



Justice Centre for Constitutional Freedoms

Flying Blind

**Governments' hasty decisions to lock down Canadians
while damaging public health and the economy**

December 3, 2020

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Executive Summary

This paper argues that:

- 1) Canadian governments at all three levels did not properly and adequately consider the specific nature and the full extent of lockdown harms that would result from the *Charter* infringements that governments initiated. Governments assumed, based on speculation and predictions, not on evidence, that the *Charter* violations would prevent large numbers of deaths; they assumed that the number of people who would otherwise have died was huge; they did not think much (or at all) about lockdown harms, nor whether these harms would be greater than the benefits.
- 2) The following harms of lockdowns could and should have been anticipated but were self-evidently ignored:
 - a. Deaths from delayed medical treatment;
 - b. Deaths from delayed diagnosis;
 - c. Deaths from suicide;
 - d. Deaths from drug overdose.
- 3) The risks posed by COVID-19 have been overestimated and mischaracterized; speculation and exaggerated estimates have been used to justify the lockdown policy that unjustifiably infringed the *Charter* rights and freedoms of all Canadians.
- 4) The data that is available indicates that:
 - a. The popular assumption that COVID-19 has increased the number of people dying in Canada is incorrect. Between 1 January 2020 and 31 August 2020, fewer Canadians died overall, of all causes, than during the same period of time in each of 2018 and 2019. As more deaths with

COVID-19 are recorded, fewer deaths are ascribed to other causes, notably cancer, heart disease, cerebrovascular diseases, pneumonia and influenza. This suggests that COVID-19 is being reported as the primary cause of death instead of these other conditions which account for the majority of deaths in Canada.

- b. The COVID-19 virus is dangerous to older people with pre-existing medical conditions, and harmless for roughly 90% of the population. People over the age of 70 represented 89.4 per cent of the 10,208 people recorded as dying with COVID-19 from March 9 to November 2, 2020. Almost all had one or more co-morbid conditions, and the vast majority had three or more serious pre-existing health conditions. Of those 10,208 deaths, only 30 (less than one third of 1%) were under 40 years of age.

- 5) As of November 30, 2020, governments still lack sufficient reliable information to justify ongoing violations of the *Charter* rights and freedoms of Canadians.

The medical and scientific information upon which Canadian governments at all levels have relied to justify lockdown measures that have shut down much of the Canadian economy and society since March of 2020, and have violated the *Charter* rights and freedoms of all Canadians, was deficient in both quality and quantity. In respect of the unintended harms that accompany “public health” lockdowns, it remains so.

Canada’s federal, provincial and municipal governments were therefore underequipped to make the decisions that faced them as COVID-19 was declared by the World Health Organization to be a pandemic.

As a result:

- Decisions made in the belief that they were informed by science were often quickly revealed as ill-conceived, yet were continued – some to this day;
- Important data that should have informed important decisions was incomplete or out-of-date;

- Vital questions, in particular the intensity of the potential harms of government actions, were not even asked;
- Alternatives to locking down the economy and society in response to COVID-19 do not appear to have been considered in the past eight months, or at the present time;
- In view of the inadequate information available to them, the governments of Canada were unnecessarily hasty in their decisions. Had they taken longer to obtain and review such information, they might well have adopted a course of action less damaging to Canadians and to their economy and society.

As they locked down Canadians, Canada's federal, provincial and municipal governments were effectively flying blind.

Apart from the massive and damaging social and economic impact that lockdowns have had and continue to have on the lives of Canadians, these violations of the *Charter* rights and freedoms of Canadians to move, travel, associate, assemble and worship were not, and are not, demonstrably justifiable in a free and democratic society.

Introduction

The problems and challenges of COVID-19 cannot be reduced to their medical aspects only. Bound up with the goals of reducing transmission and preserving healthcare system capacity are the equally important questions of *Charter* rights violations, economic sustainability, and the well-being of Canadians generally.

A parallel question concerns the ability of Canada's federal, provincial and municipal governments to maintain a strong economy and a tax-base sufficient to sustain provincial healthcare systems, given the recent and severe economic contraction.

These questions merit answers, and all governments – federal, provincial and municipal – must now consider the negative impacts of lockdown measures on the lives, health, economy and well-being of all Canadians.

Charter violations are real

There is little doubt that government restrictions on citizens' freedoms to move, travel, associate, assemble and worship are violations of the rights and freedoms protected by the *Charter*. In our research, we have not uncovered examples or instances of elected and non-elected government officials denying that lockdowns violate *Charter* rights and freedoms.

As Canada's provincial governments, informed and guided by Canada's Chief Public Health Officer Dr. Theresa Tam, introduce these lockdown measures of enforced social distancing, isolation, and mandatory closure of entire sections of the Canadian economy deemed to be 'non-essential,' they have violated our *Charter* freedoms of association,¹ peaceful assembly,² mobility and travel,³ liberty,⁴ security of the person,⁵ conscience and religion.⁶ Also, while the heaviest impacts were felt earlier in the year,

¹ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act (UK), 1982*, c 11 [*Charter*], s 2(d).

² *Charter*, s 2(c).

³ *Charter*, s 6.

⁴ *Charter*, s 7.

⁵ *Charter*, s 7.

⁶ *Charter*, s 2(a).

these measures – even in November 2020 – continue to have a severe and negative impact on Canadians’ access to healthcare, which violates the *Charter* section 7 rights to life and security of the person.⁷

Finally, these measures have had, and will continue to have, a severe impact on Canada’s economy, with a predictable negative impact on the ability to pay for healthcare. Hundreds of billions of dollars, borrowed by federal and provincial governments, will have to be repaid, with interest. This jeopardizes future funding for health care and other government programs.

In the following pages, we describe the response by federal and provincial governments to COVID-19 in the form of the lockdown measures that have impacted all facets of society. We describe the impacts of these measures on various economic indicators and on healthcare accessibility. We consider all these factors as they pertain to the *Canadian Charter of Rights and Freedoms*.

This paper was first conceived to assess the adequacy of the information upon which Canada’s governments made the decision in March 2020, to lock down much of the country, and whether alternative strategies were considered.

On November 20, 2020, the Public Health Agency of Canada published new modelling⁸ that projected a worst-case scenario in which 60,000 more Canadians are infected by the end of December, but a decline in infection if Canadians limit social contacts by 25 per cent. This modelling is now used for sombre messaging by the prime minister and premiers, and new provincial lockdowns.⁹ For example, Ontario Premier Doug Ford has ordered (20th November) lockdown measures in Toronto and Peel, banning indoor private gatherings and capping outdoor gatherings at 10 people. Restaurants are closed to indoor dining, and religious gatherings are capped at 10 people.

⁷ *Chaoulli v Quebec*, 2005 SCC 35.

⁸ <https://www.canada.ca/content/dam/phac-aspc/documents/services/diseases-maladies/coronavirus-disease-covid-19/epidemiological-economic-research-data/update-covid-19-canada-epidemiology-modelling-20201120-eng.pdf>

⁹ National Post, 21st November 2020.

Gyms are closed and non-essential retail stores ordered to move to curbside delivery. Cancelling Christmas gatherings is clearly on the table.¹⁰

Quebec has banned households from receiving visitors ‘from a different address.’ British Columbia has limited social gatherings to household members province-wide and called for an end to non-essential travel within the province and from outside it.

Saskatchewan, British Columbia and Manitoba are under new and severe lockdown measures, while Atlantic provinces cling to their “bubble.”

But government data and statistics show that COVID-19 deaths peaked in April and May, then declined sharply, with no increase back to those April-May levels.¹¹ Those dying of COVID-19, with few exceptions, are high-risk adults, aged 70 years or over. According to the latest¹² epidemiological summary published by Statistics Canada, as of 20th November 2020, the pattern remains what it has been from the start: older people, especially those with underlying health conditions, are still the most vulnerable to the COVID-19 virus and by far contribute to the greatest number of deaths. That is, 71 per cent of Canada’s 11,344 deaths are over the age of 80. A further 18.4 per cent are between 70 and 79, and a further 7.3 per cent are between 60 and 69 years of age. Only 3.3 per cent of deaths are amongst those under 60.

The fact that more cases are being reported in younger age groups, while highlighted in modelling, is irrelevant. To present the results of Statistics Canada’s epidemiological report in a different way, only 3.3 per cent of Canada’s deaths attributed to COVID-19 have been of people under the age of 60, which is 374 people in a population of 37.5 million.

There is a similar pattern with hospitalizations. While 63.4% (198,356) of cases are reported in ages 0-49, only 16.5% of hospitalizations occur in ages 0-49, and only

¹⁰ <https://www.blogto.com/city/2020/11/doug-ford-christmas-lockdown-numbers-rising/>.

¹¹ Between 1 April 2020 and 31 May 2020, 7,395 Canadians died with COVID-19. See Table 4. Although more infections were reported, between 1 October and 21 November 2020, 2,299 Canadians died with COVID-19. <https://www.worldometers.info/coronavirus/country/canada/>.

¹² <https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html>.

17.8% of ICU-admissions occur in ages 0-49. On the other hand, 70.6% of hospitalizations and 63.4% of ICU-admission have occurred in ages 60+.¹³ This suggests that rising case numbers among younger populations do not significantly impact healthcare capacity. Rather, only rising case numbers in older populations significantly impact healthcare capacity. Citing rising case numbers in younger populations, therefore, cannot serve as justification for lockdowns. Rather, where lockdowns are necessary, the data supports protecting the vulnerable, rather than violating the *Charter* rights and freedoms of the entire Canadian population.

To repeat, more younger people are among the sensationalized number of “cases,” but it remains the older Canadians who are dying with COVID-19, as has always been the case in the past eight months. Indeed, as PHAC notes with alarm, there are more and larger outbreaks (>50 individuals) affecting long-term care homes and healthcare settings. Outbreaks in long-term care homes put elderly residents at risk of life-threatening illness and Indigenous communities are now seeing rapidly rising case numbers.”

This should seem familiar. Governments are responding to the latest increase in ‘cases’ with the same methods they tried in the spring.

Since March, in an attempt to contain the spread of COVID-19, governments have denied millions of Canadians the ability to earn a living, by closing their places of employment and sending them home to live on handouts. Meanwhile, elderly and vulnerable people died anyway, and often in the most miserable circumstances in care homes, unjustifiably denied the company of their loved ones. The obvious option of improving protection for the elderly and keeping younger generations at work, and to take time off only when actually infected, was never pursued.¹⁴

¹³ <https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html#a5>.

¹⁴ For far less than the \$80 billion+ that the federal government spent on CERB, Canada’s seniors could have been accommodated in four-star hotels with full-time personal attendants.

In the process, the *Charter* rights of Canadians were not so much infringed as trampled and ploughed under, with massive and predictable harms ensuing

Today, in November 2020, Canada's federal, provincial and municipal governments are gearing up to do the same thing again. When all one has is a hammer, every problem looks like a nail, as though politicians have learned nothing.

We are well aware that the stated reason for the lockdown is to preserve the Canadian health system's critical-care capacity. If that was the entire rationale, it does not appear to have been validated by events. However, if it were so, it is doubly unfortunate that Prime Minister Trudeau's comments to the UN at the end of September have muddied the waters. When Mr. Trudeau said that the 'pandemic has provided an opportunity for a reset...to reimagine economic systems that actually address global challenges like extreme poverty, inequality and climate change,¹⁵ he removed Canada's response to COVID-19 from the undiluted realm of medicine and science.

We do not propose to enter into a debate about the Great Reset here, but we understand why reasonable people are concerned that there may be larger objectives afoot. For now, we are concerned that by their heavy-handed lockdown policies, failure to consider alternatives and urgency to act in the absence of a full consideration of unintended consequences, Canada's governments have infringed the *Charter* rights and freedoms of Canadians without the justification necessary in a free and democratic society, as required by the *Charter*.

¹⁵ <https://www.youtube.com/watch?v=n2fp0Jeyjvw>;
<https://torontosun.com/opinion/columnists/lilley-trudeau-has-eyes-set-on-a-great-reset-for-canada>.

Lockdown measures across Canada

In this section, we present a timeline of the major federal and provincial responses to the announcement that COVID-19 should be treated as a pandemic.

Many of the lockdown measures that were implemented in March still remain in effect in November – in full or in part – without a deadline as to when, if ever, they will be lifted entirely. Indeed, with the advent of a so-called “second wave” of “cases,” even in the absence of a second wave of deaths, some *Charter*-violating measures are due to be fortified and elevated.

We describe the closure of schools and recreational facilities, restrictions on travel and freedom of association, the suppression of religious freedom, and restrictions on economic activity.

In subsequent sections, we address the negative impacts of these measures, and consider whether these impacts have been properly analyzed and accounted for by way of a thorough cost-benefit analysis as required by the *Charter*.

Official scepticism at first

December 2019

COVID-19 was first identified in the Hubei Province in China.¹⁶

January 23

Canada’s Chief Public Health Officer Dr. Theresa Tam, when asked to comment on reports that masks were selling out in Vancouver, told reporters that simply wearing a mask is not an effective preventative measure:

“It can sometimes make it worse, if the person puts their finger in their eye or touches their face under their mask. We would only recommend putting a mask on if you were sick and were entering a medical facility, such as a

¹⁶ <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200121-sitrep-1-2019-ncov.pdf>

hospital. We have no recommendation for people to wear a mask (when) going about their daily business.”¹⁷

January 29

Dr. Tam told the House of Commons Health Committee that the risk presented to Canada by COVID-19 is ‘low.’

Dr. Tam (who is also a special advisor to the World Health Organization) testified,

Right now, the cases are in China. Very few are exported. Yes, there’s human-to-human transmission, but those are generally for close contacts. With regard to the severity of illness, there are some severe cases, but the deaths have occurred in older people with underlying medical conditions. With all of that pulled together, for the general public who have not been to China, the risk is low in Canada.¹⁸

They (the WHO) know they have to get to the bottom of this, but we do know that even people with mild symptoms don’t transmit very readily. Could they? It’s possible, but that’s not what drives an actual epidemic... I think we have to be reasonable in our public measures and just balance out the risks and benefits. In terms of the impacts, they are not simply health impacts, but psychological and other health impacts, as well as non-health impacts, those being societal and economic as well.¹⁹

And, she expressed her admiration for the Chinese response:

What we have seen, given my close communication with WHO, is how impressed they are by the work of China. The astoundingly rapid way in which they tried to get a handle on what is causing the outbreak, and giving the world the sequence of the virus, was very helpful. They’ve been providing information about cases, which is extremely helpful. You’ve seen the incredibly extraordinary measures that China has put in place to try to contain this within its borders. Even if this virus is capable of transmission from human to human, as I said, 99 per cent of the cases are

¹⁷ <https://edmontonjournal.com/news/national/the-road-to-canadas-covid-19-outbreak-pt-3-timeline-of-federal-government-failure-at-border-to-slow-the-virus>.

¹⁸ <https://openparliament.ca/committees/health/43-1/1/dr-theresa-tam-9/?singlepage=1>;
<https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen>.

¹⁹ *Ibid.*

in China. Not that many—like one per cent—are outside, so they are really trying very hard, and I think we have to be very supportive of the efforts.²⁰

What Dr. Tam enthusiastically called “*incredibly extraordinary measures*,” included the ‘disappearance’ of doctors who initially tried to warn the public, the severe lockdown of cities for as long as 76 days,²¹ the use of drones, and an elaborate system of contact tracing using a privacy-violating surveillance and facial recognition network that enables what some might call the nation’s ‘Social Credit System.’

In the Canadian context these techniques would be gross infringements of Canadians’ *Charter* rights and freedoms. It is beyond disappointing that a senior official would find them attractive.

It is also disappointing that official thinking in Ottawa was so hopelessly ill-informed at this time. Six weeks before Canada went into lockdown, and the shortage of personal protective equipment within Canada may have become a matter of national urgency, public health officials had such little expectation that the virus would affect Canada, that the Government of Canada sent 16 tonnes of this equipment to China. It did so in the belief that it was ‘essential to prevent and limit the spread of the virus.’ While Canada sent masks to China, Dr. Tam was critical of the effectiveness of masks.

January 31

The World Health Organization declared the COVID-19 outbreak a Public Health Emergency of International Concern.²²

²⁰ *Ibid.*

²¹ [https://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(20\)30800-8/fulltext](https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30800-8/fulltext).

²² <https://www.canada.ca/en/global-affairs/news/2020/02/canada-supports-chinas-ongoing-response-to-novel-coronavirus-outbreak.html>.

February 4

Canada airlifts 16 tonnes of personal protective equipment to China.²³

International Development Minister Karina Gould commented:

Canada is saddened by the impact of the novel coronavirus outbreak, especially the loss of life, on the Chinese population. Personal protective equipment is essential to prevent and limit the spread of the virus.

February 21

“The risk of spread of the novel coronavirus within Canada remains low.” Dr. Tam.²⁴

February 25

“We are advising people not to just generally walk about wearing masks. That’s not going to be effective.” Dr. Tam.²⁵

March 5

Prime Minister Trudeau strongly defended Canada’s open border policy:

We recognize there are countries that make different decisions. The decisions we make are based on the best recommendations of the World Health Organization (WHO) and the tremendous health experts who work within Canada and around the world.... There is a lot of misinformation out there, there is a lot of knee-jerk reaction that isn’t keeping people safe.²⁶

March 9

Canada registered its first COVID-19 death, a B.C. man in his late eighties.²⁷

²³ <https://www.canada.ca/en/global-affairs/news/2020/02/canada-supports-chinas-ongoing-response-to-novel-coronavirus-outbreak.html>.

²⁴ <https://www.canada.ca/en/public-health/news/2020/02/statement-from-the-chief-public-health-officer-on-the-release-of-repatriated-canadians-from-quarantine-following-14-day-stay-at-cfb-trenton.html>.

²⁵ <https://www.youtube.com/watch?v=cytl7bb9hX0>.

²⁶ <https://www.cbc.ca/news/politics/covid19-trudeau-coronavirus-travel-1.5486799>.

²⁷ <https://www.cbc.ca/news/canada/british-columbia/covid19-coronavirus-first-death-bc-canada-1.5483932>.

March 11

The World Health Organization declared COVID-19 to be a pandemic.^{28 29}
Dr. Tam told the Parliamentary Health Committee:

The WHO did call this a pandemic today, but the key message is that all countries can still change the course of this pandemic by doing a number of things. I will go through them very quickly, but I believe we're already doing them.³⁰

The things the Canadian governments were 'already doing' did not yet include its own 'incredibly extraordinary measures' – states of emergency that would lead to enormous harms, both directly and indirectly.

A complete policy reversal

With the WHO's declaration of a pandemic, and persuaded apparently by the doomsday predictions of Dr. Neil Ferguson, Imperial College London's celebrity epidemiologist, Canada's federal and provincial governments abruptly changed course.

In a landmark paper published mid-March, Ferguson had written,

The global impact of COVID-19 has been profound, and the public health threat it represents is the most serious seen in a respiratory virus since the 1918 H1N1 influenza pandemic.³¹

Ferguson's paper warned that millions would be killed around the globe, and called for extreme measures – "epidemic suppression is the only viable strategy at the current

²⁸ "We have therefore made the assessment that #COVID19 can be characterized as a pandemic"-@DrTedros #coronavirus.

²⁹ <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/events-as-they-happen>.

³⁰ <https://openparliament.ca/committees/health/43-1/8/dr-theresa-tam-1/>.

³¹ <https://www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf>.

time.”³² As the authoritative Montreal Economic Institute (MEI) later described it,³³ “The only option, according to Ferguson, would be radical physical distancing of the entire population, potentially for 18 months, until a vaccine was available.”

MEI added that by June, experts had uncovered serious flaws in the original Imperial College paper. Furthermore, evidence had emerged that Professor Ferguson himself had an abysmal record of making terrifying but wildly inaccurate predictions about earlier epidemics, among them BSE (Mad Cow Disease) and bird flu, and a long history of overpredicting deaths by a wide margin—a concern confirmed by data from countries that never locked down in the present crisis.

In other words, Canada and other countries have vastly overreacted to a single bad projection,³⁴ and this was known to governments by June.

The lockdown

The lockdown started with clearing out hospitals across Canada to make room for an expected surge of COVID-19 patients.

³² Suppression: “...a combination of social distancing of the entire population, home isolation of cases and household quarantine of their family members. This may need to be supplemented by school and university closures, though it should be recognised that such closures may have negative impacts on health systems due to increased absenteeism. The major challenge of suppression is that this type of intensive intervention package – or something equivalently effective at reducing transmission – will need to be maintained until a vaccine becomes available (potentially 18 months or more) – given that we predict that transmission will quickly rebound if interventions are relaxed.”

<https://www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf>

³³ https://www.iedm.org/wp-content/uploads/2020/06/note032020_en.pdf.

³⁴ <https://www.iedm.org/the-flawed-covid-19-model-that-locked-down-canada/>.

March 14

In Quebec, hospitals began cancelling ‘non-essential’ surgeries³⁵ and diagnostic testing. Ontario followed on March 15,³⁶ British Columbia on March 16,³⁷ and Alberta on March 17.³⁸

By cancelling surgeries to accommodate the expected surge of COVID-19 patients, Ontario (as one example) had by April made 11,000 empty beds available.³⁹ But almost all of them stayed empty: Newspapers described emergency departments where the lights were ‘literally switched off.’⁴⁰

March 15

Dr. Tam altered her message. She called COVID-19, “a serious public health threat. . . . Today, I am asking everyone to take strong action to help us delay the spread of COVID-19.”⁴¹

States of emergency begin

March 15

Also on March 15, the Government of Ontario led the way in declaring a provincial state of emergency. Other provinces followed over the next few days, declaring either a provincial state of emergency or both. In Alberta’s case, it was a Public Health Emergency only, on March 17. Specific powers vary from province to province but typically among other powers, the state of emergency allowed provincial governments to close borders, direct movement, requisition property and designate some

³⁵ <https://www.mccarthy.ca/en/insights/articles/covid-19-can-they-do-part-vii-quebecs-public-health-act-and-civil-protection-act>.

³⁶ <https://www.theglobeandmail.com/canada/british-columbia/article-hospitals-postpone-surgeries-treatments-to-make-space-for-potential/>.

³⁷ *Ibid.*

³⁸ <https://www.alberta.ca/release.cfm?xID=69830284041BB-FA70-03ED-82D4516CFE1CEA01>.

³⁹ <https://www.fao-on.org/en/Blog/Publications/health-2020> (Financial Accountability Office of the Government of Ontario).

⁴⁰ <https://www.ctvnews.ca/health/coronavirus/all-of-our-rooms-are-empty-hospital-ers-vacant-during-pandemic-1.4918208>.

⁴¹ CBC News <https://www.youtube.com/watch?v=VG83vVr3Oqc>.

businesses as non-essential and order them closed. Hotels, bars, restaurants, entertainment and the aviation industry were hit especially hard. Schools also were closed. Working from home became common.

All states of emergency have sunset clauses and require renewal in 14, 30 or 90 days.⁴²

March 16

Prime Minister Trudeau denied entry to foreign visitors, reversing the policy he had defended 10 days before: “We will be denying entry to Canada to people who are not Canadian citizens or permanent residents. This measure will carve out some designated exceptions including... U.S. citizens.”⁴³

March 18

Travel restrictions were imposed on Canadians, also quarantines and self-isolation established.⁴⁴

March 22

Nova Scotia became the first of the four Atlantic provinces to restrict its borders. New Brunswick, Prince Edward Island and Newfoundland and Labrador quickly followed suit, forming the ‘Atlantic Bubble.’ People trying to enter the provinces were stopped, questioned and those admitted required to self-isolate for 14 days.

April 6

Prime Minister Trudeau announces Canada Emergency Response Benefit.⁴⁵

⁴² <https://nationalpost.com/news/provincial-states-of-emergencies-were-issued-a-month-ago-most-are-coming-up-for-renewal>.

⁴³ <https://www.youtube.com/watch?v=KBPbAiNVaXs&list=PLdgoQ6C3ckQsEGVFpZLopNrugclGjfs9e&in`dex=355>.

⁴⁴ <https://www.ctvnews.ca/health/coronavirus/canada-shutting-the-border-to-most-non-citizens-due-to-covid-19-pm-trudeau-1.4854503>; <https://www.canada.ca/en/immigration-refugees-citizenship/services/coronavirus-covid19/travel-restrictions-exemptions.html#quarantine>; <https://www.canada.ca/en/public-health/news/2020/03/new-order-makes-self-isolation-mandatory-for-individuals-entering-canada.html>.

⁴⁵ <https://www.cbc.ca/news/politics/cerb-covid19-benefits-trudeau-1.5523052>.

The effects of lockdown are felt

And so in less than a week Canada went from a casual response to COVID-19 that affected a small and identifiable fraction of the population – the elderly infirm – to something that quickly led to a disruption of the economy that exceeded the Great Depression of the 1930s in scope, and an enormous loss in national wealth.

A detailed consideration of the full economic impact of lockdown measures is beyond the scope of this paper. Briefly, in the belief that large numbers of lives were at stake, whole sectors of the economy were declared non-essential and ordered to cease operations. The airline, travel, tourism, conference and hospitality industries are amongst a large group of businesses which, collectively, were forced by government to thrust millions of Canadians into unemployment. Canadians were variously encouraged or ordered to work from home if they could, and whether they were working or not, to stay at home anyway.

In human terms, it turned out to be a colossal price to pay. As Statistics Canada reported, “The employment losses resulting from the COVID-19 economic shutdown were unprecedented in their speed and depth. In just two months, employment fell to 15.7 per cent below pre-COVID February levels. By comparison, the 1981/1982 recession resulted in a total employment decline of 5.4 per cent (-612,000) over approximately 17 months.”

Unemployment peaked in May at 13.7 per cent, though to report this as a percentage is to gloss over the enormous cost in human suffering. For what this actually meant was that ‘from February to April, 5.5 million Canadian workers were affected by the COVID-19 economic shutdown. This included a drop in employment of 3.0 million and a COVID-related increase in absences from work of 2.5 million.’⁴⁶

By the week of June 14-20, the number of workers affected by the COVID-19 economic shutdown was 3.1 million, a reduction of 43 per cent since April.

⁴⁶<https://www150.statcan.gc.ca/n1/daily-quotidien/200710/dq200710a-eng.htm>.

Thousands of businesses closed,⁴⁷ some permanently, and many more are likely to close permanently in future, bringing a permanent end to employment for many Canadians. Statistics Canada reports that there were approximately 100,000 fewer active businesses in Canada during May and June, than the same months in 2019.

Active Businesses	2019	2020
Jan		802,082
Feb		797,840
Mar	798,066	767,976
Apr	796,857	713,433
May	799,591	696,080
June	799,785	699,935
July	799,446	712,150
Aug	801,469	
Sept	800,569	
Oct	801,027	
Nov	800,256	
Dec	803,175	

<https://www150.statcan.gc.ca/t1/tbl1/en/tv.action?pid=3310027001&pickMembers%5B0%5D=1.1&pickMembers%5B1%5D=2.1&cubeTimeFrame.startMonth=03&cubeTimeFrame.startYear=2019&cubeTimeFrame.endMonth=07&cubeTimeFrame.endYear=2020&referencePeriods=20190301%2C20200701>

Table I: Loss of businesses in Canada, March 2019 to July 2020.

In July, Bloomberg News reported that between 55,000 and 218,000 Canadian businesses could close permanently.⁴⁸ Certainly, many familiar retailers closed some or all of their stores. For example, Starbucks announced the forthcoming closure of 200 of its storefront outlets.⁴⁹ Bars and restaurants find it especially difficult to negotiate the stop-start-stop of lockdown policy. Restaurants Canada stated in April that ten per cent of Canada’s restaurants are already permanently closed; more would follow if a further

⁴⁷ <https://www.retail-insider.com/retail-insider/2020/7/wave-of-store-closures-to-hit-canada-in-the-summer-of-2020/>.

⁴⁸ <https://www.bnnbloomberg.ca/one-in-seven-canadian-small-businesses-is-now-at-risk-of-closing-1.1472437>.

⁴⁹ <https://www.retail-insider.com/retail-insider/2020/7/wave-of-store-closures-to-hit-canada-in-the-summer-of-2020/>.

lockdown is ordered.⁵⁰ The economic impact can be summarized by a single statistic: During the second quarter of 2020, Canada’s Gross Domestic Product fell at an annualized rate of 38.7 percent.⁵¹ It appears that governments have destroyed more than one third of the Canadian economy, without any indication as to when – or how – this destruction will be reversed, if ever.

If due diligence was attempted at all, insufficient time was allowed to examine available or what alternatives might be considered.

Analysis of lockdown measures

While lockdown measures are presumably well-intentioned, there is no question that they violated and continue to violate *Charter*-protected freedoms to move, travel, associate, assemble and worship. This was, in fact, the whole point of them. These measures obviously inflicted many different kinds of harms on Canadians, even if the full extent of these harms remains unknown at this time. We conclude this section by arguing that the government enforced these measures without adequately or coherently defining their purpose or necessity.

(1) Politicians and health officials continued to call for “flattening the curve,” even well after COVID-19 hospitalizations in the provinces had peaked

Government and health officials repeatedly referred to the goal of “flattening the curve” for the purpose of preserving capacity in hospitals for COVID-19 patients.

To “flatten the curve” is to distribute the same number of cases across a greater unit of time, in order that there might be fewer cases—and therefore, hospitalizations—at the peak of infections. This is a distinct and very different goal from trying to stop the spread of the virus entirely, as this latter goal would require lockdown measures to be far

⁵⁰ <https://www.restaurantscanada.org/industry-news/many-restaurants-wont-recover-from-covid-19-without-rent-relief/>.

⁵¹ <https://www150.statcan.gc.ca/n1/daily-quotidien/200828/dq200828a-eng.htm>.

more severe, and to remain in force for months on end, if not permanently. To date, we are unaware of public health officials having presented Canadians with an historical example of a country or society that succeeded in stopping the spread of a virus; we have only examples of temporary and targeted measures to quarantine the sick.

Do the facts support a continued lockdown? As of November 16, Canada has detected slightly more than 300,000 COVID-19 “cases,” of whom 11,027 had died. But, 238,877 have recovered and of 50,422 remaining cases considered “active,” 1,838 were in hospital and of those, only 385 were in intensive care – somewhat less than ten per cent of Canada’s ICU inventory.

Canada ⁵²	Total Beds	ICU Beds	Active Cases	Hospitalization	ICU
AB	10,833	400	13,349	348	66 ⁵³
BC	12,223	478	7,732	284	61 ⁵⁴
MB	4,209	165	8,677	292	47 ⁵⁵
NB	2,818	144	93	0	0 ⁵⁶
NL	2,373	96	25	0	0 ⁵⁷
NS	3,115	128	87	0	0 ⁵⁸
NT	54	4	0	0	0 ⁵⁹
ON	32,283	1,751	16,333	523	159 ⁶⁰
PE	489	24	1	-	_61
QC	19,677	1,216	10,964	655	93 ⁶²
SK	3,184	107	2,927	105	20 ⁶³
YT	67	0	15	-	_64
Grand Total	91,325	4,513	60,203	2,207	446

⁵² Bed capacity for Nunavut unavailable.

⁵³ Cases in Alberta, accessed November 25, 2020, <https://www.alberta.ca/coronavirus-info-for-albertans.aspx>.

⁵⁴ British Columbia COVID-19 Dashboard, accessed November 25, 2020, <http://www.bccdc.ca/health-info/diseases-conditions/covid-19/data>.

⁵⁵ Cases and Risk of COVID-19 in Manitoba, accessed November 25, 2020, <https://www.gov.mb.ca/covid19/updates/cases.html>.

⁵⁶ New Brunswick COVID-19 Dashboard, accessed November 25, 2020, <https://experience.arcgis.com/experience/8eeb9a2052d641c996dba5de8f25a8aa>.

⁵⁷ Pandemic Update – Current Status, accessed November 25, 2020, <https://covid-19-newfoundland-and-labrador-gnl.hub.arcgis.com/>.

⁵⁸ Coronavirus (COVID-19): Case Data, accessed November 25, 2020, <https://novascotia.ca/coronavirus/data/>.

⁵⁹ Northwest Territories COVID-19, accessed November 25, 2020, <https://nwt-covid.shinyapps.io/Testing-and-Cases/?lang=1>.

⁶⁰ Daily Summary of Cases in Ontario, accessed November 25, 2020, <https://www.ontario.ca/page/how-ontario-is-responding-covid-19#return>.

⁶¹ PEI COVID-19 Case Data, accessed November 25, 2020, <https://www.princeedwardisland.ca/en/information/health-and-wellness/pei-covid-19-case-data>.

⁶² Données COVID-19 au Québec, accessed November 25, 2020, <https://www.inspq.qc.ca/covid-19/donnees>.

⁶³ Saskatchewan's Dashboard, accessed November 25, 2020, <https://dashboard.saskatchewan.ca/health-wellness>.

⁶⁴ Case Counts: COVID-19, accessed November 25, 2020, <https://yukon.ca/en/case-counts-covid-19>.

Table II: Hospital Bed Capacity in Canada, as per Canadian Institute for Health Information. Hospital Beds Staffed and In Operation, 2018–2019. Ottawa, ON: CIHI; 2020.

It should also be recognized that what public health authorities routinely refer to as “cases” consist overwhelmingly of infected people who, not being in the vulnerable category by reason of advanced age or ill-health, experience no harm from the virus. Further, the accuracy of PCR testing has been publicly called into question by medical doctors and infectious disease experts, such that the number of “cases” may well be much lower than what is proclaimed on a daily basis by media headlines.

It became very clear, early on, that the healthcare system would not be overwhelmed by COVID-19 patients. Nor is the health care system in danger of being overwhelmed today. Nonetheless, politicians and health officials continued to call for “flattening the curve” and continued to impose *Charter*-violating lockdown measures into April and May, in order to ‘preserve healthcare capacity,’ and are now re-imposing such measures. Moreover, politicians appear to be relying on an assumption that, despite higher-than-ever levels of spending on government health care monopolies, it is somehow impossible for the health care system to increase the number of beds and ICU spaces; *Charter*-violating lockdown measures are necessary because governments are spending every health care dollar wisely and efficiently.

(2) Given the available data from both Canadian sources and other countries with comparable health-care systems, Canadian public health officers should have known that the provincial healthcare systems were not likely be overwhelmed by COVID-19. They should also have known to expect that the majority of severe outcomes would occur in long-term care facilities and not in general hospitals. And they should have so advised governments. Further, the over-crowding of Canadian hospitals at various times has been a long-standing problem for many years, and by no means a unique or special situation.

By the end of April, Canadian governments had sufficient data available to know that COVID-19 posed insignificant risks to the vast majority of their citizens, and that the

country's healthcare systems were highly unlikely to be overwhelmed. By the end of May it was even more clear that this was the case: Health-care systems had not been, and would not be, overwhelmed with COVID-19 patients. Six months later, in November, this still remains the case, as demonstrated by publicly available government data on hospitalization rates, hospital bed capacity, demographics, and non-existence of a "second wave" of COVID-19 deaths (as opposed to infections.)

(3) Canadian governments failed to account for the predictable negative consequences of its lockdown measures.

Canada's federal, provincial and municipal governments have thus far failed to account for the predictable negative consequences of these radical social and economic measures. Nothing in the published statements of the prime minister, provincial premiers and public health officers suggests that social, health, or economic risks were ever factored into lockdown decisions that have crippled Canada's economy and continue to harm society, including the mental, psychological, physical and spiritual well-being of Canadians. Nor has any government submitted any detailed, comprehensive risk assessment to the public, which suggests that no such analysis has been performed. Questions which the Justice Centre asked of federal and provincial officials in April 2020, about harmful effects of the lockdowns, have gone unanswered. It therefore appears that the government has simply assumed, without evidence or analysis, that lockdown measures would do more good than harm.

We argue that these measures have likely done more harm than good, given the devastating negative impacts of government decisions on the livelihoods and lives of so many Canadians who have been denied access to healthcare and employment, with resulting harm to the social, educational, recreational, psychological and spiritual dimensions of the lives of people.

In the following section, we analyze the *Charter* implications of these measures and argue that, where these measures have violated and continue to violate *Charter*-protected freedoms, governments are obliged to provide the evidence necessary to justify

them. These freedoms are *constitutionally guaranteed*, “subject only to such reasonable limits [...] as can be demonstrably justified in a free and democratic society.”⁶⁵

Lockdown measures violate our *Charter* Freedoms

The *Charter* protects the rights of all Canadians to the freedoms of association,⁶⁶ peaceful assembly,⁶⁷ mobility and travel,⁶⁸ liberty,⁶⁹ security of the person,⁷⁰ and conscience and religion.⁷¹

The various lockdown measures imposed by Canada’s federal, provincial and municipal governments continue to restrict the *Charter* freedoms of Canadians to move, travel, associate, assemble, and practice their faith, all while causing significant harm to their lives and livelihoods. We are not aware of any public official, elected or non-elected, having disputed the foregoing assertion.

The constitutional question is whether such violations of *Charter* freedoms by governments are reasonable and “demonstrably justified in a free and democratic society,” as required by section 1 of the *Charter*.⁷²

This requires serious analysis not only of the purported *benefits* of the lockdown to Canadian society, but also of its *harmful consequences*, including adverse effects on human health and overall wellbeing.

Under section 1 of the *Charter*, when governments violate *Charter* rights and freedoms, the onus is on government—not the citizen—to justify these measures. Such measures are not valid merely because governments impose them with good intentions to

⁶⁵ *Charter*, s 1.

⁶⁶ *Charter*, s2(d).

⁶⁷ *Charter*, s 2(c).

⁶⁸ *Charter*, s 6.

⁶⁹ *Charter*, s 7.

⁷⁰ *Charter*, s 7.

⁷¹ *Charter*, s 2(a).

⁷² *Charter*, s 1.

achieve desirable outcomes. Rather, the *Charter* requires governments to “demonstrably” justify such restrictions on the basis of evidence, and such evidence must prove that the restrictions do more good than harm. In this context, “harm” refers both to violations themselves and to the practical, negative impacts on Canadians’ daily lives.

Bearing in mind that assertions do not qualify as evidence, Canadian governments at all levels have thus far failed to present persuasive proof to the public showing specifically how and why the lockdowns have brought about more good than harm. Nor have governments been clear and consistent as to the specific goals of the lockdown, or the conditions under which it would be lifted. The government’s purported goal or objective has vacillated between “flattening the curve” and trying to stop the spread entirely while using the slogan “reduce the spread.” There is little if any clarity as to whether lockdown measures are intended to protect the approximately 10% of the population that is actually threatened by COVID-19, or intended to protect everyone including the 90% who face no risk of harm.

Government bears the onus of demonstrating that its laws and policies violate *Charter* freedoms as little as possible: only to the extent necessary to achieve a pressing and specific goal. The *Charter* does not allow governments to impose broad, sweeping and far-reaching measures that go further than what is truly needed to achieve a specific objective.

What would count as demonstrable justification for the lockdown measures under the *Charter*? Governments are required to demonstrate that:

- 1) COVID-19 presents a significant, generalized risk to all Canadians, such that broad lockdown measures are reasonably required because specific and targeted measures to protect the vulnerable are insufficient;
- 2) Lockdown measures would be effective in mitigating this general risk, such that the measures are rationally connected to the goal;
- 3) Lockdown measures limit *Charter* rights and freedoms as little as possible, only to the extent necessary to achieve a specific objective;
- 4) Lockdown measures bring about more good than harm.

These points above summarize the relevant test established by the Supreme Court of Canada in *R. v. Oakes*.⁷³

Alternatively, governments could establish as their objective the protection of the approximately 10% of citizens (elderly and infirm, and a very small number of under-60 adults) who are actually threatened by COVID-19. If this were indeed the objective, governments would still be obligated under the *Charter*, applying the test in *R. v. Oakes*, to demonstrate that all *Charter*-violating lockdown measures narrowly, directly and effectively served this specific objective. But focused protection of the vulnerable does not appear to be the goal of our federal, provincial and municipal governments.

As will be outlined in greater detail further below, the data on COVID-19 deaths provided by governments and their health authorities shows that COVID-19 is a significant threat only to those 70 and over, and a very small number of people under 70 who suffer from certain pre-existing health conditions. It should be noted that at-risk people under 70 are threatened by many things that are harmless for the majority, not just COVID-19.

Yet across Canada, schools have been closed on the assumption (and the claim of some politicians and public health officials) that students, faculty, and their families would be otherwise unsafe. Governments similarly ordered centres for religious and recreational activities to close, thereby limiting the rights of Canadians to worship, assemble and associate. As detailed above, provincial governments have shut down many sectors of the economy, thereby limiting the rights of Canadians to security of the person protected by section 7 of the *Charter*.⁷⁴ Canadians in all provinces and territories have been asked to accept unprecedented interference with their civil, religious and economic freedom in the absence of evidence-based modelling or statistics demonstrating why these policies were necessary. For example, Alberta Premier Jason Kenney and Chief Medical Officer Dr. Deena Hinshaw have claimed⁷⁵ that, even with lockdown

⁷³ *R. v. Oakes*, 1986 CanLII 46 (SCC), [1986] 1 SCR 103

⁷⁴ *Chaoulli v Quebec*, 2005 SCC 35.

⁷⁵ <https://www.alberta.ca/assets/documents/covid-19-case-modelling-projection.pdf>.

measures in place, as many as 32,000 Albertans would die of COVID-19: a number larger than total Alberta deaths from all causes, which is 27,000 per year. The Alberta government has thus far refused to provide the data, evidence and scientific (or other) basis for its dire prediction of 32,000 deaths. It appears that governments are still relying on the hysterical, and now completely discredited, projections made by Neil Ferguson in March of 2020.

Eight months after lockdowns were imposed, all of Canada's premiers and public health officers should be able to answer questions such as these:

- 1) How many suicides are projected to take place as a result of the government having shut down much of our economy, forcing people into unemployment, bankruptcy, or poverty?
- 2) How many do you project will die because of the rise in depression, anxiety, alcoholism, other addictions and drug overdoses that the lockdown and associated unemployment and social isolation will cause, as the lockdown drags on for weeks or even months?
- 3) How many children and spouses do you project will be abused while couples and parents remain confined to their homes, in many cases unemployed, without their usual income and social connections?
- 4) How many children will be put in foster care because of domestic abuse, or loss of their parents' ability to provide for them, or both?
- 5) How many isolated seniors are projected to become sick or die because they no longer receive regular visitors, such that nobody is able to take them to their own family doctor, or take them to an emergency unit at the hospital? How many will die at home, alone?
- 6) How many people are projected to die or to suffer permanent damage because their non-emergency (elective) surgery, their testing and their various treatments have been cancelled due to your singular focus on fighting COVID-19?
- 7) How many people are projected to suffer serious harm caused by lack of access to secondary health providers they regularly rely on, such as

physiotherapists, massage therapists, optometrists, chiropractors, osteopaths, podiatrists and dentists?

- 8) How many people are projected to die or suffer serious harm because they believe (correctly or incorrectly) that they cannot go see their doctor, or that they cannot check into emergency at the hospital?
- 9) How many children, confined to their homes while schools and playgrounds are closed and athletic and recreational activities are shut down, are projected to develop diabetes or other chronic health conditions?
- 10) How many people will develop psychiatric disorders caused by governments having eliminated social interaction at restaurants, pubs, churches, recreational facilities and community centres?
- 11) Have you or your staff researched any of these questions here above?
- 12) If yes to the foregoing question, have you created any models, estimates or projections in regard to any or all of these causes of illness, harm and death, in the same way that you have relied on models, estimates and projections in regard to COVID-19?

Canadian governments are required by the *Charter* to answer these and many other questions, pursuant to demonstrating that lockdown measures actually do more good than harm. The citizen bears no onus to prove or show that lockdowns do more harm than good.

Governments have an obligation to provide the numbers (or estimates or predictions, where actual numbers are not available) of bankruptcies, insolvencies, and foreclosures that have resulted, and will result in future, because of the lockdown measures. They have an obligation to determine how many additional instances of stress, anxiety, and depression will result from ruined financial prospects, and the full medical and health impacts of these increases in stress, anxiety and depression. They are obliged to investigate fully how the increasing prevalence of stress, anxiety, and depression will result in more alcoholism, drug abuse, drug overdoses, suicides, spousal abuse and child abuse.

Unfortunately, it appears that no Canadian government at any level has yet given appropriately serious consideration to these consequences, or to the effects of cancelling surgeries, delaying cancer diagnoses, and other denials of access to needed healthcare.

While the *Charter* does not explicitly protect the economic or financial interests of citizens, it does require government officials—elected and non-elected—to broadly analyze the harms which flow from any government action which violates *Charter* freedoms. Governments are required to consider harm to Canadians’ physical and mental health, and overall well-being, resulting from the destruction of livelihoods, as part of the *Charter*’s “demonstrably justified” analysis.

Further, it would be irrational to ignore the impact of a weaker and poorer economy on tax revenues, and the impact of reduced tax revenues on the ability to pay for necessary medical care, mental health support, and other important social structures.

The federal government in particular, which has spent more than \$320 billion in various COVID-19 responses, certainly has sufficient resources to monitor and track the positive and negative impacts of lockdown policies on Canadians, and thus to meet its *Charter* obligation to fully weigh the benefits and harms likely to be caused by its actions.

By every metric, the goal of preserving capacity for COVID-19 patients in Canadian hospitals was not only achieved, but over-achieved by way of empty beds, empty emergency wards, and empty operating rooms. It is long past time that Canadian governments prioritize the task of determining the full costs and harms of the lockdown, the negative effects of which have been borne by their own citizens.

Inaccurate Claims about the Lethality of COVID-19

Based on publicly available statistics and data on government websites in November of 2020, it is abundantly clear that COVID-19 poses virtually no risk to children, youth, young adults, and almost every adult under age 60. As far back as January, Dr. Tam informed the House of Commons Health Committee that “[w]ith regard

to the severity of illness, there are some severe cases, but the deaths have occurred in older people with underlying medical conditions.”⁷⁶

In March of 2020, UNICEF, which with the WHO is a part of the United Nations System,⁷⁷ released a summary of what was then known about COVID-19. In particular, it noted that older people with underlying health conditions were more vulnerable than young people, and linked it to the ‘same family of viruses as Severe Acute Respiratory Syndrome (SARS) and some types of common cold.’ “The virus can be fatal in rare cases, so far mainly among older people with pre-existing medical conditions,” the UN source noted.

In spite of this knowledge, K-12 schools across Canada were ordered to close their doors to students in mid-March, for the stated purpose of protecting children, teachers, and other staff.⁷⁸ Throughout March and April, many government and public health officials alluded to the risks of COVID-19 to

What the WHO knew in March 2020

COVID-19 is a disease caused by a new strain of coronavirus, linked to the same family of viruses as Severe Acute Respiratory Syndrome (SARS) and some types of common cold.

Symptoms can include fever, cough and shortness of breath. In more severe cases, infection can cause pneumonia or breathing difficulties. More rarely, the disease can be fatal. These symptoms are similar to the flu (influenza) or the common cold, which are a lot more common than COVID-19. This is why testing is required to confirm if someone has COVID-19.

The virus is transmitted through direct contact with respiratory droplets of an infected person (generated through coughing and sneezing). Individuals can also be infected from and touching surfaces contaminated with the virus and touching their face (e.g., eyes, nose, mouth). The COVID-19 virus may survive on surfaces for several hours, but simple disinfectants can kill it.

continued below...

⁷⁶ <https://openparliament.ca/committees/health/43-1/1/dr-theresa-tam-9/?singlepage=1>.

⁷⁷ https://www.unicef.org/media/66216/file/Key%20Messages%20and%20Actions%20for%20COVID-19%20Prevention%20and%20Control%20in%20Schools_March%202020.pdf

⁷⁸ “Province Announces Class Suspensions Effective March 20, Wind Down Period Until Thursday.” Saskatchewan Government. March 16, 2020. <https://www.saskatchewan.ca/government/news-and-media/2020/march/16/class-suspensions>.

children and youth, but without reference to the statistics then available showing the absence of actual risks of COVID-19 to this demographic, or to what was apparently already known to the World Health Organization and in Canada, to Dr. Tam and those political leaders she had advised in January.

Instead, for instance, on March 31, Dr. Tam stated that “[t]he young are not spared from severe outcomes.”⁷⁹

Not surprisingly then perhaps, Alberta Premier Jason Kenney stated the following in early April:

I’ve seen online and some of the chatter and discussions here, people saying, ‘Well why don’t you just kind of close down the seniors’ homes and quarantine the seniors and let the rest of society continue to function?’ Well...no age group is immune.... We have had two deaths, I think one amongst a 20-something and one amongst a 30-something, so young people can be seriously affected by this.⁸⁰

With Dr. Tam’s confusing testimony before him, why would he think otherwise? Even so, Premier Kenney’s statement lacks a sense of proportion. It seems to ignore the fact that Alberta’s population exceeds four million,⁸¹ where (unsurprisingly) more than

We are learning more about how COVID-19 affects people every day. Older people, and people with chronic medical conditions, such as diabetes and heart disease, appear to be more at risk of developing severe symptoms. As this is a new virus, we are still learning about how it affects children. We know it is possible for people of any age to be infected with the virus, but so far there are relatively few cases of COVID-19 reported among children.

This is a new virus and we need to learn more about how it affects children. The virus can be fatal in rare cases, so far mainly among older people with pre-existing medical conditions. World Health Organization, March 2020. <https://www.who.int/docs/default-source/coronaviruse/key-messages-and-actions-for-covid-19-prevention-and-control-in-schools-march-2020.pdf?sfvrsn=Baf81d524>.

⁷⁹ Wendy Cox and James Keller. “Western Canada: Death of an Alberta man in his 30s underscores that young people are not immune from COVID-19.” The Globe And Mail. April 1, 2020. <https://bulletin.theglobeandmail.com/canada/british-columbia/article-western-canada-death-of-an-alberta-man-in-his-30s-underscores-that/>.

⁸⁰ Phil Heidenreich. “Reality check: Would Alberta benefit by letting COVID-19 spread among young people to build up herd immunity?” Global News. April 10, 2020. <https://globalnews.ca/news/6802755/coronavirus-covid-19-young-people-herd-immunity/>.

⁸¹ <https://www.alberta.ca/population-statistics.aspx>.

27,000 people die every year. In relation to 27,000 annual deaths, for Premier Kenney to have asserted that young people are seriously threatened by COVID-19, based on two COVID-19 deaths among people in the 20-40 age range, is misleading in the extreme.

In Saskatchewan, Chief Medical Health Officer Dr. Saqib Shahab that “COVID does not discriminate by age or other factors — it’s a risk for all of us.”⁸² This statement is demonstrably false. The data released by Canada’s provincial governments shows that COVID-19 risk is demonstrably linked to age and other factors, such as heart disease, diabetes and those who are immunocompromised, typically referred to as co-morbidities. For example, the median age of death from COVID-19 is 84 in Alberta, and 85 in British Columbia. It remains unclear why Saskatchewan, unlike other provinces, does not report the age of those who have died with COVID-19, when this data is readily available.

One University of Toronto professor even suggested that the chances of a young person experiencing a severe outcome were like rolling a die and having the number one “pop up.”⁸³ Of course, if the statistical probability of a young person being hospitalized or dying on account of COVID-19 were really “like rolling a one on a die,” we might expect a 1/6 probability (17%) that any young person infected by COVID-19 would die from it or suffer serious harm from it. This is a false equivalence, as demonstrated by data from all Canadian provinces, and jurisdictions around the world: a young person’s chance of dying of COVID-19 is one in a million, or less, not 17 per cent.

In mid-March, the United Kingdom and other jurisdictions around the world relied on predictions by Dr. Neil Ferguson of Imperial College. His model predicted 510,000 COVID-19 deaths in the U.K. and 2.2 million deaths in the U.S.⁸⁴ Based on the statements made by Canadian premiers and chief medical officers since March, it appears that these numbers were relied upon by Canadian governments at all levels to embark on

⁸² <https://www.ckom.com/2020/07/07/hold-july-7/>.

⁸³ Carry Tait. “COVID-19 kills Alberta man in his 30s as officials warn that young people are not immune.” *The Globe And Mail*. April 1, 2020. https://Bulletin.theglobeandmail.com/canada/alberta/article-covid-19-kills-alberta-man-in-his-30s-as-officials-warn-that-young/?fbclid=IwAR2R5nJOhWfUBLPb6NS0cAYOGVmSVOk8yrvQoiWVNwRrx18c0fbqJbTfg_A.

⁸⁴ Alan Reynolds. “How One Model Simulated 2.2 Million U.S. Deaths from COVID-19.” *CATO Institute*. April 21, 2020. <https://Bulletin.cato.org/blog/how-one-model-simulated-22-million-us-deaths-covid-19>.

a novel experiment of imposing lockdowns on entire populations and economies, rather than quarantining the sick. Current lockdown policies, still in place – in full or in part – in November of 2020, suggest that government authorities still believe Dr. Ferguson’s false predictions.

As further rounds of lockdowns are now being imposed, Canadian governments owe Canadians a clear and specific explanation as to what evidence and data they are relying upon when crafting new lockdown measures, and what data justifies the continuation of lockdown policies at all. Data available on government websites in November tells us that COVID-19 poses no threat to approximately 90% of Canada’s population, and has only a negligible impact on population life expectancy. Government policies – especially when they violate fundamental *Charter* freedoms – should be based on facts and evidence, not on inaccurate predictions which amount to baseless fearmongering.

If governments are to pursue evidence-based public policy, it is necessary to consider COVID-19 accurately, in its global and historical context, and to compare the epidemiological characteristics of COVID-19 with those of other illnesses worldwide. The 1957-58 “Asian flu” and the 1968-69 “Hong Kong flu” each claimed at least one million lives,⁸⁵ at a time when world population was less than half of the 7.8 billion who inhabit the planet in 2020.

As of November 17, 2020, COVID-19 had apparently killed 1.3 million people around the world,⁸⁶ although this number includes people who died of other causes while also infected with the virus. Like the seasonal flu, the elderly and those with serious underlying health conditions are most vulnerable. Unlike the seasonal flu, children do not appear to be at risk from COVID-19. Further, as publicly available data on

⁸⁵ “Non-pharmaceutical public health measures for mitigating the risk and impact of epidemic and pandemic influenza” at page 7. World Health Organization. Accessed July 26, 2020. https://Bulletin.who.int/influenza/publications/public_health_measures/publication/en/.

⁸⁶ <https://www.who.int/publications/m/item/weekly-epidemiological-update---17-november-2020>.

government websites tells us, very few of those under 70 risk significant harm from COVID-19; roughly 90% of the population requires no protection from the virus.

Also, as of November 17, there were 51,766 reported COVID-19 deaths in the United Kingdom,⁸⁷ a country of more than 66 million people. As in other jurisdictions, the overwhelming majority of U.K. deaths were among elderly and infirm citizens; the impact on population life expectancy was minimal. In light of the reporting practices that are commonly used to tabulate COVID-19 deaths in the U.S. and other countries, the global numbers are not radically different from deaths from seasonal influenza. In the winter of 2017-18, for example, around 22,000 people in the U.K. died of the flu.⁸⁸

There were 44,683 reported COVID-19 deaths in Italy as of November 17.⁸⁹ Again, this number is not very different from the 41,066 deaths in 2014-2015 or the 43,366 deaths in 2016-2017 from seasonal influenza in Italy.⁹⁰ And, while the points along which COVID-19 and seasonal influenza may be compared are subject to some controversy (i.e. whether to calculate the lethality of both in terms of absolute numbers, vulnerable populations, or case/infection fatality ratios), the claim that COVID-19 is an “unprecedented” killer finds no support in government-provided data and statistics.

Further, it is important to recognize that the way in which medical practitioners in many jurisdictions have classified COVID-19 deaths is subject to some controversy. From the beginning of the pandemic, record-keeping has suffered from a failure to distinguish between people who had COVID-19 at time of death, and those who actually died from it. As is demonstrated further below, in some jurisdictions, any person who died *with* COVID-19 is deemed to have died *of* COVID-19, even when COVID-19 was not the primary cause of death. This issue is significant, given that COVID-19 death numbers have had an enormous influence on how governments around the world have

⁸⁷ *Ibid.*

⁸⁸https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/895233/Surveillance_Influenza_and_other_respiratory_viruses_in_the_UK_2019_to_2020_FINAL.pdf

⁸⁹ <https://www.who.int/publications/m/item/weekly-epidemiological-update---17-november-2020>.

⁹⁰“Investigating the impact of influenza on excess mortality in all ages in Italy during recent seasons (2013/14 - 2016/17 seasons).” International Journal of Infectious Diseases. [https://Bulletin.ijidonline.com/article/S1201-9712\(19\)30328-5/fulltext](https://Bulletin.ijidonline.com/article/S1201-9712(19)30328-5/fulltext).

determined their responses to COVID-19. Consider the following statements from scientific advisors and public health officials from Italy, the UK, and the U.S.:

- Prof. Walter Ricciardi, scientific advisor to the Italian minister of health, has stated publicly:

The way in which we code deaths in our country is very generous in the sense that all the people who die in hospitals with the coronavirus are deemed to be dying of the coronavirus.”⁹¹ This is confirmed in the report of the Istituto Superiore di Sanita.⁹² The discrepancy between dying “from” COVID-19 and dying “with” the disease may be very high indeed. Prof. Ricciardi went on to state: “On re-evaluation by the National Institute of Health, only 12% of death certificates have shown a direct causality from coronavirus, while 88% of patients who have died have at least one pre-morbidity – many had two or three.”⁹³

- Dr. John Lee, a professor emeritus of pathology in the UK, explains that this same bias affects cause-of-death statistics in the UK:

There is a big difference between Covid-19 causing death, and Covid-19 being found in someone who died of other causes. [...] It might appear far more of a killer than flu, simply because of the way deaths are recorded.⁹⁴

- Dr. Ngozi Ezike, director of the Illinois Department of Public Health, has gone on the record to say,

If you were in hospice and had already been given a few weeks to live, and then you also were found to have COVID, that would be counted as a COVID death. It means technically even if you died of a clear alternate cause, but you had COVID at the same time, it’s still listed as a COVID death.”⁹⁵ During the April 7 COVID-19 White House briefing, Dr. Deborah Birx stated that this is practiced across the U.S., observing, “So, I think in

⁹¹ Sarah Newy. “Coronavirus: Is Covid-19 really the cause of all the fatalities in Italy?” Stuff. March 20, 2020. <https://Bulletin.stuff.co.nz/national/health/coronavirus/120443722/coronavirus-is-covid19-really-the-cause-of-all-the-fatalities-in-italy>.

⁹² “Characteristics of COVID-19 patients dying in Italy.” Epicentro. April 29, 2020, https://Bulletin.epicentro.iss.it/en/coronavirus/Bulletin/Report-COVID-2019_29_april_2020.pdf.

⁹³ Sarah Newey. “Why have so many coronavirus patients died in Italy?” The Telegraph. March 23, 2020, <https://Bulletin.telegraph.co.uk/global-health/science-and-disease/have-many-coronavirus-patients-died-italy/>.

⁹⁴ John Lee. “How deadly is the coronavirus? It’s still far from clear.” The Spectator. March 28, 2020, <https://Bulletin.spectator.co.uk/article/The-evidence-on-Covid-19-is-not-as-clear-as-we-think>.

⁹⁵ Lauren Melendez. “IDPH Director explains how Covid deaths are classified.” Week.com. April 20, 2020, <https://week.com/2020/04/20/idph-director-explains-how-covid-deaths-are-classified/>.

this country, we've taken a very liberal approach to mortality [...] If someone dies with COVID-19, we are counting that as a COVID-19 death.⁹⁶

In Canada, the College of Physicians and Surgeons of British Columbia issued similar instructions:^{97 98 99}

Due to the public health importance of COVID-19, when it is thought to have caused or contributed to death it should be recorded in Part I of the medical certificate of cause of death.... There is increasing evidence that people with existing chronic conditions or compromised immune systems due to disability are at greater risk of death due to COVID-19. Chronic conditions may be non-communicable diseases such as coronary artery disease, COPD, and diabetes or disabilities. If the decedent had existing chronic conditions, such as those listed above, these should be listed in Part II of the medical certificate of cause of death.

In short, in some jurisdictions the number of patients killed *by* COVID-19 is certainly less than the number who died *with* it.

It is, perhaps, easy to label some phenomenon as “unprecedented” (i.e. without any historical points of comparison) and then to inflate the severity of that phenomenon. But, having compared the global and regional death tolls of COVID-19 with the actual pandemics of 1918-20, 1957 and 1968, it is difficult to maintain the position that

⁹⁶ “Remarks by President Trump, Vice President Pence, and Members of the Coronavirus Task Force in Press Briefing.” Whitehouse.gov. April 7, 2020. <https://Bulletin.whitehouse.gov/briefings-statements/remarks-president-trump-vice-president-pence-members-coronavirus-task-force-press-briefing-april-7-2020/>.

⁹⁷ <https://www.cpsbc.ca/for-physicians/college-connector/2020-V08-02/04>.

⁹⁸ There is also some difficulty in comparing some Canadian data from the start of the COVID-19 event to the present day.

For example, in March/April, only people who had been traveling, or had gone to hospital for any reason, were tested for COVID-19. This limited sample was more likely to test positive than the general (untested) population.

As the accompanying table indicates, a high percentage of those tested at that time, yielded a positive result and became a ‘case.’ (In April, one person in 11.) This seemed to indicate the virus was widely distributed: What it actually showed was that 8.99 per cent of a chosen group (of about 454,000 individuals tested over a month) most likely to have been exposed to infection, had COVID-19.

However, in the week of 16th September 474,000 of the general population were tested, and only 1.66 per cent tested positive.

Can the two numbers be usefully compared? Not really, although some comfort may be had from knowing that the percentage of people who tested positive who actually died, fell from 10 per cent during the worst of the pandemic, to less than one per cent (of a very much higher number) by the end of October.

⁹⁹ This was consistent with the World Health Organization, which stated in a general instruction, “A death due to COVID-19 may not be attributed to another disease (e.g. cancer) and should be counted independently of preexisting conditions that are suspected of triggering a severe course of COVID-19... COVID-19 should be recorded on the medical certificate of cause of death for ALL decedents where the disease caused, or is assumed to have caused, or contributed to death.” https://www.who.int/classifications/icd/Guidelines_Cause_of_Death_COVID-19.pdf?ua=1.

COVID-19 is unprecedented, or that it demands truly unprecedented responses from governments worldwide.

A reassessment of COVID-19 lethality

When a pandemic is declared, it's natural to expect that more people will die. In April, Alberta's Premier Jason Kenney and Chief Medical Officer Dr. Deena Hinshaw claimed that even with lockdown measures in place, as many as 32,000 Albertans could die of COVID-19.

Nothing of the kind happened. As of late November 2020, this virus has taken the lives of fewer than 500 Albertans, not 32,000. To provide appropriate context: every year more than 27,000 Albertans die, more than 2,000 per month on average; more than 500 each week. The fewer-than-500 COVID-19 deaths from March through November are sad and tragic. So are the other more than 17,500 deaths from other causes during the same eight-month period.

With this in mind, it is therefore instructive to consider Canada's national death toll. Table III shows deaths from all causes, for the period from January 1 to August 31, compared for 2016 through 2020.

All deaths Canada	2016	2017	2018	2019	2020
Jan	26,690	24,740	26,195	23,920	24,445
Feb	21,395	23,460	24,225	23,280	28,515
Mar	21,870	22,340	28,620	28,300	22,815
Apr	26,025	26,615	21,940	22,095	25,515
May	19,960	20,445	20,975	21,605	29,540
Jun	19,035	19,615	25,265	25,630	19,740
Jul	23,670	24,460	19,905	20,405	18,745
Aug	19,215	19,460	19,700	25,065	17,375
8-month total	177,860	181,135	186,825	190,300	186,690

Table III: All Deaths in Canada¹⁰⁰

What this chart shows – remarkably – is that even including COVID-19 deaths, fewer Canadians died in between January 1 and August 31 of 2020 than in the equivalent periods in 2018 or 2019. The table shows that despite the arrival of COVID-19 in Canada in March, total deaths in 2020 of all causes were consistent with previous years, showing that COVID-19 is not the deadly pandemic that was predicted in March by Neil Ferguson and others.¹⁰¹

Further, the people who have been listed as dying of heart disease or cancer in previous years instead have COVID-19 on their death certificates in 2020. See Table IV.

Malignant Neoplasms	2016	2017	2018	2019	2020
January	6,850	6,855	7,045	6,950	7,015
February	6,395	6,300	6,170	6,020	6,245
March	6,755	6,770	6,655	6,690	6,500
April	6,450	6,455	6,565	6,595	5,880
May	6,650	6,630	6,535	6,840	5,780
June	6,160	6,420	6,465	6,415	5,445
July	6,590	6,620	6,680	6,835	4,950
Total to 31 July	45,850	46,050	46,115	46,345	41,815

Diseases of Heart	2016	2017	2018	2019	2020
January	4,825	5,335	5,560	5,010	4,910

¹⁰⁰ <https://www150.statcan.gc.ca/t1/tb11/en/cv.action?pid=1310076801>.

¹⁰¹ It might be argued that a lower death toll nationally was caused by the lockdown itself, as reduced economic activity could lead to fewer deaths from road accidents and workplace injuries. This is an unlikely explanation, however. In 2018, the latest year for which final statistics are available, 1,922 people died on Canada’s roads, and 1,027 from workplace injuries for a combined total of 2,949 deaths. Even a 50% reduction in both would not account for the difference.

February	4,445	4,400	4,640	4,565	4,115
March	4,610	4,790	4,785	4,650	4,175
April	4,220	4,345	4,525	4,385	3,850
May	4,275	4,350	4,410	4,390	3,745
June	3,995	4,100	4,125	4,060	3,180
July	3,895	4,155	3,975	4,010	2,770
Total to 31 July	30,265	31,475	32,020	31,070	26,745

Flu/pneumonia	2016	2017	2018	2019	2020
January	580	1,270	1,685	1,000	1,015
February	635	865	1,355	715	775
March	875	840	1,045	760	735
April	650	580	660	690	515
May	460	525	510	555	305
June	385	395	385	400	215
July	365	355	430	395	190
Total to 31 July	3,950	4,830	6,070	4,515	3,750

Chronic Lower Respiratory Diseases	2016	2017	2018	2019	2020
January	1,145	1,565	1,490	1,360	1,270
February	1,080	1,235	1,185	1,055	1,155
March	1,280	1,260	1,340	1,210	1,175
April	1,120	1,130	1,190	1,170	965
May	1,015	1,075	1,070	1,075	745
June	920	900	960	1,040	655
July	900	900	880	975	610
Total to 31 July	7,460	8,065	8,115	7,885	6,575

Cerebrovascular Diseases	2016	2017	2018	2019	2020
January	1,250	1,330	1,365	1,210	1,300
February	1,130	1,170	1,130	1,110	1,110
March	1,230	1,265	1,155	1,200	1,140
April	1,055	1,070	1,115	1,135	1,030
May	1,120	1,140	1,190	1,115	970
June	1,055	1,100	1,000	1,065	835
July	1,075	1,105	985	1,010	785

Total to 31 July	7,915	8,180	7,940	7,845	7,170
COVID-19	2016	2017	2018	2019	2020

January	0	0	0	0	0
February	0	0	0	0	0
March	0	0	0	0	265
April	0	0	0	0	4,180
May	0	0	0	0	3,475
June	0	0	0	0	665
July	0	0	0	0	210
Total to 31 July	0	0	0	0	8,795

<https://www150.statcan.gc.ca/t1/tb11/en/tv.action?pid=1310078501>.

Table IV – All Canada, deaths from leading causes of death. January 1 to July 31: 2016-2020

Table IV shows a consistent pattern of cause-of-death month by month. This changes when COVID is recorded, but instead of increased deaths overall, deaths from the four main conditions drop, while COVID-19 cases rise with the result that total deaths are very close to last year.

For example, in April and May 2019, deaths from malignant neoplasms (cancer) totalled 13,435. In 2020, they dropped to 11,660, a decline of 1,775 or 13.2%. By a similar calculation, heart disease was down by 1,180. Thus in those two disease categories alone, 2,955 fewer people died in 2020 than in 2019. However, in April and May of 2020, 7,655 people died of COVID-19 – raising the overall death toll for those two months, **but as per Table III, not to a degree that is inconsistent with previous years.** Larger variations had occurred in previous years.

This led us to examine mortality rates, derived from Statistics Canada data. The graphs on the next page show mortality rates by province and region and by age group.

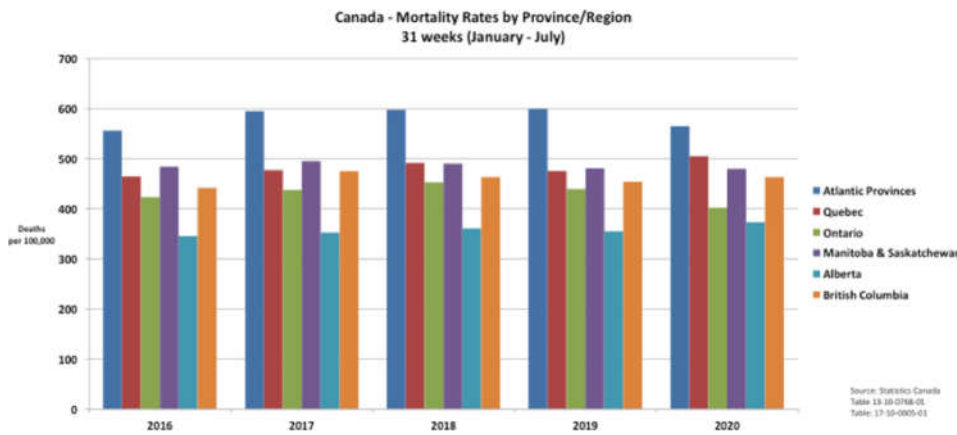


Table V – Mortality rates by region, January 1 to July 31: 2016-2020

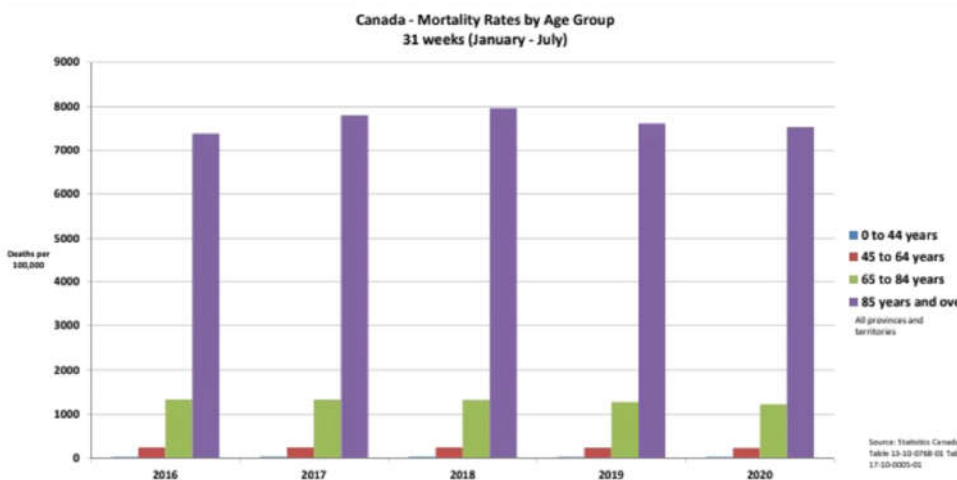


Table VI – Mortality rates by age group, January 1 to July 31: 2016-2020

Mortality rates for people over 70 years of age during the first seven months of 2020 are consistent with previous years, and in fact a little lower than in 2018.

Taken together, these tables indicate that notwithstanding the onset of COVID-19, mortality rates for the first seven months of 2020 are consistent with the mortality rates experienced in 2016-2019, showing that COVID-19 is not an unusually deadly killer.

Lockdown harms

It could be argued that Canada’s lockdown policies saved lives and were therefore justified. Eight months after lockdowns were first imposed, one can compare reality to Neil Ferguson’s fearmongering predictions that were made in March, declare success, and attribute success to lockdown measures. It is easy to speculate about the possible positive impact that lockdowns may have made. But speculation is not science, and conjecture is not evidence.

However, even the World Health Organization – considered authoritative by public health officials when it initially recommended stringent measures to combat COVID-19 – has now expressed grave reservations about lockdowns. In October the WHO asserted that lockdowns “can have a profound negative impact on individuals, communities, and societies by bringing social and economic life to a near stop.”¹⁰² Indeed. And it is to these costs – these harms, many of which are burdensome in the extreme – to which we now turn.

Economic harms

The descriptor “unprecedented” has been inappropriately applied to COVID-19, yet it certainly applies to the rapid decline in economic performance across many sectors, across Canada. In its Labour Force Survey for April 2020, Statistics Canada noted that

The magnitude of the decline in employment [in Canada] since February (-15.7%) far exceeds declines observed in previous labour market downturns. For example, the 1981-1982 recession resulted in a total employment decline of 612,000 (-5.4%) over approximately 17 months.¹⁰³

When compared to the most significant recession since the 1930s, Canada lost nearly 300 per cent more jobs in approximately one-sixth the time.¹⁰⁴ Of full- and part-time jobs, Statistics Canada noted that

¹⁰² <https://www.who.int/news-room/q-a-detail/herd-immunity-lockdowns-and-covid-19>.

¹⁰³ “Labour Force Survey, April 2020.” Statistics Canada. April 8, 2020. <https://www150.statcan.gc.ca/n1/daily-quotidien/200508/dq200508a-eng.htm?HPA=1>.

¹⁰⁴ *Ibid.*

In April, both full-time (-1,472,000; -9.7%) and part-time (-522,000; -17.1%) employment fell. Cumulative losses since February totalled 1,946,000 (-12.5%) in full-time work and 1,059,000 (-29.6%) in part-time employment.¹⁰⁵

As a result of the government-imposed lockdowns, 5.5 million Canadians were either not working or were working substantially reduced hours by April of 2020.¹⁰⁶ Even among those who had not lost their jobs outright, many experienced significantly reduced hours. Regarding solo self-employed workers, Statistics Canada found that

The number of solo self-employed workers (2.0 million)—that is, those with no employees—was little changed in April compared with February (not adjusted for seasonality). For this group of workers, the impact of the COVID-19 shutdown has been felt through a significant loss of hours worked. In April, 59.4% of the solo self-employed (1.2 million) worked less than half of their usual hours during the week of April 12, including 38.4% who did not work any hours.¹⁰⁷

It is important to note that the economic decline caused by lockdown measures has not affected Canadians equally. By June, employment levels for women in low-wage jobs (less than \$16.03 per hour) was 74.8% of pre-COVID levels compared to 84.7% for men in low-wage jobs.¹⁰⁸ Finally, Statistics Canada found that fathers with children aged 6-17 were approaching pre-COVID levels of employment, whereas mothers with children aged 6-17 were still approximately five percentage points away from pre-COVID levels in June.¹⁰⁹

Women were not the only disproportionately impacted group; vulnerable workers, young workers, and immigrant workers have thus far experienced the most severe economic outcomes. Of those working temporary and non-unionized jobs, Statistics Canada earlier noted that:

In the two months since February, employment (not adjusted for seasonality) declined by 17.8% among all paid employees. The pace of employment losses was above-average among employees with a temporary

¹⁰⁵ *Ibid.*

¹⁰⁶ *Ibid.*

¹⁰⁷ *Ibid.*

¹⁰⁸ *Ibid.*

¹⁰⁹ *Ibid.*

job (-30.2%), those with job tenure of one year or less (-29.5%) and those not covered by a union or collective agreement (-21.2%). There were also sharper declines for employees earning less than two-thirds of the 2019 median hourly wage of \$24.04 (-38.1%) and those who are paid by the hour (-25.1%).

This is consistent with the declines observed in accommodation and food services, and wholesale and retail trade, which generally have a higher proportion of workers with these characteristics. Despite these declines, there were approximately one million people in low-wage, non-unionized, hourly-paid jobs in April who worked at least some hours during the reference week. Of these, 89.1% worked at locations outside the home. Two-thirds of those working in locations outside the home were employed in accommodation and food services or wholesale and retail trade—both industries with relatively high proportions of workers in jobs usually requiring close physical contact.¹¹⁰

Further, Statistics Canada found that workers and students aged 15-24 were disproportionately impacted by lockdown measures, triggering the federal government to implement a 9 billion dollar student aid program.¹¹¹ According to Statistics Canada, when it comes to unemployment

COVID-19 has disproportionately affected Canada's youth (aged 15 to 24). As a group, they are more likely to hold less secure jobs in hard-hit industries such as accommodation and food services. From February to April, employment among youth declined by 873,000 (-34.2%), while an additional 385,000 (or one in four) who remained employed in April lost all or the majority of their usual hours worked (not adjusted for seasonality). Employment declined faster among those aged 15 to 19 (-40.4%) than among those aged 20 to 24 (-31.1%), reflecting the less secure jobs held by those in the younger age category.

Among students aged 15 to 24 in April, the unemployment rate increased to 31.7% (not adjusted for seasonality), signaling that many could face difficulties in continuing to pay for their studies. Among non-student youth, a little more than half were employed in April, down from three-quarters in February (data not seasonally adjusted).¹¹²

¹¹⁰ "Labour Force Survey, April 2020." Statistics Canada. April 8, 2020. <https://www150.statcan.gc.ca/n1/daily-quotidien/200508/dq200508a-eng.htm?HPA=1>.

¹¹¹ Rachel Aiello. "PM Trudeau announces \$9B in new COVID-19 funding for students." CTV News. April 22, 2020. <https://www.ctvnews.ca/canada/pm-trudeau-announces-9b-in-new-covid-19-funding-for-students-1.4906564>.

¹¹² "Labour Force Survey, April 2020." Statistics Canada. April 8, 2020. <https://www150.statcan.gc.ca/n1/daily-quotidien/200508/dq200508a-eng.htm?HPA=1>.

Finally, of those very recent immigrant workers, Statistics Canada noted that

Employment among very recent immigrants (five years or less) fell more sharply from February to April (-23.2%) than it did for those born in Canada (-14.0%). This is partly because this group is more likely than people born in Canada to work in industries which have been particularly affected by the COVID-19 economic shutdown, such as accommodation and food services, and less likely to work in less severely-impacted industries, such as public administration.

Employment among the total landed immigrant population declined by 18.0% from February to April (not adjusted for seasonality), as established immigrants (10 years or more) (-17.0%) and recent immigrants (more than 5 but less than 10 years) (-17.4%) fared better than their very recently-arrived counterparts.¹¹³

These statistics show the degree to which the Canadian economy, and the most vulnerable participants therein, experienced unprecedented economic harm because of provincial and federal government lockdowns of society and the economy from March to April. Although the economy has rebounded in response to the partial lifting of some measures in some provinces, Statistics Canada found that “employment in June was 1.8 million (-9.2%) lower than in February” and that “significant labour market challenges remain for youth, students, and low-wage workers.”¹¹⁴

Little changed over the summer: The unemployment rate in October was still 8.9 per cent¹¹⁵ and the number of unemployed Canadians remained 683,000 up (+60.2%) from pre-COVID February levels.¹¹⁶ In its November 6 press release, Statistics Canada noted, ‘Employment growth slows as new restrictions are implemented.’¹¹⁷

The economic impact on the entire country can be summarized by a single statistic: During the second quarter of 2020, Canada’s Gross Domestic Product fell at an annualized rate of 38.7 percent.¹¹⁸ And, although the third-quarter results did show some

¹¹³ *Ibid.*

¹¹⁴ “Labour Force Survey, June 2020.” Statistics Canada. July 10, 2020. <https://www150.statcan.gc.ca/n1/daily-quotidien/200710/dq200710a-eng.htm>.

¹¹⁵ <https://www150.statcan.gc.ca/n1/daily-quotidien/201106/dq201106a-eng.htm>

¹¹⁶ *Ibid.*

¹¹⁷ *Ibid.*

¹¹⁸ <https://www150.statcan.gc.ca/n1/daily-quotidien/200828/dq200828a-eng.htm>.

improvement, the Bank of Canada is projecting annualized growth of only one per cent in the final three months of the year, and expects any recovery to be drawn out over the next several quarters.¹¹⁹

Canada's governments should have considered the unprecedented and disproportionate impacts that lockdown measures, imposed for months on end and not just for a two-week period, would have on the economic well-being of all Canadians. Yet, if due diligence was attempted at all, insufficient time was allowed to examine what information there was, or what alternatives might be considered.

Lockdown harms to life and society

Even if the cost of lost production and accumulated government and personal debt could be considered acceptable – a proposition for which there is no consensus – there are other harms that have yet to be fully tallied. To fully understand the consequences of lockdown measures imposed by Canadian governments at all three levels, it is necessary to consider how many people died not of COVID-19 itself but as a result of *Charter*-violating policies. It is imperative that elected and non-elected policy makers know how many people were in effect allowed to die of something other than COVID-19, to save the lives of others presumed to be at risk of dying from the virus.

Lockdown harms include but are not limited to:

- **Death from delayed medical treatment;**
- **Death from delayed or cancelled diagnosis;**
- **Death from suicide;**
- **Death from drug overdose.**

These lockdown harms are quantifiable, to varying degrees.

There are many other harms that, though less amenable to measurement than the above, were responsible for severe distress for many Canadians. Having to cancel one's

¹¹⁹ <https://www.bnnbloomberg.ca/canadian-economy-grew-1-2-in-august-statscan-says-1.1515409>.

wedding, or being legally prohibited from attending the funeral of a close friend or family member, do not compare to a delayed haircut. But even delayed haircuts inflict serious harm on those who support themselves and their loved ones by cutting hair, so the impact is still severe. There are so many harms that no single paper can even attempt to address them all. However, for the record, harms not addressed in this paper include but are not limited to:

- The harm of stresses caused by social isolation¹²⁰ – depression, anxiety, alcoholism,¹²¹ obesity, family violence¹²² and psychiatric illnesses;¹²³
- The harm of delayed treatment from non-emergency medical professionals – chiropractors, podiatrists, physiotherapists, massage therapists, naturopaths, optometrists, dentists and other health providers;
- The harm caused when mothers are deterred by fear of COVID-19 from visiting clinics to ensure that their children are immunized against diseases that are far more dangerous to children than COVID-19: traditional child-killers such as whooping cough, polio and diphtheria;¹²⁴
- The harm of shortage of organ donors;¹²⁵
- Shortage of blood donors;¹²⁶
- The effects of anxiety over loss of income. According to the Financial Consumer Agency of Canada, those dealing with financial stresses are “[t]wice as likely to report poor overall health”, “[f]our times as likely to suffer from sleep problems, headaches and other illnesses”, and are also “more likely to experience strain in [...] personal relationships.”¹²⁷ Such stresses may even lead to “more serious

¹²⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7444649/>.

¹²¹ <https://vancouver.sun.com/news/local-news/its-official-covid-19-pandemic-has-led-to-an-increase-in-alcohol-use>.

¹²² <https://www.cbc.ca/news/canada/london/national-survey-domestic-violence-end-violence-now-anova-1.5698028>.

¹²³ <http://www.camh.ca/-/media/files/pdfs---public-policy-submissions/covid-and-mh-policy-paper-pdf.pdf>.

¹²⁴ <https://www.aier.org/article/a-sensible-and-compassionate-anti-covid-strategy/>.

¹²⁵ For example: <https://www.wshu.org/post/new-yorkers-prepare-covid-19-induced-shortage-us-organ-donors#stream/0>; <https://thefederalist.com/2020/09/29/media-gunning-for-scott-atlas-because-he-keeps-exposing-coronavirus-lies/>.

¹²⁶ <https://professionaleducation.blood.ca/en/organes-et-tissus/covid-19/national-covid-19-impact-data>.

¹²⁷ “Financial Stress and Its Impacts.” Financial Consumer Agency of Canada.. <https://Bulletin.canada.ca/en/financial-consumer-agency/services/financial-wellness-work/stress-impacts.html>.

health problems,” including heart disease, high blood pressure, and mental health conditions;¹²⁸

- Food insecurity attributable to COVID-related loss of employment;
 - A May-June study¹²⁹ 130 of 220 food banks by Dalhousie University found that 76 per cent of new clients accessed food banks due to job losses or a reduction in working hours;
 - 34 per cent of respondents said they will be unable to continue to pay rent 4—6 months from now if the pandemic continues;¹³¹
 - There was a 20 per cent increase in frequency of going a full day (over the course of one month) without eating;¹³²
 - One in three children are going hungry, up from one in four children before the pandemic. Twenty eight per cent of respondents received the Canada Emergency Response Benefit (CERB) but still need to rely on food banks;
- Adverse impact of school closures on children, particularly poorer children. The physical and mental harms inflicted on children, deprived of school and sociability, frightened by the constant media narrative of exaggerated dangers of COVID-19, and deprived for months on end of their swimming lessons, martial arts classes, music recitals, ballet practices and carefree playtime with their friends;¹³³
- Attention diverted away from other large killers: e.g. Tuberculosis;¹³⁴
- Canadians denied their chance to say good-bye to their dying parents, grandparents and other loved ones due to lockdown restrictions imposed on hospitals, hospices and long-term care facilities;
- Weddings that were downgraded or cancelled outright;

¹²⁸ *Ibid.*

¹²⁹ <https://www.newswire.ca/news-releases/daily-bread-food-bank-study-reveals-food-insecurity-and-food-bank-use-on-the-rise-during-covid-19-despite-government-relief-836325837.html>.

¹³⁰ <https://nationalpost.com/news/canada/statistics-canada-rejigs-low-income-stats-showing-growing-poverty-gap>.

¹³¹ *Ibid.*

¹³² *Ibid.*

¹³³ <https://www.cmaj.ca/content/192/32/E921>.

¹³⁴ <https://www.nytimes.com/2020/08/03/health/coronavirus-tuberculosis-aids-malaria.html>.

- Canadians prevented from attending the funerals of friends and family members;
- Vulnerable seniors in nursing homes, confined to their rooms and prevented, for months on end, from seeing their friends and family members, who often play an irreplaceable role in providing necessary attention, affection, love and care.

A court action in Ontario¹³⁵ has brought attention to the severe harms experienced by those in long-term care homes who, isolated in their rooms, were deprived of their family members' presence. In September 2020, a Calgary widow contacted the Justice Centre¹³⁶ with a heartbreaking account of how for four-and-one-half months she was locked out of the care facility where her husband, who suffered from Parkinson's Disease, had been placed. She had been in the habit of visiting him daily, giving him the extra care that he needed. During the time that she was locked out and could not provide that care, he lost 23 pounds, developed a UTI, sepsis, aspirational pneumonia, and a bowel blockage. He became dehydrated. She relates that she was finally allowed in to see him one day before he was rushed into Emergency, where he died.

Obviously, the neglect and lack of care is appalling. This man did not die of COVID-19. He was instead a victim of the Alberta Government's lockdown policies that prevented his wife from assisting him, as she had done in the past and would have continued doing, had she been able to continue providing for his care in the nursing home. Being robbed of those irreplaceable moments is profoundly wrong, and anything but trivial. It remains unclear to what extent this man's health declined because his wife was prohibited from providing care; family members who provide care to loved ones in long-term care facilities are often the first to notice health problems, and are uniquely positioned to advocate for immediate and high-quality care.

¹³⁵ https://www.jccf.ca/wp-content/uploads/2020/08/Urgent-Notice-of-Application-for-Judicial-Review-Maione-v.-Ontario_Redacted.pdf.

¹³⁶ Private letter used with permission.

How many times over has this needless tragedy and others like it occurred in Canada thus far? How can we even consider going back into lockdowns without diverting significant public resources to ascertain the magnitude of this problem? Without a proper tabulation, renewed lockdowns are impermissible under the *Charter*.

1) Death from Delayed Medical Treatment: Cancelled surgeries

Modeling undertaken by the CovidSurg Collaborative and published in the British Journal of Surgery, projected that based on a 12-week disruption of hospital service, 28 million surgeries would be cancelled worldwide, 395,000 of them in Canada, including 25,000 cancer procedures.¹³⁷

It is a plausible model. In October, the Chief Public Health Officer of Canada released a Report on the State of Public Health in Canada 2020 which compared the number of surgeries performed during the last two weeks of March 2020 with the equivalent period of time in 2019 and estimated that in that fortnight alone, 73,500 fewer surgeries had been performed, year over year.¹³⁸

Data from the Canadian Institute for Health Information (CIHI) demonstrate a decline in surgical procedures. When data from the final two weeks of March 2020 (the beginning of the “stay at home” period) are compared with the same time period in 2019, preliminary results (excluding QC and NU) show that there were approximately 73,500 fewer surgeries performed nationally, a decrease of 67%. Planned inpatient surgeries (-64%) and day surgeries (-75%) had larger decreases than urgent inpatient surgeries (-29%). Knee and hip procedures also showed larger decreases (-79%) than cardiac and cancer surgeries (-30% and -24%, respectively) suggesting that healthcare providers continued to prioritise urgent surgeries in the face of added pressures created by COVID-19.¹³⁹

It is safe to assume that medical authorities did their best to triage surgeries with the goal of continuing with those deemed to be the most serious, but the evidence is clear that life-saving surgeries were amongst those cancelled. For example, every quarter,

¹³⁷ <https://news.westernu.ca/2020/05/study-28-million-surgeries-shelved-by-covid-19/>.

¹³⁸ <https://www.canada.ca/en/public-health/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/from-risk-resilience-equity-approach-covid-19.html>.

¹³⁹ *Ibid* at 36 (page numbers from pdf version).

Ontario performs about 3,100 breast-cancer surgeries. Over the last nine quarters, this has been consistent. Like any serious surgical intervention, every one of these surgeries should be considered necessary; these are hardly frivolous procedures. But in the first quarter of 2020,¹⁴⁰ only 2,266 breast-cancer surgeries were performed¹⁴¹ as Ontario cleared out hospitals to make way for a wave of COVID-19 sufferers that never came. Did the Government of Ontario know, consider, or try to find out what the consequences would be, for the roughly 850 women whose presumably essential surgery was delayed for at least the two months during which surgeries were restricted?

Government evasion regarding the high cost of cancelling surgeries

On September 8, 2020, the Justice Centre wrote letters¹⁴² to Canada's provincial and territorial chief medical officers and health ministers, to enquire about the consequences of their decisions in March to cancel surgeries, diagnostic testing and other medical procedures, asking the following questions:

- 1) How many scheduled surgeries, physician consultations, diagnostic imaging procedures, blood tests and surgeries were cancelled and postponed?
- 2) What types of surgeries were postponed or canceled? How many of each type?
- 3) Of those patients whose aforementioned medical procedures were postponed or canceled, how many died between mid-March and August 31, 2020? Of these, how many would not have died if their medical procedure had not been canceled?
- 4) Of those patients whose medical procedures were postponed or canceled but who did not die, how many suffered worsening conditions? Of those suffering worsening conditions, how many have suffered permanent damage to their health?

¹⁴⁰ For Public Health Ontario, 1 April to 30 June is the first quarter.

¹⁴¹ <https://www.hqontario.ca/System-Performance/Wait-Times-for-Surgeries-and-Procedures/Wait-Times-for-Cancer-Surgeries/Time-from-Decision-to-Having-Cancer-Surgery>

¹⁴² https://www.jccf.ca/court_cases/letters-to-chief-medical-officers-and-provincial-health-ministers-regarding-decisions-to-cancel-surgeries/

- 5) How many of the medical procedures that were cancelled were rebooked, and how many of those have now been completed?
- 6) By what date will the backlog of postponed and canceled medical procedures be fully cleared?

As of November 30, 2020, the Justice Centre had not received specific responses to these questions from chief medical officers or from provincial health ministers. Vague and evasive responses from the Manitoba, British Columbia and Newfoundland governments are posted at www.jccf.ca; other governments have not responded at all. In April, for example, the University Health Network in Ontario released a study¹⁴³ suggesting that after just six weeks into a ten-week shutdown of what were said to be non-essential surgeries, as many as 35 cardiac-care patients might have died after their heart surgeries were cancelled to free up beds for the anticipated surge in COVID-19 patients.¹⁴⁴

Asked about the Network's modeling, Health Minister Christine Elliott expressed regret but said that officials have to be sure the COVID-19 peak had passed. "That is among the first things we're going to be considering as we look at easing up the economy, but we do have to see that downward trend in cases before we can do that," she told Toronto's NOW Magazine.¹⁴⁵ She then went on to say that Ontario's actions during the pandemic (had) saved thousands of lives.¹⁴⁶

Perhaps. However, the Network was reporting on six weeks into a ten-week substantive shut-down of operating-rooms, on cardiac surgeries only. But it also reported that, as well as reduced cardiac surgeries, in April 2020, there were 38 per cent fewer cancer surgeries, 73 per cent fewer vascular surgeries, 81 per cent fewer transplant surgeries, 94 per cent fewer pediatric surgeries and 96 per cent fewer other adult surgeries compared with April 2019.¹⁴⁷ Along with heart disease, the aforementioned

¹⁴³ https://drive.google.com/drive/folders/1T5I2VKuvVFD0FmFGItcH_ZX1XioH4vYU.

¹⁴⁴ <https://nowtoronto.com/news/april-28-coronavirus-updates-toronto-news>.

¹⁴⁵ <https://nowtoronto.com/news/april-28-coronavirus-updates-toronto-news>.

¹⁴⁶ <https://www.iheartradio.ca/610cktb/news/delayed-cardiac-surgeries-due-to-pandemic-may-have-caused-35-deaths-minister-1.12265519>.

¹⁴⁷ <https://www.cmaj.ca/content/cmaj/early/2020/09/01/cmaj.201521.full.pdf>.

surgeries pertaining to malignant neoplasms (cancer), cerebrovascular diseases and chronic lower respiratory diseases represent 86 per cent of all causes of death in Canada.

So, how many more than 35 Ontarians had died as of mid-April, never mind to the end of May when surgeries resumed, because of cancelled surgeries? Governments have no lack of resources to obtain and keep track of this vital information. They should be held accountable for their failure to do so, or, if they did track this information, they should be held accountable for their failure to make this information available to the public. The apparent failure of governments to track and acquire this vitally important information amounts to wilful blindness, and is inexcusable both morally and pursuant to their obligations under the *Charter*.

Indeed, according to a report by Ontario's own Financial Accountability Office, as of April 22, an estimated 52,700 hospital procedures had been cancelled in Ontario due to the coronavirus pandemic. This report¹⁴⁸ further predicted that for every week that the COVID-19 outbreak continued, a further 12,200 procedures would be delayed.

Nationwide, it is difficult to ascertain the total number of surgical procedures cancelled. However, a study published in the British Journal of Surgery in May estimated that 32,500 surgical procedures were/would be cancelled per week in Canada.^[2] Assuming this rate of cancellations continued for six weeks, 195,000 surgeries were cancelled in Canada. The actual numbers we have, for Ontario and British Columbia, roughly support this proposition.

By May 9, the Ontario number was 72,000 cancelled surgeries.¹⁴⁹

By May 24, British Columbia had cancelled 17,076 surgeries.¹⁵⁰ According to documents released to us through the British Columbia Freedom of Information and Protection of Privacy Act, 2,184 hip/knee surgeries were cancelled, 597 dental surgeries were cancelled, and 14,295 "other" surgeries were cancelled.¹⁵¹ It appears that the

¹⁴⁸ <https://www.fao-on.org/en/Blog/media/MR-health-2020>.

¹⁴⁹ <https://nationalpost.com/health/sacrificed-in-the-name-of-covid-patients-tens-of-thousands-affected-by-surgery-cancellations>.

¹⁵⁰ BC Elective Surgeries FOIP page 40.

¹⁵¹ *Ibid*.

Ministry of Health scrupulously avoided informing itself of a breakdown of this mammoth “other” category.¹⁵² How many cancer and heart-related surgeries are hidden amongst this mysterious 14,295 total of “other” surgeries? And what, pray tell, would be so difficult about tracking cancer and cardiac surgeries as separate categories? Usually the category of “other” is created to deal with insignificant left-overs. We have followed up with the various British Columbia health authorities and expect to obtain this vital information. In addition, 17,076 surgeries cancelled does not capture the number of surgeries that were truly missed. The British Columbia Ministry of Health estimates that “16,000 (in addition to cancellations) would normally have been scheduled from the waitlist.”¹⁵³ By our calculation therefore, cumulatively 33,000 surgeries were missed in British Columbia between 16 March and May 24. And indeed, British Columbia Health Minister Adrian Dix confirmed on May 7 that the province had a backlog of 30,000 elective procedures that had been cancelled because of the COVID-19 pandemic.¹⁵⁴

On September 1, the Canadian Medical Association Journal published a study estimating that by June 13, Ontario alone had accumulated a backlog of 148,000 procedures¹⁵⁵ that would take 84 weeks to clear.

It should be no surprise then, that all across Canada, newspapers and electronic media report cases where it is believed people died as a result of cancelled surgeries.

For example:

- In Medicine Hat, Alberta, 46-year-old Jerry Dunham died of heart failure shortly before Father’s Day, leaving behind two grieving daughters ages six and eight, because an operation to install a defibrillator was cancelled as part of the government’s lockdown measures.¹⁵⁶

¹⁵² BC Elective follow up FOIP, no responsive documents.

¹⁵³ BC Elective Surgeries FOIP, page 43.

¹⁵⁴ <https://globalnews.ca/news/6912856/cancelled-surgeries-coronavirus/>

¹⁵⁵ <https://globalnews.ca/news/7310078/coronavirus-ontario-surgery-backlog/>;
<https://www.cmaj.ca/content/early/2020/09/01/cmaj.201521>.

¹⁵⁶ <https://calgaryherald.com/opinion/columnists/corbella-when-it-comes-to-health-the-price-of-caution-may-be-higher-than-we-think>.

- Jasmine Yang, 60, was a Surrey woman whose scheduled surgery to treat ovarian cancer was deferred when British Columbia cancelled non-emergency surgeries such as hers. She died two days before she was due to be treated in a rescheduled operation.¹⁵⁷
- In Surrey, Chris Walcroft, a 50-year-old father of two, died on April 15 after a scheduled surgery to prepare his kidney for dialysis was cancelled the day before he was to receive it.¹⁵⁸
- In Ottawa, Martin Hawdur, 70, died after an aortic aneurysm ruptured. Diagnosed at the end of November of 2019, he was told surgery was “crucial” and that the operation would take place as soon as it could be arranged. On February 28, 2020, he was told the surgery would be in April. On March 15, as part of the lockdown measures, the British Columbia government ordered all hospitals to curtail “elective” (non-emergency) surgeries. He died May 14. His surgery had still not been scheduled.¹⁵⁹

This list above is illustrative, and by no means exhaustive.

The government defence is that only supposedly “non-essential” surgeries (‘elective’ or ‘non-emergent’ as public-health officials term them) were cancelled. But, as the research conducted by the University Health Network suggests and the personal stories make clear, not every cancelled surgery was “non-essential.” In addition to known cases of Canadians who died after their “non-essential” surgery was cancelled, there is also the continued pain and suffering of those who were waiting for orthopaedic and other surgeries. These surgeries were and are essential to being able to return to work and resume supporting one’s self and loved ones, or even just to enjoy life.

¹⁵⁷ <https://www.cbc.ca/news/health/covid-surgery-delay-unintended-consequences-1.5629360>.

¹⁵⁸ <https://www.ctvnews.ca/health/coronavirus/he-never-got-a-chance-b-c-man-dies-after-surgery-cancelled-due-to-covid-19-1.4923097>.

¹⁵⁹ <https://www.thechronicleherald.ca/news/canada/family-questions-why-kanata-man-died-waiting-for-crucial-surgery-at-heart-institute-461798/>.

A particularly heartbreaking story is that of children who are missing corrective surgeries that, while not necessarily essential to staying alive, are essential to full health. As the *Globe and Mail* reports:

Four-year-old Emmett Fisch was born with one leg four centimetres shorter than the other. Right now, the difference is barely perceptible. Emmett runs and jumps as well as any kindergartner with the help of a lift in his right sneaker. But if his condition is left untreated, the discrepancy will grow to 18 centimetres by the time he's 16, rendering him too off-kilter to walk."¹⁶⁰

The Canadian Medical Association Journal (CMAJ) estimates that 7,600 pediatric operations were postponed between mid-March and early June, depending on the province. Furthermore, about 4,000 Canadian children who should have made their way on to surgical waiting lists did not, because they could not access diagnostic procedures such as MRI scans or face-to-face appointments with specialists.

And let's not forget the deaths that received no media coverage because grieving family members were unwilling or unable to publicize their tragic experiences.

2) Death from cancelled or delayed diagnosis

If Canadians are denied access to diagnostic testing for two months, how many will find a serious condition has been missed, with serious or even fatal results? Again, those in the administration of public health who are responsible for life-or-death decisions, don't know. They don't know because they have refused or failed to gather this data, in spite of massive government resources. Let us look again at Ontario, not because Ontario is uniquely culpable, but because the sheer scale of Ontario's health services, used by 38% of Canada's population, makes it an impressive random sample for the entire country. The issues we describe in Ontario generate questions for every province to answer.

¹⁶⁰ <https://www.theglobeandmail.com/canada/article-at-torontos-sickkids-hospital-two-thirds-on-wait-list-have-missed/>.

Every month, Ontario performs between 141,000 and 158,000 MRIs and CT scans. These are expensive procedures. As with surgeries, a high degree of necessity is assumed, with potentially serious consequences if the MRI or CT scan is cancelled.

Date	Adult MRIs	Adult CT Scans	Pediatric MRIs	Pediatric CT Scans	Month Total DIPs
19-Jul	61,210	88,238	2,622	777	152,847
19-Aug	59,460	85,003	2,423	720	147,606
19-Sep	59,837	80,895	2,544	729	144,005
19-Oct	65,533	89,184	2,969	803	158,489
19-Nov	62,658	83,150	2,787	705	149,300
19-Dec	57,601	80,732	2,504	689	141,526
20-Jan	63,107	87,535	2,782	786	154,210
20-Feb	59,760	80,771	2,610	723	143,864
20-Mar	46,661	69,899	2,073	564	119,197
20-Apr	19,701	42,702	839	294	63,536
20-May	27,449	54,454	1,255	403	83,561
20-Jun	41,464	68,238	1,907	602	112,211
20-Jul	49,958	77,131	1,830	572	129,491

Source: www.hqontario.ca/System-Performance/Wait-Times-for-DiagnosticImaging

Table VII – Ontario: Diagnostic Imaging Procedures (DIPs) performed July 2019 to July 2020

The number of Diagnostic Imaging Procedures (DIPs) performed in Ontario dropped sharply in March. DIPs were half their usual number in April and May, and even by July had not returned to previous levels.

What happened to the more than 200,000 Ontarians who should have been tested, but were not? Assuming that other provinces provide the same level of DIPs to their citizens as Ontario, and assuming that lockdown reductions in other provinces had a similar impact, it is eminently reasonable to assume that 500,000 or more Canadians did not receive timely diagnostic procedures. Unless all backlogs have been cleared in every province – a question which neither chief medical officers nor health ministers have

responded to, many Canadians are still waiting for timely diagnostic procedures in November 2020. There is, unfortunately, no convenient algorithm for calculating the number of surgeries that are triggered through diagnostic testing. However, these procedures are expensive, and it is reasonable to assume they are always done for good reason. It would be unreasonable to believe that such a massive reduction in diagnosis – more than 200,000 patients in Ontario alone – would have no consequence for those who should have been tested but were not. The reduction in surgeries noted earlier must be reflected in the death count. Governments have the necessary resources to find the answers, but are failing to do so, or not publicizing the answers they have. The paucity of publicly available data on these vitally important questions suggests that governments continue to adopt an attitude of wilful blindness to lockdown harms.

Certainly, news reports of medical professionals concerned by delays in diagnosis are becoming increasingly common. This is not just in Canada but also in the U.S.¹⁶¹ and Great Britain,¹⁶² where scientists warned in July that delays to cancer diagnosis and treatment due to lockdown measures could cause at least 7,000 additional deaths in the UK alone, and as many as 35,000 deaths in a worst-case scenario. The UK has not quite twice the population of Canada,¹⁶³ suggesting 3,500 to 17,500 Canadian deaths if our lockdowns have the same impact on Canadians that UK lockdowns have had in the UK.

That was the view of *The Lancet*. Having surveyed more than 93,600 cancer patients for its own study, the authoritative, peer-reviewed British medical journal concluded:

We estimated that across the four major tumour types – breast, colorectal, lung, and oesophageal – 3,291 to 3,621 avoidable deaths and an additional 59,204 to 63,229 YLLs [years of life lost] will be attributable to delays in cancer diagnosis alone as a result of the COVID-19 lockdown in the UK.

The Lancet's estimate is for a five-year period with COVID-19 lockdown measures being in effect for one year, since March 2020.¹⁶⁴ It is to the credit of *The Lancet* that it should

¹⁶¹ <https://www.nytimes.com/2020/04/20/health/treatment-delays-coronavirus.html>.

¹⁶² <https://www.bbc.com/news/health-53300784>.

¹⁶³ 66.65 million, to 37.59 million.

¹⁶⁴ *The Lancet*, 20 July 2020 [https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045\(20\)30388-0/fulltext](https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(20)30388-0/fulltext).

have made some attempt to estimate the shocking cost in life that attended delayed diagnosis in Great Britain.

What is true in principle in Great Britain would be true elsewhere. It would therefore have behooved policy makers in Canada to have demanded something similar from the agencies competent to do this kind of modelling here, or at the very least require a literature review. Canada's federal and provincial governments chose to produce modelling on COVID-19 deaths, apparently based on the fearmongering predictions of Neil Ferguson. But these same governments produced no modelling on deaths from cancelled surgeries, and no modelling on deaths from delayed cancer screenings.

If the British study anticipated as many as 3,621 avoidable deaths in a sample of 93,600 – roughly four per cent – it would be reasonable to expect a similar result in Canada. According to the Canadian Cancer Society, every day no less than 617 people are diagnosed with cancer,¹⁶⁵ which would be 37,534 diagnoses over a period of two months. If the number of diagnoses is reduced by half, as it was in Ontario for April and May, people still get cancer. If the cancer is untreated or if treatment is delayed there will be a cost. Approximately 18,000 Canadians with cancer did not receive a diagnosis in April and May alone, excluding people whose cancer went undiagnosed in March, June and July. How many of these 18,000 Canadians have died, or now face certain death due to the delay in cancer diagnosis? It must be remembered that chief medical officers and provincial health ministries have the data and the resources to track down specific information about these missed diagnostic procedures, and about the consequences. Thus far, governments have refused or failed to acquire this information, or have acquired this information but are refusing to disclose it to the public.

Instead, elected and unelected officials have worked unceasingly since March to continue to portray COVID-19 as an unusually deadly killer, even while readily available data tells us this is not the case. This singular fixation on one virus is sustained by

¹⁶⁵ <https://www.cancer.ca/en/cancer-information/cancer-101/cancer-statistics-at-a-glance/?region=on>.

promoting and maintaining public anxiety about COVID-19, as though it is the only (or the most important) cause of death to avoid.

An adverse consequence, by the way, is not only imminent death: It can also be a deterioration of a medical condition through delayed diagnosis that renders its treatment significantly more difficult, with reduced possibilities of full recovery. A CTV story¹⁶⁶ in August makes the case:

Dr. Antoine Eskander, a surgical oncologist at the Sunnybrook Health Sciences Centre in Toronto and adjunct scientist at the Institute for Clinical Evaluative Science (ICES), believes there has been a 20- to 50-per-cent drop in cancer surgeries due to the COVID-19 pandemic.

‘I can tell you as a scientist and as a surgeon I'm seeing the impact of it in the data,’ he said.

‘Delaying the diagnosis... has led patients to come in with larger tumors. More emergency surgery or add-on surgery, as opposed to elective or booked surgery, because people are presenting at a stage where they absolutely need an emergency procedure.’¹⁶⁷

The reduced number of diagnostic procedures can of course be to some degree attributed to the unwillingness of people who need them, to attend a hospital. But this unwillingness is based on the unfounded perception that COVID-19 is an unusually deadly killer, when the governments’ data and statistics says otherwise.

One Calgary doctor went public with his concerns in April:¹⁶⁸ “I’m afraid there could be patients who could have treatable issues that come in too late or get complications from issues that could have been prevented had they shown up earlier,” commented Dr. Jeff Shaw, a cardiologist at the Foothills Hospital.¹⁶⁹

¹⁶⁶ <https://www.ctvnews.ca/health/coronavirus/collateral-damage-doctors-worry-patients-diagnosed-with-more-advanced-cancers-because-of-delays-1.5063815>.

¹⁶⁷ <https://www.ctvnews.ca/health/coronavirus/collateral-damage-doctors-worry-patients-diagnosed-with-more-advanced-cancers-because-of-delays-1.5063815>.

¹⁶⁸ <https://globalnews.ca/news/6828509/coronavirus-other-illnesses-deaths/>.

¹⁶⁹ On Twitter Shaw described the professional anguish of witnessing the results of delayed diagnosis: “I lost the battle to save a patient last night because they waited too long to come to the hospital,” said Calgary cardiologist and internal medicine specialist Dr. Jeff Shaw on Twitter earlier this week. “I know there is a lot of fear of hospitals now and concern about being turned away. If you are sick and need help, hospitals are safe and are ready to look after you.” (14 April 2020.)

And from that the layman might deduce crude expectations of how many additional cancer deaths will be registered in this country, in a range of scenarios. The truth is, the layman should not have to. We rely upon governments to know these things and to make decisions with their factual findings in mind. But if the federal or provincial governments have even an estimate, they have not made it public, despite requests to do so.

As to cancer, one can look to the Canadian Medical Association.¹⁷⁰ The three prairie provinces provided incomplete information. But even on the basis of incomplete information, it was clear that, as one would expect, Ontario's experience was repeated across Canada: Diagnostic imaging was greatly reduced. It is however indicative of the difficulties faced by decision-makers that even within the three prairie provinces, reporting protocols vary and information is not provided in a timely way; Quebec and British Columbia provided none at all.

And again, people died because of delayed diagnosis. In one tragic example, in Aaron Ogden of Yorkton, SK died in a few weeks after his scheduled CT scan was cancelled August 2020.¹⁷¹ He was only 19.

As we have already argued, when governments try to do good, they have an obligation to ensure that they do not do more harm in the process.

3) Death from Suicide

Every year, approximately 4,000 Canadians commit suicide,¹⁷² one third of them aged 45-59. By how much will this figure rise as a consequence of Canadian governments' lockdown policies?

¹⁷⁰ <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7055947/>.

¹⁷¹ <https://regina.ctvnews.ca/man-s-death-after-delayed-ct-scan-appointment-prompts-questions-about-sha-restrictions-during-covid-19-1.5071436> [More info on this in our Saskatchewan lockdown paper].

¹⁷² <https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-canada-key-statistics-infographic.html>.

To be scrupulously fair to governments, suicide statistics are notoriously hard to assemble and for that reason, always out of date and perhaps not helpful when most needed. There are good reasons for this difficulty. Apart from the resistance of surviving family members to the classification of a loved one's death as 'intentional self-harm' – to use Statistics Canada terminology – the circumstances may also be opaque. Did the deceased overdose intentionally, or by accident? Was the spectacular motor vehicle accident really an accident, or the last desperate attempt by a demoralized man to provide financial security to his family through life insurance?

It is understandable that these things may take time to resolve. However, since March 2020 the actions of the federal, provincial and territorial governments have predictably elevated the unemployment rate to 13.7 per cent, and put 2.7 million Canadians out of work.¹⁷³ Canada's unemployment promptly rose therefore from 5.6% in February to 13.7% in May, an increase of 8.1%. As much as a lockdown, it was also a lockout.

Those who suffered most were typically young, inexperienced, low-income Canadians, almost all of them working in the private sector. But across the economy, those working in accommodation and food services, arts, entertainment and recreation, manufacturing, construction, education or as flight crew, suddenly found themselves not only confined to their homes but also harassed by bylaw officers if they left them, and obliged to deal with the pressures of confinement.¹⁷⁴

In June 2020 the Canadian Mental Health Association gave a graphic appraisal of what this was like:

Being confined to close quarters at home under physical distancing measures, with concerns about money (45%), job loss (31%) and having enough food to feed their families (21%), parents report having more conflicts with their children (23%), yelling/shouting more (17%),

¹⁷³

<https://www150.statcan.gc.ca/t1/tb11/en/tv.action?pid=1410028701&pickMembers%5B0%5D=1.1&pickMembers%5B1%5D=3.1&pickMembers%5B2%5D=4.1&pickMembers%5B3%5D=5.1&cubeTimeFrame.startMonth=02&cubeTimeFrame.startYear=2020&cubeTimeFrame.endMonth=06&cubeTimeFrame.endYear=2020&referencePeriods=20200201%2C20200601>.

¹⁷⁴ <https://www150.statcan.gc.ca/n1/daily-quotidien/201009/cg-a001-eng.htm>.

disciplining their children more (17%) and using harsh words more often (11%). “The pandemic is a perfect storm of stress for parents and their kids, with one in four reporting their children’s mental health has worsened during the pandemic,” says Anne Gadermann, co-lead researcher and professor at the School of Population and Public Health, UBC.

Surely it was anticipated in Ottawa, and in every provincial and territorial capital, that many people would be driven to desperate misery, and some to suicide.

The correlation between suicide and life’s adverse circumstances – unemployment, bankruptcy, the consequent loss of home, family and sense of purpose – has been widely studied, and that with precision. Indeed, in a pre-COVID study at the University of Calgary’s School of Public Policy, Professor Ron Kneebone provided a precise estimate of the all-Canada link between unemployment and suicide: “A one percentage point increase in the unemployment rate increases the suicide rate by 2.1 percent.”¹⁷⁵

This Alberta study was admittedly conducted after five years of reduction in the province’s dominant energy industry, but the Alberta figure was higher yet – 2.8 per cent. Thus, leaving aside considerations specific to Alberta, the Kneebone study still points to a disturbing question: If that ratio is applicable across the country, then Canada’s 8.1 per cent unemployment rate, multiplied by 2.1, means a 17% increase in the suicide rate. That in turn would equate to 680 additional deaths over the course of a year, based on the established rate of 4,000 suicides per year. Even if the increase in the unemployment rate was 8.1% temporary (for three months only), and then settled in at a 5% increase for the remaining nine months of the year, this would still mean more than 470 additional deaths by suicide.

Bear in mind that these 470 additional deaths relate only to the factor of unemployment, without taking into account other considerations that are also relevant to

¹⁷⁵ “A simple analysis of the data presented in the graph shows that in Alberta a one percentage point increase in the unemployment rate increases the suicide rate by a statistically significant 2.8 percent ($p = 0.05$). This sensitivity of the suicide rate to unemployment is somewhat larger than that in Canada as a whole, where a one percentage point increase in the unemployment rate increases the suicide rate by 2.1 percent.”
<https://www.policyschool.ca/wp-content/uploads/2019/09/Social-Policy-Trends-Suicide-Trends-September-2019-FINAL.pdf>.

suicide. Millions of Canadians have been cut off from meaningful connections with friends, family members, team-mates in a sports league, co-religionists at houses of worship, and a multitude of fun interactions in various recreational activities and entertainment pursuits. Canadians have been banned from taking vacations to warm and sunny places; prohibited from taking their kids to the swimming pool; prevented from attending their 12-step recovery programs; and fined for taking a walk outside. Unless zoom and skype are adequate substitutes for in-person connections, a proposition for which governments have provided no evidence, there is no reason to doubt that lockdown measures have driven more Canadians to kill themselves, apart from the factor of rising unemployment. No wonder then, that the CMHA reported the number of people admitting suicidal thoughts had more than doubled during the lockdown, to six per cent of those surveyed.¹⁷⁶ People are indeed suffering, especially men. The Samaritans (a crisis intervention charity) reports this on their website:

A new poll of 2,000 men aged 18 to 59 found that 42% of UK men said their mental health had been negatively affected by life in lockdown, with the charity pointing to the lack of social connection as a contributing factor.¹⁷⁷

And this from men's health charity, Movember:

Almost one fifth of men say their mental health has got worse since the start of the coronavirus outbreak, according to research from men's health charity Movember. Worryingly, nearly half say that nobody has checked to find out how they're coping. This suggests there are a lot of men suffering in silence.¹⁷⁸

The details may differ, but the trend is worldwide. *The Lancet* published a 63-country study of suicide during the economic recession of 2008-09. It concluded that "overall, 41,148 of suicides were associated with unemployment in 2007 and 46,131 in 2009, indicating 4,983 excess suicides since the economic crisis in 2008.... In all world regions, the relative risk of suicide associated with unemployment was elevated by about

¹⁷⁶ <https://cmha.ca/news/warning-signs-more-canadians-thinking-about-suicide-during-pandemic>.

¹⁷⁷ <https://www.samaritans.org/news/real-people-real-stories-launches-new-research-mens-mental-health-during-lockdown/>.

¹⁷⁸ <https://ca.movember.com/story/view/id/12234/nearly-half-of-canadian-men-say-no-one-has-asked-them-how-they-are-coping-during-lockdown>.

20–30% during the study period.”¹⁷⁹ *The Lancet* describes a period of recession in Canada in October 2009, when unemployment peaked at 8.6 per cent.¹⁸⁰ At that time, that translated to 400,000 Canadians out of work – not 2.7 million.

Sadly, the consequences of suicide are not limited to the deceased. Statistics Canada reports that for every death by suicide, at least 7 to 10 survivors are significantly affected by the loss.¹⁸¹ We do not know the cost of the lockdown, in death by suicide. But shockingly, neither does the government. Canada’s prime minister and premiers were specifically asked, in mid-April 2020, what impact lockdown measures would have on suicide rates. None have responded to this question, leaving the impression that governments are making no effort to learn the truth.

4) Death from accidental drug overdoses

For all the same reasons that the lockdown was likely to cause more suicides, it was likely to cause more deaths by drug overdose.

In this area alone, there has been some government attempt to anticipate the effects of COVID-19 lockdowns, on the use of opioids at least. Data has been received too late to be helpful in guiding a response. However, earlier this year (2020) the Public Health Agency of Canada (PHAC) developed a simulation model of opioid overdose deaths that attempted some estimate on the number of deaths that might occur during the COVID-19 outbreak in 2020.

As Health Canada explains,

With an average of 11 deaths and 13 hospitalizations every day between January 2016 and March 31, 2020, the opioid crisis is one of the most serious public health crises in Canada’s recent history.

¹⁷⁹ [https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(14\)00118-7/fulltext](https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(14)00118-7/fulltext).

¹⁸⁰ <https://www150.statcan.gc.ca/n1/pub/75-001-x/2009112/article/11048-eng.htm>.

¹⁸¹ <https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-canada-key-statistics-infographic.html>.

Recent data from several jurisdictions across Canada show a worrying increase in opioid-related harms and deaths since the beginning of the COVID-19 outbreak.¹⁸²

Indeed. Since the lockdown began, opioid use has soared, at least in western Canada and likely throughout Canada.¹⁸³

British Columbia

In British Columbia¹⁸⁴ between January 1 and August 31, 2020, 1,068 people died of opioid poisoning, a 51.9 per cent increase over the same period in 2019. Most of the increase came between April and August. Meanwhile, only 208 people died with COVID-19 during this eight month period, less than one fifth of the number of opioid deaths. Government policy seems to ignore the fact that opioid poisoning is a far more consequential public health threat in British Columbia than the virus that was claiming the headlines.¹⁸⁵ Unless and until governments put forward some hard evidence (not speculation and conjecture) that lockdowns have saved lives, and explain credibly the specific number of lives saved, these numbers suggest that lockdowns kill more people than the number of lives saved.

Alberta

In Alberta,¹⁸⁶ between January 1 and June 30, 2020, 449 people¹⁸⁷ died of opioid poisoning, a 47.20 per cent increase over the same period in 2019¹⁸⁸ when 305 died. By

¹⁸² <https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/data-surveillance-research/modelling-opioid-overdose-deaths-covid-19.html?wbdisable=true>.

¹⁸³ All four western provinces have shown increases in mortality rates in 2020 over 2019 (January to July) for the under 44, and 45 to 64 age groups. Statistics Canada Table 13-10-0768-01 and Table 17-10-0005-01.

¹⁸⁴ <https://www.cbc.ca/news/canada/british-columbia/overdose-deaths-bc-august-2020-1.5735247>.

¹⁸⁵ <https://globalnews.ca/news/7308384/bc-coronavirus-update-august-31/>.

¹⁸⁶ https://nationalpost.com/news/canada/in-alberta-261-people-have-died-from-covid-19-this-year-in-just-six-months-449-have-died-from-opioid-overdoses?fbclid=IwAR2DXXgt7Uvl-1bPE3HP3GLJGp2B5_KO8TwLFUY9bkPRpah3SIAMIERCRCe.

¹⁸⁷ <https://open.alberta.ca/dataset/f4b74c38-88cb-41ed-aa6f-32db93c7c391/resource/c23b895d-1922-4d73-86dc-ce170d0a07b3/download/health-alberta-opioid-response-surveillance-report-2019-q2.pdf>.

¹⁸⁸ <https://open.alberta.ca/dataset/f4b74c38-88cb-41ed-aa6f-32db93c7c391/resource/c23b895d-1922-4d73-86dc-ce170d0a07b3/download/health-alberta-opioid-response-surveillance-report-2019-q2.pdf>.

comparison, to the end of June, 154 had died of COVID-19.¹⁸⁹ The greatest increase in opioid deaths (307) came in the months of April through June.¹⁹⁰

Ontario

In June of 2020, Ontario's Chief Coroner announced a 25 per cent increase in suspected drug-related deaths in the province between March and May 2020, compared to the monthly median reported in 2019. Ontario's increase in drug-related deaths is likely driven by a combination of causes, including an increasingly toxic unregulated ('street') drug supply, but also by barriers to access to harm reduction services and treatment, and physical distancing requirements leading to more people using drugs alone while in state-mandated isolation.

National

Between January 1 and March 31, 2020, 1,018 people died of opioid poisoning in Canada, compared to 1,148 for the same period of 2019. With lockdowns in place for only the last two weeks of this three-month period, there was likely not much impact on the number of deaths. As of November, second and third quarter numbers for all of Canada opioid overdose deaths have still to be published.

There is no shortage of literature¹⁹¹ regarding the horrific impact that opioids have had on vulnerable, mostly drug-addicted Canadians. So the same kinds of questions that we ask about suicide must be asked about the governments' awareness of the peculiar situation of drug-addicted Canadians as officials contemplated lockdown as a response to COVID-19:

- Did Canada's federal, provincial and municipal governments consider how many people were already addicted, and what the risks would be?

¹⁸⁹ <https://www.cbc.ca/news/canada/calgary/what-you-need-to-know-alberta-june-30-1.5632581>.

¹⁹⁰ <https://open.alberta.ca/dataset/f4b74c38-88cb-41ed-aa6f-32db93c7c391/resource/45e03e51-0fa8-49f8-97aa-06b527f7f42c/download/health-alberta-opioid-response-surveillance-report-2020-q1.pdf>.

¹⁹¹ <https://www.cbc.ca/news/public-health-annual-report-opioid-deaths-skyrocket-1.5780129>.

- Did Canada’s federal, provincial and municipal governments know or consider what the consequences would be if already-vulnerable drug addicts were subjected to the additional stress of isolation, unemployment and prohibitions on in-person 12-step programs and other avenues of treatment? What did they think the outcome would be, if not more opportunity to consume drugs, more desire to seek the relief afforded by drugs, less support in overcoming addiction, and accidental deaths as a result?

Scientific evidence that would support the current restrictions appears to be non-existent. The lockdowns were established only upon speculation, predictions, and other untested theories, which have now been clearly discredited, if their errors were not evident from the outset.

Steam-driven data collection in a digital age

As our own efforts to secure information have revealed, decision-makers have struggled with timeliness, the dilemma of classification and changing data input. It is a particular failure of government that while it was incurring literally hundreds of billions of dollars in new debt, it has not invested in improving the organization of the health data that would better inform their decisions.

1) Timeliness

Health data is unlikely to be current. Statistics Canada receives data from provincial agencies. And each province gathers data for its own purposes, according to its own rules, often using different classifications for data. One province therefore might report on mastectomies and orthopaedic surgery in a timely way but delay release of data on other categories. Or simply classify several procedures as ‘other.’ Statistics Canada aggregates cancer statistics together as ‘malignant neoplasms,’ while some provinces report these numbers by detailed category, but not necessarily by the same detailed category as their neighbours to the east or west.

Some provinces report by the week. Others such as Ontario report by the quarter for certain medical conditions, but by the week for others. Meanwhile, another province offers a highly detailed breakdown, leaving the analyst to make further enquiries before he can populate his tables and make useful comparisons. This is not impossible, but it takes time. Depending upon the complexity of the data, the most up-to date information available to a decision-maker might easily be 18 months old.

2) *The dilemma of classification*

In the middle of a supposed pandemic, it is particularly necessary to understand the causes of death.

1. For example a lifelong smoker now in his eighties, has emphysema, diabetes and suffers a heart attack. Taken to hospital for the latter, he contracts pneumonia and dies. What should go on the death certificate as cause of death? Two busy physicians could make different determinations without either being at fault.
2. To pneumonia and influenza of course, can now be added COVID-19 as a life-ender for vulnerable and usually elderly people.
3. Suicide numbers in particular take longer to determine: A death that looks like an accident – a drug overdose perhaps – may upon closer examination prove to be an intentional act. (Or vice versa.)

Statistics Canada receives all death registration forms from the provinces, checks for completeness and quality of the data, receives revisions and additional information from the provinces and issues revised data (and publishes by how much the initial estimate has been revised). This does mean however, that political leaders do not have real-time information upon which to base decisions that have in some cases, life and death significance for citizens.

3) *Changing data input*

On March 24 in the U.S., the Center for Disease Control advised physicians, medical examiners, and coroners that COVID-19 would:

- Be recorded as the underlying cause of death ‘more often than not.’
- Be recorded as the cause of death listed in Part I of the death certificate¹⁹² even in assumed cases;
- Be recorded as the primary cause of death even if the decedent had other chronic co-morbidities. All co-morbidities for COVID-19 would be listed now in Part II, rather than in Part I as they had been since 2003 for all other causes of death.¹⁹³

This had the effect of elevating the number of COVID-19 deaths recorded in the U.S.

In Canada, similar instructions were issued, by for example the College of Physicians and Surgeons of British Columbia.^{194 195 196}

Inconsistency in testing criteria makes it particularly difficult to see the bigger picture, as with Case Fatality Rates (CFR). Even if it could be accepted that a test result in March is comparable to a test result in October – unlikely, since protocols and tests have changed since early in the crisis – the testing population changed. Early emphasis for COVID-19 testing was on travelers and close contact individuals with

¹⁹² Cause of death statement- This section of the certificate is divided in Parts I and II. Part I is used to show the immediate cause of death and any underlying cause or causes. Part II should be used for any significant condition or disease that contributed to the death but which is not part of the sequence leading directly to death.
<https://gpnotebook.com/simplepage.cfm?ID=x20120623140607030327#:~:text=This%20section%20of%20the%20certificate,sequence%20leading%20directly%20to%20death.>

¹⁹³ NVSS COVID-19 Alert No. 2.

<https://www.cdc.gov/nchs/data/nvss/coronavirus/Alert-2-New-ICD-code-introduced-for-COVID-19-deaths.pdf>.

¹⁹⁴ <https://www.cpsbc.ca/for-physicians/college-connector/2020-V08-02/04>.

¹⁹⁵ There is also some difficulty in comparing some Canadian data from the start of the COVID-19 event to the present day. For example, in March/April, only people who had been traveling, or had gone to hospital for any reason, were tested for COVID-19. This limited sample was more likely to test positive than the general (untested) population. As the accompanying table indicates, a high percentage of those tested at that time, yielded a positive result and became a ‘case.’ (In April, one person in 11.) This seemed to indicate the virus was widely distributed: What it actually showed was that 8.99 per cent of a chosen group (of about 454,000 individuals tested over a month) most likely to have been exposed to infection, had COVID-19.

However, in the week of 16th September 474,000 of the general population were tested, and only 1.66 per cent tested positive.

Can the two numbers be usefully compared? Not really, although some comfort may be had from knowing that the percentage of people who tested positive who actually died, fell from 10 per cent during the worst of the pandemic, to less than one per cent (of a very much higher number) by the end of October.

¹⁹⁶ This was consistent with the World Health Organization, which stated in a general instruction, “A death due to COVID-19 may not be attributed to another disease (e.g. cancer) and should be counted independently of pre-existing conditions that are suspected of triggering a severe course of COVID-19... COVID-19 should be recorded on the medical certificate of cause of death for ALL decedents where the disease caused, or is assumed to have caused, or contributed to death.” https://www.who.int/classifications/icd/Guidelines_Cause_of_Death_COVID-19.pdf?ua=1.

symptoms. Since then, testing has expanded far beyond that, including even children presenting with cold symptoms.

In Ontario, for example, the July-through-October period accounted for 72 percent of all ‘Patients approved for testing’ in 2020. That means that when COVID-19 was causing the most fatalities, in April and May, much less testing was happening.¹⁹⁷

During the early stages of an emerging outbreak, when not all cases are resolved or reported, improving crude CFR estimates by removing sources of bias can provide preliminary information for public health professionals and policy-makers on the population burden of disease. Further studies are needed to quantify the reporting rates given the possibility of asymptomatic infection, the underdiagnosis of COVID-19 cases owing to mild illness, and province-, country-or region-specific rates.

This quantification can improve CFR estimates to provide a more accurate measure of virulence for SARS-CoV-2 as it spreads through the populations in Canada and the US.¹⁹⁸

We look to Alberta for another example of how changing testing protocols can make data collection and comparison challenging. At the onset of COVID-19, Alberta tested very few people at first, and only the most serious cases. This was reasonable; tests kits were scarce in March. Alberta then expanded the testing regimen, ultimately inviting anybody who wanted a test to receive one. Selected drug stores were authorized to conduct testing on a walk-in basis. Next Alberta returned to a more limited invitation: only those with symptoms should be tested. So while it is always possible to compare positive results with tests administered, the results are less useful than they might have been.

There are other factors affecting the CFR over time. Based on reported numbers, the crude CFR (cumulative deaths/cases) for Canada peaked at 8.4 percent in June and dropped to 4.9 percent by mid-October.

¹⁹⁷ The comparable figure for all of Canada was 68 per cent.

¹⁹⁸ <https://www.cmaj.ca/content/192/25/E666>.

Was the disease more lethal in its early stages? That the same virus, in and of itself, would be more lethal or less lethal at different times seems highly unlikely. These different rates suggest that by the end of May 2020, the virus had made its way through society to a large extent, sadly taking the lives of vulnerable people, but without posing any danger to approximately 90 per cent of Canadians. Or perhaps treatments improved over time?

On October 27, 2020, Alberta’s Chief Medical Officer Dr. Hinshaw ordered that residents of Edmonton and Calgary should gather in groups no larger than 15 for social events, citing rising numbers of “cases.” In late November, social visits were prohibited entirely, a lockdown measure more severe than in most of Ontario. This is an excellent example of the over-urgent tendency to lock-down. What has been counted in Alberta and elsewhere as COVID-19 “cases” includes thousands of instances of people who test positive but experience no symptoms or illness; hospitalization rates are 2% to 3% of the number of “cases.” Further, government officials have yet to explain why, specifically, it is insufficient for individuals to safeguard their vulnerable loved ones (elderly people with pre-existing conditions) on an individual basis, and why it is necessary to curtail the human rights and fundamental freedoms of those not threatened by the virus. Government restrictions that violate the *Charter* freedoms of Canadians who are not threatened by the virus (roughly 90% of the population) are not properly grounded in relevant considerations such as the numbers of deaths, hospitalizations, and ICU capacity.

Were deaths more likely to be determined as COVID-19 early in the pandemic?

Date	Deaths	Tests	Positives	Deaths/Cases	Pos/Tests %
19-Feb-20	0	0	7	0	
26-Feb-20	0	0	5	0	
4-Mar-20	1	0	33	3.03	
11-Mar-20	6	44,176	134	4.48	0.3
18-Mar-20	19	80,886	825	2.3	1.02
25-Mar-20	69	116,076	3685	1.87	3.17
1-Apr-20	284	106,967	7848	3.62	7.34
8-Apr-20	523	106,878	9611	5.44	8.99

15-Apr-20	931	114,895	9736	9.56	8.47
22-Apr-20	1012	184,922	12004	8.43	6.49
29-Apr-20	1184	187,802	11173	10.6	5.95
6-May-20	1126	202,966	11373	9.9	5.6
13-May-20	743	194,403	8179	9.08	4.21
20-May-20	727	163,019	7867	9.24	4.83
27-May-20	756	221,260	6938	10.9	3.14
3-Jun-20	502	231,469	4917	10.21	2.12
10-Jun-20	316	261,011	3608	8.76	1.38
17-Jun-20	241	266,139	2686	8.97	1.01
24-Jun-20	137	287,284	2165	6.33	0.75
1-Jul-20	120	250,019	2296	5.23	0.92
8-Jul-20	87	282,311	2035	4.28	0.72
15-Jul-20	64	314,245	2544	2.52	0.81
22-Jul-20	50	282,464	3537	1.41	1.25
29-Jul-20	46	337,329	3106	1.48	0.92
5-Aug-20	33	305,226	2673	1.23	0.88
12-Aug-20	53	338,425	2667	1.99	0.79
19-Aug-20	46	324,914	2720	1.69	0.84
26-Aug-20	42	340,463	2938	1.43	0.86
2-Sep-20	21	345,572	3814	0.55	1.1
9-Sep-20	35	401,039	4502	0.78	1.12
16-Sep-20	46	474,822	7860	0.59	1.66
23-Sep-20	57	528,042	10298	0.55	1.95
30-Sep-20	239	464,277	14362	1.66	3.09
7-Oct-20	124	510,375	15558	0.8	3.05
14-Oct-20	140	531,422	16807	0.83	3.16

<https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html>.

Table VIII: Deaths, tests and positives

Were other approaches considered?

It is also inexcusable, not to mention contrary to the *Charter*, that Canada's federal and provincial governments chose not to seriously examine options that might have justified less destructive policies.

Protect the vulnerable, allow less-vulnerable people to work

Right at the start, the World Health Organization issued an advisory that COVID-19 is age selective. On March 4, by way of UNICEF, which with the WHO is a part of the United Nations System,¹⁹⁹ the WHO made public what has turned out to be one of the most significant (and most ignored) facts about COVID-19:

Older people, and people with chronic medical conditions, such as diabetes and heart disease, appear to be more at risk of developing severe symptoms. We know it is possible for people of any age to be infected with the virus, but so far there are relatively few cases of COVID-19 reported among children.²⁰⁰

The WHO linked COVID-19 to the “same family of viruses as Severe Acute Respiratory Syndrome (SARS) and some types of common cold.”²⁰¹

The WHO implication was clear: Governments should protect the most vulnerable but allow those least likely to suffer serious harm from the virus to continue going to work²⁰² not to mention going to school, university, the gym, or a house of worship.

This was before COVID-19 was even declared a pandemic, and three weeks before the governments of Canada had committed themselves to locking down millions of healthy people, something never tried before in human history; during all previous millennia of recorded history, quarantine has been for sick people, not healthy ones.

¹⁹⁹ https://www.un.org/en/pdfs/18-00159e_un_system_chart_17x11_4c_en_web.pdf.

²⁰⁰ https://www.unicef.org/media/66216/file/Key%20Messages%20and%20Actions%20for%20COVID-19%20Prevention%20and%20Control%20in%20Schools_March%202020.pdf.

²⁰¹ *Ibid.*

²⁰² Among others, Texas Lt. Governor Dan Patrick. <https://www.youtube.com/watch?v=fP1GkV06PYY>.

The Great Barrington Declaration

A practical approach to protect the vulnerable without harming the remaining 90% of the population was announced by internationally recognized medical doctors and infectious disease specialists on October 4, 2020. Three respected epidemiologists²⁰³ from Harvard, Stanford and Oxford universities, none with known political affiliations, published the Great Barrington Declaration,²⁰⁴ advocating for ‘Focussed Protection’ for the vulnerable, while letting the healthy get back to work.

The Declaration’s main argument is worth quoting at length.

Current lockdown policies are producing devastating effects on short and long-term public health. The results (to name a few) include lower childhood vaccination rates, worsening cardiovascular disease outcomes, fewer cancer screenings and deteriorating mental health – leading to greater excess mortality in years to come, with the working class and younger members of society carrying the heaviest burden. Keeping students out of school is a grave injustice.

Keeping these measures in place until a vaccine is available will cause irreparable damage, with the underprivileged disproportionately harmed.

Fortunately, our understanding of the virus is growing. We know that vulnerability to death from COVID-19 is more than a thousand-fold higher in the old and infirm than the young. Indeed, for children, COVID-19 is less dangerous than many other harms, including influenza.

As immunity builds in the population, the risk of infection to all – including the vulnerable – falls. We know that all populations will eventually reach herd immunity – i.e. the point at which the rate of new infections is stable – and that this can be assisted by (but is not dependent upon) a vaccine. Our goal should therefore be to minimize mortality and social harm until we reach herd immunity.

The most compassionate approach that balances the risks and benefits of reaching herd immunity, is to allow those who are at minimal risk of death

²⁰³ Dr. Martin Kulldorff, professor of medicine at Harvard University, a biostatistician, and epidemiologist with expertise in detecting and monitoring infectious disease outbreaks and vaccine safety evaluations. Dr. Sunetra Gupta, professor at Oxford University, an epidemiologist with expertise in immunology, vaccine development, and mathematical modeling of infectious diseases.

Dr. Jay Bhattacharya, professor at Stanford University Medical School, a physician, epidemiologist, health economist, and public health policy expert focusing on infectious diseases and vulnerable populations.

²⁰⁴ <https://gbdeclaration.org/>.

to live their lives normally to build up immunity to the virus through natural infection, while better protecting those who are at highest risk. We call this Focused Protection.²⁰⁵

This is no partisan manifesto. The authors describe themselves as “coming from both the left and the right and from around the world.” They launched the Declaration with co-signatures from 42 like-minded medical professionals. As of early November, the Declaration had attracted the signed support of 11,618 medical and public health scientists, and 33,129 medical practitioners.²⁰⁶

In spite of all the known lockdown harms that had emerged by this time, it was summarily rejected by many politicians. Some commentary was vicious. One of the three leading signatories, Dr. Sunetra Gupta, says she has had e-mails calling her ‘evil.’ Others called the Declaration ‘age-based apartheid,’ ‘unethical and simply not possible,’ and ‘f***ing stupid.’²⁰⁷

But notwithstanding the logic of focused protection, it does not appear that any government in Canada seriously considered any alternative to lockdowns, in spite of the fact that this experiment of locking up healthy people had never been tried before in any country, region or civilization in human history.

The WHO warns about lockdowns – Canada has yet to listen

On October 15, the World Health Organization stated that while lockdowns can slow COVID-19 transmission by limiting contact between people, “these measures can have a profound negative impact on individuals, communities, and societies by bringing social and economic life to a near stop.”²⁰⁸ Canada’s provincial and federal governments evidently do not agree with (or are not prepared to consider) the World Health Organization’s assessment of the negative consequences of lockdown. On October 27,

²⁰⁵ *Ibid.*

²⁰⁶ <https://gbdeclaration.org/view-signatures/>.

²⁰⁷ “The idea is... unethical and simply not possible,” wrote Professor Sir Robert Lechler, president of the Academy of Medical Sciences, this weekend. Sir Simon Stevens, the chief executive of NHS England, called it “age-based apartheid”. “That’s everyone being polite”, says Dr Rupert Beale, a group leader at the government-funded Francis Crick Institute in London. “What everyone really thinks is, ‘this is all f***ing stupid’.” <https://www.standard.co.uk/news/health/coronavirus-scientists-at-war-a4569551.html>.

²⁰⁸ <https://www.who.int/news-room/q-a-detail/herd-immunity-lockdowns-and-covid-19>.

Prime Minister Trudeau warned Canadians of continued restrictions and that even after a subdued Halloween, “There may not be the kinds of family gatherings we want to have at Christmas.”²⁰⁹ Dr. Tam echoed the prime minister a few days later that “this is a different kind of Christmas,” and that families would need to follow “basic core public health measures.”²¹⁰

There is a moral argument against the measures that have been imposed on young Canadians. The one clear understanding we had of COVID-19 from the onset was that it primarily affects older people with pre-existing and serious medical conditions, as is true for all flu-like infections. Yet we have imposed severe restrictions on young people, including very young children, despite the almost zero risk COVID-19 poses to their health, often in the name of “protecting grandma.” What governments fail to explain is that the best way to protect grandma is for her own family members to take appropriate precautions, for example: connect with her only by zoom or skype, or stay six feet away if visiting in person, or meet with her only outdoors, or refrain from hugs and handshakes. Forcing all school children to live in a constant state of fear by mask-wearing and keeping distance from others does nothing to help individual grandmothers, many of whom deliberately and knowingly choose in-person contact with their grandchildren and their friends over a lonely existence that might decrease the chance of catching the virus. Government restrictions on schools, sporting activities, gyms, entertainment events and even outside gatherings are a manifestation of this.

Perhaps the preferred option should be finding a way to live with COVID-19 and minimize its damage, rather than continuing with a futile effort to stop the virus entirely. As Ottawa’s Medical Officer of Health, Dr. Vera Etches, told the Ottawa health board,²¹¹ as a 29-day lockdown was lifted in Ottawa: “I have suggested to the province we find a more balanced approach for the way forward. The approach I’m recommending is that

²⁰⁹ <https://nationalpost.com/news/politics/the-covid-19-pandemic-really-sucks-and-christmas-is-now-in-jeopardy-trudeau-warns>.

²¹⁰ <https://www.iheartradio.ca/580-cfra/news/dr-tam-fires-back-at-messaging-criticism-says-advice-evolved-with-science-1.13843610>.

²¹¹ <https://thepostmillennial.com/ottawa-top-doctor-says-people-need-to-learn-to-coexist-with-covid>.

we learn to coexist with COVID with care.” Dr. Etches said it was crucial to “balance harms,” going forward.

We definitely see harms from the transmission of COVID and we’re worried about hospitalizations and deaths and people not being well. But we’re also seeing really significant harms from the closures and the impact on people’s businesses and employment and people’s mental health. We need to find new ways to live with the virus.²¹²

It is another option. And given that there are and always were alternatives, it’s fair to question then, why Canada’s federal and provincial governments:

- 1) Had the confidence to take the actions they did, in the absence of sufficient data and without considering the very predictable lockdown harms to the well-being of Canadians that are discussed at length in this paper; or
- 2) Why the possibility of instead protecting the vulnerable part of the population and letting the non-vulnerable part go to work and otherwise maintain their physical and mental health, was never seriously contemplated.

Section Five – Flying Blind

Science, Experts and Political Leadership

Canadians who are understandably confused by governmental determination to ignore the hidden yet painfully real costs of imposing and re-imposing lockdowns, may question the motives, even the good faith, of their elected representatives. The expert knowledge of men and women who have devoted their adult lives to the study of epidemiology is a national resource of the first importance. Although it is possible and in some cases necessary to question the competence of unelected officials, it is seldom necessary to question their good faith. As for elected officials, being inadequately informed of the competing harms of government policy, they are much more likely to be

²¹² *Ibid.*

driven in their overreach simply by the fear of being held responsible for multiple deaths, than their willing participation in some malicious design.

The mission of the Justice Centre for Constitutional Freedoms is to hold governments accountable when they violate the rights and freedoms set out in the *Canadian Charter of Rights and Freedoms*. Lockdown measures violate our *Charter* freedoms to move, travel, associate, assemble and worship, and to date no politician or public health official has denied this. The *Charter* places the onus on governments to justify *Charter* violations as reasonable and truly necessary; there must be a rational connection between a particular measure and a particular outcome. There is no onus on the citizen to explain why violations of her *Charter* freedoms are not justified.

However, the incentives of medical experts and political leaders are not the same. The expert from whom a safety strategy is requested has no incentive to offer anything but a plan that from a medical perspective is as bullet-proof as it can be. They do so on the understanding that if their advice has non-medical consequences, it falls to political leadership to decide what consequences are acceptable.

Professor Neil Ferguson is explicit about this in his March report,

We do not consider the ethical or economic implications of either strategy here, [mitigation or suppression] except to note that there is no easy policy decision to be made. Suppression, while successful to date in China and South Korea, carries with it enormous social and economic costs which may themselves have significant impact on health and well-being in the short and longer-term. Mitigation will never be able to completely protect those at risk from severe disease or death and the resulting mortality may therefore still be high. Instead we focus on feasibility, with a specific focus on what the likely healthcare system impact of the two approaches would be.²¹³

In other words, the advice to government is, “If you don’t follow my advice, people will die. But it’s your call.”

²¹³ <https://www.imperial.ac.uk/media/imperial-college/medicine/sph/ide/gida-fellowships/Imperial-College-COVID19-NPI-modelling-16-03-2020.pdf>.

It would have been helpful if Ferguson (and public health officials who followed his lead) had been more specific about the obvious and predictable lockdown harms – the things he conceded would be ‘enormous social and economic costs.’ For, these include the deaths and suffering implicit in cancelled surgeries and diagnostic testing as we have described earlier, as well as the likely increase in suicide and drug-related deaths. To ignore these, is by default to choose to kill Peter in order to save Paul: There can be no moral basis for such a decision. And it would not have been beyond the mandate of public health officials to advocate that concern for “public health” cannot be limited to concern for only one virus, to the exclusion of a broader and more wholesome concern for public health. There is more to public health than not dying of COVID. Indeed, to the degree that economic harm limits a country’s capacity to respond to this and future public health emergencies, it is very much within the purview of public health officials to point that out.

But to repeat, such is the adversarial nature of politics and reportage, there is no reward for a medical expert who offers a nuanced plan that recognizes non-medical priorities that turns out to be correct. There can be professional ruin, however, if such a plan can be portrayed as leading to identifiable deaths from an identified and well-publicized virus. (Meanwhile, deaths from other causes draw less attention.)

The incentive for medical experts then, is always to play it safe.

Political leadership meanwhile, seldom has expert understanding of its own upon which to draw. Hence their first problem is knowing which science to believe.

With that decided, the primary driver for elected representatives is their fear that whatever they do, they will be held responsible for deaths that however inevitable or unavoidable they might in fact have been, will be represented by their opposition and by grieving survivors as negligence or a callous preference for the economy over human lives. Unfortunately, Canada’s federal and provincial elected officials will have to contend with the grieving relatives of those who died from drug overdoses, or because their medically necessary surgery was cancelled: there is no easy political route in any

event. Still, it appears that the politicians' safest response is to say that they always followed the best expert advice available.

If things go well, there will be no hard questions. If they go badly, it's still their safest answer. But for the politician whose incentive is to be re-elected, that makes all other considerations secondary, especially economic ones.

And here we see where Canadian governments have been 'flying blind.'

The function of a government is to make exactly those kinds of decisions, to weigh risk against benefit, priority against priority. Unfortunately, apart from the realms of conjecture, assertion and speculation, our elected leaders have not yet provided actual evidence to demonstrate that closing down society and the economy has saved lives, nor that continued lockdown measures will save lives. Canadian politicians did not have sufficient information to do that in March and arguably in April, but since at least May they have had plenty of information by which to reconsider lockdowns. Having been informed of the harms they were being asked to avoid – the relatively small number of lives at risk from COVID-19 – they failed to investigate the alternative social, economic and health harms their lockdown would inflict on all of society. This was arguably excusable in March and April, but not since May of 2020, by which time the government's own data made it abundantly clear that COVID-19 would not kill millions of people and would not inflict permanent health damage on large numbers of younger people. The politicians could have asked themselves the tough questions about lockdown harms that needed to be asked. Moreover, they could have and should have answered those questions when citizens asked them, and can still answer them today.

They could have considered alternative approaches. But they didn't.

And so:

- 1) *Decisions made in the belief that they were informed by science were often quickly revealed as ill-conceived, yet were continued – some, such as renewed lockdown measures in several provinces, to this day.*

As detailed in Appendix A, expert advice has proved unreliable and, on many occasions, self-contradictory.²¹⁴ Important data that should have informed decisions of consequence, was incomplete or out of date. Governments lacked the statistical detail necessary to make well-informed decisions regarding the extent and effect of COVID-19 in Canada, and to properly estimate the unintended consequences of their actions. Vital questions, in particular the intensity and gravity of predictable lockdown harms, were not even asked.

As a result, while complete certainty eludes us, the data and statistics set out in this paper provide ample reason to believe that political leaders, in a panicked effort to save people from dying of COVID-19, have instead caused the deaths of many other people through cancelled surgeries and diagnostic procedures, as though it was somehow worse to die of COVID-19 than from other causes. Tragically, some people have responded to the lockdown by increasing their use of drugs, and some by taking their own lives.

- 2) *Not only was there too little information, there was insufficient consideration of what information there was: Decisions were made precipitately, in great haste.*

After all, the COVID-19 pandemic was considered serious enough to put millions of Canadians out of work and incur hundreds of billions of dollars in new debt on behalf of all Canadians (especially younger ones), with no end in sight. It is therefore scandalous that governments at all levels did not gather the data they needed to fully inform the decisions they made: Given the size of the government intervention in society,

²¹⁴ Occasionally, it has also been frivolous, as when Canadian Chief Medical Officer Dr. Theresa Tam recommended masturbation as the safest way to have sex. <https://www.canada.ca/en/public-health/news/2020/09/statement-from-the-chief-public-health-officer-of-canada-on-september-2-2020.html>.

too little time was taken to consider not only intended consequences, but the unintended consequences.

Further, elected and unelected government officials seem to believe that they must choose between saving the economy and saving lives.

This is a false dichotomy.

This claim ignores the simple fact that healthcare requires money, and first-rate healthcare requires a lot of it. A crippled economy that is riddled with high rates of unemployment, bankruptcies, insolvencies and other business failures will not generate enough money for good healthcare, resulting in Canadians dying prematurely because of inadequate or inferior healthcare. Further, the accumulation of hundreds of billions of dollars in new debt, which our children and grandchildren will need to repay with interest, will also reduce the ability to fund medical care and long-term care facilities (nursing homes). A strong and prosperous economy is the only way to generate sufficient wealth to pay for needed medical services. The problem of lockdown measures should not, therefore, be framed in terms of economic profitability versus saving lives.

Considerable time will pass before we can calculate the full cost—in health and in lives—of the predictable increases in anxiety, depression, mental illness, and suicide caused by government-mandated and government-enforced social isolation, and the predictable increases in unemployment, bankruptcies, insolvencies and poverty that lockdown measures have inflicted on Canadians.

In sum, all levels of Canadian government over-reacted to the COVID-19 pandemic. In doing so, they arbitrarily and intentionally limited Canadians' *Charter* freedoms to move, travel, associate, assemble and worship. They should have known better and could have known better: Their limitation on Canadians' *Charter* freedoms was not demonstrably justified in March, nor are further lockdown measures justified in November of 2020.

Essentially governments abdicated their role to unelected and unaccountable officials: chief medical officers. And in so doing, apart from all other failures here

described, elected policy-makers at all levels of government who ultimately bear responsibility for government actions, forgot the golden rule of political decision-making:

Experts should be on tap.

They should not be on top.

Authorship

This paper was researched and written by the Justice Centre's staff lawyers and paralegals, with input from medical doctors.

Appendix A: Mixed messages: How the story changed

On February 21, Dr. Tam indicated that the risk of spread in Canada “remains low.” On March 15, Dr. Tam indicated that “COVID-19 is a serious public health threat.” See [here](#) for quotes and more information.

<https://www.canada.ca/en/public-health/news/2020/02/statement-from-the-chief-public-health-officer-on-the-release-of-repatriated-canadians-from-quarantine-following-14-day-stay-at-cfb-trenton.html>.

In April, the WHO indicated that “(a)n assessment of the public health impact of PHSM (lockdowns) for COVID-19 is not yet available but is needed.” In October, a WHO official indicated that lockdowns are only “justifiable” to buy time and that they have one sure effect: that they make “poor people an awful lot poorer.” See [here](#) for quotes and more information.

https://apps.who.int/iris/bitstream/handle/10665/331773/WHO-2019-nCoV-Adjusting_PH_measures-2020.1-eng.pdf

On March 15, Dr. Tam claimed that border closures do not work. The next day, PM Trudeau announced the closure of the Canadian border. See [here](#) for quotes and more information.

<https://www.youtube.com/watch?v=KBPbAiNVaXs&list=PLdgoQ6C3ckQsEGVFpZLo pNrugclGjfs9e&index=355> at 1:15.

On March 25, Dr. Tam recommended against the use of masks for people who are asymptomatic.

On April 6, Dr. Tam now recommended masks for asymptomatic people who are unable to socially distance. Sometime during the week prior to November 4, the Public Health Agency of Canada quietly updated its guidance to acknowledge the reality of aerosolized transmission of COVID-19, undermining the efficacy of social distancing and of single-layer masks. See [here](#) for quotes and more information.

On April 25, Premier Ford said that lockdown protesters were “yahoos” and “absolutely irresponsible.” On June 5, Premier Ford applauded anti-racism protesters saying that he “always encourage(s) peaceful and safe protest.” See [here](#) for quotes and more information.

On March 5, Dr. Williams the Ontario Chief Medical Officer of Health stated with regard to PCR testing “(The virus) can be found, but of course, some of those tests that find those are PCR tests which detects (*sic*) pieces of virus. (Is the virus) viable or not is another question.”

Global News https://www.youtube.com/watch?v=AEiy4E_jXLM at 21:00.

General Danger of Covid

2020-02-21 Tam - “I want to assure Canadians that the risk of spread of the novel coronavirus within Canada remains low.”

<https://www.canada.ca/en/public-health/news/2020/02/statement-from-the-chief-public-health-officer-on-the-release-of-repatriated-canadians-from-quarantine-following-14-day-stay-at-cfb-trenton.html>.

2020-02-04 Hajdu – “Mr. Speaker, one of the interesting elements of the coronavirus outbreak has been the spread of misinformation and fear across Canadian society. That was actually noted by an interviewer on the weekend. In fact, she asked me how Canadians can be assured that they are getting the right information. One way might be if the opposition does not sensationalize the risk to Canadians and allows Canadians to understand where they can find a wealth of information.” Hansard

<https://www.ourcommons.ca/DocumentViewer/en/43-1/house/sitting-14/hansard>.

2020-03-15 Tam – “COVID-19 is a serious public health threat. . . . Today, I am asking everyone to take strong action to help us delay the spread of COVID-19”. CBC News <https://www.youtube.com/watch?v=VG83vVr3Oqc> at 1:15.

Lockdowns

2020-04-15 WHO - “An assessment of the public health impact of PHSM (*Public Health and Social Measures: i.e. lockdowns*) for COVID-19 is not yet available but is needed. This assessment needs to take into account the social consequences and economic costs of such measures, which may be considerable.”

<https://www.who.int/publications/i/item/considerations-in-adjusting-public-health-and-social-measures-in-the-context-of-covid-19-interim-guidance>.

2020-10-09 WHO – “(W)e are saying that we really do have to learn how to coexist with this virus in a way that doesn’t require constant closing down of economies, but at the same time, in a way that is not associated with high levels of suffering and death. It is what we are calling the middle path. And the middle path is about being able to hold the virus at bay, whilst keeping economic and social life going.

...

We think lockdowns only serve one purpose, and that is to give you a bit of breathing space. . . . While you have got that breathing space you should be really building up your testing, building up your contact tracing, building up your local organization so that as you release lockdown—you are bound to get more cases, but you can deal with it really, really elegantly.

...

We in the (WHO) do not advocate lockdowns as the primary means of controlling this virus. The only time we believe a lockdown is justified is to buy you time to reorganize, regroup, rebalance your resources, protect your health workers who are exhausted. But by and large we would rather not do it. . . .

...

(W)e may well have a doubling of world poverty by next year. We may well have at least a doubling of child malnutrition. . . . This is a terrible, ghastly global catastrophe. . . . So we really do appeal to all world leaders, stop using lockdown as your primary

control method. . . . (R)emember, lockdowns just have one consequence that you must never ever belittle, and that is, making poor people an awful lot poorer.”

Dr. David Nabarro, WHO Special Envoy on COVID-19. The Spectator
<https://www.youtube.com/watch?v=eNOxl6kH4QQ>.

Borders

2020-02-17 Hajdu – “I understand that (there are) some voices that would say that we should shut down the border to China. . . . Canada is following expert advice from the World Health Organization and working closely with allied partners. . . who have decided to take a different approach than the Australians and the Americans have taken for a whole bunch of reasons. First being, that it’s much easier to support people from a region that’s experiencing such an outbreak if we know where they are coming from. And the evidence says when you shut down a border like that, it gets much harder to detect where people are coming from because people are determined to get into a country or return home, and they will find alternative routes to do so.

Secondly, the long-term implications of shutting down borders is, one, they are not very effective in controlling disease, as a fact, they are not effective at all, and secondly, they actually long term can create a greater risk to global public health and here is why: China has been very open (W)hat we know is that, within a week or so, they were letting the World Health Organization and therefore, all of the partner countries know that they had an outbreak on their hand(s). And more than that, they were sharing the sequence of the virus, which was really important to other countries like Canada to be able to have the evidence to do the investigation and the testing in Canada. Imagine now if countries were to suspect that if they had an outbreak, the border would get closed, there would be sanctions economically and all of a sudden. . . countries stopped sharing that information.”

Global News <https://www.youtube.com/watch?v=L3O1EBQXI6U> at 11:45.

2020-02-25 Tam - In response to a question on the closure of borders: “It may be sort of anti-intuitive for people to understand this, but the more countries that are impacted means that your border measures are going to be much less effective and definitely not feasible. So we are . . . focusing on general messaging to all travelers.” CTV News <https://www.youtube.com/watch?v=cytI7bb9hX0> at 2:30.

2020-03-15 Tam - On closure of border: “So the science . . . if you look at the global epidemiology to date . . . countries that have enacted travel bans, for example, have not been able to keep out this particular virus.”

CBC News <https://www.youtube.com/watch?v=VG83vVr3Oqc> at 25:00.

2020-03-16 Trudeau – “(W)e will be denying entry to Canada to people who are not Canadian citizens or permanent residents. This measure will carve out some designated exceptions including. . . U.S. citizens.”

CPAC

https://www.youtube.com/watch?v=KBPbAiNVaXs&list=PLdgoQ6C3ckQsEGVFpZLo_pNrugclGjfs9e&index=355 at 1:15.

2020-03-18 Trudeau – “We have agreed that both Canada and the United States will temporarily restrict all non-essential travel across the Canada/U.S. border.” CPAC CPAC <https://www.youtube.com/watch?v=NrNDt2JVEde> at 0:20.

2020-04-27 Tam – Referring to U.S. border: “To execute an actual border reduction wasn’t actually very obvious in any of our planning. . . because we just felt well, the virus is both sides.”

CBC News <https://www.youtube.com/watch?v=711ytyCWsCM> at 3:30 and 34:00.

Masks

2020-02-25 Tam - “We are advising people not to just generally walk about wearing masks. That’s not going to be effective.

CTV News <https://www.youtube.com/watch?v=cytI7bb9hX0> at 4:15.

2020-03-30 Tam - “I think the scientific evidence is that if you are sick, then put on a mask to prevent those droplets from flying . . . in any space as you are perhaps going to the clinic or having to move yourself around the community for essential needs. Putting a mask on a (sic) asymptomatic person is not beneficial, obviously, if you are not infected. . . . What we worry about is actually the potential negative aspects of wearing masks where people are not protecting their eyes or other aspects of where the virus could enter your body and that gives you a false sense of confidence. But also, it increases the touching of your face. If you think about it, if you have got a mask around your face, sometimes you can’t help it. . . . The other thing is the outside of the mask could be contaminated as well. . . . (E)ven in a hospital setting, we find that it’s removing a person’s protective equipment that can actually lead to infection.”

CTV News https://www.youtube.com/watch?v=_edxN5kkBtc at 0:30.

2020-04-06 Tam - Mask policy change due to pre-symptomatic and asymptomatic transmission: “(T)he special advisory committee has come to a consensus that wearing a non-medical mask, even if you have no symptoms, is an additional measure that you can take to protect others around you.”

660 News <https://www.youtube.com/watch?v=nDtChBAevUQ> at 0:45.

Incidentally, the WHO modified their mask recommendations on the same day. https://apps.who.int/iris/bitstream/handle/10665/331693/WHO-2019-nCov-IPC_Masks-2020.3-eng.pdf?sequence=1&isAllowed=y.

2020-05-21 Tam - “(I)t’s when we got more evidence about asymptomatic and pre-symptomatic individuals. . . . (I)t is an added layer of protection even for people who don’t have symptoms to wear a mask to prevent transmission to others. And even though the evidence base hasn’t changed too much. . . the chief medical office has felt that they

can recommend this for people who cannot maintain that two metre distance.” CTV News <https://www.youtube.com/watch?v=asDYGyQxcq4> at 0:40.

2020-05-27 Tam - “During high heat and humidity, wearing a mask can make breathing difficult. Therefore, when you are outdoors, maintaining physical distancing is best. Reserve the mask for use indoors for short periods of time when physical distancing cannot be maintained.”

<https://www.canada.ca/en/public-health/news/2020/05/statement-from-the-chief-public-health-officer-of-canada-on-covid-197.html>.

2020-09-02 Tam - “The lowest risk sexual activity during COVID-19 involves yourself alone. . . . When engaging in sexual activity you can reduce your risk by . . . consider(ing) using a mask that covers the nose and mouth.”

<https://www.canada.ca/en/public-health/news/2020/09/statement-from-the-chief-public-health-officer-of-canada-on-september-2-2020.html>.

2020-11-04 MSN News - Sometime during the week prior to November 5, the Public Health Agency of Canada quietly updated its guidance to acknowledge the reality of aerosolized transmission of COVID-19, undermining the efficacy of social distancing and of single-layer masks. MSN News

<https://www.msn.com/en-ca/news/canada/canada-quietly-updates-covid-19-guidelines-on-risk-of-airborne-spread/ar-BB1aHqPO?li=AAggFp5;>

Public Health Agency of Canada

<https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/prevention-risks.html>.

Protests

2020-04-25 Ford – On anti-lockdown protests: “You see these people that are absolutely irresponsible, its reckless to do what they are doing. And personally, I think its selfish. . . . (W)e have a bunch of yahoos out in the front of Queen’s Park, sitting there protesting that the place isn’t open, as they’re breaking the law and putting everyone in

jeopardy, putting themselves in jeopardy. . . . We are better than this as a people, as a province.”

CBC News <https://www.youtube.com/watch?v=LDLoqaET2Xg> at 0:35.

2020-06-05 Ford – On anti-racism protests: “I always encourage peaceful and safe protest or march. I think that’s important, that’s how you get your voice heard.”

Global News <https://www.youtube.com/watch?v=NODqHBTSJ0E> at 26:40.

2020-06-08 Trudeau – On anti-racism protests “We have seen that people feel a deep need to stand in solidarity with racialized Canadians, with indigenous Canadians who continue to face unacceptable levels of systemic discrimination in this country. This is a time for people to make sure their voice is (sic) heard. But it’s also a time in which we need to follow public health instructions as best as possible which is why I and many others wore masks even as we tried to keep our distances even in those massive crowds. But, we need to make sure we are getting that balance right, of looking to build a better world, looking to ensure that real change happens now and into the coming months, while at the same time ensuring that we slow and decrease the spread of COVID-19.” CTV News <https://www.youtube.com/watch?v=7wyFXSPj4mA> at 5:45.

Testing

2020-03-05 Dr. Williams – “(The virus) can be found, but of course, some of those tests that find those are PCR tests which detects (sic) pieces of virus. (Is the virus) viable or not is another question.”

Global News https://www.youtube.com/watch?v=AEiy4E_jXLM at 21:00.

Appendix B: An abbreviated timeline

COVID-19 was first identified in the Hubei Province in China in December 2019.²¹⁵

January 31, the World Health Organisation declared COVID-19 to be a ‘public health emergency of international concern.’²¹⁶

March 11, the WHO upgraded it to a pandemic.²¹⁷

Also in March UNICEF, which with the WHO is a part of the United Nations System, released a summary of what was known about COVID-19. In particular, it noted that older people with underlying health conditions were more vulnerable than young people, and linked it to the ‘same family of viruses as Severe Acute Respiratory Syndrome (SARS) and some types of common cold.’ The virus, could be fatal in rare cases.

March 13, the Canadian lockdown begins with the closure of Parliament (initially for five weeks, later extended.)²¹⁸ Political leaders begin seeking expert advice – mainly from Chief Medical Officers, federal and provincial. On the basis of this advice, they then took a number of actions that together became colloquially known as ‘the lockdown.’

²¹⁵ <https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200121-sitrep-1-2019-ncov.pdf>

²¹⁶ [https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-\(2005\)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-\(2019-ncov\)](https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-health-regulations-(2005)-emergency-committee-regarding-the-outbreak-of-novel-coronavirus-(2019-ncov))

²¹⁷ “We have therefore made the assessment that [#COVID19](#) can be characterized as a pandemic”-[@DrTedros](#) [#coronavirus](#)

²¹⁸ <https://globalnews.ca/news/6672830/coronavirus-trudeau-economic-aid-package/>

March 15, hospitals start cancelling ‘non-essential’ surgeries and diagnostic testing. Ontario March 15,²¹⁹ British Columbia March 16,²²⁰ Alberta March 19,²²¹ Quebec (TBD. March sometime.)

March 18, travel restrictions imposed on Canadians.²²²

April 9, the Government of Canada released ‘data and modeling to inform public health action.’²²³ This document predicted that with strong public health measures the death toll in Canada would be between 11,000 and 22,000 over the course of the pandemic; without controls, it would exceed 300,000.

Mid-April to May 31, Canadian deaths attributed to COVID-19 increased, then fell away sharply and remained at low levels from June to time of writing. (End of November.)²²⁴

October 15, the World Health Organization stated that while lockdowns can slow COVID-19 transmission by limiting contact between people, ‘these measures can have a profound negative impact on individuals, communities, and societies by bringing social and economic life to a near stop.’²²⁵

²¹⁹ <https://www.theglobeandmail.com/canada/british-columbia/article-hospitals-postpone-surgeries-treatments-to-make-space-for-potential/>

²²⁰ Ibid.

²²¹ <https://globalnews.ca/news/6705348/coronavirus-patients-worried-after-alberta-cancels-non-urgent-surgeries/>

²²² <https://www.ctvnews.ca/health/coronavirus/canada-shutting-the-border-to-most-non-citizens-due-to-covid-19-pm-trudeau-1.4854503>

²²³ <https://www.canada.ca/content/dam/phac-aspc/documents/services/diseases/2019-novel-coronavirus-infection/using-data-modelling-inform-eng.pdf>

²²⁴ https://www.google.com/search?q=COVID+deaths+Canada&rlz=1C5CHFA_enCA710CA710&oq=COVID+deaths+Canada&aqs=chrome..69i57j69i60.6359j0j7&sourceid=chrome&ie=UTF-8

²²⁵ <https://www.who.int/news-room/q-a-detail/herd-immunity-lockdowns-and-covid-19>