Form 25
Alberta Rules of Court
Rule 5.34, 5.36, and 5.37
Clerk's Stamp

COURT FILE NO.	2001-14300
COURT	COURT OF QUEEN'S BENCH OF ALBERTA
JUDICIAL CENTRE	CALGARY
APPLICANTS	REBECCA MARIE INGRAM, HEIGHTS BAPTIST CHURCH, NORTHSIDE BAPTIST CHURCH, ERIN BLACKLAWS and TORRY TANNER
RESPONDENTS	HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF ALBERTA and THE CHIEF MEDICAL OFFICER OF HEALTH
DOCUMENT	**SURREBUTTAL EXPERT'S REPORT**
ADDRESS FOR SERVICE AND CONTACT INFORMATION OF PARTY FILING THIS DOCUMENT	Rath & Company Barristers and Solicitors 282050 Highway 22 W Foothills, AB, T0L 1W2 Attention: Jeffrey R. W. Rath Email: jrath@rathandcompany.com Telephone: 403-931-4047 Facsimile: 403-931-4048 Counsel for Rebecca Marie Ingram

SURREBUTTAL REPORT OF DAVID REDMAN

1. My name is David Redman, I am an expert in the area of Emergency Management, including the functions of, Mitigation, Preparedness, Response and Recovery.

2. I authored an Expert Report in this Action, which was duly executed by me on January 21, 2021.

3. My qualifications were set out in my January 21, 2021, Expert Report.

4. Attached as Schedule A is a copy of my surrebuttal report which sets out my direct response opinion to the Rebuttal Report of Mr. Scott Long, and where appropriate, provides the information and the assumptions on which my opinion is based on.

DATE:_____

_____

SIGNATURE OF EXPERT
DAVID REDMAN

SCHEDULE A – SURREBUTTAL OPINION

1. I have read and reviewed the Expert Report of Scott Long. I make these surrebuttal comments based on my training, experience and expertise in direct response to Mr. Scott Long's rebuttal report.

Direct Response to Mr. Long's "Schedule B – Summary of Opinion"

2. Mr. Long's paragraph 1:
It is factually inaccurate to categorize the COVID-19 pandemic as simply a "public emergency". A decision was made to use the *Public Health Act*, rather than the *Emergency Powers Act*, so that the response could be led and informed by medical professionals, which is contemplated in the Alberta Pandemic Influenza Plan (APIP).

Mr. Redman's Response:
I am confused by parts of this statement. A Provincial declaration of a "State of Emergency", i.e. a Public Emergency, is the highest level of emergency and powers, available to a Premier. A declaration of a public health emergency, under the powers of a Minister, is subordinate to that of a Premier declaring a state of emergency.

In addition, Mr. Long quotes the *Emergency Powers Act*. I am unsure if such an Act even exists. There is an *Emergency Powers Regulation*, which falls under the *Alberta Public Health Act*. It is, therefore, not possible that he meant this Regulation, as both these instruments place the additional powers in the hands of health authorities. He may have meant the *Emergencies Act* (Federal), which is not applicable at the Provincial order of government. As a member of AEMA, he should know of and have referenced the *Emergency Management Act*, which allows for a declaration of a "State of Emergency".
I still do not understand how this would have meant that Health Authorities would not have had the ability to respond effectively as the Minister of Health works for and at the behest of the Premier. In fact, in my opinion it would be the exact opposite.

The line "to categorize a pandemic simply as a "public emergency", implies that Mr. Long believes a public emergency is less than a public health emergency.

Yes, the response was led by medical professionals - NOT the PREMIER as is required in a pandemic.

Most, and specifically Alberta's current medical professional leadership team, are not experts in emergency management. This resulted in the selection of the wrong and constantly changing aim, the wrong governance task force, which I question if one was

actually properly established, lack of a process, and the critical reviewing of all previous lessons learned and the entire operational planning process. Mr. Long should have performed, or at least demanded, that this be completed at least in the second wave. His predecessor was allowed to laterally transfer to an ADM position in Parks Alberta after the first wave, implying that emergency management was deemed not as critical in the "worse" pandemic in decades, in any of the "waves".

The difference between the lead agency and who leads a government response is critical to understanding how badly we (Albertans) were failed. Mr. Long knows, or ought to know, that the Premier leads in time of emergency, and that the subject matter "lead" agency handles the specific hazard while all tasks, given and implied, from the Governance Task Force are developed and coordinated by AEMA across all of government, other orders of government, the private sector, and the public. This is what was previously done for all hazards, such as fires, floods, tornados and terrorism, and should have been done in this pandemic.

3. Mr. Long's paragraph 2:
The process of developing a plan is more valuable than the actual plan itself. It is the "process" that affords participants the deeper understanding of the problem the plan is intended to address, which in turn affords them the ability to adapt to changing circumstances as an incident unfolds. It is unwise to rigidly adhere to a plan.

Mr. Redman's Response:
I totally agree with this statement as in my expert report I wrote that:

> The purpose of writing these plans in advance is to ensure that the government could rapidly advise the public of the scope of the new hazard, and publicly issue a complete written plan to address it.
> This way, the public can see the entire plan, see the phases of the plan, and all steps that will be taken. The public then understands their role in the plan.
> The response to any pandemic ~~would~~ is then coherent and transparent.
> **[Expert Report of David Redman, executed January 21, 2021, at paras. 6 – 8]**

In case it is not clear, this means that we take the existing pre-written plan which was written based on extensive and hard learned lesson, take the actual specific hazard, follow the detailed emergency management process, under the leadership of the Premier and the Task Force on the Pandemic, and draft a step by step Pandemic Plan with all stakeholders involved that is flexible to changing conditions or issues, and finally issue it to the public.

This process, alluded to by Mr. Long, with all partners needed to be included, under the direction of a full cross-government and private sector Task Force, appears never ~~have~~ to have been done. If it had been done Mr. Long would have presented evidence to prove it was done, as this process produces a lot of documentation. Instead, he has presented the theory of why it should have been done, but never presents any proof it was done. If it had been conducted, the Alberta response would have been completely different.

I agree that it is "unwise to rigidly adhere to a plan". But a well written plan has built-in flexibility and a detailed feedback process, it is built in sections (i.e., an annex on LTC homes) that can be individually adjusted based on evidence (not just a single belief such as lockdowns). So, and pursuant to Mr. Long's statement, if it is unwise to rigidly adhere to a plan, why did the CMOH rigidly adhere to the concept that only lockdowns will save us in this pandemic, when massive evidence proved that lockdowns have no significant effect in controlling the spread of the virus in countries like Canada? The CMOH had only one narrow response, and in my opinion, it was the wrong one, because only the virus was of any concern as a health professional was running the response. There never was a plan. Just a belief.

If a COVID-19 plan was drafted or exists, why has it not been disclosed? Currently it is only referenced or referred to.

4. Mr. Long's paragraph 3:

Alberta's response to COVID-19 has been constantly changing, not because there has been no plan, as asserted in the Expert Report of David Redman, filed January 22, 2021 (the Redman Report), but because of the rapidly changing landscape of the pandemic. In my opinion, Alberta's COVID-19 response has been reasonable given the circumstances and the uncertainty. The response has not been perfect, but the standard for emergency management is not perfection.

Mr. Redman's Response:

I fundamentally disagree with this assertion and challenge it on the fact that there if no evidence that a plan actually existed. The only response has been to "lockdown" Alberta until a miracle vaccine saves Alberta; this does not constitute a "plan".

It has been very evident that the proverbial "goal posts" have been constantly changing under this government's response: from slow the virus ("flatten the curve"); to no one can catch COVID-19 as it is deadly to some (you will kill your grandparents); to no one can catch COVID-19 as it is deadly to all (young people are at risk of catching the new variants

that **may** be more deadly); to no one is safe until we are all vaccinated with one dose, two doses, booster doses, there are new variants.

The appropriate goal should have always been "To minimize the impact of COVID-19 on Alberta".

Mr. Long believes the Alberta response has been "reasonable". I strong object to that position.

I identify three main reasons why Alberta's COVID-19 response has not been reasonable. First, Alberta failed to provide targeted protection for the most vulnerable, our seniors. We knew in February 2020 that COVID-19 was age and comorbidity related. 95% of deaths worldwide were in people over the age of 60 with severe comorbidities. It was not reasonable to ignore this fact and assume lockdowns would protect this group. Canada ranked lasted in the OECD in protection of their seniors, particularly in Long term Care Homes.

Canada has the worst record for COVID-19 deaths in long-term care homes compared with other wealthy countries, according to a new report released on Tuesday by the Canadian Institute for Health Information (CIHI).[1] This is not a "reasonable response".

This failure was admitted to by Canada's Chief Public Health Officer Dr. Theresa Tam, wherein she referenced our seniors by stating that "we failed the most vulnerable".[2] While this is an admission of the failure of Canada's response, Mr. Long has admitted that Alberta simply did what other jurisdiction did, including other provinces. Alberta performed as poorly in protecting the vulnerable as did any other province. From an emergency management perspective, this is a complete failure as emergency management protocols dictate the immediate protection of the vulnerable.

Second, Alberta has failed to follow the hard lessons learned from previous pandemics which showed that Non-Pharmaceutical Interventions (NPI) do not significantly impact the spread of a virus[3], such as COVID-19, in a country like Canada. This is not a "reasonable response".

Considering the hard lessons that were experienced and revived in the first wave, these lesson were ignored once more, as dozens of peer reviewed studies confirmed that COVID-

[1] https://www.cihi.ca/en/long-term-care-and-covid-19-the-first-6-months
[2] https://www.ctvnews.ca/health/coronavirus/we-failed-the-most-vulnerable-dr-tam-s-biggest-takeaway-after-a-year-of-covid-19-1.5345393
[3] https://apps.who.int/iris/bitstream/handle/10665/329438/9789241516839-eng.pdf

19 spread in lockdown and non-lockdown countries had no significant difference[4]. Again, I would reiterate that this is not a reasonable response.

The emergency management preprocess would consider and weight the facts that NPIs may present various collateral damage, including but not limited to:

i. Mental Health;
ii. Societal Health;
iii. Children's education and social development;
iv. the diagnosis and treatment for people with other severe diseases, and
v. to the economy, business, and the future economic viability of our country.

It is NOT reasonable to ignore the deaths and damage in all of these areas in a "reasonable response", yet that is what Alberta has done. Alberta's response appears to be that only a COVID-19 death is important, and all other consequences are to be ignored.

Third, and finally, I do not consider it reasonable to completely ignore the legal doctrines to which the government must adhere. A proper emergency management response plan would take into consideration any legal, constitutional and Charter issues and properly weigh them against the actions considered.

Mr. Long's opinion appears to consider that the deaths of our seniors was inescapable, that lockdowns actually stopped the spread of COVID-19 in spite of evidence and massive studies before and during the pandemic, that the massive collateral damage done by lockdowns was unavoidable (and has not even been demonstrably measured by the CMOH), and that the destruction of our democracy is an acceptable outcome.

For Mr. Long to state that the "response has not been perfect, but the standard for emergency management is not perfection" is unacceptable and insulting. It implies that this response is better than what? Of course, there are bad outcomes in an emergency. But this response has been deadly and damaging in ways never required or acceptable. The lockdowns have caused multiples of more damage than what they were intended to prevent.

5. Mr. Long's paragraph 4:

Having reviewed the Redman Report, I disagree with its "black and white" approach. The Redman Report is flawed in a number of ways, including:

a. The assertion that COVID-19 is not a public health emergency;

[4] https://www.aier.org/article/lockdowns-do-not-control-the-coronavirus-the-evidence/

b. The suggestion that quarantining long term care facilities was a viable and effective solution;

c. It does not account for the potential variant spread; and

d. The suggestion that the Swedish approach should have been adopted in Alberta.

Mr. Redman's Response:

Mr. Long's labelling of the measures imposed on Albertan's as "Moderate Restrictions" without qualifying or providing actual comparable measures is a bare and flawed opinion. In my opinion, these are not "moderate restrictions".

An integral part of the emergency management process is the cost-benefit analysis that looks at all the benefits and consequences of the measures and takes into consideration any collateral damage, short to long term, of the responding actions.

Out of a workforce of 21 million Canadians, during the first wave, over 8.9 million Canadians were out of work and were on CERB. Not working from home, on government assistance to stay home and not work. As of September 2020, nearly $80 billion was paid out in CERB assistance – while this is a national amount, Alberta experienced a similar trend and contributed to these staggering amounts. This does not include the workers still paid by their employers but not at work. I categorically reject the notion that this was a "moderate" response.

Constant closure, opening with massive groups on-line learning, cohort isolation, reclosing, cohort closure again, then re-closure of schools. Two years of our children's education and social development, not to mention their mental health issues, these are all "moderate" responses? In Alberta, for those under the age of 20, there have been zero COVID-19 deaths. Non-lockdown countries experienced very similar trends. Our schools needed no lockdowns not moderate restrictions that destroyed two years for our youth that serious science says will affect these students for their entire life.

As of August 2, 2021, Government of Alberta[5]:

[5] https://www.alberta.ca/stats/covid-19-alberta-statistics.htm#severe-outcomes

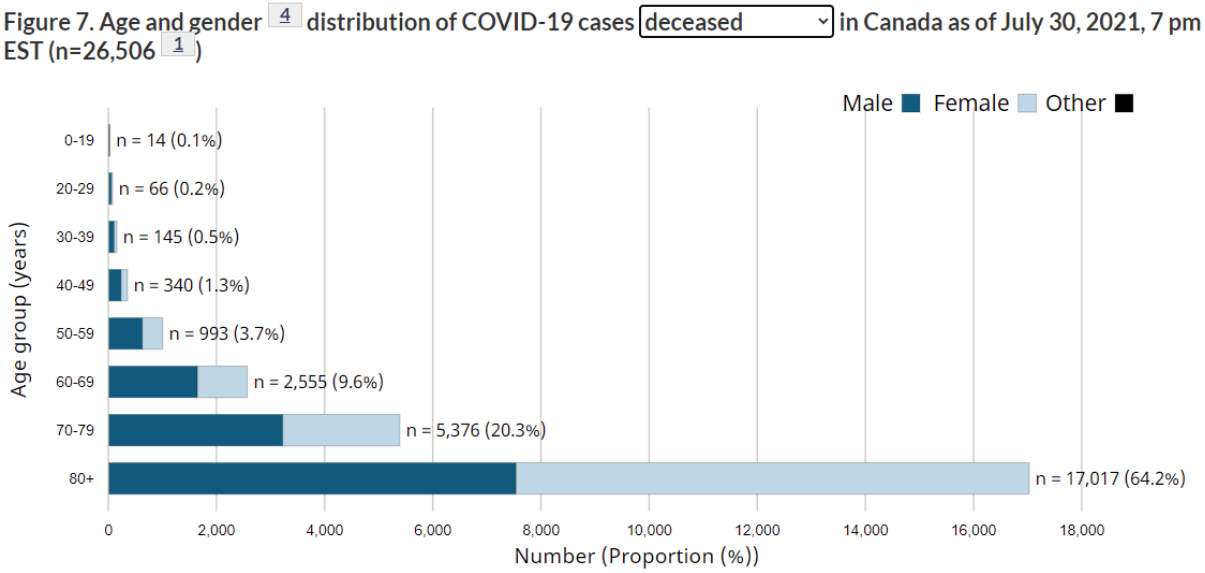
Table 5. Total Hospitalizations, ICU admissions and deaths (ever) among COVID-19 cases in Alberta by age group

Age Group	Cases	Hospitalized			ICU			Deaths		
	Count	Count	Case rate	Pop. rate	Count	Case rate	Pop. rate	Count	Case rate	Pop. rate
Total	235038	9755	4.2	220.6	1836	0.8	41.5	2328	1.0	52.6
Under 1 year	1423	60	4.2	116.0	14	1.0	27.1	0	0.0	0.0
1-4 years	8959	42	0.5	19.3	8	0.1	3.7	0	0.0	0.0
5-9 years	12417	25	0.2	9.0	12	0.1	4.3	0	0.0	0.0
10-19 years	31772	165	0.5	31.0	23	0.1	4.3	0	0.0	0.0
20-29 years	42836	530	1.2	89.6	64	0.1	10.8	11	0.0	1.9
30-39 years	44802	946	2.1	132.2	141	0.3	19.7	15	0.0	2.1
40-49 years	36762	1192	3.2	195.9	245	0.7	40.3	49	0.1	8.1
50-59 years	27240	1693	6.2	307.4	424	1.6	77.0	118	0.4	21.4
60-69 years	15694	1719	11.0	362.3	498	3.2	105.0	292	1.9	61.5
70-79 years	6692	1546	23.1	593.2	318	4.8	122.0	487	7.3	186.9
80+ years	6296	1834	29.1	1307.5	88	1.4	62.7	1355	21.5	966.0
Unknown	145	3	2.1	NA	1	0.7	NA	1	0.7	NA

As of July 21, 2021, the COVID-19 statistics for Sweden[6]:

[6] https://www.statista.com/statistics/1107913/number-of-coronavirus-deaths-in-sweden-by-age-groups/

Alberta and Sweden are not anomalies. Please note that in all of Canada, as of July 30, 2021, there have been a total of 14 deaths from COVID-19 in people under the age of 20[7]. See the data from Health Canada, updated weekly, below. The new variants have been in Sweden even longer than in Canada.



The "moderate" restrictions (and the perceived intentional use of fear) created a tsunami of current and future deaths and negative outcomes due to delayed or missed diagnosis and treat of other severe illness.

Under the direction of the Premier, following establishment of the Task Force, the Emergency Management Organization (EMO) would conduct the Operational Planning Process. As part of this process, many “Courses Open” would be developed for each task or group of tasks. Then a full Cost Benefit Analysis would be conducted to compare each “Course Open” in relation to other possible “Courses Open”.

Had this emergency management process been conducted, the **known** limited ability of lockdowns to limit the spread of COVID-19 and the severe collateral damages caused by the inappropriate use of NPIs, should have excluded the use of lockdowns.

After each wave, data continued to re-establish this fact. This additional information on the inability of these NPIs to limit the spread of COVID-19 and the severe collateral damages being caused by NPIs, should have been part of the cost benefit analysis, after each wave. Had these Cost Benefit Analyses actually occurred, they would have been coordinated by

[7] https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html

Mr. Long, or his predecessor. It is obvious from Mr. long's comments that this process was not followed, and that lockdowns were never evaluated for their deadly and damaging collateral effects.

Alberta's "moderate restrictions" did nothing to save our seniors (over 60 years of age) who make up over 94%[8] of the deaths in Canada. We simply failed our seniors. While this is my opinion and position, Canada's Chief Public Health Officer Dr. Theresa Tam and the OECD have made similar commentary regarding the lack of protection of our seniors.

A proper cost/benefit analysis would weigh the use of NPIs against their well known collateral damage / death including:

i. Mental Health;
ii. Societal Health;
iii. Education and social development of children;
iv. Delayed and missed diagnosis of and treatment for other severe illness (diabetes, heart disease, cancer, dementia, liver diseases, etc.);
v. Economic bankruptcy, debt, massive federal and P / T debt and the resulting costs of servicing that debt on other societal programs in the future; and
vi. Distrust and the negative impacts on our democracy.

As a proper analysis was not performed within the scope of a emergency management response plan, there is no justification that any of these impacts were warranted for those not in the high risk categories as they were not at more risk than from annual influenza. This lower risk category includes all under the age of 50, and for those 50 - 60 without severe comorbidities.

Most of this data was already known in February or March 2020, and a proper EMO led Cost Benefit Analysis should have been performed as the data and evidence never changed, from wave to wave.

As an example, I provide some comparative statistics for COVID-19[9] and other causes of death.

[8] https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html
[9] Health Canada – COVID-19 – deaths by Age March 5, 2021 (Reference 59)

Traffic Collision Fatalities[10]

Canada Age 0-60 years
COVID-19 = 879
Car Accident = 1331
"Over 50% more likely to die as a traffic collision fatality than to die from COVID-19"
Canada Age 20-40 years

Canada Age 20 – 40 years
COVID-19 = 111
Car Accident = 630
"Well over five times more likely to die as a traffic collision fatality than to die from COVID-19".

Heart disease[11]

Canada Age 20 – 40 years
Heart disease 33+126+156 = 315
COVID-19 = 111
"Over two and a half times more likely to die of heart disease than to die from COVID-19".

Canada Age 40-60 years
Heart Disease
Heart Disease 283+515+1037+1866 = 3701
COVID-19 = 764
"Nearly five times more likely to die of heart disease than to die from COVID-19".

Canada Age 60-70 years
Heart disease
Heart Disease 2887+3755 = 6642
COVID-19 = 1700
"Nearly 4 times more likely to die of heart disease than to die of COVID-19".

Canada Age 70 years and up
Heart Disease
Heart Disease 4946+12947+23951 = 41,844
COVID-19 = 19,493

[10] Transport Canada – 2018 – Motor Vehicle Traffic Collision deaths (Reference 57)
[11] Statistics Canada – Leading Causes of Death 2019 (Reference 58)

“Well over twice more likely to die of heart disease than to die of COVID-19”.

The Health Care system was never at risk.

If we had not sent healthy staff home who may have been exposed (which is not recommended as a NPI), if we had built real surge capacity, if we had protected our seniors (Health Canada Data has constantly showed that over 65% of acute care beds and over 60% of ICU beds in use were seniors), then our hospital system would never have been even challenged.

Figure 7. Age and gender [4] distribution of COVID-19 cases hospitalized in Canada as of July 30, 2021, 7 pm EST (n=75,235 [1])

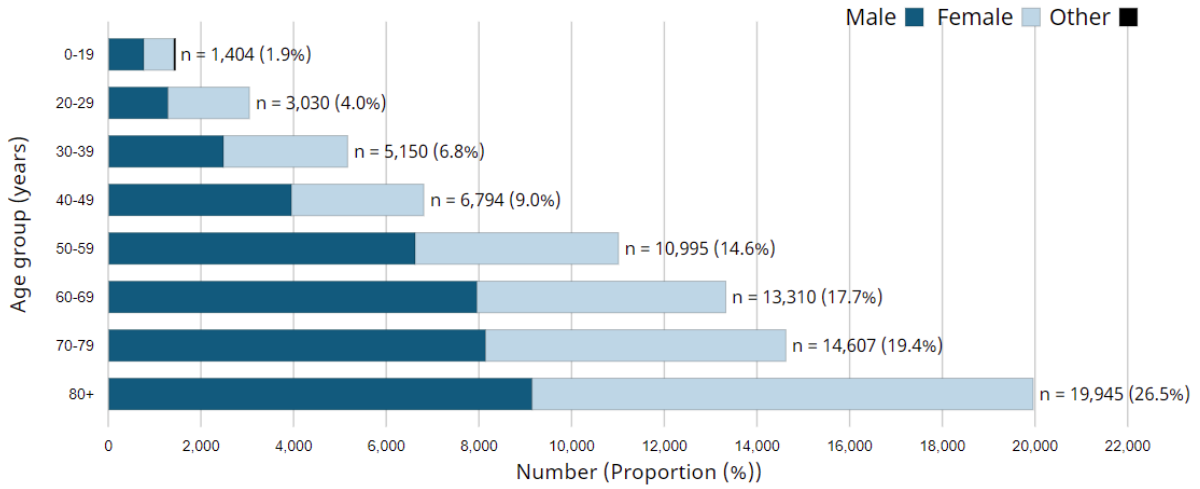
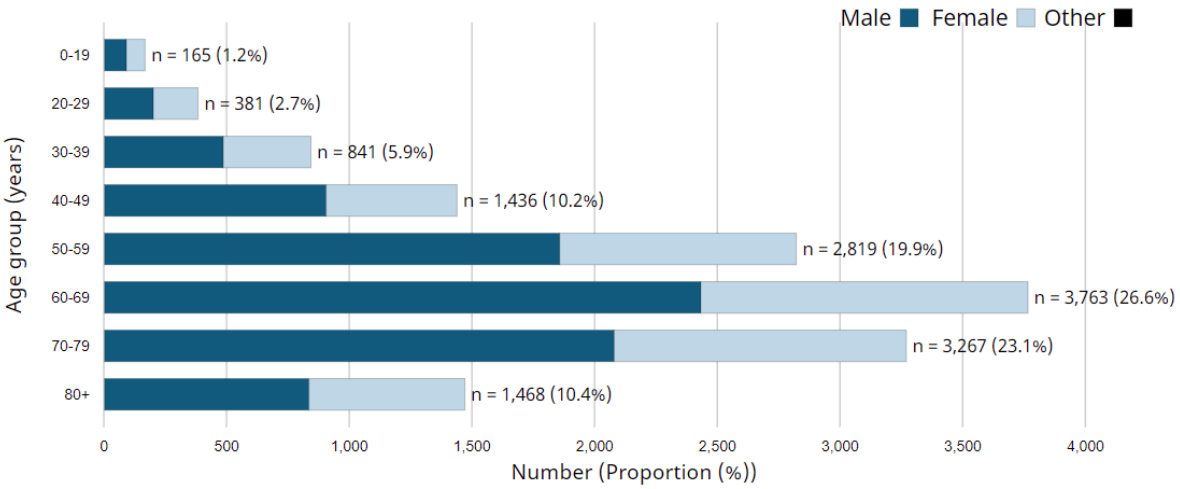
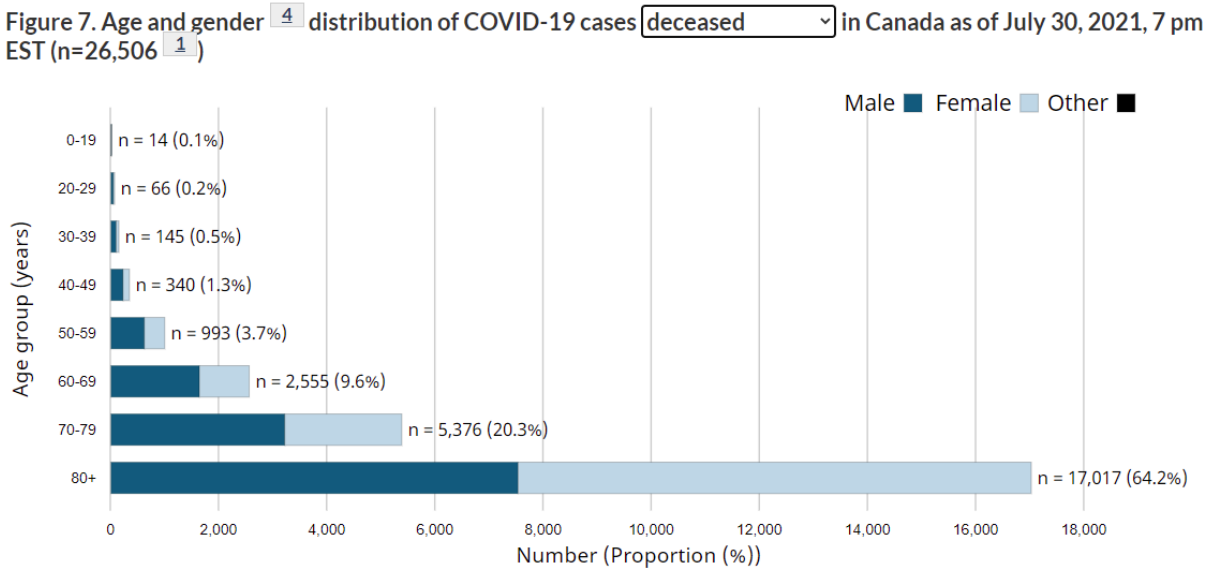


Figure 7. Age and gender [4] distribution of COVID-19 cases admitted to ICU in Canada as of July 30, 2021, 7 pm EST (n=14,140 [1])





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

It is important to note that at the "peak" in Alberta, 900 acute care beds out of over 9000 acute care beds had COVID-19 patients. It was not COVID overwhelming our hospitals, but we are not told what it was. Furthermore, hospital beds were emptied for COVID-19 and left empty while the tsunami of backlog patients and treatments occurred. Heart attack patients died at home out of fear of going to the hospital and catching COVID-19, because of the "moderate" restrictions and full blown use of fear to enforce them.

Direct Response to Mr. Long's "Schedule C – Report"

6. Mr. Long's paragraph 1:

The COVID-19 pandemic has been a highly dynamic, worldwide event. At the outset, the global environment and the health impacts were extremely uncertain. There were a number of factors that needed to be considered in responding to the virus, including but not limited to: transmissibility of the virus, level of protective measures required, availability of PPE, secondary impacts on the health care system, societal impacts, and potential effects on critical infrastructure operations.

Mr. Redman's Response:
This is exactly why we have developed and implemented emergency management. It is a system which handles large, complex, evolving, emergencies.

Emergency Management coordinates through a process which involves:

i. The Establishment of a clear aim or goal for the Province. The Aim should have been, "To minimize the impact of COVID-19 on Alberta".
ii. The establishment of a Task Force, under the personal leadership of the Premier. the Task Force should have included at least the 10 most impacted Ministries, selected senior leadership of critical private sector agencies, representatives of the municipal order of government, and in an emergency of this size perhaps even representatives of the official opposition.
iii. A detailed hazard assessment on COVID-19, where the age related nature of the virus would have been fully understood, but also it's potential impact on more than just humans.
iv. An assessment of tasks, given and implied, to respond to the aim. The existing Alberta Pandemic Influenza Plan (APIP) would have been used a s a starting point for the development of these tasks.
v. An assessment of major factors affecting achievement fo the aim (the virus, partners in the response, ground (i.e., all of Alberta (rural and urban differences), environment (i.e., the effect of weather and seasons as this is a seasonal virus), time (likely to last several years before a vaccine, likely to be endemic forever due to nature of the virus) and space (for protection of those most at risk, then others, all critical infrastructure, and much more).
vi. An assessment of course open, to address all of the tasks, both given and implied, broken into logic teams for analysis.
vii. A full and in-depth Cost Benefit Analysis (Advantages / Disadvantages) Process for each major grouping of courses Open. This is to ensure that the collateral effects of each action are described and noted in relation to each other to ensure that dangerous actions are fully presented to leadership for a transparent decision, making process.
viii. Presentation to the Task Force and the Premier for decisions on each major area for decisions on which course open is best.
ix. A written plan is then produced, for signature by the Premier. The written Plan is then presented to the public, so they understand their role in the plan and how to give suggestions and feedback to the government.
x. The plan is a living document, with written updates to the Plan and its annexes when and if required.

It would be logical for Mr. Long to next explain why AEMA was not then immediately tasked to coordinate the response under the direction of a Cross Government Task Force. He has failed or neglected to provide such an explanation.

Albertans have yet to see how the Government built a plan to handle many of these stated areas, particularly the societal impacts and the effects on critical infrastructure.

7. Mr. Long's paragraph 2:

> Initially, the timeline and potential availability of a vaccine along with its effectiveness was also uncertain. Even with the continued expansion of the amount and different manufacturers for the vaccine, availability remains a closely monitored and reported issue. Vaccines, with varying levels of effectiveness, have formed a significant part of society's overall response to this pandemic.

Mr. Redman's Response:

Vaccines are a red herring. In an epidemic or pandemic, you can never count on a vaccine if one currently does not exist. Following normal development and safety protocols, a vaccine can take two to three years to be developed and approved. The fact that one became available in record time is for a different team of experts to discuss.

For our seniors, target protection could have saved many. That said, the average age of death in Alberta is 80, and 89.8% of all "COVID-19 deaths" been listed with at least two comorbidities.[12] While unfortunate, these deaths represent a portion of the population that is frail and something was likely going to end their lives, just this year it was COVID-19.

The risk from seasonal influenza is the same for people under the age of 50, as can be seen in the Government of Alberta age-related table found below. The plan should have developed targeted protection for those most at risk, and removed fear for the rest of our population.

[12] https://www.alberta.ca/stats/covid-19-alberta-statistics.htm#highlights

Table 5. Total Hospitalizations, ICU admissions and deaths (ever) among COVID-19 cases in Alberta by age group

Age Group	Cases	Hospitalized			ICU			Deaths		
	Count	Count	Case rate	Pop. rate	Count	Case rate	Pop. rate	Count	Case rate	Pop. rate
Total	235038	9755	4.2	220.6	1836	0.8	41.5	2328	1.0	52.6
Under 1 year	1423	60	4.2	116.0	14	1.0	27.1	0	0.0	0.0
1-4 years	8959	42	0.5	19.3	8	0.1	3.7	0	0.0	0.0
5-9 years	12417	25	0.2	9.0	12	0.1	4.3	0	0.0	0.0
10-19 years	31772	165	0.5	31.0	23	0.1	4.3	0	0.0	0.0
20-29 years	42836	530	1.2	89.6	64	0.1	10.8	11	0.0	1.9
30-39 years	44802	946	2.1	132.2	141	0.3	19.7	15	0.0	2.1
40-49 years	36762	1192	3.2	195.9	245	0.7	40.3	49	0.1	8.1
50-59 years	27240	1693	6.2	307.4	424	1.6	77.0	118	0.4	21.4
60-69 years	15694	1719	11.0	362.3	498	3.2	105.0	292	1.9	61.5
70-79 years	6692	1546	23.1	593.2	318	4.8	122.0	487	7.3	186.9
80+ years	6296	1834	29.1	1307.5	88	1.4	62.7	1355	21.5	966.0
Unknown	145	3	2.1	NA	1	0.7	NA	1	0.7	NA

COVID-19 is extremely age related. For those under 50, and those under 60 without severe comorbidities (see table below on comorbidities) Albertan's did not need to be told that they needed a vaccine to be safe.

Alberta statistics on COVID-19 and comorbidities[13]:

Figure 17: Percent of COVID-19 cases with no comorbidities, one comorbidity, two comorbidities, or three or more comorbidities by case severity (non-severe, hospitalized but non-ICU, ICU but not deceased, and deceased), all age groups and both sexes combined, all Alberta. Comorbitities included are: Diabetes, Hypertension, COPD, Cancer, Dementia, Stroke, Liver cirrhosis, Cardiovascular diseases (including IHD and Congestive heart failure), Chronic kidney disease, and Immuno-deficiency. Data updated on 2021-08-02.

[13] https://www.alberta.ca/stats/covid-19-alberta-statistics.htm#comorbidities

8. Mr. Long's paragraph 3:

As the response has evolved, our understanding of the risks to the health care system and to society as a whole have evolved. There are lessons to be identified and implemented as a result of this pandemic. As with other disaster events, these will be identified and implemented.

Mr. Redman's Response:

Yet the response to the virus has NOT evolved. The same response was used in spite of previous and new evidence, data, studies and the evolving science. Lockdowns, that is, the inappropriate use of NPIs, was seen as the only solution, while waiting for a vaccine to save us all.

I question and challenge Mr. Long's assertion that any lessons were identified, analyzed and "lessons learned" were implemented as the virus progressed. Mr. Long has not tendered a single piece of evidence of any progression in the development of Alberta's response to the virus or which lessons were "learned".

9. Mr. Long's paragraph 4:

Having reviewed the Redman Report, I disagree with its "black and white" approach. The Redman Report is flawed in a number of ways, including:

a. The assertion that COVID-19 is not a public health emergency;

b. The suggestion that quarantining long term care facilities was a viable and effective solution;

c. It does not account for the potential variant spread; and

d. The suggestion that the Swedish approach should have been adopted in Alberta.

Mr. Redman's Response:

I will discuss each of Mr. Long's points in this paragraph in the sections that follow.

10. Mr. Long's paragraph 6:

Alberta's approach favoured moderate restrictions to individuals, while instituting a number of supports to minimize economic disruptions and ensuring the health care system could continue to operate. More stringent public health measures, such as those adopted in

Taiwan, while more effective at controlling the spread of COVID-19, would not have been feasible in Alberta.

Mr. Redman's Response:

I have previously challenged Mr. Long's characterization of the response as "Moderate" in paragraph 5.

Mr. Long seems to have used this word to support the Premier's position that Alberta restrictions were less than some other Provinces. The point is that almost all the restrictions were not required. But these "moderate" restrictions were not moderate at all, either in severity or duration. When it comes to emergency management, any restrictions to *Charter* Rights and Freedoms are not considered to be moderate.

The destruction of two years of schooling for our children, never necessary at all as they were never at risk, was not moderate. The impact will last their entire life.
The deferred diagnosis and treatment for Albertan's with heart disease, dementia, diabetes, cancer, and other severe diseases will not have "moderate" outcomes.

Professor Douglas Allen, Simon Fraser University, performed a study and published his findings. In it her writes:

> Using a cost/benefit method proposed by Professor Bryan Caplan, and using two extreme assumptions of lockdown effectiveness, the cost/benefit ratio of lockdowns in Canada, in terms of life-years saved, is between 3.6–282. That is, it is possible that lockdown will go down as one of the greatest peacetime policy failures in Canada's history."[14]

First, the supports Mr. Long refers to were needed because of an inappropriate and unnecessary set of "moderate" restrictions. The economic disruptions have not been "moderate": business bankruptcies have increased and once the supports are withdrawn we will likely experience many more. We are witnessing the nearly doubling the federal debt from $750 billion to $1.3 trillion to support "lockdowns" will all be paid by the same taxpayer for generations. The same is true for Alberta. These casually stated "supports" for "moderate" but unnecessary restrictions will be paid for by our grandchildren.

Sending "exposed" front-line workers (including medical staff) home to self isolate for 14 days created part of the medical shortages and burn out. Not correctly protecting the most at risk created at least 65% of the hospitalizations and ICU capacity usage. Incompetence is not "moderate".

[14] https://www.sfu.ca/~allen/LockdownReport.pdf

This is stated why? My position has always been based on the fact that with over 20,000 trucks a day crossing the Canada-USA border and bring essential supplies (mostly food), Canada is not an island nation. Any comparison of Taiwan, New Zealand, S Korea, and Australia to Canada is but a red herring.

11. Mr. Long's paragraph 7:

Generally, the Redman Report suffers from a "black and white" approach to emergency response. The Redman Report also has the benefit of significant hindsight.

Mr. Redman's Response:

An emergency management approach, as described previous, is the opposite of a "black and White" approach. Mr. Long has presented only the "lockdown" approach. It has been described above how a full, cross government team should have created courses open with multiple options, with the Premier selecting the best course open, with options to switch to based on feedback and actual evidence.
The only "black and white" approach has been by the Medical Officer of Health (MOH) of Alberta, who should not have been placed in charge by the Premier, in the "lockdowns are the only response!" approach.

I have continuously stated this emergency management approach and detailed the need for a target approach to the management of this virus response. The Premier's office has acknowledge receipt of my position, starting in April 2020. My position is not one of hindsight. I would be happy to submit the information sent to the Premier and the responses.

12. Mr. Long's paragraph 8:

Additionally, the Redman Report does not acknowledge the short time frame within which COVID-19 arose and its spread to Canada. There was approximately 8 to 9 weeks of advance notice.

Mr. Redman's Response:

With this statement, Mr. Long calls his own "expertise" into question as he admits to "approximately 8 to 9 weeks of advance notice." As his belief that 8 to 9 weeks is not enough time to amend and customize a pandemic plan, I challenge him being tendered as an "expert" in emergency management.

In my opinion this was sufficient to revise the existing pandemic plan and adapt it to COVID-19, as one could have been written and distributed to Albertans within 3 weeks.

That this use of the emergency management process was not used, has caused deadly and damaging results that will last decades. Mr. Long has essentially admitted that the process was not implemented resulting in a failure to publish a COVID-19 pandemic plan, and has failed to explain why.

Further, I will provide a previous example of how fast such plan development can happen, from my previous involvement.

In 2001, on September 12, at 0800 hrs (the day after the tragedy of September 11, 2001), the Premier of Alberta, the Honourable Ralph Klein, formed the Task Force on Security. I was personally part of the team that morning. By 1000 hrs that morning, I was placed in charge of coordinating a team of 26 experts, that eventually grew to hundreds, reporting to the Task Force (10 Ministers and their Deputies and about 12 other stakeholders from the private sector). By November 9, 2001, we had written a complete Crisis Management Counter-Terrorism Plan with the full involvement of every private sector in Alberta, all the municipalities, and not-for-profit entities. This plan was signed by the Premier and released to the public (the non-classified version). This was accomplished in approximately eight weeks considering that we did not have an existing plan to adapt or work from.

13. Mr. Long's paragraph 10:

Although the *Public Health Act* contains many of the same emergency management authorities as the *Emergency Management Act*, it also includes specific authorities applicable to a public health emergency such as the ability to make public health orders, which is an authority not found under the *Emergency Management Act*. The tools available under the *Emergency Management Act* would not have allowed the Chief Medical Officer of Health to make some of the recommended public health provisions. For instance, the Chief Medical Officer of Health has used the authority granted to her under the *Public Health Act* to make numerous orders specific to the medical aspects of the COVID-19 response.

Mr. Redman's Response:

Mr. Longs statements here are simply in error. Please see my response to Mr. Longs statement in his paragraph 1 of his testimony, paragraph 2 of this document. I make the following two main points in response.

First, Public Health Orders should be used as a last resort, not a planned first resort. The primary purpose of these public health orders was to enforce the "lockdown" response to COVID-19. As described throughout this surrebuttal, such a "lockdown" response

methodology causes massive collateral damage and a cost benefit analysis (which was required before using NPIs in this manner) shows it does at least ten time the harm as good.

The primary purpose of these public health orders were to enforce the "lockdown" response to COVID-19. As described throughout this Surrebutteal, this "lockdown" response methodology causes massive collateral damage and a cost benefit analysis (which was required before using NPIs in this manner) shows it does at least ten time the harm as good.

The World Health Organization (WHO) declared the COVID-19 virus a Public Health Emergency of International Concern on January 30th, 2020, and a pandemic on March 11th, 2020. On March 16th, 2020, Alberta declared a state of public health emergency. A day later, various activities were prohibited including gatherings of more than 50 people. By late March or early April 2020, Alberta was effectively locked-down, within the 8-9 weeks to prepare as stated by Mr. Long.

Public Health orders were not used as a last resort, they were the first, and repeatedly ONLY, measure utilized. After approximately five months (mid May to late September), NO emergency management process was performed. Public health orders were again utilized as the only response to plunge Alberta back into "lockdowns" in the fall.

Second, the powers under the *Emergency Management Act*, placing the Premier in charge of the powers, supersede the powers of any Minister or civil servant. The civil service works for the Premier, not the other way around. Public health orders, where and if ever needed, could have still been declared. The statement made by Mr. Long is patently incorrect is false and as the acting Director of AEMA he should have known that.

14. Mr. Long's paragraph 11:

The decision to utilize the *Public Health Act* to declare a state of public health emergency was both logical and sensible, given that this was an emergency brought on by a novel coronavirus. Utilizing the *Public Health Act's* emergency provisions was also a reasonable decision because, in cases of pandemic illnesses, the APIP contemplates the response being led and informed by health professionals, with a focus on science-based advice.

Mr. Redman's Response:

The decision to use the *Public Health Act* was neither sensible nor logical nor reasonable. Mr. Long does not provide any proof to substantiate his opinion.

Mr. Long should have been able to opine and describe the process that was implemented, which would have included:

i. The Premier's full role in the decision making process.
ii. All experts involved.
iii. Documentation produced.
iv. Dates of decisions leading up to the first instance and all subsequent declarations.
v. Proof of the disclosure to the legislature of the evidence requiring the declaration, and all updated to the legislature for extension.
vi. A copy of a COVID-19 pandemic response plan.

The APIP, drafted to be the initial guidance plan and with 8-9 weeks advanced notice, DID NOT contemplate placing the CMOH in charge of the worst pandemic in recent history. I led the team that drafted the 2005 version, much of which is still in the 2014 version.

Mr. Long has ignored any existing emergency management plans in Alberta and in fact is making statements here that are blatantly untrue.

Mr. Long has stated that the APIP "contemplated" the pandemic response being led by the health professionals. The APIP did not contemplate this in any way. The plan was based on the Premier leading the response, coordinated by the emergency management process and agencies.

The opening statement in the Plan reads as follows:
Alberta's Pandemic Influenza Plan (APIP) is a provincial strategic plan jointly developed by Alberta Health, Alberta Health Services (AHS), and the Alberta Emergency Management Agency (AEMA) to guide response and recovery, with an emphasis on how these organizations work together. Pandemic influenza planning and preparedness activities are equally important and are incorporated into all-hazards planning as a continuing part of the emergency management cycle.

This clearly does not say health officials are in charge, rather that they are part of a team, with the Emergency Management Agency "to guide response and recovery".

The Goals of the APIP (Tasks Given) are then defined as follows:

Goal - The goal of pandemic planning is to provide guidance and direction for activities aimed at:
• Controlling the spread of influenza disease and reducing illness (morbidity) and death (mortality) by providing access to appropriate prevention measures, care, and treatment.
• Mitigating societal disruption in Alberta through ensuring the continuity and recovery of critical services.
• Minimizing adverse economic impact.

• *Supporting an efficient and effective use of resources during response and recovery.*

It is equally clear that the first goal defined above is predominately health, but the other three goals are NOT health led. Even the first goal requires support from many other government Ministries and private sector agencies, all of which should be coordinated by the emergency management agency. This is because the EMO are the experts in cross government and private sector coordination for all emergencies and disasters.

Then the APIP states the 5 overarching assumptions that will define the response in a pandemic as follows:

i. *The effects of, and response to, a pandemic influenza are not limited to the health sector. A whole of society approach will be used in mitigating the effects of a pandemic influenza including public and private sectors, communities, families and individuals.*

Assumption 1. Very clear this does not say health authorities lead.

ii. *Pandemic planning is aligned with an all-hazards approach to emergency management.*

Assumption 2. Very clear emergency management process and agencies will coordinate.

iii. *Alberta Health, AHS and AEMA as well as other stakeholders will use existing pandemic and emergency response plans during a pandemic influenza.*

Assumption 3. Clearly, they did not!

iv. *Increased absenteeism is expected. Schools, workplaces and the health care system will likely experience workforce shortages.*

Assumption 4. This requires full cross government and private sector coordination and is not a health authority's role. It also clearly does not envision closing workplaces. It envisions working through shortages when people are actually sick. not when they are ordered to self quarantine because they may have been exposed. All previous lessons learned recommended not to isolate exposed individuals as it had little to no positive effect on spread but had many adverse collateral effects.

v. *Antivirals will be effective against the pandemic virus.*

Assumption 5. Not discussed in any plan ever given to Albertans.

Then to say "based on science-based advice" is an intentional incomplete statement. Science from anyone who did not support "lockdowns" was completely, and it appears intentionally, ignored. It was certainly never included in any cost benefit analysis ever presented to Albertans. Like minded "special advisory boards" were formed to draft daily support for lockdowns, ignoring and disputing any other option.

15. Mr. Long's paragraph 12:

The Redman Report identifies the concept of "hardening" long-term care facilities and reinforcing Alberta Health Services, but is silent on some practical aspects of this concept. While some functions, such as contact tracing, have been able to scale up rapidly, other areas of the health care system are not as amenable to rapid scale up due to the specialized knowledge required, level of training required, the cross globe demand for health care workers and other medium to long-term considerations.

Mr. Redman's Response:

I will expand on my concept of "hardening" of long-term care facilities below, but first must point out that Alberta's response for protection of our seniors was simply absent.

Alberta's response did not protect seniors at all. Alberta's plan, did not consider multiple and varied methodologies, deduced with options, for the:

- protection of seniors in LTC homes,
- protection of seniors living alone,
- protection of seniors living in multi-generational homes,
- ability for choice between quarantine and non-quarantine based on respect of individual rights and freedoms of the seniors.

Canada would not have placed last in the OECD for protection of our seniors in LTC homes, repeatedly in each wave. This has been stated, with refences previously.

Alberta instituted a "bubble" in Edmonton to allow for the NHL to finish their regular season and the play-offs. A similar "bubble" could have been instituted for staff and residents of LTC and other vulnerable segments of the population. The staff in the "bubble" would be placed in a Alberta funded facility, living and travelling in this quasi-quarantine. This would mean they could work in as many facilities daily as they wished, within normal health and safety rules. This also means that residents of the LTC homes did not need to be isolated in their rooms. This has likely caused unmeasurable mental health negative outcomes that should have been avoided completely. Residents should have continued to mix within their LTC home with their friends and colleagues.

Entertainment/entertainers could have been "quarantined within the bubble" along with the staff, for the LTC homes and the staff. Addition methodologies developed for loved ones to visit, either with quarantine options or remotely. All of this could have been developed through an emergency management process, but was simply not accomplished.

It is assumed that accommodation, meals and transportation would have been provided free of charge by the Government of Alberta, but alternative options may have been developed if an emergency management process had been followed or even contemplated

The first approach is to ask staff to voluntarily enter a "quarantine bubble" but this would not have been assumed in the emergency management process. There is a real-life example of this happening in France.[15]

Additional salary and benefits could and should have been offered. This would likely have cost far less than the deaths and the hospitalization that followed in our LTC and among our vulnerable population, not to mention the debt incurred because of CERB or the other economic fallouts due to locking down the entire population to protect our senior that likely did not work.

Once into the first wave, adjustments could have been made, using what I have frequently presented as the Fort MacMurray option. Teams, lets call them Gold Team and Silver Team, would rotate: 14 days in pre-quarantine, 30 days in LTC, 16 days full pay and benefits back home. Or something like that. Spares on each team that follow the process would accommodate for when a member does actually get sick while at home, as envisioned in the APIP. Crews in Fort Mac have worked like this for decades. That an emergency management expert did not envision this method is troubling.

If we had placed a priority on rapid testing, by the second wave it is likely that we could have had staff show up in the morning, from home, take a test, and do their shift, with a quarantined backup staff available.

For an emergency management expert to try to imply that this is not possible, that it is unlikely, or not reasonable, causes me great concern.

With respect to the Mr. Long's position on "rapid scale up" he appears to take the position that it was simply not possible, when in fact it was. I read his response as saying "it was hard, so we did not do it." It also shows a lack of understanding on how to create real surge

[15] https://www.ctvnews.ca/health/coronavirus/freedom-in-france-a-nursing-home-takes-on-covid-and-wins-1.4923363

capacity, not capacity by closing other medical functions such as non-essential surgeries, creating new much long wait times for the foreseeable future.

Surge staff options can be developed with a full team of experts and partners considering:

i. Recall of willing retirees;
ii. Requests to other jurisdiction by individual specialty if abundance in one area or P/T can be made available (mutual aid);
iii. Rapid training programs for less skilled positions;
iv. Evaluation of minimum requirements for each task, use of volunteers with basic skills;
v. Use of medical students; or
vi. Using infected but asymptomatic staff in areas where possible.

The fact that the process needs many experts and team to come up with a coherent plan, is why emergency management process exists.

The CMOH focused on lockdowns to protect our seniors and failed, as it was known from previous lessons learned that the use of NPIs do not limit the spread of a virus like COVID-19 in a country like Canada due to our inability to "isolate" from the rest of the world. The CMOH's use of these inappropriate (at best) public health orders to force exposed individuals to self-isolate doubled down on this problem. The practice of sending healthy to self quarantine for 14 days, if they or a family member may have come into contact with a person who has tested positive, was never envisioned in lessons learned from previous pandemics. In fact the WHO guidance does not recommend the quarantine of "exposed individuals", as there are many consideration that have been thoroughly analysed.[16]

As the Head of Emergency Management, I wrote the APIP in 2005. At that time, the use of NPIs was well know and would have been part of the Cost Benefit Analysis, done before their use, and this document would have led this discussion, that I would have coordinated.

16. Mr. Long's paragraph 13:

As part of the "hardening" of long-term care facilities, Redman Report suggests isolating staff and residents to reduce the risk of COVID-19. For this approach to be successful, staff and residents would need to remain wholly isolated. The family members of those staff members would also need to remain isolated to ensure that COVID-19 was not contracted by a family member, spread to a staff member of a long-term care facility, and then spread within the long-term care facility. This approach would mean that neither staff (including

[16] https://apps.who.int/iris/bitstream/handle/10665/329438/9789241516839-eng.pdf

their families) nor residents would have any freedoms for the duration of the COVID-19 pandemic. These individuals and their families would essentially need to be entirely prohibited from grocery shopping, spending time with others outside of their household, going to school or church – virtually all activities outside of work to ensure COVID-19 was not contracted and spread throughout the long-term care facilities.

Mr. Redman's Response:

Mr. Long is incorrect. As described above, a simple "quarantine bubble" rotation would have been worked into the response. Such a rotation would resolve many of the concerns and issues raised by Mr. Long.

Further, it is troubling that Mr. Long would ever consider placing the workers' families in quarantine with them. It appears this illogical idea is simply to make quarantine sound impossible.

17. Mr. Long's paragraph 15:

The Redman Report is silent regarding the impact or consequences of COVID-19 variants that have gained worldwide attention. As the United Kingdom variant became the predominant form of the virus in that country, the British government was forced to adopt severe restrictions to avoid the National Health System being overwhelmed.

Mr. Redman's Response:

COVID-19 is known to as SARS CoV-2, a coronavirus. We know coronaviruses evolve. There are thousands of coronavirus variants and the use of "variants of concern" or "variants" is a term used to espouse fear. Right from January 2020, we should have built a resilient emergency management-based response to this virus, SARS CoV-2, as we knew it would evolve. To make this out as a surprise either means that Mr. Long was not involved in any COVID-19 response process or he is not informed as to the virus, both troubling suppositions.

One must also note two things:

- As the variants of concern have evolved, who is at most risk has not changed. It is still seniors, over 60 with multiple comorbidities.
- Shortages and failures in other countries healthcare systems must be considered based on the shortages and concerns that pre-existed this pandemic. A lack of acute care beds before the pandemic in other countries systems needed even better surge capacity development as outlined above, but is necessarily relevant in Alberta.

18. Mr. Long's paragraph 16:

Both Canada and Alberta have reported variant strains of the COVID-19 virus. The variants initially identified in the United Kingdom (B.1.1.7 variant) and Brazil (P.1 variant) have become dominant strains of the COVID-19 virus present in the province. Another variant, known as the Delta variant (B.1.617.2 variant) is becoming increasingly prevalent.

Mr. Redman's Response:

Just as discussed above, the variants were expected. Any pandemic emergency response plan would have contemplated this and provided for contingencies, if required. As with any other coronavirus, including the common cold, it is likely and contemplated for that any variants may escape the vaccine envelop. This should not be a surprise by any expert tasked with dealing with a pandemic response.

The response is the same, you identify and isolate the vulnerable and at risk. As variants appear, who is at risk likely does not change. A proper emergency response plan will provide for a risk identification mechanism.

It is unclear why Mr. Long states this, other than for educational purposes for those who have not been following this pandemic.

19. Mr. Long's assertion that:

"The Swedish Model is not an Effective Model"

Mr. Redman's Response:

A completely inaccurate description of what I have said about Sweden. That said, Sweden followed what we had planned to do in Alberta, and for that matter, all of Canada.
Sweden has followed an approach that has not "ordered" any business to close, has not breached rights and freedoms, has not closed schools, has not sent exposed individuals into quarantine, and as a matter of fact has strong recommended against the wearing of masks (recently recommending their use only on public transportation). As a consequence, Sweden has not seen the massive collateral deaths and damage that the lockdowns have caused here in Canada.

Unfortunately, Sweden did not target their response to protect seniors. That is why they have seen many deaths in their seniors. Sweden has its reasons/laws for not quarantining their seniors' homes, but regardless, we in Canada could have.

As of June 30, 2021, the deaths in Sweden are as follows (that is 18 months in Sweden of the Coronavirus)[17]:
Ages 60 and older - 14,058
Ages 50 - 60 - 373
Ages 0 - 50 - 199

Sweden experienced no lockdowns, all of the same variants, and an earlier appearance of these variants than in Canada and yet none of this had led to deaths and overwhelming of the medical system in Sweden. In fact, for the majority of those under 60, just like in Canada, this virus has less impact than the seasonal flu. Vehicle fatalities are much worse than the coronavirus, yet we have not banned cars.

20. Mr. Long's paragraph 18:

The Redman Report endorses the response model used in Sweden, which focused on protection of the senior citizen population and resulted in minimal restrictions placed on the majority of the population. Sweden suffered far worse mortality rates than any of its Nordic neighbors where more restrictive measures were adopted. As of July 5, 2021, Sweden ranks 11th overall for the number of COVID-19 cases per million. Canada is 87th.

Mr. Redman's Response:

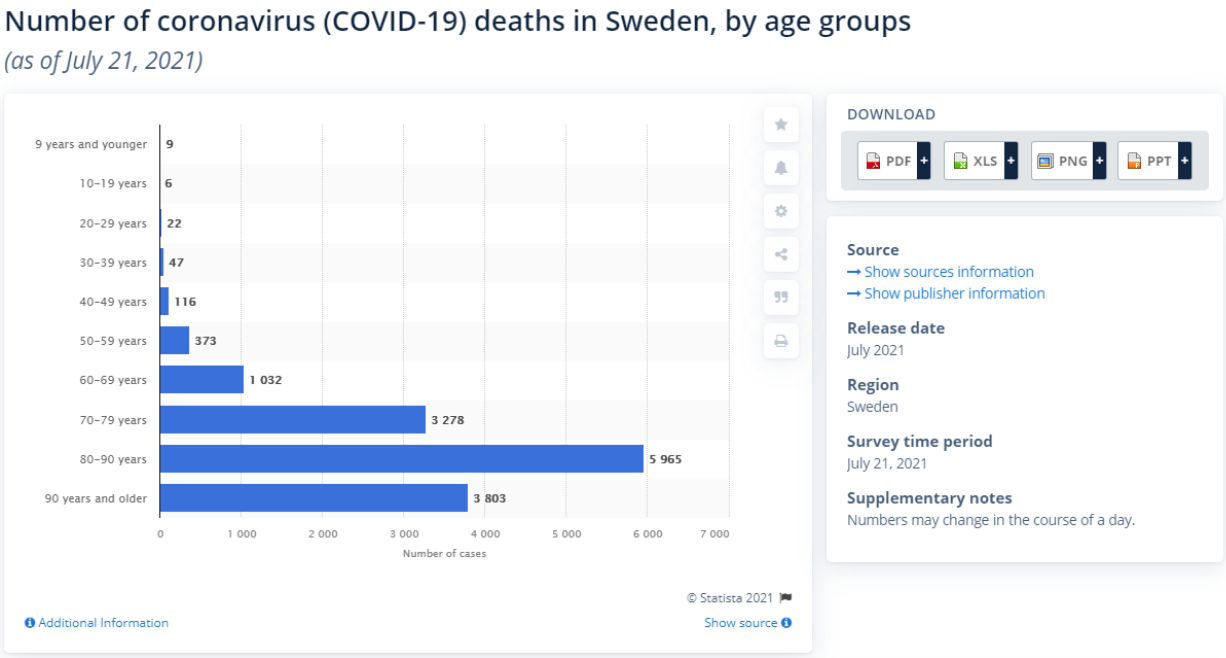
This is an untrue statement for several reasons:

- Sweden did not do focussed protection for it's seniors as stated above, leading to many deaths in that age group. But in that age group alone. I strongly recommend protection for the most at risk, not like what was done in Sweden. See the data as of the end of July 2021 below.
- Mr. Long, like western media, quotes the fact that Sweden did worse that its two Nordic neighbours of Finland and Norway. This is intentional to downplay the Swedish non-lockdown approach.
- Compared to all its European neighbours, Sweden has done better (far better in some cases) in COVID-19 deaths than most of its neighbours, including hard lockdown countries like Italy, Spain, the UK, France, Belgium, Poland and Hungry.[18]
- Sweden ranks 34 not 11th, as of August 2, 2021, in COVID-19 deaths.

By population alone, one could compare Quebec to Sweden, which on a per capita basis, Quebec (8.5 million) faired slightly better than Sweden (10.2 million), and Quebec had some of the toughest lockdowns including curfews.

[17] https://www.statista.com/statistics/1107913/number-of-coronavirus-deaths-in-sweden-by-age-groups/
[18] https://www.statista.com/statistics/1104709/coronavirus-deaths-worldwide-per-million-inhabitants/

More importantly, Sweden has not destroyed it's economy, so it has the ability to pay for the measures it did put in place, without doubling its national debt. It has not experienced the massive collateral deaths and damage that Mr. Long completely ignores. Alberta has yet to release any data on collateral damage and deaths. A proper pandemic emergency response plan must address all of the issues not just focus on the virus.



21. Mr. Long's paragraph 19:

Brazil took a similar approach with minimal restrictions, allowing the virus to run unchecked in the hopes of establishing herd immunity. Brazil has reported over 500,000 COVID-19 deaths during this pandemic. A variant strain of COVID-19 was also identified in Brazil.

Mr. Redman's Response:

Comparing Brazil to Canada is simply preposterous and erroneous for numerous reasons: their medical system, their poverty rates, their climate, and their environment lead to an impossible comparison. But is you want a crazy comparison, look at Belarus, where the dictator said COVID-19 was a hoax, and held mass rallies and public gatherings; COVID-19 was simply ignored. At worst, Belarus came in middle of the European pack in terms of deaths per capita, better than almost all the hard lockdown neighbours in Europe. If you cherry pick examples, you can make any case.

But if you do real science-based studies you know that lockdowns do not have significant effect on the spread of COVID-19.[19] The deaths per capita is directly related to how well seniors were protected, or not, and is not related to lockdown or no lockdown.

22. Mr. Long's paragraph 20:

Conversely, jurisdictions that have taken firm public health driven response actions, such as Taiwan, South Korea, Australia, and New Zealand, have fared better and enjoyed more rapid return to economic and social well-being.

Mr. Redman's Response:

With this statement, Mr. Long has contradicted his assertion in paragraph 6, being "More stringent public health measures, such as those adopted in Taiwan, while more effective at controlling the spread of COVID-19, would not have been feasible in Alberta."

I agreed and provided my reason for my agreement above. It seems that Mr. Long wants us to believe that it is possible in Canada and that we should have locked down sooner, longer and harder. It is impossible to lockdown Canada as we are not an island, possess the largest land border in the world, and rely heavily on daily transport of essential goods into Canada. If Canada imposed a full isolation response, including fully closing the border, the majority of Canadians would have starved to death within a week.

I also contend that if you only count COVID-19 deaths as a measure of success, then you have intentionally ignored collateral deaths and damage.

23. Mr. Long's paragraph 21:

Alberta's emergency response to the COVID-19 pandemic was more moderate, when compared with Taiwan and New Zealand, with restrictions on individual freedoms being balanced against health, social, and economic concerns.

Mr. Redman's Response:

A baseless statement and a comparison that is not possible for the reasons noted above. Also, the restrictions have not been moderate. Finally, Mr. Long has not tendered any evidence that there was a balance between health, social and economic concerns.

24. Mr. Long's paragraph 22:

[19] https://www.aier.org/article/lockdowns-do-not-control-the-coronavirus-the-evidence/

Due to Alberta's geographic location, more firm public health responses, such as those in Taiwan and New Zealand (both being island nations), were likely not possible. As a result of Canada's close economic relationship with the United States, Canada and Alberta's responses to the COVID-19 pandemic could not exist in isolation. The border needed to remain open in some capacity.

Mr. Redman's Response:

So why the statements above in paragraphs 20 and 21. Mr. Long has gone back and forth, never stating evidence or why these alternate positions are given, other than in a failed attempt to say Alberta's response is better. He continues to contradict himself.

It is important to note and remember that approximately 20,000 trucks a day cross the Canada-USA border, meaning we could never follow the Taiwan model.

25. Mr. Long's paragraph 23:

One of the primary considerations at the outset of the COVID-19 pandemic was preserving the integrity of the health care system and aligns with the goals set out in the APIP. This was to ensure that the health care system would continue to be available - both to treat those suffering from significant COVID-19 infections but also to ensure that it remained able to respond and treat those with other urgent or life-threatening illnesses or injuries. The APIP recognizes the potential that, if health care services are overwhelmed, critical health services will be prioritized and that some health services may be suspended or deferred to support the health care system's operational requirements.

Mr. Redman's Response:

An incorrect and baseless statement.

The aim in Alberta has, incorrectly, been to "preserve the integrity of the health care system but this is not aligned with the APIP. Mr. Long does not know his own plan. That said the aim should have been "To minimize the **impact** of COVID-19 on Alberta". Such an objective would have been aligned with the APIP.

The APIP provides for the following General Assumptions[20]:

- The effects of, and response to, a pandemic influenza are not limited to the health sector. A whole of society approach will be used in mitigating the effects of a

[20] Alberta's Pandemic Influenza Plan, March 2014, page 11: https://open.alberta.ca/publications/alberta-s-pandemic-influenza-plan

pandemic influenza including public and private sectors, communities, families and individuals.

- Pandemic planning is aligned with an all-hazards approach to emergency management.
- Alberta Health, AHS and AEMA as well as other stakeholders will use existing pandemic and emergency response plans during a pandemic influenza.
- Increased absenteeism is expected. Schools, workplaces and the health care system will likely experience workforce shortages.
- Antivirals will be effective against the pandemic virus.

And the "Goal" the APIP identifies is[21]:

- The goal of pandemic planning is to provide guidance and direction for activities aimed at: Controlling the spread of influenza disease and reducing illness (morbidity) and death (mortality) by providing access to appropriate prevention measures, care, and treatment.
- Mitigating societal disruption in Alberta through ensuring the continuity and recovery of critical services.
- Minimizing adverse economic impact.
- Supporting an efficient and effective use of resources during response and recovery.

So we closed entire floors of hospitals (reserved only for COVID-19 patients), cancelled surgeries, postponed treatments, created a wave of fear so bad that people chose to die in their homes instead of going to hospitals, restricted access to family doctors through social distancing requirements and public health orders, sent healthy staff home based on contact tracing and isolation of exposed individuals (this NPI is not recommended by the WHO, has been deemed ineffective in all previous lessons learned, for any severity of pandemic), all in the name of protecting the health cares system, but at the expense of the very people it was built to protect.

Again, real surge capacity does not come through lockdowns. The APIP recognizes that surge capacity may be required. It definitely does not envisage the use of lockdowns.

This statement has created fear that has been inflicted on Albertans for 15 months. It will likely have long term effects on our society.

26. Mr. Long's paragraph 24:

[21] Ibid, page 9.

Another aspect that was closely examined was critical infrastructure required to support the ongoing functioning of society as a whole. This included determination of key staff involved in such areas as water treatment, power generation, telecommunications, food distribution networks, community governance, emergency management and health related sectors such as pharmacies, dentists and other health related service providers. This required a detailed examination of the impacts of these critical staff not being available to maintain or operate equipment fulfilling these functions as the identified individuals were typically not in the senior executive positions.

Mr. Redman's Response:

I challenge Mr. Long to provide proof that this was performed. He has not tendered a single piece of proof that any consideration, analysis or plan was even attempted for the sectors or institutes he has listed.

Food supply is a perfect example of Alberta's failures with the meat packing plants being a clear case in point. There was no plan in advance: when an outbreak did occur, it appear to come as a complete surprise to health care officials, and the solution was to close the plants.

From all indications, the CMOH made rules and orders up on the fly. There was no plan developed in the 8-9 weeks before the pandemic was announced. Worse, there was no plan developed in the four months between the first and second waves. The plan was, and continues to be, to use lockdowns.

27. Mr. Long's paragraph 25:

The Redman Report also does not consider the effect of COVID-19 on other areas where there have been significant COVID-19 impacts on the community and to the economy. For example:

a. The meat packing industry in Alberta was significantly impacted early in the pandemic and again in the second wave. This was likely due to close proximity in working conditions and due to some staff living in high density residential settings, such as in dormitory-style housing with co-workers or in extended family living arrangements.

b. Individuals experiencing homelessness were also affected. In many instances, these individuals would not have a place to self-isolate if experiencing COVID-19 symptoms or if they tested positive. Additional efforts were made to support these vulnerable populations and to reduce the risk of community transmission.

c. Individuals being detained, both in remand centres and within provincial prisons. Again, due to the living situation of these individuals and the staff that operates these institutions, a policy of complete isolation would not be feasible.

Mr. Redman's Response:

In response to section a:

Mr. Long has stated the problem once more, but never offered any proof the Alberta response consider this problem, before it arose. In emergency management, and in the goals outlined in the APIP, shortage of staff due to illness should have been part of the written Alberta Plan, particularly for critical infrastructure. I challenge Mr. long to produce evidence that there is a written plan and that this area was considered, with solutions provided. My position was and continues to be, that this is part of the emergency management process that was ignored. In addition, working through an outbreak is what should have been developed, not closing critical infrastructure as was done.

In response to subparagraph b:

While Mr. Long raises this issue, he has failed to describe in detail the plan for these individuals, when it was devised, who wrote it, and who was responsible for its action. He has not met the burden to even prove that this segment of the population was considered.

I believe the City of Edmonton was never made aware of such a Government of Alberta plan at any point during the COVID-19 response. Mr. Long has failed to prove this plan exists and when the City of Edmonton was advised and how they were involved. There is no mention of this in the City of Edmonton's Plan, or any Alberta plan. If the emergency management process had been followed this aspect would have been written, with input from the urban and rural municipalities and actioned, starting in March 2020.

In response to subparagraph c:

Again, there is no proof that a plan was developed, who was involved, or when it was issued. There is no proof that these issues were considered or analysed.

I must state that these are all great points **would be covered in an emergency management process,** but Mr. Long has failed to prove any of it was done, not simply mused about in this response.

28. Mr. Long's paragraph 26:

Overall, I believe Alberta's response, from an emergency management perspective, to the COVID-19 pandemic has been reasonable. The response has been flexible and changing to meet the circumstances as they arise.

Mr. Redman's Response:

This is patently incorrect, from an emergency management perspective. From my observations, emergency management played no role in the Alberta response to this pandemic. There is simply no evidence to substantiate Mr. Long's assertion. In addition, the response has not offered target protection for those most at risk, has caused massive collateral damages and is not reasonable. Further, it has not been flexible, unless you consider the use of lockdowns, sooner, longer and hard to be flexibility.

29. Mr. Long's paragraph 27:

It is not a "failing" of Alberta's COVID-19 response that the response has not adhered to the letter of the APIP. Disaster plans must be treated as a "starting point" when responding to emergency events. Rigid adherence to a pre-existing plan is not well-accepted by emergency management professionals and would ignore lessons being learned as an event unfolds along with nuances that the plan may not have foreseen.

Mr. Redman's Response:

While the majority of Mr. Long's statement is correct, I request that Mr. Long to show the new plan was ever produced, with all the background supporting documentation. The fact that nothing has been published by Alberta leads me to believe no plan was contemplated.

I make this statement based on a number of considerations.

First, Mr. Long neglects to prove that the pre-written plan incorporated all lessons that were learned before COVID, but offers no documentation or evidence that any new material challenged these lessons that were learned.

Second, all the evidence showing that lockdowns did not have a significant impact in controlling the spread of COVID-19 in countries like Canada were simply ignored. This was no nuance or unforeseen result.

Third, the evidence that, wave after wave, Canada's seniors were not protected and that Canada ranked last in the OECD for protection of seniors was ignored. No nuance or emerging actions were taken, the lockdowns were simply used again.

Fourth, the massive collateral damage done to mental health, societal health, the education and development of our children, to Albertans with other severe illnesses and diseases and to our national and private sector economy only saw one response: the RIGID belief in and application of lockdowns.

As events unfolded, nothing changed in this government's response to COVID-19 so all the results remained the same. No lessons were learned.

30. Mr. Long's paragraph 28:

Alberta Health and AEMA have consulted with other Canadian provinces and internationally to identify response options. Alberta's response to COVID-19 could not have existed in isolation. In my opinion, Alberta Health and Alberta Health Services have demonstrated deep capabilities and competencies in leading the public health response efforts through their extant structures, organizations, processes, and procedures.

Mr. Redman's Response:

Mr. Long takes the position of "We did what everyone else did, so that makes it all right."

Simply not true.

Many countries and individual states in the USA did not follow the lockdown method. They have saved their seniors, they have not experienced massive collateral damage, they have not ignored their democratic rights and freedoms, and yet they are completely ignored in this statement. This assertion is based on a peer reviewed comparisons of 35 lockdown methodologies verses non-lockdown examples.[22]

Anyone who offered advice that did not follow the lockdown model was ignored, censored, threatened, or fired.

In Ontario where the College of Surgeons and Physicians published an unbelievable letter to their doctors stating[23]:

"Physicians hold a unique position of trust with the public and have a professional responsibility to not communicate anti-vaccine, anti-masking, anti-distancing and anti-lockdown statements and/or promoting unsupported, unproven treatments for COVID-19. Physicians must not make comments or provide advice that encourages the public to act contrary to public health orders and recommendations."

They added: "Physicians who put the public at risk may face an investigation by the CPSO and disciplinary action, when warranted."

The same is true in British Columbia[24]:

---

[22] https://www.aier.org/article/lockdowns-do-not-control-the-coronavirus-the-evidence/
[23] https://torontosun.com/opinion/editorials/editorial-college-of-physicians-and-surgeons-of-ontario-wrong-to-silence-doctors
[24] https://vancouversun.com/news/local-news/b-c-doctors-could-face-penalty-for-veering-from-covid-19-health-guidelines-college

Dr. Heidi Oetter, registrar and CEO of the college, said public statements from doctors that contradict accepted COVID-19 public health orders and guidance are "confusing and potentially harmful to patients."

Doctors who veer from the guidelines could face an investigation or regulatory action, if the college considers it warranted, she said.

In the end, this statement by Mr. Long rings of hubris, not emergency management.

31. Mr. Long's paragraph 29:

The response has not been perfect. When the COVID-19 pandemic comes to a close, like with other disaster and emergency events, the response will be studied and potential improvements will be identified and implemented.

Mr. Redman's Response:

I cannot believe that Mr. Long, as a purported expert in emergency management, is willing to or able to consider any information that may indicate that "lockdowns" were not the only, or correct, response to this pandemic.

A Lessons Learned Process by Mr. Long, and likely the government he has been asked to represent, will be a waste of tax payers money.