of serious complications from respiratory infections because of normal changes occurring in the body that affect the respiratory system. Some respiratory infections (e.g., influenza and COVID-19) during pregnancy may also lead to other adverse outcomes, such as premature labor and delivery.

Data suggests that in general, most pregnant individuals who acquire COVID-19 in pregnancy experience mild to moderate symptoms and deliver healthy babies at full-term. It is presumed that the rate of pregnant individuals experiencing no symptoms of COVID-19 (i.e., asymptomatic) is common.

There is evolving evidence to suggest that pregnancy is a risk factor for severe COVID-19. Pregnant individuals who experience severe COVID-19 are at increased risk of complications requiring intensive care at the hospital and may need mechanical ventilation (i.e., needing a machine to help with breathing). Other potential complications include premature birth, stillbirth, cesarean delivery and newborn admission to the neonatal intensive care unit (NICU). Women with the following risk factors are at an especially elevated risk of developing severe COVID-19:

- age (35 years and older)
- severe and/or uncontrolled asthma
- obesity
- pre-pregnancy or gestational diabetes
- pre-pregnancy high blood pressure
- heart disease

To date, there is no convincing data suggesting that a pregnant person with COVID-19 can pass the infection to the fetus during pregnancy or to the baby at delivery, and the virus has not been found in breastmilk. However in the absence of data, the possibility for these outcomes cannot be excluded.

Like everyone else, pregnant people need to protect themselves from exposure to COVID-19, seek appropriate testing and call their health care provider if they develop symptoms.

[1]The Public Health Agency of Canada
This information is current as of June 1, 2021.

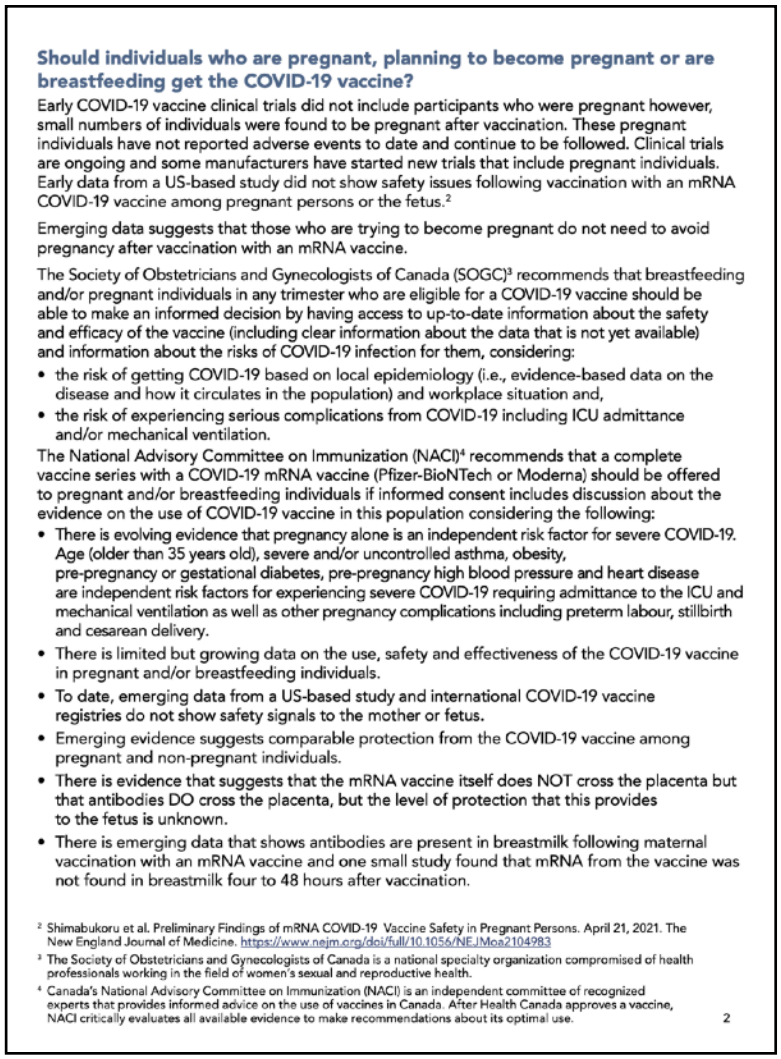
1

Commentary on Government of Manitoba Information Bulletin:

The intent of this bulletin that was published on the Government of Manitoba's Covid response website was to provide couples with unbiased information that the average person could use to develop an informed consent prior to agreeing to receive the Covid 19 vaccination.

The information is at best incredibly biased and misleading. It does not accurately reflect the commonly available information concerning both the known risk of Covid 19 to pregnant women, and the unknown risks related to an entirely new kind of vaccine that has never before been used in human history.

The very first statement in the information sheet factually states that immunization has been used for over 50 years; however, it does not inform the reader that the mRNA vaccines are a completely new technology that has never before been used in



Should individuals who are pregnant, planning to become pregnant or are breastfeeding get the COVID-19 vaccine?

Early COVID-19 vaccine clinical trials did not include participants who were pregnant however, small numbers of individuals were found to be pregnant after vaccination. These pregnant individuals have not reported adverse events to date and continue to be followed. Clinical trials are ongoing and some manufacturers have started new trials that include pregnant individuals. Early data from a US-based study did not show safety issues following vaccination with an mRNA COVID-19 vaccine among pregnant persons or the fetus.[2]

Emerging data suggests that those who are trying to become pregnant do not need to avoid pregnancy after vaccination with an mRNA vaccine.

The Society of Obstetricians and Gynecologists of Canada (SOGC)[3] recommends that breastfeeding and/or pregnant individuals in any trimester who are eligible for a COVID-19 vaccine should be able to make an informed decision by having access to up-to-date information about the safety and efficacy of the vaccine (including clear information about the data that is not yet available) and information about the risks of COVID-19 infection for them, considering:

- the risk of getting COVID-19 based on local epidemiology (i.e., evidence-based data on the disease and how it circulates in the population) and workplace situation and,
- the risk of experiencing serious complications from COVID-19 including ICU admittance and/or mechanical ventilation.

The National Advisory Committee on Immunization (NACI)[4] recommends that a complete vaccine series with a COVID-19 mRNA vaccine (Pfizer-BioNTech or Moderna) should be offered to pregnant and/or breastfeeding individuals if informed consent includes discussion about the evidence on the use of COVID-19 vaccine in this population considering the following:

- There is evolving evidence that pregnancy alone is an independent risk factor for severe COVID-19. Age (older than 35 years old), severe and/or uncontrolled asthma, obesity, pre-pregnancy or gestational diabetes, pre-pregnancy high blood pressure and heart disease are independent risk factors for experiencing severe COVID-19 requiring admittance to the ICU and mechanical ventilation as well as other pregnancy complications including preterm labour, stillbirth and cesarean delivery.
- There is limited but growing data on the use, safety and effectiveness of the COVID-19 vaccine in pregnant and/or breastfeeding individuals.
- To date, emerging data from a US-based study and international COVID-19 vaccine registries do not show safety signals to the mother or fetus.
- Emerging evidence suggests comparable protection from the COVID-19 vaccine among pregnant and non-pregnant individuals.
- There is evidence that suggests that the mRNA vaccine itself does NOT cross the placenta but that antibodies DO cross the placenta, but the level of protection that this provides to the fetus is unknown.
- There is emerging data that shows antibodies are present in breastmilk following maternal vaccination with an mRNA vaccine and one small study found that mRNA from the vaccine was not found in breastmilk four to 48 hours after vaccination.

[2] Shimabukoru et al. Preliminary Findings of mRNA COVID-19 Vaccine Safety in Pregnant Persons. April 21, 2021. The New England Journal of Medicine. https://www.nejm.org/doi/full/10.1056/NEJMoa2104983

[3] The Society of Obstetricians and Gynecologists of Canada is a national specialty organization compromised of health professionals working in the field of women's sexual and reproductive health.

[4] Canada's National Advisory Committee on Immunization (NACI) is an independent committee of recognized experts that provides informed advice on the use of vaccines in Canada. After Health Canada approves a vaccine, NACI critically evaluates all available evidence to make recommendations about its optimal use.

2

humans , and that the long term effects are unknown.

The paper discusses that people should be able to make informed decisions about the safety and efficacy of the vaccine considering a number of factors, but no evidence that is reliable, peer reviewed, and confirmed, is provided.

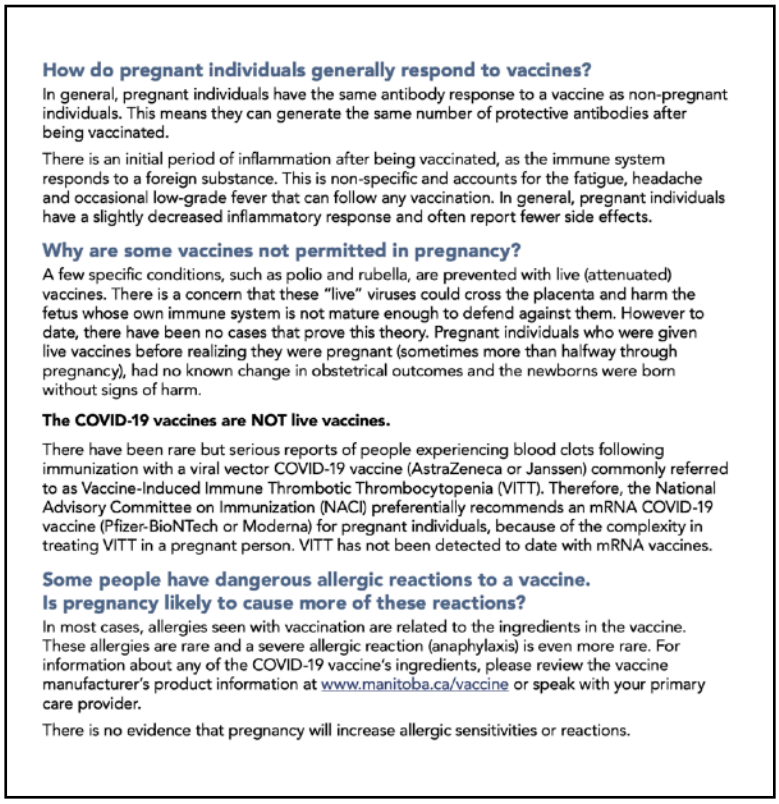
The paper does not give any guidance as to what the chances are of actually contracting Covid-19 and having a severe reaction. This information is critical if a patient is to make a decision about taking an experimental drug whose long term effects are unknown.

The information being provided is suggestive, based on non confirmed, non peer reviewed papers, as well as anecdotal evidence. However, paediatricians and medical professionals were and are pressuring their patients to take the mRNA vaccine.

The information provided leads the patient to believe that there is safety associated with this vaccine since vaccines have been used for over 50 years. It does not make the patient aware of the novel and experimental nature of the mRNA vaccines themselves.

It is odd how the mNRA vaccines were / are being recommended to the most highly at risk individuals in our society, namely pregnant women, without any discussion or cautions about longterm effects that are entirely unknown.

It is interesting as well, how potential therapeutic medicines were dismissed out of hand, and **doctors were prohibited to prescribe them, despite the fact that most of these therapeutic medicines have a long and documented safety record, in some cases with over 75 years of safety data and many large scale and small scaled tests.** They were not permitted in comparison to the approval of a new and unique mRNA treatment.



How do pregnant individuals generally respond to vaccines?

In general, pregnant individuals have the same antibody response to a vaccine as non-pregnant individuals. This means they can generate the same number of protective antibodies after being vaccinated.

There is an initial period of inflammation after being vaccinated, as the immune system responds to a foreign substance. This is non-specific and accounts for the fatigue, headache and occasional low-grade fever that can follow any vaccination. In general, pregnant individuals have a slightly decreased inflammatory response and often report fewer side effects.

Why are some vaccines not permitted in pregnancy?

A few specific conditions, such as polio and rubella, are prevented with live (attenuated) vaccines. There is a concern that these "live" viruses could cross the placenta and harm the fetus whose own immune system is not mature enough to defend against them. However to date, there have been no cases that prove this theory. Pregnant individuals who were given live vaccines before realizing they were pregnant (sometimes more than halfway through pregnancy), had no known change in obstetrical outcomes and the newborns were born without signs of harm.

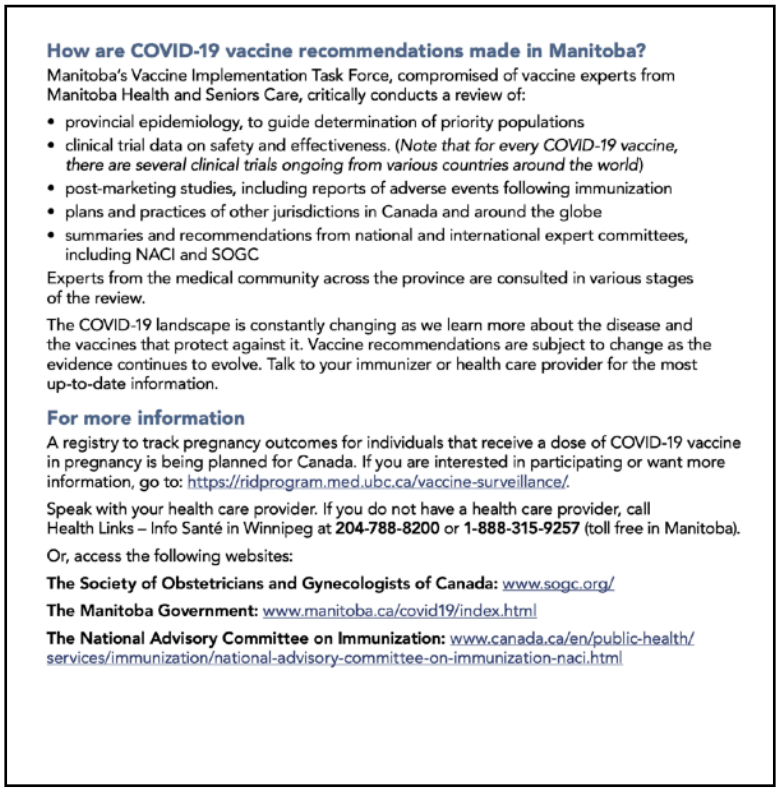
The COVID-19 vaccines are NOT live vaccines.

There have been rare but serious reports of people experiencing blood clots following immunization with a viral vector COVID-19 vaccine (AstraZeneca or Janssen) commonly referred to as Vaccine-Induced Immune Thrombotic Thrombocytopenia (VITT). Therefore, the National Advisory Committee on Immunization (NACI) preferentially recommends an mRNA COVID-19 vaccine (Pfizer-BioNTech or Moderna) for pregnant individuals, because of the complexity in treating VITT in a pregnant person. VITT has not been detected to date with mRNA vaccines.

Some people have dangerous allergic reactions to a vaccine. Is pregnancy likely to cause more of these reactions?

In most cases, allergies seen with vaccination are related to the ingredients in the vaccine. These allergies are rare and a severe allergic reaction (anaphylaxis) is even more rare. For information about any of the COVID-19 vaccine's ingredients, please review the vaccine manufacturer's product information at www.manitoba.ca/vaccine or speak with your primary care provider.

There is no evidence that pregnancy will increase allergic sensitivities or reactions.



How are COVID-19 vaccine recommendations made in Manitoba?

Manitoba's Vaccine Implementation Task Force, compromised of vaccine experts from Manitoba Health and Seniors Care, critically conducts a review of:

- provincial epidemiology, to guide determination of priority populations
- clinical trial data on safety and effectiveness. (*Note that for every COVID-19 vaccine, there are several clinical trials ongoing from various countries around the world*)
- post-marketing studies, including reports of adverse events following immunization
- plans and practices of other jurisdictions in Canada and around the globe
- summaries and recommendations from national and international expert committees, including NACI and SOGC

Experts from the medical community across the province are consulted in various stages of the review.

The COVID-19 landscape is constantly changing as we learn more about the disease and the vaccines that protect against it. Vaccine recommendations are subject to change as the evidence continues to evolve. Talk to your immunizer or health care provider for the most up-to-date information.

For more information

A registry to track pregnancy outcomes for individuals that receive a dose of COVID-19 vaccine in pregnancy is being planned for Canada. If you are interested in participating or want more information, go to: https://ridprogram.med.ubc.ca/vaccine-surveillance/.

Speak with your health care provider. If you do not have a health care provider, call Health Links – Info Santé in Winnipeg at **204-788-8200** or **1-888-315-9257** (toll free in Manitoba).

Or, access the following websites:

The Society of Obstetricians and Gynecologists of Canada: www.sogc.org/

The Manitoba Government: www.manitoba.ca/covid19/index.html

The National Advisory Committee on Immunization: www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci.html

The product information sheet prepared by and published by the vaccine manufacturers states that the effects on fertility and long term toxicity is unknown, but the information bulletin given to patients makes no mention of this.

The decision to take a risk on a novel medication must be made based on a realistic evaluation of the facts surrounding the risks associated with Covid 19 itself.

The actual statistics show that the statistical risk of becoming infected by and dying from Covid 19 is statistically non existent for this age group.

It is also known that the current vaccines do not prevent a person from contracting Covid 19, nor does it prevent the spread of the disease from or to vaccinated or unvaccinated persons.

Evidence concerning the short term nature of the vaccine's protection has been known since the time the emergency use authorization was given.

This evidence was provided in the monograms provided by the manufactures when FDA approval was given.

It is unfathomable how this age group of women would be coerced into taking such a vaccine risk when the risk due to the disease is almost non-existent.

It is also important to understand, that until the CDC revised their definition of the term "vaccine" in 2021, that the mRNA vaccines did not actually meet the original definition of the word.

Concerning this group of persons, the basis for the safety cautions from the manufactures of the vaccines are because studies have not been completed for long and short term effects on this group of people.

The named agencies and individuals have been promoting the Covid 19 vaccines as being safe for women in the child bearing years, **despite the lack of actual study data and evidence to support this contention**. As a result, it is important to actually review the data related to women in the child bearing years to understand what risks are actually faced by women in this age group.

We have chosen to define the Child Bearing Age group to be people from 20 years of age to 40 years of age. Now we acknowledge that the actual range can be less than 19 and more than 40; however, the 20 to 40 age group is representative of the largest group.

According to Statistics Canada the mean age of a mother at the time of delivery (live births) for the 2019 is 31.2 years of age.

In 2020 following are the statistics for women between the ages of 20 and 40 years of age:

		Numbers of Deaths 2020								
Age	**Total**	**Total**	**Covid**	**Pregnancy***	**Cancer**	**Heart**	**Influenza**	**Accident**	**Suicide**	**Murder**
20 - 39	5,096,479	2,890	20	24	416	114	29	655	341	39
Odds of Dying	1 in X	**1 in 1,763**	**1 in 254,824**	**1 in 15,635 ***	**1 in 12,251**	**1 in 44,706**	**1 in 175,741**	**1 in 7,781**	**1 in 14,946**	**1 in 130,679**
	Odds of Death are 1 : the Number in the row Above Example: the odds of dying of any cause is 1 in 1,763									

In the main child bearing age range there are a total of 5,096,479 women.
A Total of 20 Covid-19 deaths were reported for this age group in 2020.

The Odds of dying from any cause for this age group is: 1 in 1,763
The Odds of dying from being pregnant is: 1 in 15,635*
The Odds of dying from Covid 19 is: 1 in 254,824

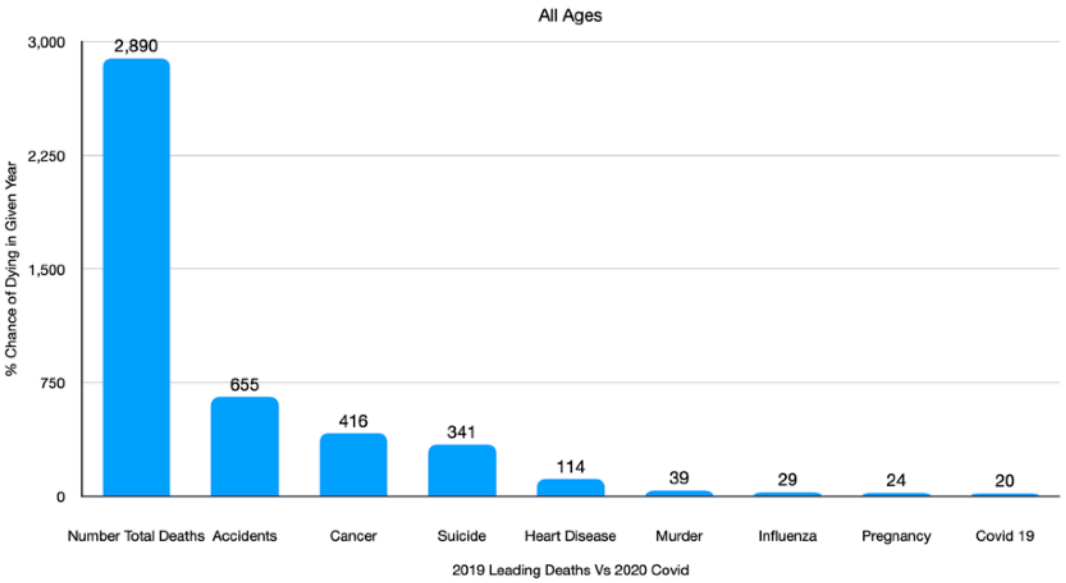
So the odds of dying from complications related to being pregnant and dying from simply being pregnant were 16 times higher than from getting and dying of Covid 19.

**We point out that the risk of death, to the mother, due to pregnancy is properly represented in the above table, as we know how many pregnancies actually occurred in Canada in 2019, as reported by Statistics Canada. So the risk of death resulting from pregnancy is actually calculated as the number of mother deaths divided by the number of reported pregnancies. Statistics Canada reported a total of 375,229 pregnancies that resulted in live or still births (does not include abortions) in Canada in 2018/2019 year. So the actual probability of death resulting from pregnancy is 24 Deaths / 375,229 or a risk of 1 in 15,635. Compared with a Covid Death Rate of 1 in 254,824.*

The following is a bar chart that is a graphical representation of the information contained in the table directly above.

2020 Women of Child Bearing Years Cause of Death

2019 Odds of Dying All Causes	
Number of People	5,096,479
Number Total Deaths	2,890
Accidents	655
Cancer	416
Suicide	341
Murder	39
Influenza	29
Heart Disease	114
Pregnancy	24
Covid 19	20
Percent Chance of Death Any Cause	**0.0567%**
Odds of Death in 2019	**1 in 1,763**



The statistics show that a woman of child bearing age has an almost zero chance of contracting and dying from Covid 19.

The chance of a woman dying from being pregnant is slightly higher than the chance of that same woman dying of Covid 19.

A woman in the child bearing age group has almost double the chance of being murdered than of contracting and dying of Covid-19, and finally a woman in this age group has 145 X higher chance of dying from any cause whatsoever, than she does of contracting an dying of Covid-19.

Given the following facts, it is inconceivable that any competent paediatrician / medical professional would advise a woman who is pregnant, or planning on getting pregnant, to take the mRNA injection:

- No peer reviewed detailed studies had or have been completed on this age group;
- The effects of the vaccine on the unborn child's development and health are not known;
- The effects of the vaccine on a nursing child are not known;
- The long term effects of the vaccine on fertility are not known;
- The long term potential for carcinogenic effects of the vaccine are not known;
- The long term effects for child development are not known;
- The long term effects on anyone who takes the vaccine are not known

Yet, to this day the Government of Manitoba is claiming on their website that the Covid 19 vaccines are proven safe and effective for women who are pregnant or thinking about becoming pregnant.

The information presented above, for women of child bearing age was known or ought to have been known by medical professionals prior to recommending the use of the mRNA treatment to pregnant or nursing women.

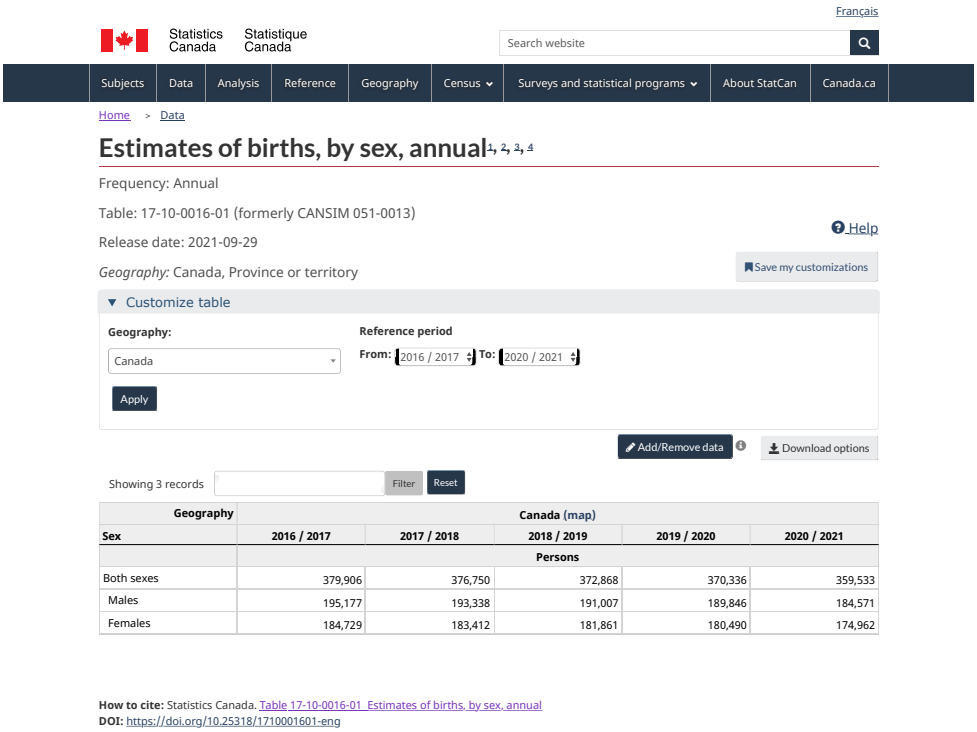
Any harm caused once the information became known to them or ought to have become known to them, is part of the alleged crimes.

Monitoring of adverse reactions to vaccines is of paramount importance at all times; however, when a completely new type of technology is introduced, that has never been used before (mRNA), extreme caution and vigilance must be exercised. No such vigilance was exercised by the Canadian Government and Health Officials, prior to mandating these vaccines on the entire population including pregnant and breast feeding women.

Before leaving this issue, we have included the following table from Statistics Canada. The table shows the estimate of births by sex on an annual basis from 2016 to 2021.

We note the significant decrease in the number of births in 2020/2021 versus all other reporting years. The decrease in births for 2020/2021 compared to 2016/2017 was approximately 20,000 birth decrease.

There may be many factors affecting these numbers; however, given the situation and the introduction of a novel mRNA vaccine in late 2020, an investigation of this significant decrease would be warranted, and yet, to our knowledge no investigation has been initiated.



Français

Statistics Canada | Statistique Canada

Search website

Subjects | Data | Analysis | Reference | Geography | Census | Surveys and statistical programs | About StatCan | Canada.ca

Home > Data

Estimates of births, by sex, annual[1, 2, 3, 4]

Frequency: Annual

Table: 17-10-0016-01 (formerly CANSIM 051-0013)

Release date: 2021-09-29

Help

Geography: Canada, Province or territory

Save my customizations

▼ Customize table

Geography: Canada

Reference period From: 2016 / 2017 To: 2020 / 2021

Apply

Add/Remove data | Download options

Showing 3 records | Filter | Reset

Geography	Canada (map)				
Sex	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020	2020 / 2021
	Persons				
Both sexes	379,906	376,750	372,868	370,336	359,533
Males	195,177	193,338	191,007	189,846	184,571
Females	184,729	183,412	181,861	180,490	174,962

How to cite: Statistics Canada. Table 17-10-0016-01 Estimates of births, by sex, annual
DOI: https://doi.org/10.25318/1710001601-eng

6.2 Statistics Infographics

The authors believe that a thorough and clear understanding of the risks associated with the Covid 19 pandemic is fundamental.

The following infographic sheets have been prepared to clearly describe the information contained in Section 5.1 of this report.

Those people who are responsible for the alleged criminal actions either knew or ought to have known the actual risks associated with Covid 19 prior to implementing sweeping and unprecedented mandates that have caused such devastating harm to the Canadian people.

Medical professionals certainly understand science, and statistics and risk.

It is inconceivable that the overall risks of the Covid 19 infection were not clearly understood, when early as May 2021, this information was available to the public at large.

When there is a fiduciary trust between two parties, a special trust and a special responsibility exists between those two parties.

It is the contention of the authors that the data available was so obvious, that disregard of that information was in fact a criminal offence, and that any harm resulting from those criminal offences must be accounted for, and those responsible brought to justice.

Manitoba Health Fact Sheet

DID YOU KNOW?

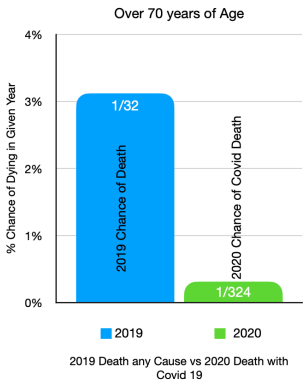
What Are Your Odds?

The following is a discussion of the risks presented by Covid-19 based on the actual statistics reported by Statistics Canada as of May 2021 and as presented in the previous graphs and tables.

2019 Over 70 years Old - Odds of Dying

2019 Odds of Dying All Causes		
Number of People		4,668,591
Number Total Deaths		145,569
Percent Chance of Death Any Cause		**3%**
Odds of Death in 2019	**1 in**	**32**

2020 Odds of Dying With Covid 19		
Number of People		4,676,492
Number Covid Deaths		14,441
Percent Chance of Death From Covid 19		0.31%
Odds of Death in 2020 with Covid 19	**1 in**	**324**



If you are over the age of 70

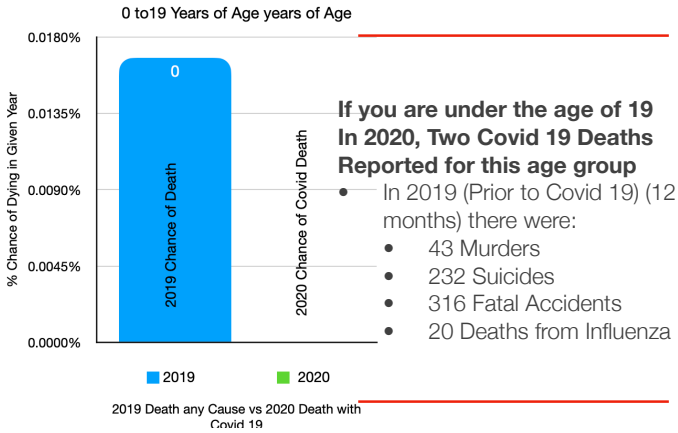
- In 2019, (prior to Covid 19) there were 4,668,591 people over the age of 70 in Canada.
- In 2019, there were a total of 145,569 deaths in this age group.
- In 2019, (prior to Covid 19) **your odds of dying** in a given year if you were over 70 years of age are: **1 in 32**.
- In 2020, your **odds of dying from Covid-19**, if you are over 70 year of age are: **1 in 324**

So your odds of simply dying for any reason in 2019 were ten time higher than your odds of dying with Covid 19, in 2020.

2019 Zero to 19 years Old - Odds of Dying

2019 Odds of Dying All Causes		
Number of People		8,139,512
Number Total Deaths		1,365
Percent Chance of Death Any Cause		**0.0168%**
Odds of Death in 2019	**1 in**	**5,963**

2020 Odds of Dying With Covid 19		
Number of People		8,144,135
Number Covid Deaths		2
Percent Chance of Death From Covid 19		0.0000%
Odds of Death in 2020 with Covid 19	**1 in**	**4,072,068**



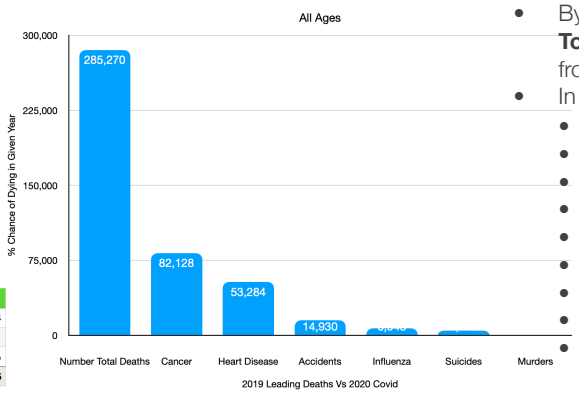
If you are under the age of 19 In 2020, Two Covid 19 Deaths Reported for this age group

- In 2019 (Prior to Covid 19) (12 months) there were:
  - 43 Murders
  - 232 Suicides
  - 316 Fatal Accidents
  - 20 Deaths from Influenza

2019 All Ages Leading Causes of Death

2019 Odds of Dying All Causes		
Number of People		37,324,486
Number Total Deaths		285,270
Murders		501
Suicides		4,528
Accidents		14,930
Influenza		6,943
Cancer		82,128
Heart Disease		53,284
Percent Chance of Death Any Cause		**0.7643%**
Odds of Death in 2019	**1 in**	**131**

2020 Odds of Dying With Covid 19		
Number of People		38,037,204
Covid		16,151
Percent Chance of Death From Covid 19		0.0425%
Odds of Death with Covid 19 in 2020	**1 in**	**2,355**



At any age (in the General Population)

- By May 14, 2021, there has been a **Total of 15,606 reported deaths** from Covid 19
- In 2019 (Prior to Covid 19) there were:
  - 387 Murders
  - 4,012 Suicides
  - 13,746 Accidents
  - 6,893 Deaths from Influenza
  - 52,541 Deaths from Heart Disease
  - 80,152 Deaths from Cancer
  - 6,912 Deaths from Diabetes
  - 6,166 Deaths from Alzheimer's
  - 13,660 Deaths from Heart Attack

Manitoba Health Fact Sheet

DID YOU KNOW?

mRNA Vaccines & Pregnancy

What are the real risks of Covid 19 to pregnant women and what do we know about the new mRNA vaccines.

Facts:

1. mRNA vaccines are new and have never been used in humans before
2. There are no long term studies on the effects of the mRNA vaccines
3. The safety and efficacy of mRNA vaccines in pregnant woman has not been established
4. It is unknown if mRNA vaccines are excreted in human milk
5. The risk of the mRNA vaccines to newborns and infants is not known
6. It is unknown if mRNA vaccines have an impact on fertility.
7. Anaphylaxis has reportedly been associated with the mRNA vaccine.
8. Carcinogenic potential has not been assessed
9. Genotoxicity has not been assessed
10. Reproductive & Developmental Toxicity in Humans has not been assessed

Risk of Death

According to Statistics Canada the mean age of a mother at the time of delivery (live births) for the 2019 is 31.2 years of age.

According to Statistics Canada the mean age of a mother at the time of delivery (live births) for the 2019 is 31.2 years of age.

In 2020 following are the statistics for women between the ages of 20 and 40 years of age:

	Numbers of Deaths 2020									
Age	Total	Total	Covid	Pregnancy*	Cancer	Heart	Influenza	Accident	Suicide	Murder
20 - 39	5,096,479	2,890	20	24	416	114	29	655	341	39
Odds of Dying	1 in X	1 in 1,763	1 in 254,824	1 in 15,635 *	1 in 12,251	1 in 44,700	1 in 175,741	1 in 7,781	1 in 14,946	1 in 130,679
	Odds of Death are 1 : the Number in the row Above Example: the odds of dying of any cause is 1 in 1,763									

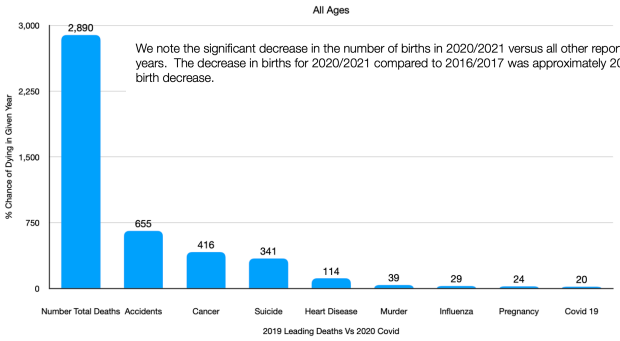
In the main child bearing age range there are a total of 5,096,479 women.
A Total of 20 Covid-19 deaths were reported for this age group in 2020.

The Odds of dying from any cause for this age group is: 1 in 1,763
The Odds of dying from being pregnant is: 1 in 15,635*
The Odds of dying from Covid 19 is: 1 in 254,824

So the odds of dying from complications related to being pregnant and dying from simply being pregnant were 16 times higher than from getting and dying of Covid 19.

2020 Women of Child Bearing Years Cause of Death

2019 Odds of Dying All Causes	
Number of People	5,096,479
Number Total Deaths	2,890
Accidents	655
Cancer	416
Suicide	341
Murder	39
Influenza	29
Heart Disease	114
Pregnancy	24
Covid 19	20
Percent Chance of Death Any Cause	0.0567%
Odds of Death in 2019	1,763



Manitoba Health Fact Sheet

DID YOU KNOW?

mRNA Vaccine Safety Data

What do we know about the testing of and safety of the mRNA Vaccines.

Facts:

1. mRNA vaccines are **new** and have **never** been used in the general population before
2. mRNA vaccines are like no other vaccine ever used wide scale before
3. The mRNA vaccine **does not** prevent you from getting Covid-19
4. The mRNA vaccine **does not** prevent you from transmitting Covid-19
5. Protection levels **drop off** substantially over a short period of time
6. There are no long term studies on the effects of the mRNA vaccines
7. The safety and efficacy of mRNA vaccines in pregnant women has not been established
8. It is unknown if mRNA vaccines are excreted in human milk
9. The risk of the mRNA vaccines to newborns and infants is not known
10. It is unknown if mRNA vaccines have an impact of fertility
11. Anaphylaxis has been reported associated with the mRNA vaccine
12. Carcinogenic potential has not been assessed
13. Genotoxicity has not been assessed
14. The risk of vaccine induced Myocarditis and Pericarditis in young people is not known
15. Reproductive & Developmental Toxicity in Humans has not been assessed
16. According to Pfizer, between December 1, 2020 to February 28, 2021 (3 months) they had received 42,086 reported cases of adverse reactions to their mRNA vaccine; this included 1,223 fatal cases. Pfizer listed 9 full pages of “Adverse Events of Special Interest”.
17. According to the VigiAcess System (WHO) in 2021alone, there were 2,879,136 adverse reactions reported with the Covid-19 Vaccine, as of writing this report they had reported over 3.3 million.
18. Canadian government website related to Covid-19 adverse reactions, stopped reporting deaths attributed to the vaccines.
19. In Canada, if you are under the age of 14, you are 15,780 times more likely to experience an adverse reaction from the covid-19 vaccine, than you are from dying of Covid-19.

6.3 Harm Caused by Mitigative Measures

Based on the statistical data that was available to decision makers, the extreme mitigation measures undertaken throughout Manitoba and Canada were unnecessary.

In most age groups, the chances of contracting Covid 19 and then dying from Covid 19 was statistically insignificant. In fact, the risk of death from any other cause other than Covid 19 was higher in all age groups.

So the imposition of incredibly damaging restrictions was unwarranted, based on the statistics, and therefore, the damages caused by those mitigative measures were not justified.

Types of mitigative measures imposed included, but were not limited to the following:

- Forced Masking;
- Forced or Mandated Vaccination;
- Closure of Businesses, Lockdowns;
- Other Measures that were Implemented but not Recommended by Pandemic Plan

Based on the risks posed by Covid 19, none of these mitigative measures were required to be implemented and each measure resulted in significant harm. In addition, many of the measures implemented were specifically dismissed as ineffectual long before and during the actual Covid 19 Pandemic.

In addition, despite the existence of the The Canadian Pandemic Influenza Plan 2006, and many other similar plans throughout the World, many of the most important recommendations of the plans were never implemented and in fact **discouraged or outlawed**.

As an example, the The Canadian Pandemic Influenza Plan 2006 states the following:

2.5 Response

- It is unlikely that an effective vaccine will be available at the start of pandemic influenza activity in Canada but it may be available for a second wave.
- Mass immunization campaigns will occur when sufficient quantities of the new vaccine are available; this will increase the demand for public health human resources.
- The use of antivirals to decrease the risk of transmission from the first cases infected with a novel virus and their contacts will be considered as a strategy to contain or slow the spread of novel viruses that have pandemic potential and that are identified in Canada. **The use of this strategy will be limited to cases identified early in the Pandemic Alert Period in Canada.** During the Pandemic Period, this strategy will change to the nationally agreed upon strategy for the pandemic period.
- Public health authorities will manage pandemic vaccine supply when a pandemic vaccine is available, as well as the supply and distribution of antiviral drugs which are contained within the National Antiviral Stockpile.
- The Pandemic Influenza Committee will provide technical expertise during the pandemic period in order to inform the national response and facilitate consistency in response activities across Canada.

Bullet three paragraph specifically talks about he use of antivirals; however, the use of antivirals was immediately dismissed for lack of peer reviewed studies, while at the same time, the use of a completely new mRNA vaccine for use in untested populations throughout the World, was approved without peer reviewed extensive studies.

A brief discussion of each of these measures, the damage done, and the efficacy of each is discussed below, along with references to studies and profiles that were available at the time.

6.3.1 Forced Masking

The imposition of mandated non medical cloth masks in public spaces was mandated in early 2020.

This was despite significant evidence that non medical masks were not recommended by the Canada's Emergency Pandemic Plan, the CDC Plan and various CDC studies.

It appears that much of the information presented historically supporting the use of masks was based on assumptions concerning those people in the medical professions. In other words, masks when used in a medical setting by trained medical personnel, may have a significantly different effect on transmission as opposed to the general population using a variety of masks types without any medical training, in everyday environments and situations.

Appendix F, Section 2.6 of the Canadian Pandemic Influenza Plan 2006 states:

2.6 Use of Masks During a Pandemic

Although there is a lack of evidence that the use of masks prevented transmission of influenza during previous pandemics; in the early phase of an influenza pandemic, it may be prudent for HCWs to wear masks when interacting in close face-to-face contact with coughing individuals to minimize influenza transmission. This use of masks is advised when immunization and antivirals are not yet available but is not practical or helpful when pandemic influenza has entered the community. There is no evidence that the use of masks in general public settings will be protective when the virus is circulating widely in the community.

The Canadian Pandemic Influenza Plan goes on to say:

7.4 Use of Masks by Well Individuals

Trigger

Declaration of the arrival of one or more confirmed cases in the local community by the local public health authority

Advantages

- May decrease exposure to large droplets containing virus
- Psychologically reassures people that they are taking measures to prevent infection

Disadvantages

- Hands and other surfaces may be contaminated when mask is removed (requires public education).
- May cause panic if the availability of masks is limited
- Public purchase of masks may limit the availability of masks in health care settings where they are required.
- Not all members of the public can afford to purchase masks. If recommended by public health authorities, there could be an expectation that they will be publicly funded and provided by public health programs.
- It is not feasible to wear masks constantly for the duration of pandemic wave.
- Use of masks, apart from other infection control practices, is of limited effectiveness and may provide a false sense of security.

Conclusion

This measure is not feasible or sustainable on a population basis. It is not likely to be effective in reducing disease spread in the general population and therefore is not recommended as a community-based strategy. It is acknowledged that individual people who are wearing a recommended mask properly at the time of an exposure may benefit from the barrier that a mask provides. The WHO has recommended that mask use by the public should be based on risk, including frequency of exposure and closeness of contact with infectious persons and suggests that based on this risk assessment use of masks in crowded settings such as public transit may be justified.[7] At the time of a pandemic, however, when the virus is circulating in the community it will not be possible for public health authorities to assess and compare risks of exposure in specific public settings (e.g., public transit, restaurants, recreational complexes). Therefore, members of the public may wish to purchase and use masks for individual protection; however, outside of known high-risk settings (e.g. a hospital with cases) this would not be an appropriate use of public resources.

Well individuals caring for cases in a non-traditional site or home setting should follow the recommendations provided by the Infection Control Working Group for individuals functioning in this capacity (see Annex F).

- Not recommended as a community-based intervention or measure

According to a March 2, 2021 article in the American institute for Economic Research:
"Does the CDC really think that masks prevent the wearer from getting Covid, or from spreading it to others?

The CDC admits that the scientific evidence is mixed, as their most recent report glosses over many unanswered scientific questions. But even if it were clear – or clear enough – as a scientific matter that masks properly used could reduce transmission, it is a leap to conclude that a governmental mandate to wear masks will do more good than harm, even as a strictly biological or epidemiological matter.

Mask mandates may not be followed; masks worn as a result of a mandate may not be used properly; some mask practices like double masking can do harm, particularly to children; and even if a mask mandate results in some increased number of masks being worn and worn properly, the mandate and the associated publicity may reduce the public's attention to other more effective safeguards, such as meticulous hygiene practices.

Thus, it is not surprising that the CDC's own recent conclusion on the use of nonpharmaceutical measures such as face masks in pandemic influenza, warned that scientific "evidence from 14 randomized controlled trials of these measures did not support a substantial effect on transmission..."

Moreover, in the WHO's 2019 guidance document on nonpharmaceutical public health measures in a pandemic, they reported regarding the value of face masks "there is no evidence that this is effective in reducing transmission..."

Similarly, in the fine print to a recent double-blind, double-masking simulation the CDC stated that "The findings of these simulations [supporting mask usage] should neither be generalized to the

effectiveness ...nor interpreted as being representative of the effectiveness of these masks when worn in real- world settings.""

Below is a link to the American Institute for Economic Research Article:
https://www.aier.org/article/the-cdcs-mask-mandate-study-debunked/

Below is a link to the WHO study on the efficacy of Non-Pharmaceutical Public Health Measures, from 2019:
https://apps.who.int/iris/bitstream/handle/10665/329438/9789241516839-eng.pdf?ua=1

On page 26 of the WHO report they state:

OVERALL RESULT OF EVIDENCE ON FACE MASKS

1. Ten RCTs were included in the meta-analysis, and there was no evidence that face masks are effective in reducing transmission of laboratory-confirmed influenza.

In a May 2020 report titled "Non-pharmaceutical Measures for Pandemic Influenza in Non-healthcare Settings - Personal Protective and Environmental Measures" the CDC states the following:

> "Face Masks
>
> Figure 2. Meta-analysis of risk ratios for the effect of face mask use with or without enhanced hand hygiene on laboratory-confirmed influenza from 10 randomized controlled trials with >6,500 participants. A) Face mask...
>
> In our systematic review, we identified 10 RCTs that reported estimates of the effectiveness of face masks in reducing laboratory-confirmed influenza virus infections in the community from literature published during 1946–July 27, 2018. In pooled analysis, we found no significant reduction in influenza transmission with the use of face masks (RR 0.78, 95% CI 0.51–1.20; I2 = 30%, p = 0.25) (Figure 2). One study evaluated the use of masks among pilgrims from Australia during the Hajj pilgrimage and reported no major difference in the risk for laboratory-confirmed influenza virus infection in the control or mask group (33). Two studies in university settings assessed the effectiveness of face masks for primary protection by monitoring the incidence of laboratory-confirmed influenza among student hall residents for 5 months (9,10). The overall reduction in ILI or laboratory-confirmed influenza cases in the face mask group was not significant in either studies (9,10). Study designs in the 7 household studies were slightly different: 1 study provided face masks and P2 respirators for household contacts only (34), another study evaluated face mask use as a source control for infected persons only (35), and the remaining studies provided masks for the infected persons as well as their close contacts (11–13,15,17). None of the household studies reported a significant reduction in secondary laboratory-confirmed influenza virus infections in the face mask group (11–13,15,17,34,35). Most studies were underpowered because of limited sample size, and some studies also reported suboptimal adherence in the face mask group.
>
> Disposable medical masks (also known as surgical masks) are loose-fitting devices that were designed to be worn by medical personnel to protect accidental contamination of patient wounds, and to protect the wearer against splashes or sprays of bodily fluids (36). There is limited evidence for their effectiveness in preventing influenza virus transmission either when worn by the infected person for source control or when worn by uninfected persons to reduce exposure. Our systematic review found no significant effect of face masks on transmission of laboratory-confirmed influenza.
>
> We did not consider the use of respirators in the community. Respirators are tight-fitting masks that can protect the wearer from fine particles (37) and should provide better protection against influenza virus exposures when properly worn because of higher filtration efficiency. However, respirators, such as N95 and P2 masks, work best when they are fit-tested, and these masks will be in limited supply during the next pandemic. These specialist devices should be reserved for use in healthcare settings or in special subpopulations such as immunocompromised persons in the community, first responders, and those performing other critical community functions, as supplies permit.
>
> In lower-income settings, it is more likely that reusable cloth masks will be used rather than disposable medical masks because of cost and availability (38). There are still few uncertainties in the practice of face mask use, such as who should wear the mask and how

> long it should be used for. In theory, transmission should be reduced the most if both infected members and other contacts wear masks, but compliance in uninfected close contacts could be a problem (12,34). Proper use of face masks is essential because improper use might increase the risk for transmission (39). Thus, education on the proper use and disposal of used face masks, including hand hygiene, is also needed."

Link to CDC Study:

https://wwwnc.cdc.gov/eid/article/26/5/19-0994_article

CDC also released a report on February 19, 2021, titled "Maximizing Fit for Cloth and Medical Procedure Masks…"

This study must be carefully scrutinized, and is, at the least, misleading to the casual reader.

In the Summary CDC States:

Summary

What is already known about this topic?

Universal masking is recommended to slow the spread of COVID-19. Cloth masks and medical procedure masks substantially reduce exposure from infected wearers (source control) and reduce exposure of uninfected wearers (wearer exposure).

What is added by this report?

CDC conducted experiments to assess two ways of improving the fit of medical procedure masks: fitting a cloth mask over a medical procedure mask, and knotting the ear loops of a medical procedure mask and then tucking in and flattening the extra material close to the face. Each modification substantially improved source control and reduced wearer exposure.

What are the implications for public health?

These experiments highlight the importance of good fit to maximize mask performance. There are multiple simple ways to achieve better fit of masks to more effectively slow the spread of COVID-19.

The study however, was a strictly laboratory based and theoretical study under controlled conditions in a laboratory and does not represent what is actually achievable in the Real World, by untrained non-medical personnel using the masks over a long period of time; for instance all day at work.

In "the fine print" of this CDC report, they admit this as they say:

> *"The findings in this report are subject to at least four limitations. First, these experiments were conducted with one type of medical procedure mask and one type of cloth mask among the many choices that are commercially available and were intended to provide data about their relative performance in a controlled setting.* ***The findings of these simulations should neither be generalized to the effectiveness of all medical procedure masks or cloths masks nor interpreted as being representative of the effectiveness of these masks when worn in real-world settings.*** *Second, these experiments did not include any*

> *other combinations of masks, such as cloth over cloth, medical procedure mask over medical procedure mask, or medical procedure mask over cloth. Third, these findings might not be generalizable to children because of their smaller size or to men with beards and other facial hair, which interfere with fit. Finally, although use of double masking or knotting and tucking are two of many options that can optimize fit and enhance mask performance for source control and for wearer protection, double masking might impede breathing or obstruct peripheral vision for some wearers, and knotting and tucking can change the shape of the mask such that it no longer covers fully both the nose and the mouth of persons with larger faces."*

Given the severe and clear limitations as set out by the CDC: how can it be possible, in the same article, that the CDC promotes the use of masks, saying that well-fitted masks reduce the risk of Covid-19 transmissions, while also claiming in the same report, that their laboratory findings should not be generalized as to their effectiveness.

The CDC has another study which examines the use of "Double Masks". Their conclusion and cautions on the validity of this study are the same as with the one referenced above.

One again they are using artificially controlled laboratory results, and then applying those results to the real world and making recommendation that do not stand up to their own scrutiny.

In another article by the American Institute for Economic Research, dated February 11, 2021, they state:

> *"Importantly, the evidence just is and was not there to support mask use for asymptomatic people to stop viral spread during a pandemic. While the evidence may seem conflicted, the evidence (including the peer-reviewed evidence) actually does not support its use and leans heavily toward masks having no significant impact in stopping spread of the Covid virus.*
>
> *In fact, it is not unreasonable at this time to conclude that surgical and cloth masks, used as they currently are, have absolutely no impact on controlling the transmission of Covid-19 virus, and current evidence implies that face masks can be actually harmful. All this to say and as so comprehensively documented by Dr. Roger W. Koops in a recent American Institute of Economic Research (AIER) publication, there is no clear scientific evidence that masks (surgical or cloth) work to mitigate risk to the wearer or to those coming into contact with the wearer, as they are currently worn in everyday life and specifically as we refer to Covid-19. "*

Below is a link to this article:

https://www.aier.org/article/masking-a-careful-review-of-the-evidence/

6.3.2 Forced or Mandated Vaccinations

The intent of this report is to highlight issues that were known or ought to have been known to be causing harm on or about May of 2021.

mRNA “vaccines” were given emergency approval for use in Canada on December 9, 2020.

Health Canada issued the following statement on December 9, 2020:

There are a number of significant issues surrounding this announcement and the effect it had on the Canadian population at large.

Health Canada authorizes first COVID-19 vaccine

From: Health Canada

Statement

December 9, 2020 Ottawa, ON Health Canada

Thanks to advances in science and technology, and an unprecedented level of global cooperation, today, Canada reached a critical milestone in its fight against COVID-19 with the authorization of the first COVID-19 vaccine.

Health Canada received Pfizer's submission on October 9, 2020 and after a thorough, independent review of the evidence, Health Canada has determined that the Pfizer-BioNTech vaccine meets the Department's stringent safety, efficacy and quality requirements for use in Canada.

As part of its continued commitment to openness and transparency, Health Canada is publishing a number of documents related to this decision, including a high-level summary of the evidence that Health Canada reviewed to support the authorization of the vaccine. More detailed information will be available in the coming weeks, including a detailed scientific summary and the full clinical trial data package.

Canadians can feel confident that the review process was rigorous and that we have strong monitoring systems in place. Health Canada and the Public Health Agency of Canada will closely monitor the safety of the vaccine once it is on the market and will not hesitate to take action if any safety concerns are identified.

The terms and conditions of the Pfizer-BioNTech vaccine authorization require the manufacturer to continue providing information to Health Canada on the safety, efficacy and quality of the vaccine to ensure the benefits of the vaccine continue to be demonstrated through market use.

The initial indication of the vaccine is for use in people 16 years of age or older. Pfizer-BioNTech are running further clinical trials on children of all age groups and the indication could be revised in the future to include children if the data from these studies support it.

The vaccine was authorized under Health Canada's Interim Order Respecting the Importation, Sale and Advertising of Drugs for Use in Relation to COVID-19. This process allowed Health Canada to assess information submitted by the manufacturer as it became available during the product development process, while maintaining Canada's high standards.

The press release makes a number of statements and refers to a number of documents.

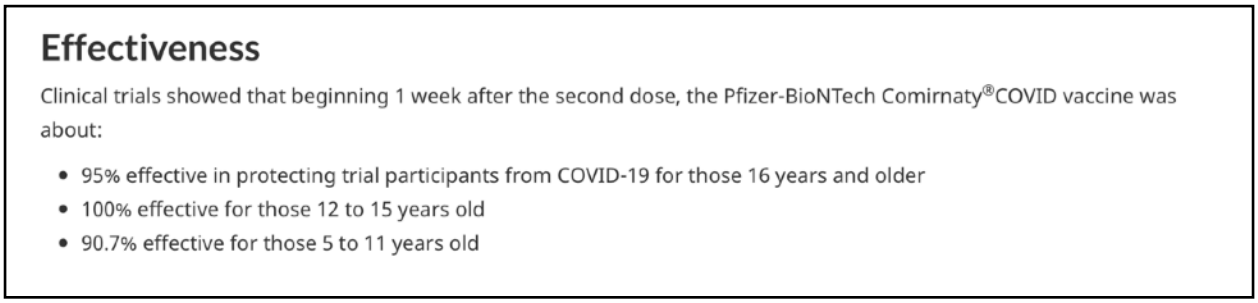
The claims made on the linked website do not correspond with the information provided by Pfizer-BioNTech in the monograph information.

Further, the press release assures Canadians that there is a strong monitoring system in place and that Health Canada is closely monitoring the situation. What they do not mention is that the monitoring system is a voluntary one, and has been heavily criticized for years for under reporting adverse reactions by at least ten fold or more. Health Canada took no steps to update the reporting system, make it mandatory, or encourage medical professionals to report.

It is inconceivable that the mass compulsory implementation of a completely new type of mRNA vaccine was carried out with no increase in the level or detail of monitoring and reporting.

Keep in mind that mRNA vaccines have never before been used in humans, let alone on the massive Worldwide scale that the Covid 19 vaccines were implemented.

According to Health Canada at the time, the public was assured the mRNA vaccine effectiveness was as follows:



Effectiveness

Clinical trials showed that beginning 1 week after the second dose, the Pfizer-BioNTech Comirnaty®COVID vaccine was about:

- 95% effective in protecting trial participants from COVID-19 for those 16 years and older
- 100% effective for those 12 to 15 years old
- 90.7% effective for those 5 to 11 years old

These claims did not mention the quickly waning efficacy of the vaccines, and the complete lack of any effectiveness in preventing infection or the spread of infections.

The manufacturer monographs specifically cautioned about reductions in effectiveness over time, and the data to support the effectiveness of the vaccines was only reported over an extremely short period of time.

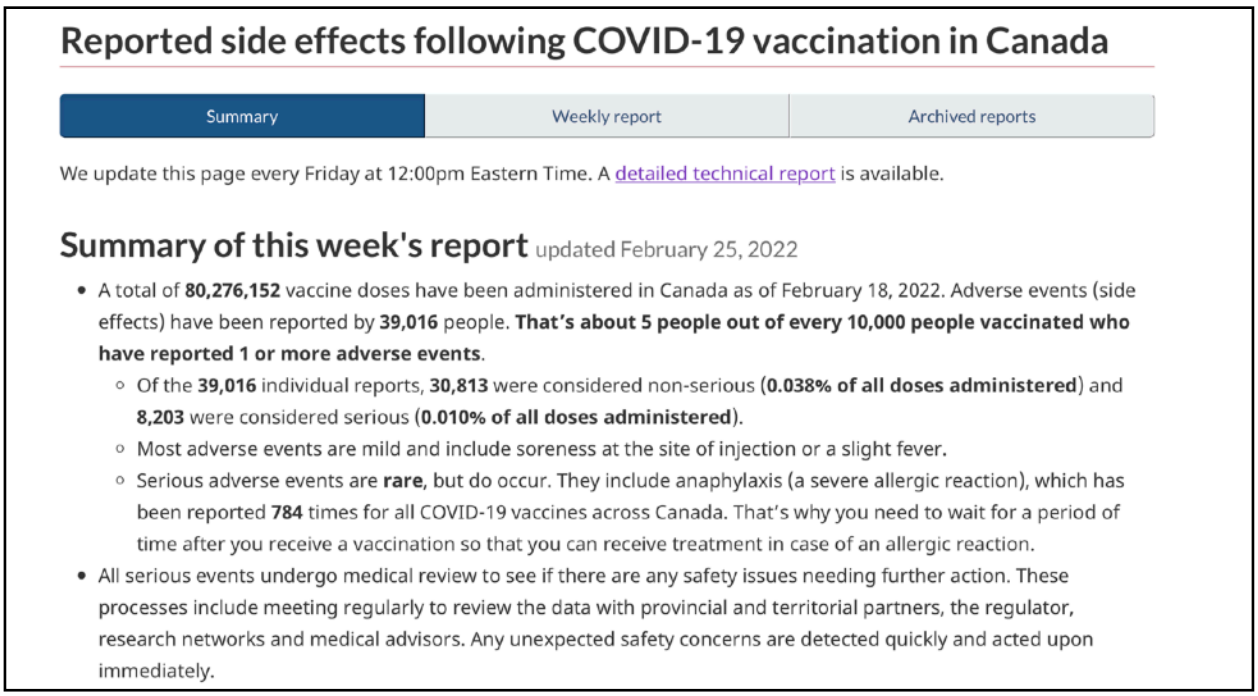
The information release also advises that mixed dosage schedules are fine, but the manufacturer specifically warns that mixed doses are not recommended.

Currently evidence that is available has identified many short and long term issues with both the vaccines and the studies used to get emergency approval and subsequent full approvals of the vaccines. Yet the mRNA vaccines continue to be mandated and administered to people who have virtually not risk from dying of Covid 19.

Given the extraordinary measures that were undertaken to force citizens to take the vaccine, those same authorities had an extra responsibility to ensure the vaccine was as safe as promoted.

When you consider all of these factors, the actual risks to citizens of the Covid-19 infection, and the unknown effects, efficacy and the long term effects of taking a new vaccine, the risks were not justified. The real risks related to the vaccines were glossed over so that normal Canadians could not have provided an informed consent to take it.

At the date of writing this report, Health Canada is reporting the following concerning side effects of the vaccines:



Reported side effects following COVID-19 vaccination in Canada

Summary | Weekly report | Archived reports

We update this page every Friday at 12:00pm Eastern Time. A detailed technical report is available.

Summary of this week's report updated February 25, 2022

- A total of **80,276,152** vaccine doses have been administered in Canada as of February 18, 2022. Adverse events (side effects) have been reported by **39,016** people. **That's about 5 people out of every 10,000 people vaccinated who have reported 1 or more adverse events**.
  - Of the **39,016** individual reports, **30,813** were considered non-serious (**0.038% of all doses administered**) and **8,203** were considered serious (**0.010% of all doses administered**).
  - Most adverse events are mild and include soreness at the site of injection or a slight fever.
  - Serious adverse events are **rare**, but do occur. They include anaphylaxis (a severe allergic reaction), which has been reported **784** times for all COVID-19 vaccines across Canada. That's why you need to wait for a period of time after you receive a vaccination so that you can receive treatment in case of an allergic reaction.
- All serious events undergo medical review to see if there are any safety issues needing further action. These processes include meeting regularly to review the data with provincial and territorial partners, the regulator, research networks and medical advisors. Any unexpected safety concerns are detected quickly and acted upon immediately.

Previously Health Canada was reporting the number of deaths being attributed to the vaccines, but they no longer report these deaths, nor do they report them in their list of serious side effects. Why is this? How can someone make an informed decision without this information.

Note the way that Covid-19 deaths are reported vs. Vaccine Related deaths.

To be included in the Covid-19 death count, Covid-19 only has to be detected in the deceased person, there is no appointment of severity or contribution to death reported.

Conversely, when someone dies after receiving the Covid 19 vaccine, the death is not necessarily recored as a vaccine related death. To be consistent with the way Covid 19 deaths are being reported, a death should be counted as due to the Covid-19 vaccine, when anyone dies after receiving the vaccine.

Why are these two very different standards being applied?

An organization called the Public Health and Medical Professionals for Transparency, made a Freedom of Information request to the US FDA for all of the data within Pfizer's Covid-19 biological file. The FDA refused to release the data, so the group sued the FDA, and won the release of the information.

Many significant and highly relevant documents concerning the testing carried out by Pfizer have now been released and much more information will be released under the court order in the upcoming months.

The Vaccine Adverse Event Reporting System (VAERS) Results

Data current as of 02/25/2022

Messages:

- VAERS data in CDC WONDER are updated every Friday. Hence, results for the same query can change from week to week.
- These results are for 16,579 total events.
- Rows with zero Events Reported are hidden. Use Quick Options above to show zero rows.

Vaccine Type	Events Reported	Percent (of 16,579)
ADENOVIRUS TYPE 4 &7 VACCINE, LIVE ORAL (ADEN_4_7)	1	0.01%
ANTHRAX VACCINE (ANTH)	31	0.19%
BACILLUS CALMETTE-GUERIN VACCINE (BCG)	4	0.02%
CHOLERA VACCINE (CHOL)	1	0.01%
COMVAX (HBHEPB)	193	1.16%
COVID19 VACCINE (COVID19)	13,427	80.99%
DIPHTHERIA AND TETANUS TOXOIDS ACELLULAR PERTUSSIS POLIOVIRUS INACTIVATED HAEMOPHILUS INFLUENZA B AND HEPATITIS B VACCINE (HEXAVAX) (6VAX-F)	3	0.02%
DIPHTHERIA AND TETANUS TOXOIDS AND ACELLULAR PERTUSSIS VACCINE (DTAP)	695	4.19%
DIPHTHERIA AND TETANUS TOXOIDS AND ACELLULAR PERTUSSIS VACCINE + INACTIVATED POLIOVIRUS VACCINE (DTAPIPV)	8	0.05%
DIPHTHERIA AND TETANUS TOXOIDS AND ACELLULAR PERTUSSIS VACCINE + HEPATITIS B + INACTIVATED POLIOVIRUS VACCINE (DTAPHEPBIP)	413	2.49%
DIPHTHERIA AND TETANUS TOXOIDS AND ACELLULAR PERTUSSIS VACCINE + INACTIVATED POLIOVIRUS VACCINE + HAEMOPHILUS B CONJUGATE VACCINE (DTAPIPVHIB)	227	1.37%
DIPHTHERIA AND TETANUS TOXOIDS AND PERTUSSIS VACCINE (DTP)	672	4.05%
DIPHTHERIA AND TETANUS TOXOIDS PERTUSSIS AND HAEMOPHILUS INFLUENZA B VACCINE (HEXAVAX) (DTPHIB)	222	1.34%
DIPHTHERIA AND TETANUS TOXOIDS, PEDIATRIC (DT)	13	0.08%
DIPHTHERIA/PERTUSSIS/POLIO (ORAL [LIVE] OR INACTIVATED NOT NOTED) (DPP)	1	0.01%
DIPHTHERIA/TETANUS/PERTUSSIS/HEPATITIS B (DTPHEP)	1	0.01%
HAEMOPHILUS B CONJUGATE VACCINE (HIBV)	1,377	8.31%
HAEMOPHILUS B POLYSACCHARIDE VACCINE (HBPV)	9	0.05%
HEPATITIS A (HEPA)	100	0.60%
HEPATITIS A AND HEPATITIS B VACCINE (HEPAB)	9	0.05%
HEPATITIS B VACCINE (HEP)	912	5.50%
HUMAN PAPILLOMAVIRUS (TYPES 6, 11, 16, 18) RECOMBINANT VACCINE (HPV4)	193	1.16%
HUMAN PAPILLOMAVIRUS (TYPES 6, 11,16, 18, 31, 33, 45, 52, 58) RECOMBINANT VACCINE (HPV9)	28	0.17%
HUMAN PAPILLOMAVIRUS VACCINE (HPVX)	26	0.16%
HUMAN PAPILLOVAVIRUS BIVALENT (HPV2)	5	0.03%
INFLUENZA (H1N1) MONOVALENT (INJECTED) (FLU(H1N1))	58	0.35%
INFLUENZA (H1N1) MONOVALENT, (INTRANASAL SPRAY) (FLUN(H1N1))	9	0.05%
INFLUENZA VIRUS VACCINE, NO BRAND NAME (FLUX(SEASONAL))	340	2.05%
INFLUENZA VIRUS VACCINE, QUADRIVALENT (INJECTED) (FLU4(SEASONAL))	155	0.93%
INFLUENZA VIRUS VACCINE, QUADRIVALENT (INTRANASAL SPRAY) (FLUN4(SEASONAL))	10	0.06%
INFLUENZA VIRUS VACCINE, QUADRIVALENT, ADJUVANT (INJECTED) (FLUA4(SEASONAL))	6	0.04%
INFLUENZA VIRUS VACCINE, QUADRIVALENT, CELL-CULTURE-DERIVED (INJECTED) (FLUC4(SEASONAL))	7	0.04%
INFLUENZA VIRUS VACCINE, QUADRIVALENT, RECOMBINANT (INJECTED) (FLUR4(SEASONAL))	5	0.03%
INFLUENZA VIRUS VACCINE, TRIVALENT (INJECTED) (FLU3(SEASONAL))	646	3.90%
INFLUENZA VIRUS VACCINE, TRIVALENT (INTRANASAL SPRAY) (FLUN3(SEASONAL))	22	0.13%
INFLUENZA VIRUS VACCINE, TRIVALENT, ADJUVANT (INJECTED) (FLUA3(SEASONAL))	8	0.05%
INFLUENZA VIRUS VACCINE, TRIVALENT, CELL-CULTURE-DERIVED (INJECTED) (FLUC3(SEASONAL))	3	0.02%
INFLUENZA(H1N1) MONOVALENT, UNKNOWN MANUFACTURER (FLUX(H1N1))	22	0.13%
JAPANESE ENCEPHALITIS VIRUS VACCINE (JEV)	2	0.01%
JAPANESE ENCEPHALITIS VIRUS VACCINE, INACTIVATED, ADSORBED (JEV1)	1	0.01%
LYME VACCINE (LYMERIX) (LYME)	9	0.05%
MEASLES VACCINE (MEA)	8	0.05%
MEASLES, MUMPS AND RUBELLA VIRUS VACCINE, LIVE (MMR)	256	1.54%
MEASLES, MUMPS, RUBELLA, AND VARICELLA VACCINE (PROQUAD) (MMRV)	24	0.14%
MENINGOCOCCAL B VACCINE (MENB)	10	0.06%
MENINGOCOCCAL POLYSACCHARIDE VACCINE (MEN)	41	0.25%
MENINGOCOCCAL VACCINE (MENACTRA) (MNQ)	46	0.28%
MUMPS VIRUS VACCINE, LIVE (MU)	4	0.02%
PERTUSSIS, ADSORBED VACCINE (PER)	3	0.02%
PLAGUE VACCINE (PLAGUE)	3	0.02%
PNC20 (PNC20)	1	0.01%
PNEUMOCOCCAL VACCINE, POLYVALENT (PPV)	203	1.22%
PNEUMOCOCCAL, 13-VALENT VACCINE (PREVNAR) (PNC13)	411	2.48%
PNEUMOCOCCAL, 7-VALENT VACCINE (PREVNAR) (PNC)	687	4.14%
POLIOVIRUS VACCINE INACTIVATED (IPV)	579	3.49%
POLIOVIRUS VACCINE TRIVALENT, LIVE, ORAL (OPV)	839	5.06%
RABIES VIRUS VACCINE (RAB)	15	0.09%
ROTAVIRUS (NO BRAND NAME) (RVX)	8	0.05%
ROTAVIRUS VACCINE (ROTASHIELD) (RV)	10	0.06%
ROTAVIRUS VACCINE, LIVE, ORAL (RV1)	93	0.56%
ROTAVIRUS VACCINE, LIVE, ORAL, PENTAVALENT (RV5)	376	2.27%
SMALLPOX VACCINE (SMALL)	17	0.10%
TETANUS AND DIPHTHERIA TOXOIDS AND ACELLULAR PERTUSSIS VACCINE (BOOSTRIX/ADACEL) (TDAP)	70	0.42%
TETANUS AND DIPHTHERIA TOXOIDS, ADULT (TD)	31	0.19%
TETANUS TOXOID (TTOX)	10	0.06%
TETRAMUNE (DTAPH)	3	0.02%
TYPHOID VACCINE (TYP)	18	0.11%
VARIVAX-VARICELLA VIRUS LIVE (VARCEL)	164	0.99%
YELLOW FEVER VACCINE (YF)	24	0.14%
ZOSTER VACCINE (VARZOS)	241	1.45%
UNKNOWN VACCINES (UNK)	257	1.55%
Total	**24,326**	**146.73%**

Note: Submitting a report to VAERS does not mean that healthcare personnel or the vaccine caused or contributed to the adverse event (possible side effect).

We point out that this information was in the possession of and known to the FDA in February of 2021.

We have not endeavoured to undertake a complete review of all of the documents that are expected to be undertaken by the law enforcement agencies who will be investigating this matter.

Some of the highlights are as follows:

Document: BNT162b2 5.3.6 Cumulative Analysis of Post-authorization Adverse Event Reports

This report was completed by Pfizer based on a request by the FDA date February 4, 2021.

The report details and summarizes safety data for the period ending February 28, 2021.

It is interesting to note that Pfizer states that safety reports are submitted voluntarily, so the magnitude of under reporting is unknown. This statement by Pfizer seems to be in direct conflict with the statements made by Health Canada about how they are closely monitoring the safety of the vaccine.

According to the report, as of February 28, 2021, there were 42,086 case reports of Adverse Events associated with the Pfizer vaccine, these were collected using their voluntary reporting system. Pfizer states they have no idea how much the voluntary system has under reported the actual number of Adverse Events.

Further more, the estimated number of doses administered has been redacted from the document, so it is not possible to determine the overall incidence of reported events related to the number of doses administered at that time.

The report states the following:

> Cumulatively, through 28 February 2021, there was a total of 42,086 case reports (25,379 medically confirmed and 16,707 non-medically confirmed) containing 158,893 events. Most cases (34,762) were received from United States (13,739), United Kingdom (13,404) Italy (2,578), Germany (1913), France (1506), Portugal (866) and Spain (756); the remaining 7,324 were distributed among 56 other countries.

The incidences were further broken down into the following tables:

Table 1. General Overview: Selected Characteristics of All Cases Received During the Reporting Interval

Characteristics		Relevant cases (N=42086)
Gender:	Female	29914
	Male	9182
	No Data	2990
Age range (years): 0.01 -107 years Mean = 50.9 years n = 34952	≤ 17 18-30 31-50 51-64 65-74 ≥ 75 Unknown	175[a] 4953 13886 7884 3098 5214 6876
Case outcome:	Recovered/Recovering	19582
	Recovered with sequelae	520
	Not recovered at the time of report	11361
	Fatal	1223
	Unknown	9400

a. in 46 cases reported age was <16-year-old and in 34 cases <12-year-old.

We note the quality of the reporting is significantly lacking as follows:

Of the 42,086 case reports, in 2,990 of the cases, the gender of the person was unknown.

Of the 42,086 case reports, in 6,876 cases, the age of the person was unknown.

Of the 42,086 case reports, in 9,400 cases the case outcome was unknown.

Of the 42,086 case reports, in 11,361 cases, the person had not recovered at the time of the report.

Of the 42,086 case reports, in 1,223 cases, the person had died.

Despite the extremely incomplete, voluntarily collected data, Pfizer still identified a number of Safety concerns as expressed in Table 3 of their report:

3.1.2. Summary of Safety Concerns in the US Pharmacovigilance Plan

Table 3. Safety concerns

Important identified risks	Anaphylaxis
Important potential risks	Vaccine-Associated Enhanced Disease (VAED), Including Vaccine-associated Enhanced Respiratory Disease (VAERD)
Missing information	Use in Pregnancy and lactation Use in Paediatric Individuals <12 Years of Age Vaccine Effectiveness

According to the voluntary data collected, Pfizer identifies a number of “Safety Concerns” surrounding the vaccines, and yet there is no indication that either Pfizer, the FDA or Canada Health undertook any enhancement to the voluntary data collection system they had in place.

We specifically note, that Pfizer directly stated in the above table that there was “Missing Information” concerning the use of the the vaccine in pregnant women, in children under the age of 12 years, and unknown information concerning the overall effectiveness of the vaccine.

Information was presented in the report concerning certain “Important Identified Risks” in certain specific counties.

We further refer to the notes that were included with Table 4 of the report.

The following tables review the important risk potentials and then describe the data to February 28, 2021 and provide certain comments on the data.

Table 4 concerns Anaphylaxis.

The main discussion here surrounds data collected in the United Kingdom.

Note “b” states that there were 4 individuals in the anaphylaxis evaluation that died on the same day they were vaccinated. The report goes on to diminish the vaccine / death connection by stating that each of the patients had significant underlying conditions that contribute to their deaths.

This statement is extremely significant since the same type of consideration was not given to diminish the death of an individual from Covid 19, when the person had significant underlying conditions.

Table 5 concerns Vaccine Associated Enhanced disease (VAED).

Notes contained in the description include the following:

Table 5. Important Potential Risk

Topic	Description
Important Potential Risk	**Post Authorization Cases Evaluation (cumulative to 28 Feb 2021) Total Number of Cases in the Reporting Period (N=42086)**
Vaccine-Associated Enhanced Disease (VAED), including Vaccine-Associated Enhanced Respiratory Disease (VAERD)	No post-authorized AE reports have been identified as cases of VAED/VAERD, therefore, there is no observed data at this time. An expected rate of VAED is difficult to establish so a meaningful observed/expected analysis cannot be conducted at this point based on available data. The feasibility of conducting such an analysis will be re-evaluated on an ongoing basis as data on the virus grows and the vaccine safety data continues to accrue. The search criteria utilised to identify potential cases of VAED for this report includes PTs indicating a lack of effect of the vaccine and PTs potentially indicative of severe or atypical COVID-19[a]. Since the first temporary authorization for emergency supply under Regulation 174 in the UK (01 December 2020) and through 28 February 2021, 138 cases [0.33% of the total PM dataset], reporting 317 potentially relevant events were retrieved:

There was once again a detailed discussion of the incidence data in a number of countries including the United Kingdom and many others; but no specific mention of Canada was made. It is not known whether or not this lack of data from Canada is the result of lack of data collection, however, the incidence of cases in other countries should have caused Canadian authorities to study the phenomena in Canada to determine what was going on.

	Conclusion: VAED may present as severe or unusual clinical manifestations of COVID-19. Overall, there were 37 subjects with suspected COVID-19 and 101 subjects with confirmed COVID-19 following one or both doses of the vaccine; 75 of the 101 cases were severe, resulting in hospitalisation, disability, life-threatening consequences or death. None of the 75 cases could be definitively considered as VAED/VAERD. In this review of subjects with COVID-19 following vaccination, based on the current evidence, VAED/VAERD remains a theoretical risk for the vaccine. Surveillance will continue.

Table 6, on the Pfizer report, concerns the use of the vaccine in Pregnancy and Lactation, in children under 12 years of age, and generally the effectiveness of the vaccine overall.

The information provided is characterized as “Missing Information”.

The reporting that was provided in Table 6 does raise a number of serious issues surrounding the use of the vaccine, especially on pregnant and breast feeding women.

On page 38 to 48 of this report contains the information provided to Pregnant and or Beast feeding women by the Government of Manitoba.

As of February 28, 2021, the information available to health Authorities identified the risks associated with these individuals and their babies as identified by Pfizer. These risks included such things as:

Pregnancy cases: 274 cases including:

- 270 mother cases and 4 foetus/baby cases representing 270 unique pregnancies (the 4 foetus/baby cases were linked to 3 mother cases; 1 mother case involved twins).
- Pregnancy outcomes for the 270 pregnancies were reported as spontaneous abortion (23), outcome pending (5), premature birth with neonatal death, spontaneous abortion with intrauterine death (2 each), spontaneous abortion with neonatal death, and normal outcome (1 each). No outcome was provided for 238 pregnancies (note that 2 different outcomes were reported for each twin, and both were counted).

- 146 non-serious mother cases reported exposure to vaccine in utero without the occurrence of any clinical adverse event. The exposure PTs coded to the PTs Maternal exposure during pregnancy (111), Exposure during pregnancy (29) and Maternal exposure timing unspecified (6). Trimester of exposure was reported in 21 of these cases: 1st trimester (15 cases), 2nd trimester (7), and 3rd trimester (2).
- 124 mother cases, 49 non-serious and 75 serious, reported clinical events, which occurred in the vaccinated mothers. Pregnancy related events reported in these cases coded to the PTs Abortion spontaneous (25), Uterine contraction during pregnancy, Premature rupture of membranes, Abortion, Abortion missed, and Foetal death (1 each). Other clinical events which occurred in more than 5 cases coded to the PTs Headache (33), Vaccination site pain (24), Pain in extremity and Fatigue (22 each), Myalgia and Pyrexia (16 each), Chills (13) Nausea (12), Pain (11), Arthralgia (9), Lymphadenopathy and Drug ineffective (7 each), Chest pain, Dizziness and Asthenia (6 each), Malaise and COVID-19 (5 each). Trimester of exposure was reported in 22 of these cases: 1st trimester (19 cases), 2nd trimester (1 case), 3rd trimester (2 cases).
- 4 serious foetus/baby cases reported the PTs Exposure during pregnancy, Foetal growth restriction, Maternal exposure during pregnancy, Premature baby (2 each), and Death neonatal (1). Trimester of exposure was reported for 2 cases (twins) as occurring during the 1st trimester.

Breast feeding baby cases: 133, of which:

- 116 cases reported exposure to vaccine during breastfeeding (PT Exposure via breast milk) without the occurrence of any clinical adverse events;
- 17 cases, 3 serious and 14 non-serious, reported the following clinical events that occurred in the infant/child exposed to vaccine via breastfeeding: Pyrexia (5), Rash (4), Infant irritability (3), Infantile vomiting, Diarrhoea, Insomnia, and Illness (2 each), Poor feeding infant, Lethargy, Abdominal discomfort, Vomiting, Allergy to vaccine, Increased appetite, Anxiety, Crying, Poor quality sleep, Eructation, Agitation, Pain and Urticaria (1 each).

Breast feeding mother cases (6):

- 1 serious case reported 3 clinical events that occurred in a mother during breast feeding (PT Maternal exposure during breast feeding); these events coded to the PTs Chills, Malaise, and Pyrexia
- 1 non-serious case reported with very limited information and without associated AEs.

Table 6. Description of Missing Information

Topic	Description
Missing Information	**Post Authorization Cases Evaluation (cumulative to 28 Feb 2021) Total Number of Cases in the Reporting Period (N=42086)**
	• In 4 cases (3 non-serious; 1 serious) Suppressed lactation occurred in a breast feeding women with the following co-reported events: Pyrexia (2), Paresis, Headache, Chills, Vomiting, Pain in extremity, Arthralgia, Breast pain, Scar pain, Nausea, Migraine, Myalgia, Fatigue and Breast milk discolouration (1 each). Conclusion: There were no safety signals that emerged from the review of these cases of use in pregnancy and while breast feeding.

The information bulletin being given out by the Province of Manitoba, (to the current date) does not make the reader aware of any of these issues which were known by February of 2021.

Pfizer further defines what they considered to be "fully vaccinated" as follows:

The coding conventions for lack of efficacy in the context of administration of the COVID-19 vaccine were revised on 15 February 2021, as shown below:

- PT "Vaccination failure" is coded when ALL of the following criteria are met:
  - The subject has received the series of two doses per the dosing regimen in local labeling.
  - At least 7 days have elapsed since the second dose of vaccine has been administered.
  - The subject experiences SARS-CoV-2 infection (confirmed laboratory tests).
- PT "Drug ineffective" is coded when either of the following applies:
  - The infection is not confirmed as SARS-CoV-2 through laboratory tests (irrespective of the vaccination schedule). This includes scenarios where LOE is stated or implied, e.g., "the vaccine did not work", "I got COVID-19".
  - It is unknown:
    - Whether the subject has received the series of two doses per the dosing regimen in local labeling;
    - How many days have passed since the first dose (including unspecified number of days like" a few days", "some days", etc.);
    - If 7 days have passed since the second dose;
  - The subject experiences a vaccine preventable illness 14 days after receiving the first dose up to and through 6 days after receipt of the second dose.

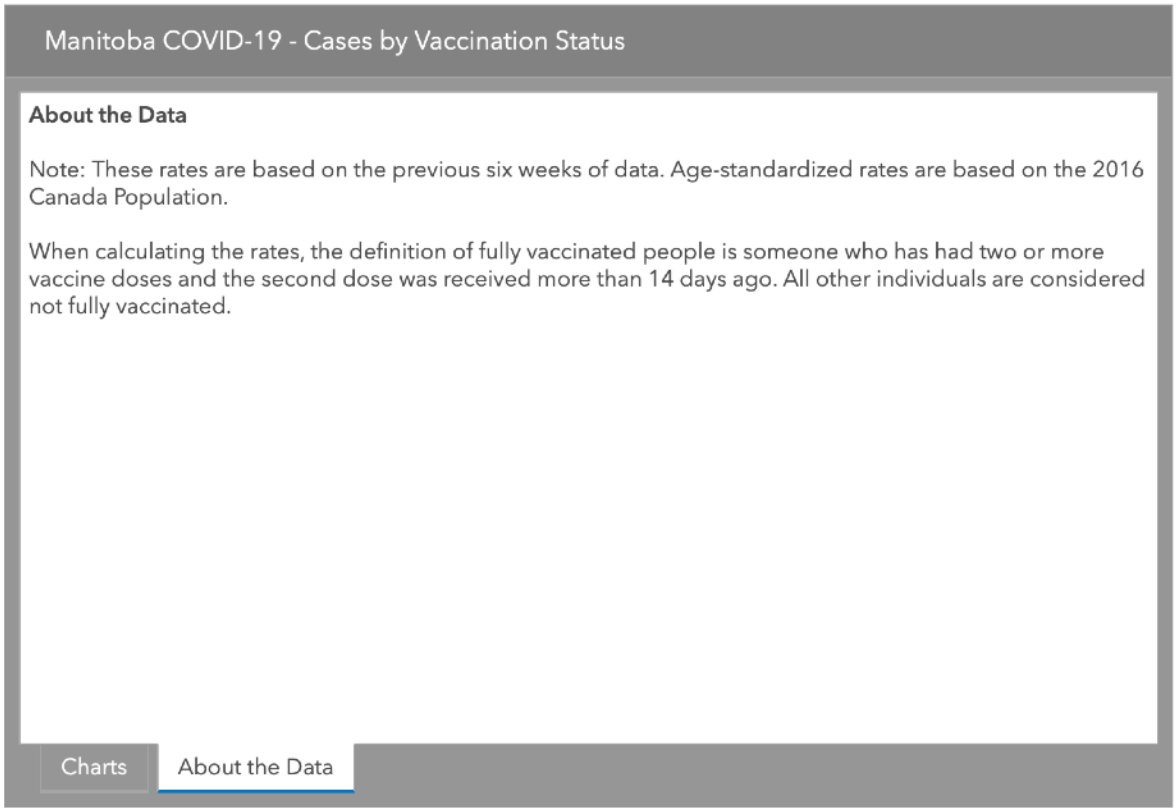
Note: after the immune system as had sufficient time (14 days) to respond to the vaccine, a report of COVID-19 is considered a potential lack of efficacy even if the vaccination course is not complete.

However, this is not the same basis upon which the Government of Manitoba was evaluating the Vaccine Effectiveness.

According to the Government of Manitoba Covid 19 information site:

https://www.gov.mb.ca/covid19/updates/cases.html#vaccine-status

The following definition of Fully Vaccinated has been utilized to calculate the risk factors:



Pfizer who is the manufacturer and developer of one of the mRNA vaccines evaluates a vaccine failure based on a different criteria than the Government of Manitoba.

Pfizer defines fully vaccinated as occurring either 14 days after the initial dose or 7 days after the second dose.

Why is it then that the Government of Manitoba has decided to define fully vaccinated as occurring only after 14 days after two doses had been received.

This revision in the criteria from that used by the FDA and Pfizer significantly exaggerates the effectiveness of the vaccine, and misleads people who are trying to make an informed decision to take the vaccine.

According to the The Canadian Pandemic Influenza Plan 2006, Health Canada was responsible to provide the following:

> A plan needs to be in place to monitor vaccine safety and to ensure the timely communication of any potential adverse event following immunization (AEFI) during the pandemic. Information on potential AEFIs must still be communicated in a timely manner from local to P/T public health authorities and on to the Immunization and Respiratory Infections Division, CIDPC, PHAC. The CIDPC will provide information to the Biologics and Therapeutic Products Directorate, HC and other stakeholders. Specific targeted studies and epidemiological investigations may be required in addition to passive surveillance.

In response to this requirement, Health Canada took no action except to maintain their already in place voluntary reporting system. Most people are not even aware that this system exists in Canada. It is called: Canadian Adverse Events Following Immunization Surveillance System (CAEFISS).

Why would a mandatory system not be put into place when a completely new form of injection was being mandated throughout Canada?

It is also of great interest, that as of the writing of this report, the reported side effects following COVID-19 vaccination in Canada, does NOT report death as a side effect of the vaccine!

https://health-infobase.canada.ca/covid-19/vaccine-safety/summary.html

The Health Canada site discusses serious side effects such as anaphylaxis but no discussion of deaths.

Different countries monitor vaccine side effects with a similar voluntary information system. The United States has a system known as VAERS.

As of February 25, 2022, the VAERS system was reporting 811,629 Adverse Event Reports related to the Covid-19 vaccines; 13,427 of these Adverse Events were Deaths.

Below is a chart showing all deaths reported for all years for all vaccine products in the United States.

Note that the Covid-19 vaccine accounts for 81% of all deaths **for all reported years**, and the Covid-19 vaccine has only been available since December 2021.

The World Health Organization has a system called VIGI ACCESS, which they use to monitor adverse reactions due to various Vaccines.

VigiAccess™ Uppsala Monitoring Centre | WHO Collaborating Centre for International Drug Monitoring FAQ

covid-19 vaccine Search

covid-19 vaccine contains the active ingredient(s): **Covid-19 vaccine**.
Result is presented for the active ingredient(s).
Total number of records retrieved: **3360132**.

Distribution

- Adverse drug reactions (ADRs)
- Geographical distribution
- Age group distribution
- Patient sex distribution
- ADR reports per year

Year	Count	Percentage
2022	478534	14
2021	2879136	86
2020	2318	0
2019	101	0
2018	38	0
2017	3	0
2016	1	0
2015	1	0

The chart above is taken directly from the VigiAccess system. The report shows the total number of ADR (Adverse Reaction Reports) per year from 2015 to 2022. We note that in 2021, there were 2,879,136 Adverse reaction reports associated with Covid-19 Vaccines. For the combined years 2015 through 2019, there were only 144 ADR's reported for **all other vaccines**.

The WHO system provides additional insight as to which age groups are most affected by the Averse Reactions:

VigiAccess™ Uppsala Monitoring Centre | WHO Collaborating Centre for International Drug Monitoring FAQ

covid-19 vaccine Search

covid-19 vaccine contains the active ingredient(s): **Covid-19 vaccine**.
Result is presented for the active ingredient(s).
Total number of records retrieved: **3360132**.

Distribution

› Adverse drug reactions (ADRs)

› Geographical distribution

⌄ Age group distribution

Age group	Count	Percentage
0 - 27 days	517	0
28 days to 23 months	2010	0
2 - 11 years	13524	0
12 - 17 years	69124	2
18 - 44 years	1334224	40
45 - 64 years	1002084	30
65 - 74 years	298346	9
≥ 75 years	198542	6
Unknown	441761	13

The chart indicates that 70% of all adverse reactions occurred in the 18 to 64 age group.

6.3.3 Forced Closure of Businesses

Most businesses were either closed completely or were severely restricted to the number of people who would be allowed in.

The governments somehow designated certain businesses as vital and allowed these businesses to remain open, while closing others. In this way the government arbitrarily decided which businesses would remain in business and which ones would go out of business.

Examples of businesses that were considered vital were Liquor Stores; Large Box Stores.

Many business owners found themselves in unimaginable positions where their life's work was lost due to bankruptcy directly resulting from the forced closures and restrictions.

Based on the statistical analysis previously presented the closure and restrictions of businesses was totally unwarranted.

In fact the The Canadian Pandemic Influenza Plan 2006

7.0 Community-Based Disease Control Strategies

Controlling the spread of influenza in the community likely will not be possible without an effective vaccine, assuming that the novel virus will cause illness with similar characteristics to other influenza A infections. Specifically, the short incubation period, high infectiousness, ability of the virus to survive for extended periods of time on environmental surfaces, non-specific clinical symptoms, and potential for asymptomatic infection and spread from asymptomatic individuals greatly limits the effectiveness and feasibility of most traditional public health control measures. During the SARS outbreak, no vaccine or virus-specific drugs were available for treatment or prophylaxis; therefore, the need to effectively isolate communicable cases and identify and quarantine their respective contacts became paramount. A recent modeling exercise concluded that influenza would be "difficult to control even with 90% quarantining and contact tracing because of the high level of presymptomatic transmission."[6]

Because the potentially high attack rate of a novel virus in the general population will stretch all existing health care resources, ideally planners should consider dedicating resources only to measures that will effectively mitigate the impact of the pandemic. Unfortunately most community-based measures under consideration, including the widespread use of masks, cancellation of public gatherings and closure of schools and businesses, have been anecdotally reported to be ineffective, or their effectiveness has not been formally evaluated. The use of mathematical modeling to predict the potential effectiveness of these types of interventions may provide estimates of their impacts that will help in the development of future planning documents.

The plan goes on to say about

7.3 Restrict Indoor Public Gatherings (other than schools)

(e.g. close theatres and other venues where large amounts of people gather indoors in close proximity, halt mass public transportation services)

Trigger

When the local public health authority indicates that transmission is occurring within the community[25]

Advantages

- Decreases the number of venues in which spread to a large number of people is possible

Disadvantages

- May feed public panic and cause societal disruption
- Negative economic impact on business owners (may generate compensation claims)
- Sustainability for the duration of the pandemic wave may be problematic, especially when the pandemic activity is widespread.

25 These types of measures would be likely be most effective prior to cases with transmission occurring in the community. However in the absence of disease, it would be difficult to justify this type of drastic measure for which there is no sound data for its effectiveness.

Conclusion

This type of measure may be feasible but compliance and sustainability might be difficult, especially because effectiveness is unproven. This is particularly true for gatherings and activities that are considered "essential" (e.g. public transportation) and would cause significant societal disruption should they be discontinued.

If the epidemiology of the pandemic suggests higher morbidity and/or mortality in a specific group of individuals (e.g. adolescents), then canceling events known to attract this specific high-risk group should be considered, especially if the virus is being efficiently transmitted. The objective of these targeted cancellations or restrictions would be to avoid a sudden increase in demand for health care services as a consequence of a "spike" in cases due to efficient transmission at a large gathering.

Once the virus is circulating in a community, indoor gatherings at events or at locations for businesses may be suspended without public health intervention because of public reluctance to participate in large gatherings. Because the effectiveness of this measure is unknown and it may be difficult to sustain, the Working Group does not recommend its broad implementation. However, it is recommended that those who are involved in hosting large gatherings ensure the availability of hand-sanitation supplies in public washrooms.

- Not recommended for broad implementation
- Consider if high-risk gatherings can be identified

6.3.4 Other Measures Implemented but Not Recommended

The Canadian Influenza Pandemic Plan 2006 states that the following measures are not recommended for implementation, despite that many were actually implemented in Manitoba.

7.7 Other Measures NOT Recommended for Implementation

All of the measures or general principles addressed in this document were also raised during the WHO international consultation process (March 2004), as outlined in the meeting report.[1] The consensus was that the measures that follow were either not necessary or not appropriate. The Public Health Measures Working Group also agrees with these conclusions.

Measure	Comments
Urge entire population in an affected area to check for fever at least once daily	• A potential measure to decrease interval between symptom onset and patient isolation; however, this has not been effective in other situations
Introduce thermal scanning into public places	• Experience has not shown this measure to be effective
Widespread environmental or air disinfection	• Not practical
Disinfect clothing, shoes or other objects of persons exiting affected areas	• Not recommended for public health purposes • May be required by veterinary authorities to prevent spread of infection in animals
Restrict travel to and from affected areas	• Enforcement considered impractical in most countries • Likely to occur voluntarily when risk is appreciated by the public
Cordon sanitaire	• Enforcement considered impractical

6.4 Criminal Mismanagement of the ICU

In the years leading up to and in the month immediately leading up to the pandemic, the Manitoba Government took steps that essentially crippled the ability of the medical system in the province to respond to any emergency situation that might arise.

These steps were taken despite the Government being aware of the current and projected situation related to ICU capacity in the province, and despite their having participated in and contributed to the The Canadian Pandemic Influenza Plan for the Health Sector 2006.

The steps taken went far beyond reasonable austerity steps and we allege were criminal in having severely restricted the Manitoba Health system from protecting Manitobans.

In 2012 The Manitoba Centre for Health Policy (University of Manitoba) completed a report "Garland A, Fransoo R, Olafson K, Ramsey C, Yogendren M, Chateau D, McGowan K. The Epidemiology and Outcomes of Critical Illness in Manitoba. Winnipeg, MB: Manitoba Centre for Health Policy, April 2012. ".

http://mchp-appserv.cpe.umanitoba.ca/deliverablesList.html

The stated goals of the report is stated as:

> "This report provides a comprehensive, population–based evaluation of the epidemiology and outcomes of care provided in Intensive Care Units (ICUs) among people aged 17 and older in Manitoba, over the nine years from 1999/2000 to 2007/08. The care of critically ill patients occurs primarily in ICUs, and the report concentrates on that care. "

The report was prepared for Manitoba Health.

The report states that in 2007/2008, Manitoba had 118 designated ICU Beds. 82 of these ICU beds were located in Winnipeg, the remaining 36 were in elsewhere in the province.

The report states that in 2007 Manitoba had 9.8 ICU Beds per 100,000 population, and that the Canadian Average was 13.5.

So, in 2007 overall in Manitoba the supply of ICU hospital beds was 72% of the National Average.

The report states that:

> "Mortality is high among people receiving ICU care. Approximately 17% died in the hospital and another 2.7% died within six months. "

A report was prepared by the Canadian Institute for Health Information, dated August 2016, Canadian Institute for Health Information. Care in Canadian ICUs. Ottawa, ON: CIHI; 2016.

In that report the authors state:

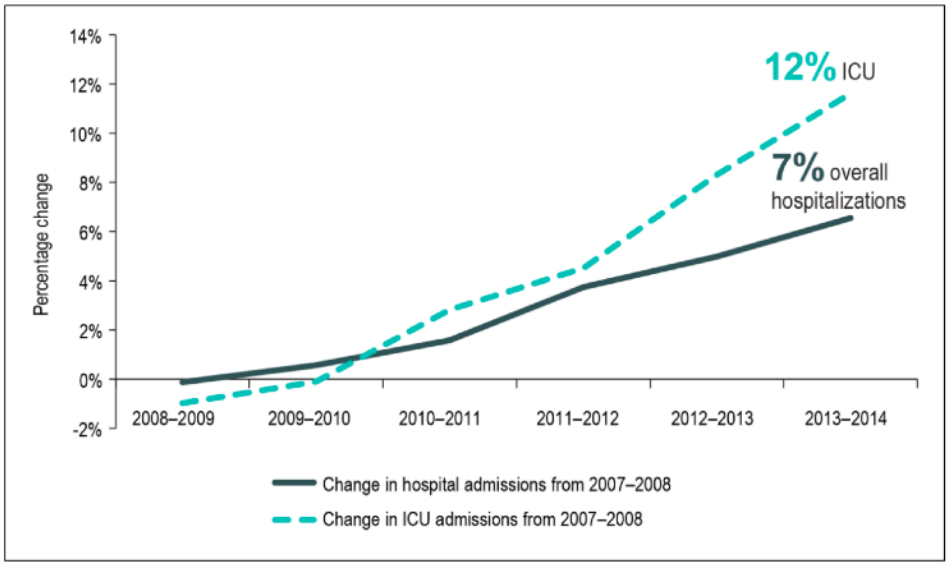
> *"The use of ICUs in Canada is increasing faster than acute care hospitalizations overall. In 2013–2014, there were more than 230,800 adult ICU admissions in Canada, an increase of 12% since 2007–2008. During the same time frame, adult hospital admissions increased by 7%.*

So during the time period from 2007 to 2013, the Centre found that there was a 12% increase in ICU stays across Canada.

Trends and ICU admissions

The use of ICUs is increasing faster than overall hospital admissions. In 2013–2014, there were more than 230,800 adult ICU admissions in Canada, outside of Quebec. This number is up from the more than 206,800 adult ICU admissions in 2007–2008, and represents an increase of 12% over this period (versus 7% for overall hospital admissions) (Figure 4).

Figure 4 Change in ICU and hospital admissions for adult patients in Canada, 2007–2008 to 2013–2014



Notes
ICU admissions includes stays in SDUs and PTDUs.
Data excludes hospital and ICU admissions for Quebec but includes the territories.
Sources
Discharge Abstract Database, 2007–2008 to 2014–2015, and Ontario Mental Health Reporting System, 2007–2008 to 2013–2014, Canadian Institute for Health Information.

We note that since 2007 when Manitoba had 118 ICU Beds, the population of Manitoba has significantly increased by 216,000 people.

By 2015 Manitoba Health had reduced the total number of ICU beds in the province to 93.

By 2016, Manitoba Health had reduced the total number of ICU beds in the province to 82.

By 2017, Manitoba Health had reduced the total number of ICU beds in the the province to 73.

By the fall of 2019, Manitoba Health had reduce the total number of ICU beds in the province to 55, with the closure of the Seven Oaks General Hospital ICU.

In 2007 Manitoba had a ratio of approximately 9.8 beds per 100,000 population, which was below the Canadian national average 0f 13.5 ICU beds to 100,000 population.

By the fall of 2019, Manitoba had reduced ICU bed capacity by over 200%, to 55 ICU beds. This is a ratio of approximately 4 ICU beds per 100,000 population.

This ratio is approximately 330% lower than the Canadian average.

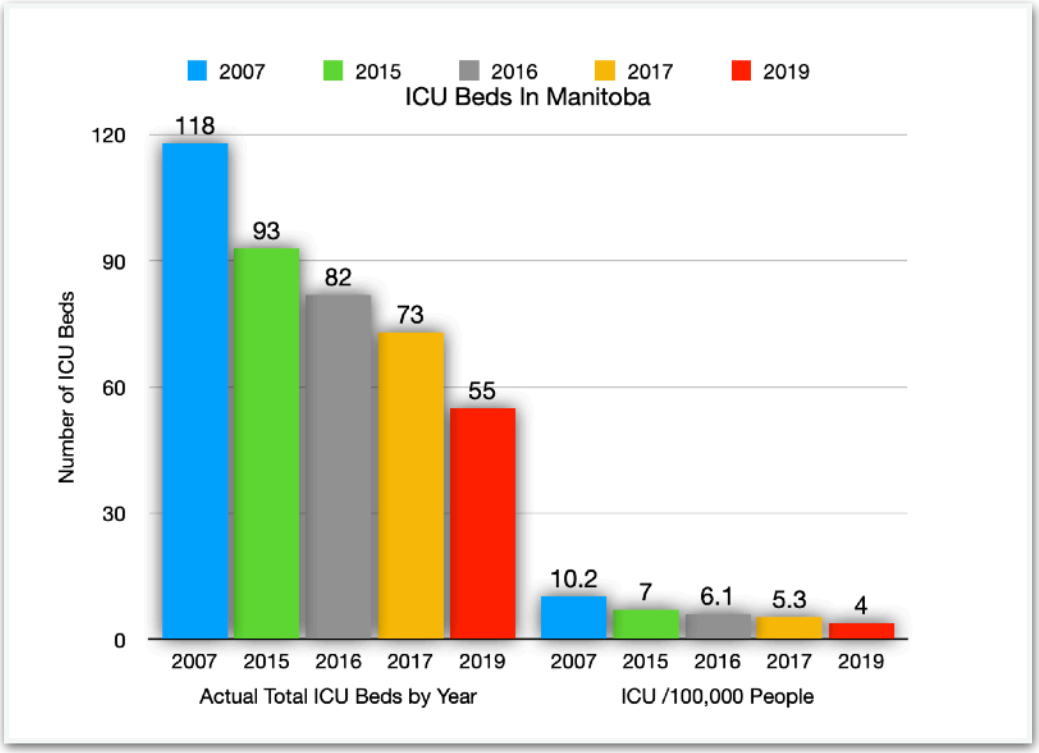
This despite the fact that ICU bed usage was growing in Canada.

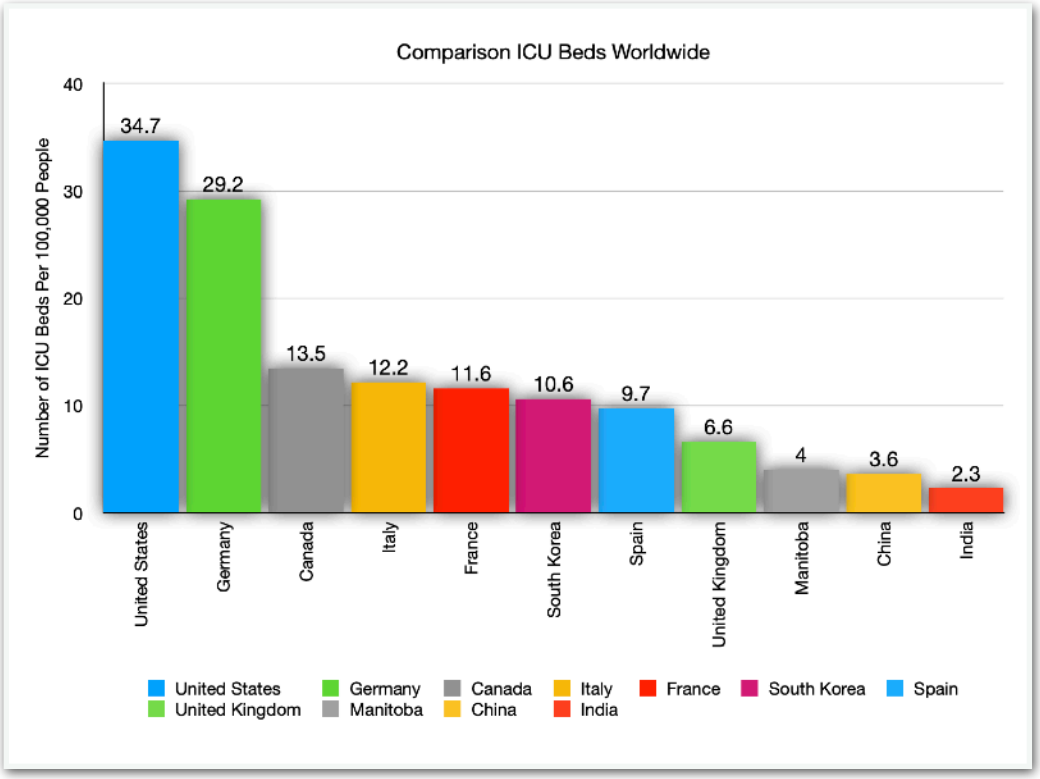
This despite an increase in population of 216,000 people.

This despite the 2010 experience with the H1N1 Virus. Manitoba Health produced a report titled: “H1N1 Flu In Manitoba, Manitoba’s Response, Lessons Learned 2010”. It does not appear that the recommendation or lessons learned were implemented form that report. https://www.gov.mb.ca/health/documents/h1n1.pdf

According to the report, at the peak, of the H1N1 pandemic there were 38 patients on ventilators in Manitoba, which was approximately 40% of the capacity.

Below is a comparison of ICU bed capacity reductions leading up to the 2020 pandemic, as well as a comparison of ICU bed capacity in selected other countries around the world:


2007
2015
2016
2017
2019
ICU Beds In Manitoba
Number of ICU Beds
120
90
60
30
0
118
93
82
73
55
10.2
7
6.1
5.3
4
2007 2015 2016 2017 2019
Actual Total ICU Beds by Year
2007 2015 2016 2017 2019
ICU /100,000 People


Comparison ICU Beds Worldwide
Number of ICU Beds Per 100,000 People
40
30
20
10
0
34.7
29.2
13.5
12.2
11.6
10.6
9.7
6.6
4
3.6
2.3
United States
Germany
Canada
Italy
France
South Korea
Spain
United Kingdom
Manitoba
China
India
United States
Germany
Canada
Italy
France
South Korea
Spain
United Kingdom
Manitoba
China
India

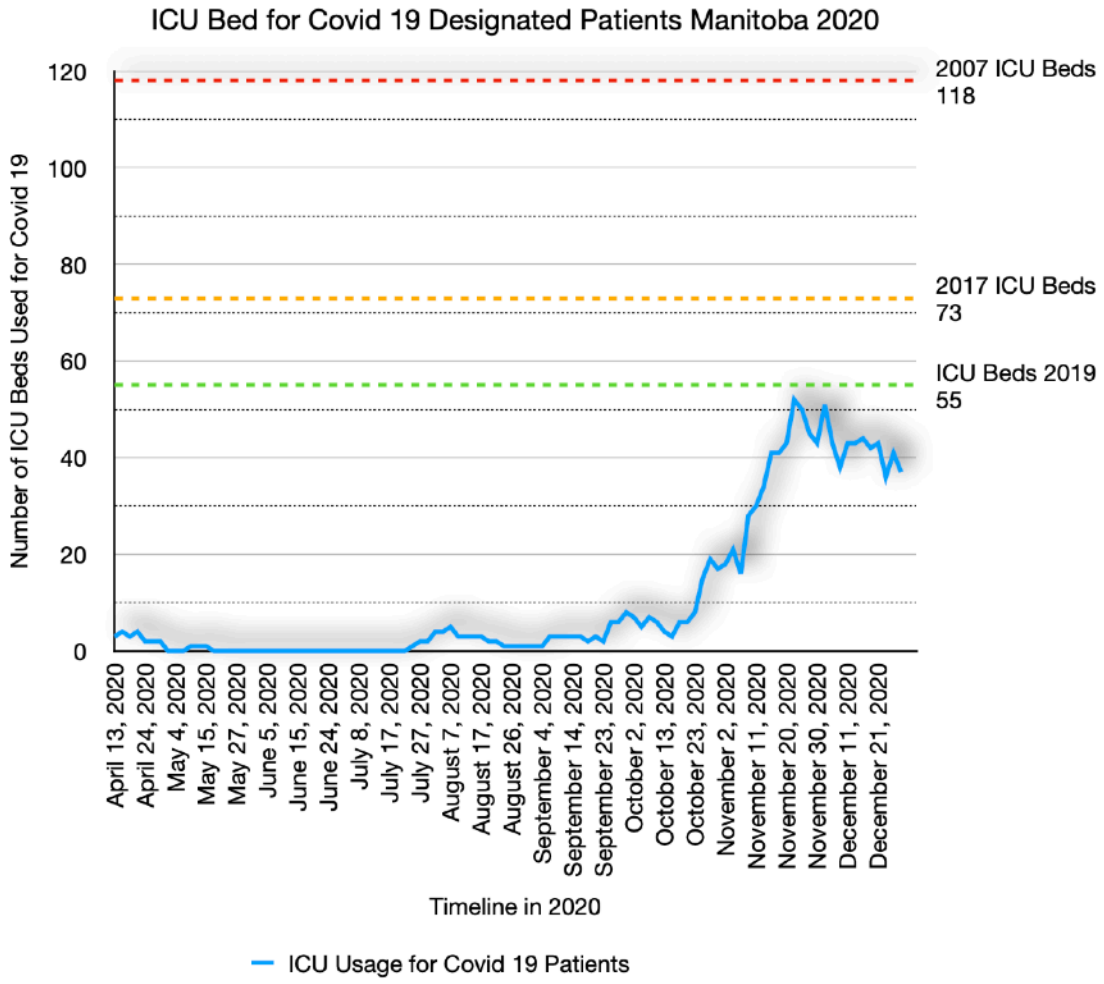
During the Covid 19 pandemic, which started in late 2019, and was first reported in early 2020, Manitoba Health had reduced the number of ICU beds, and the staff to operate them to a level that was comparable to a third world country.

According to documents obtained from the Winnipeg Regional Health Authority (WRHA), in 2017 there were 402 Critical Care Health Nurse Positions Available; and there were 279 Critical Health Care Nurses Employed in their system.

By 2019, WRHA reported that there were 187 Critical Care Health Nurse positions available; and there were 140 Critical Care Health Nurses Employed.

This is a 200% reduction in Critical Care Health Nurses in TWO Years, immediately preceding the Covid 19 pandemic.

Below is a chart which reports the actual daily Covid 19 related ICU bed usage in Manitoba for 2020.



The Chart shows the number of ICU beds that the Province of Manitoba reported to be used for Covid 19 Patients.

The Blue Line shows the Daily Number of ICU beds occupied by Covid 19 Patients

The Red Dotted Line at the top, indicates the number of ICU beds available in Manitoba in 2007.

The Yellow Dotted Line In the Middle, indicates the number of ICU beds available in Manitoba in 2017.

The Green Dotted Line, indicate the number of ICU beds available in Manitoba in the Fall of 2019 with the closure of the Seven Oaks Hospital ICU.

Maximum ICU Bed Usage Occurred May 21, 2021: 76 Beds

Vaccinations Began in December 16, 2020

It is Unknown how many of these ICU beds were occupied by people in the ICU BECAUSE OF COVID 19, rather than in ICU for other reasons WITH COVID 19.

The chart clearly indicates the dramatic impact that the ICU bed reductions had on the ability of the Health Care system to respond to the Covid 19 pandemic.

The fact that the ICU capacity had been cut by approximately 200% immediately leading up to the Covid 19 pandemic, directly impacted the health of Manitobans and the ability of our health care system to adequately care for them.

The extent of the reductions is unprecedented in Canada.

Pallister Cuts 18 ICU Beds across Winnipeg

Treaty 1 Territory, Winnipeg, MB – The Manitoba NDP revealed today the Pallister Conservative government has reduced the number of available ICU beds across Winnipeg's health care system by more than 20%.

Records obtained through freedom of information requests show there were a total of 73 general ICU beds operating in January 2017. In July 2019 there were 63, which included the seven beds at Seven Oaks General Hospital that were closed in September 2019. Yesterday, WRHA officials confirmed there are 55 beds in operation across the system—meaning 18 beds have been lost in just two years.

"In the middle of a virus epidemic, Winnipeg hospitals are down 18 ICU beds. This is a direct consequence of Brian Pallister's decision to close three emergency rooms and fire hundreds of nurses," said NDP Leader Wab Kinew.

Yesterday, WRHA officials admitted they are struggling to staff beds because of a shortage of nurses and other health care workers like respiratory therapists. Some of the closed beds are a result of Pallister's move to close ICU units at hospitals like Seven Oaks—a move which was justified at the time because there were "very few patients". Capacity issues have led to cancelled surgeries and have even resulted in transferring patients from Winnipeg hospitals to the Brandon site.

"Pallister's cuts have created such dysfunction in our health care system that they actually have to transfer patients out of the largest, highest quality sites in our province because of lack of beds. That doesn't make sense for patient care or their families," Kinew said.

6.4.1 ICU Bed Infographics

Following are a number of infographics which can be used to illustrate the ICU capacity issues in Manitoba during the time leading up to the pandemic and through 2020.

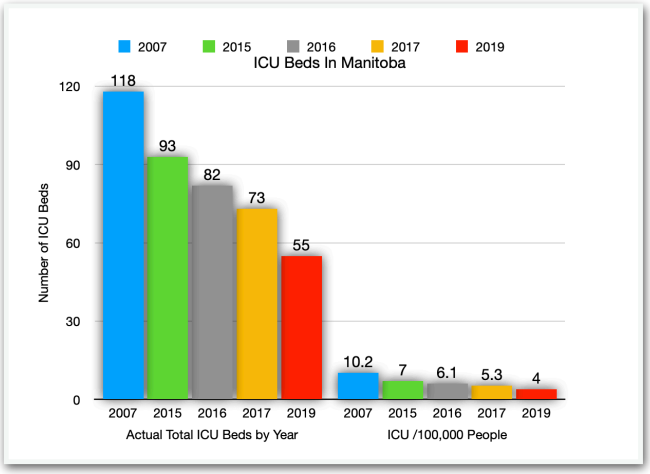
Such a dramatic decrease in Manitoba's capacity to address a medical emergency, in and of itself, is criminally negligent, and the public were largely kept in the dark about what was going on, or had no appreciation for it. Where was the outcry from the medial societies?

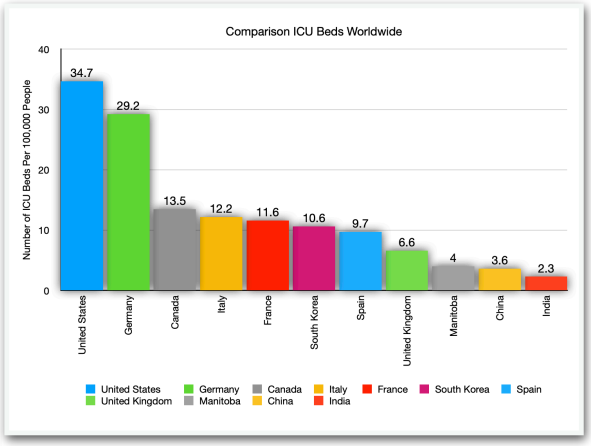
Manitoba Health Fact Sheet

DID YOU KNOW?

ICU Beds in Manitoba Prior to 2020

Number of ICU Beds In Manitoba



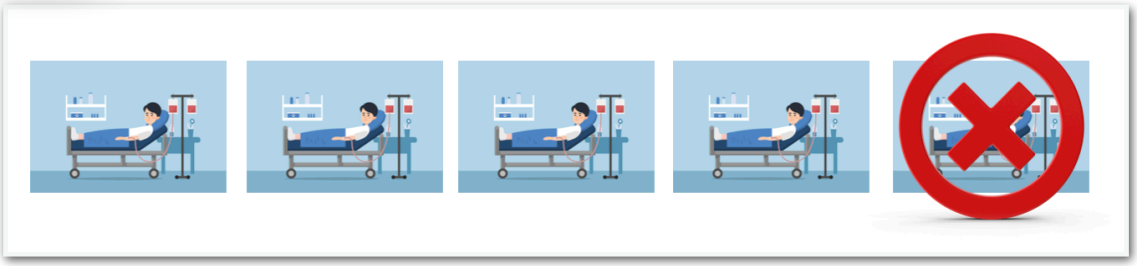


Canada Average ICU Bed Per 100,000 People = 13.5
Manitoba ICU Bed Per 100,000 People (2019) = 4

2016 Study CIHI - ICU Admissions in Canada Increased 12% between 2007 to 2013
Manitoba ICU Bed Count Decreased by 214% from 2007 to 2019

In 2013 - 2014; 34% of ICU Patients in Manitoba Received Short Term Invasive Ventilation

ICU 6 Month Mortality Rate: 20%

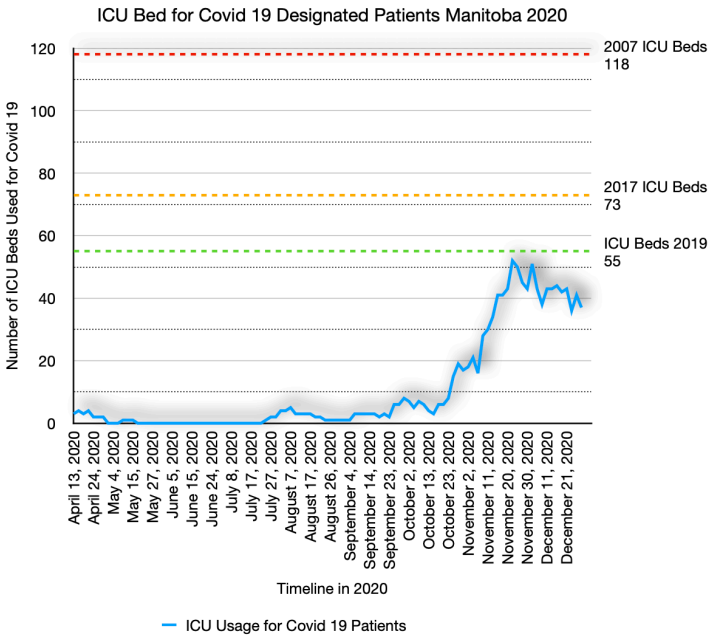


DESPITE INCREASING DEMAND FOR ICU BEDS, BETWEEN 2007 AND 2019 MANITOBA REDUCED THE NUMBER OF ICU BEDS BY 215%.

Manitoba Health Fact Sheet

DID YOU KNOW?

ICU Beds Used in Manitoba 2020



The Chart on the Left shows the number of ICU beds that the Province of Manitoba reported to be used for Covid 19 Patients.

The **Blue Line** shows the Daily Number of ICU beds occupied by Covid 19 Patients

The **Red Dotted Line** at the top, indicates the number of ICU beds available in Manitoba in 2007.

The **Yellow Dotted Line** In the Middle, indicates the number of ICU beds available in Manitoba in 2017.

The **Green Dotted Line**, indicate the number of ICU beds available in Manitoba in the Fall of 2019 with the closure of the Seven Oaks Hospital ICU.

Maximum ICU Bed Usage Occurred May 21, 2021: 76 Beds

Vaccinations Began in December 16, 2020

It is Unknown how many of these ICU beds were occupied by people in the ICU BECAUSE OF COVID 19, rather than in ICU for other reasons WITH COVID 19.

According to the WRHA*

2017
402 Critical Care Health Nurse Positions Available;

279 Critical Care Health Nurses Employed;

2019
187 Critical Care Health Nurse Positions Available;

140 Critical Care Health Nurses Employed

200% Reduction In Staff

** Winnipeg Regional Health Authority*

7.0 CONCLUSIONS

The authors of this document have grave concerns regarding the overall response to the Covid 19 pandemic; the steps taken and not taken to address that pandemic.

We acknowledge that at the onset of almost any emergency, it can be expected that some confusion and uncertainty will result in less than optimum responses being implemented. What has been documented in this report goes drastically beyond those reasonable shortcomings, and rises to a criminal level.

Those individuals and agencies who took on the responsibility to develop and implement Canada's response to the Covid 19 Pandemic had a fiduciary duty to ensure that the measures taken and the mandates enforced on the entire population were necessary, mitigative, based on the best science available and that the overall collateral damage to society was carefully considered.

The people who were responsible for preparing Canada's pandemic response (The Canadian Pandemic Influenza Plan for the Health Sector 2006), had been planning for just such an event since 2006. A detailed plan had been developed with broad participation of health care professionals and legislators across the country. In fact, it was developed in concert with similar plans around the World.

Despite this planning, despite the availability of scientifically based information which should have been used as a basis for the actual pandemic response, many aspects of the original plan were ignored.

As scientific facts and statistics became available the pandemic response doubled down on mandates and recommendations that were proven ineffective and damaging.

It was quickly known, that the risk of dying from Covid 19 varied significantly between different age groups of people, and that co-morbidities played a huge role in those medical outcomes. Despite this fact, the mandates were enforced against all areas of the population, including those people who had no statistically significant risk from Covid 19.

Despite the fact that the The Canadian Pandemic Influenza Plan for the Health Sector 2006, included for stockpiling and using certain therapeutic treatments at the outset of an infection, these therapeutics were never utilized.

Despite the fact that the The Canadian Pandemic Influenza Plan for the Health Sector 2006 stated that cloth masks are ineffective, mandates for masks were implemented anyway.

Despite the fact, that the The Canadian Pandemic Influenza Plan for the Health Sector 2006 stated that overall lockdowns were ineffective, mandates for lockdowns were implemented.

Despite the fact that there was significant experience with proven to be safe and widely available therapeutics for the early treatment of Covid 19, the government actively prevented their use.

Despite a statistically zero risk of death to people under the age of 19, the government is still mandating a new vaccine for this population group, despite the fact that no controlled peer reviewed testing has been carried out for this group.

Despite a near statistically zero risk of death to pregnant and nursing women, the government is still mandating a new vaccine for this population group, despite the fact that no controlled peer reviewed testing has been carried out, on this specific group. Long term effects on both fertility and fetal development are unknown.

Despite having studies highlighting the need for increasing ICU Bed capacity in Manitoba, the government undertook a reduction in ICU bed capacity of over 200% between 2007 and the fall of 2019, with the closure of the Seven Oaks General Hospital ICU beds. The consequences of this kind of reduction was easily foreseen, given that the ICU bed capacity in Manitoba was one of the lowest in Canada, and on par with China. The pandemic started within months of the Seven Oaks General Hospital closures.

These unnecessary and unprecedented actions directly resulted in a level of social, human, physical, legal and financial damage that the people and the country of Canada will struggle with for decades to come.

The country has almost torn itself apart with unprecedented protests, and the eventual implementation of the Emergency Measures Act.

Although outside of the scope of this report, the Constitutionality of many of the mandates is being challenged.

In our opinion, never has so much damage been done to so many by so few.

The people responsible knew or ought to have known what the consequences of their actions were, and they knew or ought to have known that those actions were not necessary given the statistical information available at the time.

A complete, unbiased criminal investigation must be immediately undertaken to determine who is responsible for the crimes that are alleged to have been committed, to carefully identify all of the crimes that have been committed, and bring the alleged perpetrators to justice.

We further recommend that steps be immediately taken to safeguard any information, internal correspondence etc., that is necessary for the investigation.

Actions that are contrary to the Government's own Pandemic Emergency Plans are ongoing and an immediate injunction against these actions must be put into place to stop further harm to the public.

It is imperative that the safety and well being of Canadians be preserved and, therefore, it is necessary that this criminal investigation proceed immediately.

List of Appendices

Appendix One:

Canadian Pandemic Influenza Plan for the Health Sector 2006

Appendix Two:

Pfizer 5.3.6 Cumulative Analysis of Post-authorization Adverse Event Report

Appendix Three:

Government of Manitoba Public Health Factsheet Information for Pregnant & Breast Feeding individuals

Appendix Four:

Government of Manitoba Public Health Factsheet Covid-19 mRNA Vaccines for Individuals Aged 12 Years and Older

Appendix Five:

Government of Manitoba Public Health Covid-19 Vaccine for Children 5 to 11 Years Old

Appendix Six:

Government of Manitoba Important Notice for Manitobans Aged 30+

Appendix Seven:

Pfizer Canada - Comirnaty Product Monograph Date of Revision November 19, 2021

Appendix Eight:

United States Senate - Office of Senator Ron Johnson February 1, 2022

Appendix Nine:

John Hopkins Institute for Applied Economics - A Literature Review and Meta-Analysis of the Effects of Lockdowns on Covid-19 Mortality January 2022

Appendix Ten:

May 18, 2021 Covid-19 Report - A Citizen's Perspective

Appendix Eleven:

H1N1 Flu In Manitoba, Manitoba's Response, Lessons Learned
2010

Appendix Twelve:

The Epidemiology and Outcomes of Critical Illness in Manitoba, April 2021

Appendix Thirteen:

Intracellular Reverse Transcription of Pfizer BioNTech Covid 19 mRNA Vaccine in Vitro In Human Liver Cells February 25, 2022