Form 25
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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	**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

EXPERT 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. My qualifications are set out in Schedule A.

3. Attached as Schedule B is a copy of my report which sets out the information and the assumptions on which my opinion is based on and a summary of my opinion.

DATE: January 21, 2021

SIGNATURE OF EXPERT
DAVID REDMAN

SCHEDULE A – SUMMARY OF QUALIFICATIONS

1. I hold a Bachelor's Degree in Electrical Engineering from the Royal Military College of Canada, and a Master's Degree of Science in Electrical Engineering from the United States Naval Postgraduate School. I am a graduate of both the Canadian Land Forces Command and Staff College, in Kingston, Ontario and the Canadian Forces Command and Staff College, in Toronto, Ontario.

2. I served in the Canadian Armed Forces for twenty-seven years as an officer, predominately in command appointments in operational field positions, and have worked with all levels of government and extensively with the private sector to develop emergency management in Alberta, Canada, and North America.

3. I was assigned to three tours as a Commanding Officer responsible for strategic, operational and tactical international logistical operations: the withdraw of all Canadian personnel and resources from Canadian Forces Europe in Lahr following the end of the Cold War, the withdraw of all Canadian United Nations personnel and resources from the Former Republic of Yugoslavia during the 1995 War and the deployment of Canadian NATO Forces into Bosnia.

4. During my military career, I served in nineteen geographic locations, including three NATO postings to Germany, a posting to California, and postings or employment in most Provinces and Territories in Canada. I was also deployed on operational tours in support of the United Nations and NATO; in Egypt in 1978, Croatia in 1995 and Bosnia in 1996.

5. I was hired by the Government of Alberta in November 2000 and my first appointment was with Disaster Services Alberta (DSA), later renamed Emergency Management Alberta (EMA) and now called the Alberta Emergency Management Agency ("**AEMA**"), serving a year as the Director of Community Programs. In that capacity I was responsible for support to municipal government's mitigation, preparation, response and recovery to major emergencies and disasters throughout the province.

6. Following September 11, 2001, I was appointed as Director of Crisis Management Programs. In this capacity I was responsible for leading the development of the Alberta Counter-Terrorism Crisis Management Plan ("**ACTCMP**"). Once the ACTCMP was developed, I was appointed to lead the plan's implementation and daily coordination across all orders of government and the private sector in Alberta. The ACTCMP fully integrated both the public sector and the private sector response to threats.

7. In January 2004, I became the Executive Director of AEMA, responsible for leading all emergency management activities for the Government of Alberta, including, but not limited to response to Natural and Human Induced Hazards. In this capacity I worked with

and extensively briefed federal, provincial, municipal agencies and widely across all industry sectors. I worked in depth with the federal and state government of the USA in the areas of Critical Infrastructure Protection and Emergency Management. I was responsible for the direction of Provincial Emergency Management during the devastating floods that hit Alberta in June 2005. I held the Executive Director appointment until I retired from Public Service in December 2005.

8. For the next eight years I worked as a consultant in emergency management, working with both the public sector and private sectors. During this period I was frequently called upon by the Auditor General of Canada, as an Emergency Management Expert in the drafting of, conducting of and final report writing of detailed federal audits.

9. I retired fully in December 2013.

SCHEDULE B - OPINION

1. I have read and reviewed the articles, studies and statistics I reference in this Expert Opinion and am of the opinion that they represent the

Emergency Management

2. Epidemics and Pandemics occur frequently, almost annually. The annual Influenza is an example of the most common epidemic that every few years becomes a pandemic when a new strain emerges and it spreads across countries and continents.

3. Right from the start, one must state that a pandemic is a Public Emergency not a Public Health Emergency as all areas of society are affected: public sector, private sector, not-for-profits, and all citizens.

4. In Canada, we have emergency management processes that we normally use during pandemics in the form of pre-written pandemic response plans. The aim of these plans is to allow our leaders to rapidly minimize the impact of a new pandemic on our society. Attached as **Exhibit "A"** to this report is *Alberta's Pandemic Influenza Plan dated 2014*.

5. The goal of pandemic planning, as identified on page 9 of *Alberta's Pandemic Influenza Plan dated 2014*, is to provide guidance and direction for activities aimed at:

    a. Controlling the spread of influenza disease and reducing illness (morbidity) and death (mortality) by providing access to appropriate prevention measures, care and treatment.

    b. Mitigating societal disruptions in Alberta through ensuring the continuity and recovery of critical services.

    c. Minimizing adverse economic impacts.

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

6. 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.

7. 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.

8. The response to any pandemic is then coherent and transparent.

Alberta's Response

9. Alberta's response to the SARS-CoV-2 virus ("**COVID-19**") has been incoherent, constantly changing, and fails to follow any plan. In actuality, it appears there is no plan.

10. The focus on only COVID-19 case counts has led to a completely flawed response, as it only attempts to deal with only one objective of the identified pandemic goal, thus failing on a comprehensive basis.

11. In February 2020 we knew that over 95% of the deaths in China and Europe were in seniors, over the age of 60, with multiple comorbidities. Attached as **Exhibit "B"** are screenshots supporting these conclusions.

12. Alberta should have immediately developed options for the protection of concentrations of our seniors over the age of 60 with comorbidities. Our long-term care homes ("**LTC Homes**") should have been placed in quarantine, for both the residents and the staff.

13. Attached as **Exhibit "C"** are various screenshots of statistics from the Government of Alberta COVID-19 website.

14. The Alberta statistics show that 95.3% of the 1345 deaths have been in seniors over the age of 60.

15. Of all the deaths attributed to COVID-19 by the Alberta government, 75.7% had 3 or more comorbidities or 97.1% had at least one comorbidity.

16. This means that only 63 of the deaths have occurred in Albertans under the age of 60. This is similar to the annual deaths from pneumonia and chronic lower respiratory diseases in Alberta.[1]

17. It is likely hundreds of these deaths could have been avoided, as approximately 80% of the deaths in the first wave occurred in LTC Homes. In June 2020, the Canadian Institute for Health Information reported that Canada had a higher proportion of COVID-19 deaths within LTC settings than other OECD countries included in its comparison. At that time, deaths in Canadian LTCs from COVID-19 were at 81% of the total, while OECD countries reported LTC COVID-19 deaths of 10-66% (average of 38%) of their totals.[2]

18. Provincially, and federally, our governments did not need to follow the failed lock down practice of China or Europe. We knew who was most at risk and had time to quarantine our seniors in LTC Homes. Instead, we sacrificed our seniors.

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[1] https://open.alberta.ca/opendata/deaths-cause-by-gender-and-age
[2] https://hillnotes.ca/2020/10/30/long-term-care-homes-in-canada-the-impact-of-covid-19/

19. Our leaders and doctors constantly tell us that we are in danger of overwhelming our medical system. If Alberta quarantined the LTC Homes, our hospital capacity would have been less challenged because since the first presumptive case of COVID-19 was identified in the province, 61% of hospitalizations and 58% of ICU capacity has been occupied by those over the age of 60.

20. We would likely not have needed to stop or delay many other medical procedures.[3]

21. The Alberta Government has ignored the other elements of the goal of pandemic planning: mitigating societal disruption in Alberta through ensuring the continuity and recovery of critical services; minimizing adverse economic impacts; and supporting an efficient and effective use of resources during response and recover.

22. Ignoring these other three objectives and following a failed lockdown response has caused massive collateral damage in terms of deaths and long-term effects on our population. I have read numerous articles that speak to collateral damage and have observed these issues arising in Alberta. Examples of collateral damage that has been largely ignored by mainstream media, includes but is not limited to:

    a. Our Social fabric[4];
    b. Our Mental Health[5];
    c. Other Health Conditions[6];
    d. Our Children's Education[7]; and
    e. Our Economy[8].

23. As an emergency manager I am horrified.

24. I have observed that everyday the number of deaths in LTC Homes grows, in spite of society-wide lockdowns.

25. I have observed that the public is blamed for not locking down hard enough.

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[3] https://lfpress.com/opinion/columnists/goldstein-canadas-medical-wait-times-longest-ever-because-of-covid-19
[4] https://www150.statcan.gc.ca/n1/pub/45-28-0001/2020001/article/00051-eng.htm
[5] https://www.msn.com/en-ca/news/canada/opioid-deaths-skyrocket-mental-health-suffers-due-to-pandemic-restrictions-new-federal-report-says/ar-BB1au4mD?pfr=1
[6] https://www.washingtonexaminer.com/news/catastrophic-unexplained-deaths-at-home-in-uk-nearly-nine-times-more-than-those-from-coronavirus; & https://www.nytimes.com/2020/10/20/health/coronavirus-excess-deaths.html
[7] https://youngminds.org.uk/media/3808/youngminds-submission-to-education-committee-the-impact-of-covid-19-on-education-and-childrens-services.pdf; https://www.publichealthontario.ca/-/media/documents/ncov/main/2020/08/covid-19-school-closure-reopening-impacts.pdf?la=en; & https://edmontonjournal.com/news/local-news/alberta-teachers-concerned-about-students-mental-health-academic-performance-survey
[8] https://www.ctvnews.ca/health/coronavirus/new-closures-will-be-fatal-for-thousands-of-small-businesses-advocate-warns-1.5184987

26. In fact, the deaths mount because our leaders continue to choose not to quarantine our LTC Homes.

27. As a result of our leaders continuing to abandon our emergency management processes and give in to fear, we have massively impacted the rest of our citizens for generations to come, who are at little to no risk of dying of COVID-19.

28. The declaration of a Public Health Emergency is only useful and appropriate when the threat to public health is confined to one municipality or small region as the threat can be dealt with public health measures and the threat does create wider economic or societal problems.

29. When the threat to public health transcends municipalities or regions, a declaration of a Public Emergency is the appropriate approach as the resources and powers available under a Public Emergency are much broader and the threat requires various approaches not just public health measures. A public health threat, such as an epidemic or pandemic, not only creates economic or societal challenges but can create risks to infrastructure, critical services, logistics, and supply-chains. These public emergencies, which affect all areas of society and involve the public sector, private sector, not-for-profit sector and every citizen, cannon be dealt with public health measures alone.

What Should Have Been Done

30. Alberta should release a comprehensive, four-component goal based COVID-19 pandemic plan, showing what is to be done phase-by-phase, and what the public's role is in each phase.

31. Vigorously enact a plan to protect our most vulnerable (those over age 60 with multiple co-morbidities).

32. Ensure all critical infrastructure (including but not limited to hospitals) is ready for people who get sick and who need to take sick-days.

33. Make rapid testing a priority for all levels of government and LTC Home workers. Rapid testing is still only available in limited situations and quantities.

34. Remove the fear campaign from the media. This needs a PLAN and will not be easy. Governments' and the Medical Officer's of Health daily facts must be given with context. There is no need to announce how many people have tested positive from COVID-19 each day. Be ready with solid messaging that, with the context of what we know now, the way ahead is not based on case count but rather on a confidence that we have the medical resources in our system, and speak to all Four Goals of the Pandemic Plan.

35. End all talk of future lock downs and loosen social distancing rules. Making people fear each other is always the wrong approach to any challenge.

36. Guarantee to keep schools and day cares open.

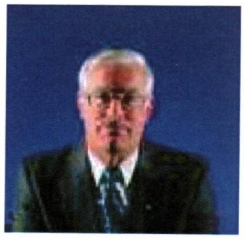
37. Relaxed social distancing rules, using Sweden's standards as a model.

38. Get everyone under 65 without pre-existing compromised immune systems, who can and want to work, fully back to work.

39. Continue to vaccinate as vaccines become available, for the current strain of COVID-19.

40. I make this Affidavit in support of the Origination Application challenging the Government of Alberta's infringement of my civil rights and the orders of the CMOH.

Exhibit A – David Redman



Biography – David Redman

David Redman has worked with all orders of government and extensively with the private sector to develop emergency management in Alberta, Canada and North America.

Prior to work in EMA, he had a twenty-seven career as an officer in the Canadian Armed Forces. His military experience was predominately in command appointments in operational field positions, including three tours as a Commanding Officer, responsible for massive strategic, operational and tactical international logistical operations. These operations included but were not limited to the withdraw of all Canadian personnel and resources from Canadian Forces Europe in Lahr following the end of the Cold War; the withdraw of all Canadian United Nations personnel and resources from the Former Republic of Yugoslavia during the 1995 War; and the deployment of Canadian NATO Forces into Bosnia). During his military career, he served in nineteen geographic locations, including three NATO postings to Germany, a posting to California, and postings or employment in most Provinces and Territories in Canada. He also was deployed on operational tours in support of the United Nations and NATO; in Egypt in 1978, Croatia in 1995 and Bosnia in 1996.

David Redman joined the Government of Alberta in 2000. His first appointment was in Emergency Management Alberta in November 2000, first serving a year as the Director of Community Programs. In that capacity he was responsible for support to municipal government's preparation, response and recovery to major emergencies and disasters throughout the province.

Following September 11, 2001, he was appointed as Director of Crisis Management Programs. In this capacity he was responsible for leading the development of the Alberta Counter-Terrorism Crisis Management Plan (ACTCMP). Once developed, he was appointed to lead the plan's implementation and daily coordination across all orders of government and the private sector in Alberta. The plan fully integrated both the public sector and the private sector response to threats.

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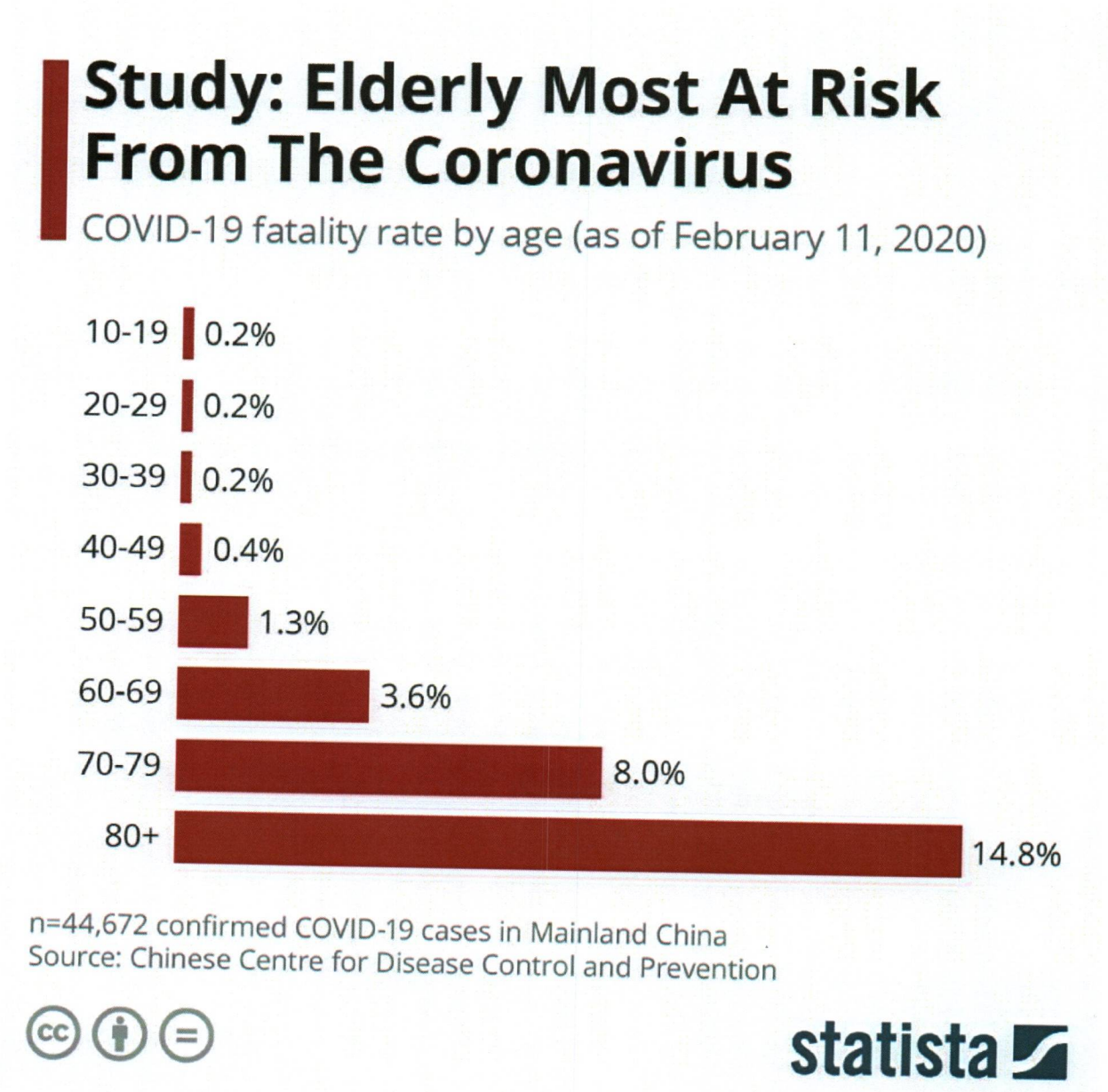
Exhibit "B" – Selected COVID-19 Statistics from Around the World

https://www.statista.com/chart/20860/coronavirus-fatality-rate-by-age/

Study: Elderly Most At Risk From The Coronavirus

by
Niall McCarthy,
Feb 18, 2020



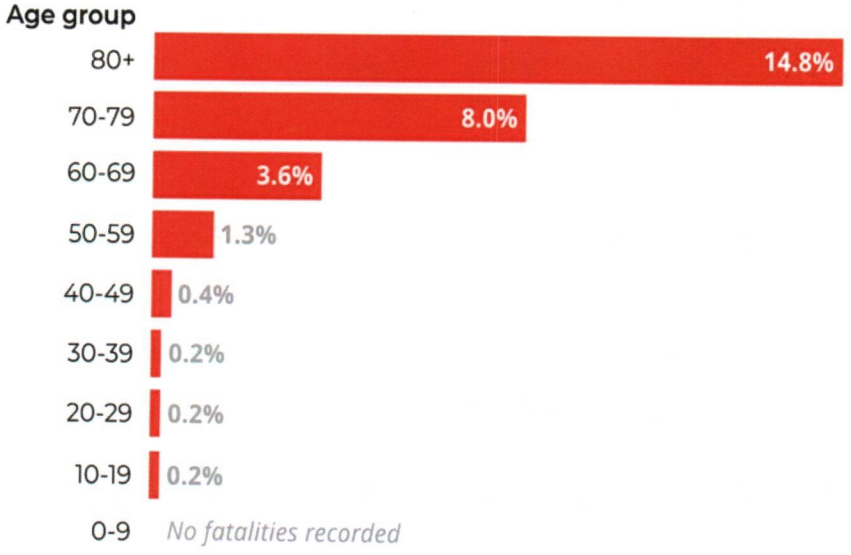
Why are older people more at risk of coronavirus?

Written March 17, 2020

https://theconversation.com/why-are-older-people-more-at-risk-of-coronavirus-133770

COVID-19 death rate by age group

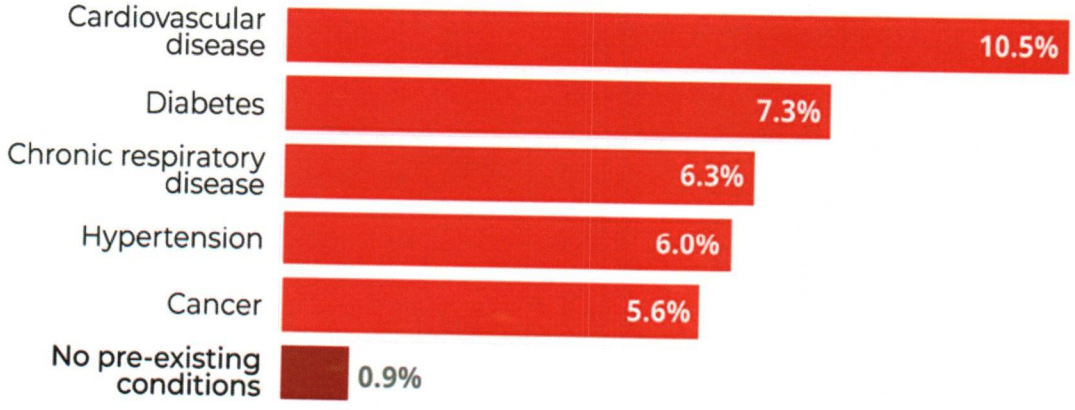
Death rate due to COVID-19 (all cases)



Source: Author provided

Pre-existing medical conditions and COVID-19

COVID-19 death rate by pre-existing medical condition



Source: Author provided

The age distribution of mortality from novel coronavirus disease (COVID-19) suggests no large difference of susceptibility by age

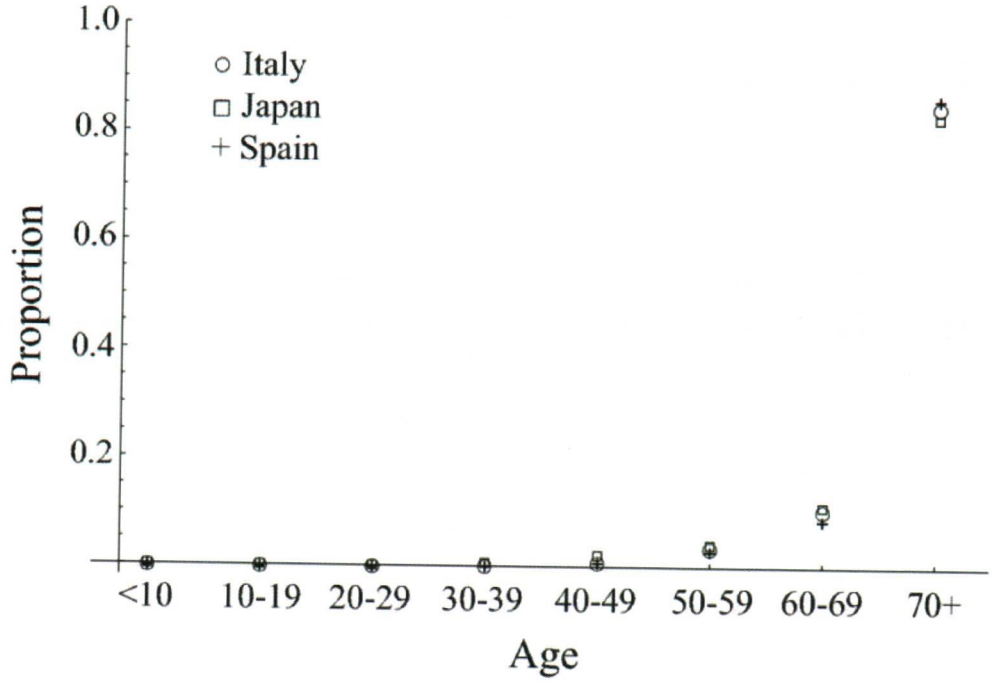
Published: October 6, 2020

https://www.nature.com/articles/s41598-020-73777-8

May 12 2020 data for deaths by age

Figure 1

From: The age distribution of mortality from novel coronavirus disease (COVID-19) suggests no large difference of susceptibility by age



The age distribution of mortality by COVID-19 in Italy reported on 13th May 2020, Japan reported on 7th May 2020, and Spain reported on 12th May 2020. Circle, square, and "+" denote Italy, Japan, and Spain.

Exhibit "C" – Selected COVID-19 Statistics from the Government of Alberta website

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

(screenshots taken January 18, 2021)

Table 3. 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	116837	4973	4.3	114.0	795	0.7	18.2	1436	1.2	32.9
Under 1 year	636	34	5.3	65.3	10	1.6	19.2	0	0.0	0.0
1-4 years	3620	14	0.4	6.4	2	0.1	0.9	0	0.0	0.0
5-9 years	4992	7	0.1	2.5	2	0.0	0.7	0	0.0	0.0
10-19 years	13418	67	0.5	12.8	9	0.1	1.7	0	0.0	0.0
20-29 years	21760	235	1.1	39.4	23	0.1	3.9	5	0.0	0.8
30-39 years	22209	383	1.7	54.2	39	0.2	5.5	7	0.0	1.0
40-49 years	18449	476	2.6	79.9	89	0.5	14.9	14	0.1	2.4
50-59 years	13903	712	5.1	128.6	161	1.2	29.1	42	0.3	7.6
60-69 years	8663	858	9.9	187.9	233	2.7	51.0	147	1.7	32.2
70-79 years	4290	929	21.7	377.8	168	3.9	68.3	290	6.8	117.9
80+ years	4861	1256	25.8	923.7	58	1.2	42.7	930	19.1	684.0
Unknown	36	2	5.6	NA	1	2.8	NA	1	2.8	NA

Note:
Based on total hospitalizations and ICU admissions ever.
Row percent is out of the number of cases in each age group.
Each ICU admission is also included in the total number of hospitalization
Case rate (per 100 cases)
Population rate (per 100,000 population)

Table 5. Number and 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, 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 (weekly) on 2021-01-10.

	Non-Severe		Non-ICU		ICU		Deaths	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
No comorbidity	71787	67.2%	718	21.2%	97	16.6%	37	2.8%
With 1 condition	21386	20.0%	596	17.6%	136	23.3%	97	7.4%
With 2 conditions	7428	7.0%	620	18.3%	146	25.0%	183	14.0%
With 3 or more conditions	6212	5.8%	1453	42.9%	205	35.1%	990	75.7%

Table 4. Number and percent of health conditions among COVID-19 deaths. Data updated (weekly) on 2021-01-10.

Condition	Count	Percent
Hypertension	1124	86.0%
Dementia	694	53.1%
Cardio-Vascular Diseases	690	52.8%
Renal Diseases	589	45.1%
Diabetes	577	44.1%
Respiratory Diseases	530	40.6%
Cancer	308	23.6%
Stroke	280	21.4%
Liver Diseases	50	3.8%
Immuno-Deficiency Diseases	25	1.9%

Note:
One individual can have multiple conditions.