** N.B.: We are authorized to incur up to $2,500 in costs to access the following records, so please track the ongoing cost and if you are unable to complete the responses within that budget please contact me before proceeding beyond that amount. **

What records do you wish to access?

Please provide a detailed description of the records you wish to access.
The information will help locate the records.

1. Transmissibility

On this government website (https://www.saskatchewan.ca/government/news-and-media/2021/november/09/covid-19-vaccination-remains-best-protection-against-serious-illness) dated Nov. 9, 2021 it states:

> "COVID-19 Vaccination Remains Best Protection Against Serious Illness…
>
> The COVID-19 vaccine is not a cure. It will not prevent every COVID-19 transmission. It will reduce the risk of transmission…"
> (Underlining added)

1.1 Records of the evidence regarding the claim that the COVID-19 "vaccines" will reduce the risk of transmission.

1.2 Records of the evidence suggesting that the COVID-19 "vaccines" will not reduce the risk of transmission, particularly with respect to the Omicron variant.

Context for Transmissibility Records

In this study (https://www.medrxiv.org/content/10.1101/2021.09.28.21264262v1) researchers from several California universities concluded:

> "We found no significant difference in cycle threshold values between vaccinated and unvaccinated, asymptomatic and symptomatic groups infected with SARS-CoV-2 Delta."

Second, in a Nov. 19, 2021 article in The Lancet, "The epidemiological relevance of the COVID-19-vaccinated population is increasing" (https://www.thelancet.com/journals/lanepe/article/PIIS2666-7762(21)00258-1/fulltext) it states:

> "High COVID-19 vaccination rates were expected to reduce transmission of SARS-CoV-2 in populations by reducing the number of possible sources for transmission and thereby to reduce the burden of COVID-19 disease. Recent data, however, indicate that the epidemiological relevance of COVID-19 vaccinated individuals is increasing… [T]he COVID-19 case rate per 100.000 was higher among the subgroup of the vaccinated compared to the subgroup of the unvaccinated in all age groups of 30 years or more."

Third, in this Sept. 30, 2021 study "Increases in COVID-19 are unrelated to levels of vaccination across 68 countries and 2947 counties in the United States" (https://link.springer.com/article/10.1007%2Fs10654-021-00808-7) Harvard researchers conclude:

> "At the country-level, there appears to be no discernable relationship between percentage of population fully vaccinated and new COVID-19 cases in the last 7 days (Fig. 1). In fact, the trend line suggests a marginally positive association such that countries with higher percentage of population fully vaccinated have higher COVID-19 cases per 1 million people. Notably, Israel with over 60% of their population fully vaccinated had the highest COVID-19 cases per 1 million people in the last 7 days. The lack of a meaningful association between percentage population fully vaccinated and new COVID-19 cases is further exemplified, for instance, by comparison of Iceland and Portugal. Both countries have over 75% of their population fully vaccinated and have more COVID-19 cases per 1 million people than countries such as Vietnam and South Africa that have around 10% of their population fully vaccinated… Across the US counties too, the median new COVID-19 cases per 100,000 people in the last 7 days is largely similar across the categories of percent population fully vaccinated (Fig. 2)… Of the top 5 counties that have the highest percentage of population fully vaccinated (99.9–84.3%), the US Centers for Disease Control and Prevention (CDC) identifies 4 of them as "High" Transmission counties."

Fourth, according to Ontario's COVID-19 data (https://covid-19.ontario.ca/data) as of January 8, 2022 that up to about Dec. 23, 2021 the unvaccinated had more cases per 100,000 people then both the partially vaccinated and the fully vaccinated, but as of about Dec. 23, 2021 the lines cross over and there were more cases per 100,000 among the fully vaccinated than the unvaccinated.

Fifth, according to this Wall Street Journal Commentary (https://www.wsj.com/articles/omicron-makes-bidens-vaccine-mandates-obsolete-covid-healthcare-osha-evidence-supreme-court-11641760009?mod=opinion_lead_pos5) Nobel Prize winner Dr. Montagnier states:

> "…data from Denmark and the Canadian province of Ontario indicate that vaccinated people have higher rates of Omicron infection than unvaccinated people...
>
> …there is no scientific basis for believing these mandates will curb the spread of the disease."

Sixth, according to Reuters (https://www.reuters.com/business/healthcare-pharmaceuticals/who-says-more-research-needed-vaccine-efficacy-against-omicron-2022-01-11/) on January 11, 2022 the World Health Organization essentially admitted that the current "vaccines" are not effective enough in preventing Omicron infection:

> "A World Health Organization technical body said on Tuesday that current COVID-19 vaccines may need to be reworked to ensure they are effective against Omicron and future variants of the coronavirus.

> The technical group, made up of independent experts, said it would consider a change in vaccination composition and stressed that shots needed to be more effective in protecting against infection…
>
> A vaccination strategy based on repeated booster doses of the original vaccine composition is unlikely to be appropriate or sustainable."

Lastly, at a January 12, 2022 press conference, Premier Scott Moe, while reading from prepared notes, said (https://www.facebook.com/PremierScottMoe/videos/248885413990059/ at 5:00):

> "Vaccination is not preventing the spread of Omicron. We need to be very clear and honest about that."

2. Natural Immunity

According to this website at https://www.saskhealthauthority.ca/news-events/news/why-do-i-still-need-vaccine-if-ive-already-had-covid , which is dated Nov. 19, 2021 it states:

> "Currently, the evidence is showing that the protection provided by a full COVID-19 vaccine series is stronger and longer than the protection from natural infection," reported Dr. Satchan Takaya, Infectious Diseases Specialist and Medical Lead for Infection Prevention and Control for the Saskatchewan Health Authority."
> (Underlining added)

2.1 Records of the evidence regarding natural immunity, also described as the immunity conferred from previous COVID-19 infection, that are in the possession or under the control of the Ministry of Health ("the Ministry").

2.2 Records of how the Ministry is continually updating its policy regarding natural immunity, particularly in light of Omicron's ability to "breakthrough" the protection provided by the Pfizer injections.

2.3 Dr. Marc Hellerstein received his medical degree from Yale University and his Ph.D. from MIT, and is a professor at the University of California - Berkeley. In a Dec. 11, 2020 article, "What are the roles of antibodies versus a durable, high quality T-cell response in protective immunity against SARS-CoV-2?" he states:

> "Although most vaccine candidates are focusing on spike protein as antigen, natural infection by SARS-CoV-2 induces broad epitope coverage, cross-reactive with other betacoronviruses."
> -See https://www.sciencedirect.com/science/article/pii/S2590136220300231

Records regarding the meaning of "protection" provided by the Pfizer or Moderna "vaccines".

2.3.1 Records regarding not only the production of antibodies, which are now known to decrease fairly quickly over time, but also the role of T-cells, B cells, antibody-secreting plasma cells, and the full range of a person's immune response.

2.4 Records regarding the role of natural immunity in ending the pandemic.

2.5 Records on reinfection among people with natural immunity to COVID-19.

2.5.1 Records regarding people who recovered from previous infection then transmitting to other people.

2.5.2 Records comparing the transmissibility to others of (i) people who have recovered from previous infection, versus (ii) people with 2 or 3 Pfizer or Moderna injections.

2.6 According to an August 3, 2021 article in the Globe and Mail, "Unvaccinated Canada: Who's left behind, and why aren't they getting their COVID-19 shots?" (https://www.theglobeandmail.com/canada/article-unvaccinated-canada-whos-left-behind-and-why-arent-they-getting-their/):

> "Canadians who have so far declined to get a shot tend to skew younger, but otherwise they don't conform to a tidy profile."

Records of who Saskatchewan's unvaccinated people are. Do they tend to be in low risk age categories?

Context for Natural Immunity Records

However, in a Dec. 8, 2021 article as reported by CNBC, Pfizer's CEO Albert Bourla stated that "[P]reliminary research shows the new omicron variant can undermine protective antibodies generated by the vaccine the company developed with BioNTech."
-See https://www.cnbc.com/2021/12/08/omicron-pfizer-ceo-says-we-may-need-fourth-covid-vaccine-doses-sooner-than-expected.html

Further, on Nov. 11, 2021 Dr. Paul Alexander compiled a report entitled, "140 Research Studies Affirm Naturally Acquired Immunity to Covid-19: Documented, Linked, and Quoted"
-See https://www.drpaulalexander.com/blogs/news/122-research-studies-affirm-naturally-acquired-immunity-to-covid-19-documented-linked-and-quoted

3. Deaths

According to the COVID-19 dashboard (https://dashboard.saskatchewan.ca/health-wellness), as of February 4, 2022 there have been 1,005 deaths.

3.1 Records regarding how deaths were/are classified as being "caused" by COVID-19.

3.2 Records detailing how co-morbidities were accounted for in deaths classified as "COVID-19" deaths.

For example, if a person had a number of co-morbidities, and COVID-19 was only a 1% contributing factor to their death, would that be counted as a COVID-19 death?

3.3 Records detailing the methodology in determining whether a person's death is counted in the above dashboard.

3.4 Records detailing whether this methodology changed over time, or whether this has been the same approach since January of 2020.

3.5 According to the Association of American Physicians and Surgeons' website (https://aapsonline.org/bidens-bounty-on-your-life-hospitals-incentive-payments-for-covid-19/?fbclid=IwAR2YA8_SyvyY_QNKutnr5sYg_xIqYeGyxRzT5HNR7JlXnZ6Uklg-k3rBYeQ):

> [T]here are deaths from restrictions on effective treatments for hospitalized patients. Renz and a team of data analysts have estimated that more than 800,000 deaths in America's hospitals, in COVID-19 and other patients, have been caused by approaches restricting fluids, nutrition, antibiotics, effective antivirals, anti-inflammatories, and therapeutic doses of anti-coagulants.

3.5.1 Records of any data regarding how many deaths in Saskatchewan were caused by restrictions on effective treatments for hospitalized patients, including but not limited to, any restricting of fluids, nutrition, antibiotics, effective antivirals, anti-inflammatories, and therapeutic doses of anti-coagulants.

3.5.2 Records of any data regarding how many deaths in Saskatchewan occurred after restrictions on effective treatments for hospitalized patients, including but not limited to, any restricting of fluids, nutrition, antibiotics, effective antivirals, anti-inflammatories, and therapeutic doses of anti-coagulants.

3.5.3 Records of any data regarding any deaths occurring after any restrictions of hydroxychloroquine, fluvoxamine and/or ivermectin.

3.6 Records of deaths which occurred within 21 days of a person receiving an approved COVID-19 "vaccine", and whether such deaths were/are counted toward the unvaccinated statistics, the vaccinated, or some other category.

3.6.1 Records relating to how deaths which occur within 21 days of receiving an approved "vaccine" have been accounted for and whether the methodology has been the same since January 1, 2020 or whether the methodology has changed.

3.6.2 Records of any evidence of any correlation between people receiving an approved "vaccine" and dying with COVID-19 within 21 days.

3.6.3 Records of the number of deaths which occurred within 21 days of receiving an approved COVID-19 "vaccine", broken down by month.

3.7 According to a November 27, 2021 article in the Saskatoon StarPhoenix, "After deadliest year in half a century, Sask. on track for higher deaths" (https://thestarphoenix.com/news/local-news/taking-a-deep-dive-on-deaths-covid-19-and-others-over-the-last-two-years):

> "Saskatchewan recorded 10,107 deaths from all causes in 2020 — the most in one calendar year in the last half-century — amid the COVID-19 pandemic…
>
> Deaths linked officially to COVID-19 account for about one-quarter of the increase in overall deaths last year compared to the average from the five previous years…
>
> Drug toxicity deaths increased substantially from fewer than 100 in Saskatchewan over the first five years of the last decade to 172 to 2018 and 179 in 2019. These deaths skyrocketed to 314 in 2020, a jump of 135 over 2019, which is less than a quarter of the higher number of deaths last year."

Records on all cause mortality/"excess mortality" for 2021 as compared to pre pandemic.

3.7.1 Records relating to the resources being devoted to addressing the significant increase in non-COVID-19 deaths as compared/contrasted with those being devoted to addressing the COVID-19 deaths.

3.8 Records of the number of people without comorbidities in the following categories who suffered a death caused by COVID-19 - meaning COVID-19 was 50% or more responsible for the death.

0 – 4:
5 – 11:
12 – 18:
19 – 30:
31 – 40:
41 – 50:
51 – 60:
61 – 70:
71 – 80:
80+

4. Hospitalizations

According to this website: https://dashboard.saskatchewan.ca/health-wellness , as of February 4, 2022 there were 363 hospitalized cases.

4.1 Records relating to how hospitalizations were/are classified as being "caused" by COVID-19.

4.2 Records relating to how hospitalizations were/are classified as "incidental".
-See for example https://globalnews.ca/news/8497344/covid-19-saskatchewan-incidental-hospitalization-reporting/

4.3 Records relating to the methodology in determining whether a person's hospitalization is counted in the above dashboard.

4.4 Records relating to whether this methodology changed over time or has been the same since January of 2020.

4.5 Records of statistics which distinguish between hospitalizations caused by COVID-19 and those which are referred to as "incidental hospitalizations".

4.6 Records of the rate of hospitalizations, including the ICU, of people with natural immunity compared/contrasted with the unvaccinated, partially vaccinated, doubly vaccinated and triple vaccinated.

4.7 According to the Association of American Physicians and Surgeons' website (https://aapsonline.org/bidens-bounty-on-your-life-hospitals-incentive-payments-for-covid-19/?fbclid=IwAR2YA8_SyvyY_QNKutnr5sYg_xIqYeGyxRzT5HNR7JlXnZ6Uklg-k3rBYeQ):

> The CARES Act, which provides hospitals with bonus incentive payments for all things related to COVID-19 (testing, diagnosing, admitting to hospital, use of remdesivir and ventilators, reporting COVID-19 deaths, and vaccinations)…
>
> The hospital payments include:
>
> -A "free" required PCR test in the Emergency Room or upon admission for every patient, with government-paid fee to hospital.
> -Added bonus payment for each positive COVID-19 diagnosis.
> -Another bonus for a COVID-19 admission to the hospital.
> -A 20 percent "boost" bonus payment from Medicare on the entire hospital bill for use of remdesivir instead of medicines such as Ivermectin.
> -Another and larger bonus payment to the hospital if a COVID-19 patient is mechanically ventilated.
> -More money to the hospital if cause of death is listed as COVID-19, even if patient did not die directly of COVID-19.
> -A COVID-19 diagnosis also provides extra payments to coroners.

> CMS implemented "value-based" payment programs that track data such as how many workers at a healthcare facility receive a COVID-19 vaccine. Now we see why many hospitals implemented COVID-19 vaccine mandates. They are paid more.
>
> Outside hospitals, physician MIPS quality metrics link doctors' income to performance-based pay for treating patients with COVID-19 EUA drugs. Failure to report information to CMS can cost the physician 4% of reimbursement.

Further, according to 980 CJME's website (https://www.cjme.com/2021/10/26/saskatchewan-reveals-plan-to-vaccinate-kids-5-to-11-against-covid/) in a story entitled, "Saskatchewan reveals plan to vaccinate kids 5 to 11 against COVID" dated October 26, 2021 it stated:

> "The Ministry of Health is implementing new temporary fee codes to compensate physicians for counselling unvaccinated patients in their office while they are there for another service," the government said in a release. "There is also a new fee code to compensate participating physicians for providing vaccinations in their office."

4.7.1 Records relating to payments and/or fees to hospitals relating to COVID-19.

4.7.2 Records relating to payments and/or fees to doctors relating to COVID-19.

4.7.3 Records relating to any payments, government-paid fees and/or incentives from pharmaceutical companies for administering PCR tests.

4.7.4 Records relating to any payments and/or other incentives for any positive COVID-19 diagnoses.

4.7.5 Records relating to any payments and/or other incentives for any COVID-19 admissions to hospitals.

4.7.6 Records relating to any payments and/or other incentives for using specific drugs or treatments for COVID-19, such as remdesivir, and not others.

4.7.7 Records relating to any payments and/or other incentives if a COVID-19 patient is mechanically ventilated.

4.7.8 Records relating to any payments and/or other incentives if cause of death is listed as COVID-19, even if patient did not die directly of COVID-19.

4.7.9 Records relating to any payments and/or other incentives to coroners relating to COVID-19.

4.7.10 Records relating to any payments and/or other incentives based on the number of staff at healthcare facilities who received a COVID-19 "vaccine".

4.7.11 Records relating to any other payments and/or other incentives for anything relating to COVID-19 not addressed above.

4.8 Records of hospitalizations which occurred within 21 days of a person receiving an approved COVID-19 “vaccine”, and whether such hospitalizations were/are counted toward the unvaccinated statistics, the vaccinated, or some other category.

4.8.1 Records detailing how it was/is decided that hospitalizations which occur within 21 days of receiving an approved COVID-19 “vaccine” were/are counted toward the unvaccinated statistics, the vaccinated, or some other category.

4.8.2 Records of any evidence of any correlation between people receiving an approved COVID-19 “vaccine” and being hospitalized with COVID-19 within 21 days.

4.8.3 Records of the monthly number of hospitalizations which occurred within 21 days of a person receiving an approved COVID-19 “vaccine” from January of 2020 to present.

4.8.4 Records of any evidence which suggests that the immune system may be temporarily suppressed after a person receives an approved COVID-19 “vaccine”.

4.8.5 Records in any way relating to the suppression, concealment and/or destruction of any evidence or findings relating to COVID-19.

4.8.6 Records in any way relating to avoiding, deferring, delaying, obstructing, impairing and/or interfering with any investigation relating to any evidence relating to COVID-19.

4.9 Records of any comparative analysis with any other province(s) relating to any relationship between hospitalizations, cases and deaths within 21 days of people receiving an approved COVID-19 “vaccine”.

4.10 Records of the monthly number of hospitalizations COVID-19 has <u>caused</u>, ie. not incidental hospitalizations, for people in the following age categories from January of 2020 to present.

0 – 4:
5 – 11:
12 – 18:
19 – 30:
31 – 40:
41 – 50:
51 – 60:
61 – 70:
71 – 80:
80+

5. Daily case counts

According to this website (https://dashboard.saskatchewan.ca/health-wellness), as of February 4, 2022 the "Seven-day Average of Daily New Cases" is 867.

5.1 Records relating to how the dashboard accounts for a single person testing positive more than once.

For example, would that count as more than one case, or how much time is required between tests from the same person to count as a second positive case?

5.2 Records relating to the processes which were put in place to ensure the number of cases is not artificially inflated by the same person testing positive multiple times.

5.3 According to Public Health Ontario's website (https://www.publichealthontario.ca/en/about/blog/2021/explained-covid19-pcr-testing-and-cycle-thresholds):

> PCR tests tell you if the virus is detected (positive) or not (negative)…
>
> The PCR machine makes millions of copies of the DNA by running multiple "cycles" (like a washing machine). This process is called amplification…
>
> The cycle threshold (Ct) value is the actual number of cycles it takes for the PCR test to detect the virus…
>
> Ct values are influenced by a number of factors including the PCR test kit, when the sample was collected, the machine used for testing, the technique of the health professional obtaining the sample and the type of sample (sampling method). In fact, different samples from the same person may result in different Ct values.

5.3.1 Records relating to the cutoff point for the number of cycles for positive results.

5.3.2 Records relating to how that cutoff point was determined as appropriate, including whether the appropriate cutoff point has changed over time.

5.3.3 Records relating to the Ct value which is used in determining a positive test, including whether it has changed over time.

5.3.4 Records relating to comparing/contrasting the cutoff point and Ct value for positive tests in Saskatchewan and whether these are consistent with other jurisdictions in Canada and internationally.

5.3.5 Records relating to the use of this test at an elevated Ct level beyond what the World Health Organization and/or the CDC recommend.

5.4 Records relating to conflicts of interest given the financial incentive payments for COVID-19 related matters.

5.4.1 Given the financial incentive payments for COVID-19 related matters, records relating to how the Ministry addressed its own conflict of interest in determining the appropriate cutoff point for cycles.

For example, using a higher cutoff point for the cycles would result in more positive COVID-19 tests.

5.5 Records relating to how it was/is decided that cases which occur within 21 days of receiving an approved COVID-19 "vaccine" were/are counted toward the unvaccinated statistics, the vaccinated, or some other category.

5.5.1 Records relating to whether this methodology changed over time, or whether this has been the same approach since January of 2020.

5.5.2 Records relating to any evidence of any correlation between people receiving an approved COVID-19 "vaccine" and then testing positive for COVID-19 within 21 days.

5.6 Records relating to data comparing/contrasting the rate of infection among people with natural immunity, the unvaccinated, partially vaccinated, doubly vaccinated and triple vaccinated.

6. Adverse events

"Adverse Events Following Immunization for COVID-19" ("AEFI") is found at this website (https://www.saskatchewan.ca/government/health-care-administration-and-provider-resources/treatment-procedures-and-guidelines/emerging-public-health-issues/2019-novel-coronavirus/covid-19-vaccine/covid-19-vaccine-information/covid-19-vaccine-details/adverse-events-following-immunization-for-covid-19).

Records relating to AEFIs data broken down by age.

6.1 Records relating to non-incidental hospitalizations for unvaccinated healthy people, ie. without co-morbidities, under 30.

6.1.1 Records relating to any comparison of (i) AEFIs for people under 30, with (ii) non-incidental hospitalizations for unvaccinated healthy people, ie. without co-morbidities, under 30.

6.2 Records relating to the last two updates of the AEFI system and how pharmacovigilance is addressed.

Context: “Pharmacovigilance” is the process of collecting, monitoring, and evaluating Adverse Events for safety signals to reduce harm and promote safety to the public in the context of pharmaceutical and biological agents.

6.3 Records relating to underreporting of AEFIs in relation to approved COVID-19 “vaccines” and how this was/is addressed.

Context: There is research which concludes there is “serious under-reporting of adverse drug reactions” in some cases (see for example https://link.springer.com/article/10.2165/00002018-200427070-00004).

6.3.1 Records relating to the underreporting factor for both non-serious AEFIs, serious AEFIs not including deaths, and AEFIs which are deaths, and the methodology for calculating said underreporting factors.

6.4 Records relating to without prejudice settlement agreements, including confidentiality agreements, with people who have suffered 1 or more AEFIs.

6.4.1 Records of the number of such settlements entered into, in each of 2020, 2021 & 2022.

6.4.2 Records of the total amount of money paid as part of said settlements in each of 2020, 2021 & 2022.

6.5 Records relating to the potential carcinogenic/mutagenic concern that is well established in the field of toxicology regarding the swabs used in the collection process for the PCR and Rapid Antigen testing.

6.5.1 Records relating to any data regarding risks associated with frequent testing.

6.5.2 Records relating to the information regarding risks of frequent testing, particularly in children, that was/is disseminated, and how this information was/is disseminated.

6.6 On the above referenced AEFI website, it states:

> **What happens when an AEFI is reported?**
> When an AEFI is reported Public Health may follow-up with you to collect more information and complete an AEFI report form, if appropriate, which will then be sent to the local medical health officer (MHO). The MHO reviews the report and if there is any recommended follow up, you will be contacted with those recommendations.
>
> On both a provincial and national level these reports are anonymized and then reviewed to identify any unusual concerns. These reports are vital to ensure the safety of all vaccination programs in Canada.

Records relating to the number of reported AEFIs in each of 2020, 2021 & 2022 from patient to doctor.

6.6.1 Records relating to the number of reported AEFIs in each of 2020, 2021 & 2022 from doctors to MHOs.

6.6.2 Records relating to the number of reported AEFIs in each of 2020, 2021 & 2022 from MHOs to the provincial level.

6.6.3 Records relating to the number of reported AEFIs in each of 2020, 2021 & 2022 from MHOs to the national level.

6.6.4 Records relating to ensuring all reported AEFIs were properly captured and communicated to the next level, all the way to the national database.

6.6.5 Records relating to ensuring consistency and accuracy from one MHO to another and all across the province regarding reported AEFIs.

6.6.6 Records relating to the number of reported AEFIs from doctors to MHOs which were denied by MHOs, and therefore not captured at the provincial or federal levels.

6.6.7 Records relating to communications between the Ministry, and/or the SHA and/or MHOs regarding reported AEFIs.

6.7 Records relating to "temporal associations" between COVID-19 vaccinations and serious or unusual adverse events, as distinct from AEFIs.

Context: In the Saskatchewan Immunization Manual, Chapter 11 at page 2 it states:

> Health-care professionals must inform clients about the benefits and risks of being immunized vs. unimmunized. Health-care professionals need to be familiar with the frequency and nature of all reactions that may occur post-immunization. They must also report serious or unusual adverse events <u>temporally associated</u> with immunization to officials at their local public health office.
> (Underlining added)

6.8 Records of the number of thrombosis (deep vein thrombosis/pulmonary emboli, etc.) which occurred within 6 weeks of administration of an approved COVID-19 "vaccine".

6.8.1 Records relating to how many of these occurrences were reported as AEFIs, temporal associations, or not reported as either.

6.8.2 Records relating to the number of days between vaccination and manifestation of the said thrombosis (deep vein thrombosis/pulmonary emboli, etc.).

6.8.3 Records relating to which "vaccine" and which dose (ie. first, second, third) were within 6 weeks of the said thrombosis (deep vein thrombosis/pulmonary emboli, etc.).

6.8.4 Records relating to the ages of the people who experienced said thrombosis (deep vein thrombosis/pulmonary emboli, etc.).

6.9 Records of the number of strokes/Transient ischemic attacks which occurred within 6 weeks of administration of an approved COVID-19 “vaccine”.

6.9.1 Records relating to how many of these occurrences were reported as AEFIs, temporal associations, or not reported as either.

6.9.2 Records relating to the number of days between vaccination and manifestation of the said strokes/Transient ischemic attacks.

6.9.3 Records relating to which “vaccine” and which dose (ie. first, second, third) were within 6 weeks of the said strokes/Transient ischemic attacks.

6.9.4 Records relating to the ages of the people who experienced the said strokes/Transient ischemic attacks.

6.10 Records of the number of heart attacks which occurred within 6 weeks of administration of an approved COVID-19 “vaccine”.

6.10.1 Records relating to how many of these occurrences were reported as AEFIs, temporal associations, or not reported as either.

6.10.2 Records relating to the number of days between vaccination and manifestation of the said heart attacks.

6.10.3 Records relating to which “vaccine” and which dose (ie. first, second, third) were within 6 weeks of the said heart attacks.

6.10.4 Records relating to the ages of the people who experienced the said heart attacks.

6.11 Records of the number of myocarditis/pericarditis which occurred within 6 weeks of administration of an approved COVID-19 “vaccine”.

6.11.1 Records relating to how many of these occurrences were reported as AEFIs, temporal associations, or not reported as either.

6.11.2 Records relating to the number of days between vaccination and manifestation of the said myocarditis/pericarditis.

6.11.3 Records relating to which “vaccine” and which dose (ie. first, second, third) were within 6 weeks of the said myocarditis/pericarditis.

6.11.4 Records relating to the ages of the people who experienced the said myocarditis/pericarditis.

6.12 Records of the number of disseminated intravascular coagulopathy which occurred within 6 weeks of administration of an approved COVID-19 “vaccine”.

6.12.1 Records relating to how many of these occurrences were reported as AEFIs, temporal associations, or not reported as either.

6.12.2 Records relating to the number of days between vaccination and manifestation of the said disseminated intravascular coagulopathy.

6.12.3 Records relating to which “vaccine” and which dose (ie. first, second, third) were within 6 weeks of the said disseminated intravascular coagulopathy.

6.12.4 Records relating to the ages of the people who experienced the said disseminated intravascular coagulopathy.

6.13 Records of the number of thrombocytopenia which occurred within 6 weeks of administration of an approved COVID-19 “vaccine”.

6.13.1 Records relating to how many of these occurrences were reported as AEFIs, temporal associations, or not reported as either.

6.13.2 Records relating to the number of days between vaccination and manifestation of the said thrombocytopenia.

6.13.3 Records relating to which “vaccine” and which dose (ie. first, second, third) were within 6 weeks of the said thrombocytopenia.

6.13.4 Records relating to the ages of the people who experienced the said thrombocytopenia.

6.14 Records of the number of Guillain-Barre syndrome which occurred within 6 weeks of administration of an approved COVID-19 “vaccine”.

6.14.1 Records relating to how many of these occurrences were reported as AEFIs, temporal associations, or not reported as either.

6.14.2 Records relating to the number of days between vaccination and manifestation of the said Guillain-Barre syndrome.

6.14.3 Records relating to which “vaccine” and which dose (ie. first, second, third) were within 6 weeks of the said Guillain-Barre syndrome.

6.14.4 Records relating to the ages of the people who experienced the said Guillain-Barre syndrome.

6.15 Records of the number of neurological events which occurred within 6 weeks of administration of an approved COVID-19 “vaccine”.

6.15.1 Records relating to how many of these occurrences were reported as AEFIs, temporal associations, or not reported as either.

6.15.2 Records relating to the number of days between vaccination and manifestation of the said neurological events.

6.15.3 Records relating to which “vaccine” and which dose (ie. first, second, third) were within 6 weeks of the said neurological events.

6.15.4 Records relating to the ages of the people who experienced the said neurological events.

6.16 Records of the number of shingles which occurred within 6 weeks of administration of an approved COVID-19 “vaccine”.

6.16.1 Records relating to how many of these occurrences were reported as AEFIs, temporal associations, or not reported as either.

6.16.2 Records relating to the number of days between vaccination and manifestation of the said shingles.

6.16.3 Records relating to which “vaccine” and which dose (ie. first, second, third) were within 6 weeks of the said shingles.

6.16.4 Records relating to the ages of the people who experienced the said shingles.

6.17 Records of the number of deaths which occurred within 6 weeks of administration of an approved COVID-19 “vaccine”.

6.17.1 Records relating to how many of these occurrences were reported as AEFIs, temporal associations, or not reported as either.

6.17.2 Records relating to the number of days between vaccination and manifestation of the said deaths.

6.17.3 Records relating to which “vaccine” and which dose (ie. first, second, third) were within 6 weeks of the said deaths.

6.17.4 Records relating to the ages of the people who experienced the said deaths.

6.18 Records relating to the legal obligation to report COVID-19 AEFIs.

Context: Reporting of Adverse Events Following Immunization (AEFIs) following the administration of publicly funded vaccines, including COVID-19 vaccines, is a legal obligation under *The Public Health Act, 1994*.

6.18.1 If not captured above, records relating to how the legal obligation to report COVID-19 AEFIs was communicated to doctors.

6.18.2 If not captured above, records relating to how the consequences of failing to report COVID-19 AEFIs was communicated to doctors.

6.18.3 If not captured above, records relating to how suspected deficiencies in reporting of COVID-19 AEFIs were addressed.

6.18.4 If not captured above, records relating to investigations of suspected deficiencies in reporting of COVID-19 AEFIs.

6.18.5 If not captured above, records relating to addressing deficiencies in reporting of COVID-19 AEFIs, up to and including discipline.

6.19 Records relating to the legal obligation to report temporal associations between COVID-19 vaccinations and serious or unusual adverse events, as distinct from AEFIs.

6.19.1 If not captured above, records relating to how the legal obligation to report COVID-19 temporal associations was communicated to doctors.

6.19.2 If not captured above, records relating to how the consequences of failing to report COVID-19 temporal associations was communicated to doctors.

6.19.3 If not captured above, records relating to how suspected deficiencies in reporting of COVID-19 temporal associations were addressed.

6.19.4 If not captured above, records relating to investigations of suspected deficiencies in reporting of COVID-19 temporal associations.

6.19.5 If not captured above, records relating to addressing deficiencies in reporting of COVID-19 temporal associations, up to and including discipline.

7. The 4 Pillars of Pandemic Response

Records relating to the extent, if any, which teams of doctors have been engaged to address the following:

1. Reducing spread of the illness;
2. Early treatment;
3. In-hospital treatment; and
4. "Vaccination".

7.1 Records relating to the extent, if any, to which doctors were required to provide regular, ie. weekly or monthly, reports with evidence reviews and scientific updates regarding the above 4 "pillars of pandemic response".

7.1.1 Records relating to a feedback loop, if any, for physicians who were/are treating COVID-19 in Saskatchewan to advise what is working and what is not, such that protocols and policies can change and be updated.

7.1.2 Records relating to whether anything was/is in place to collect data and collaborate with all parties involved in vaccine safety, including Health Canada, to continually monitor and evaluate the safety of the "vaccines".

7.2 Records relating to what processes were/are in place, if any, to continually improve on each of the above 4 "pillars of pandemic response".

7.2.1 Records relating to random audits of the different processes to ensure alignment with policy obligations.

7.2.2 Records relating to the use of serology testing.

7.2.2.1 If not captured above, records relating to reducing or banning serology testing.

7.3 Records relating to what consideration was given, if any, for a multi-drug treatment protocol for early treatment and/or in-hospital treatment.

7.3.1 Records relating to the use of chloroquine and/or hydroxychloroquine for early treatment, either alone or in combination with other drugs, including the evidence which was relied on.

Context: It was known in 2005 that chloroquine is a potent inhibitor of SARS coronavirus infection and spread. See 2005 Virology Journal study: https://www.ncbi.nlm.nih.gov/labs/pmc/articles/PMC1232869/?fbclid=IwAR2s0bNMYL_fm-OeW60UrMOWYptFuao5l54yeqPg_zR22Dou0nqLrk4rXcc

> "Chloroquine is effective in preventing the spread of SARS CoV in cell culture. Favorable inhibition of virus spread was observed when the cells were either treated with chloroquine prior to or after SARS CoV infection."

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7534595/

> "Hydroxychloroquine is effective, and consistently so when provided early, for COVID-19: a systematic review"

7.3.2 Records relating to the use of vitamins C, D, zinc, quercetin and/or melatonin for early treatment, including the evidence which was relied on.

Context: https://www.health.harvard.edu/blog/do-vitamin-d-zinc-and-other-supplements-help-prevent-covid-19-or-hasten-healing-2021040522310

> "Based on the science, there is reason to be hopeful that supplements such as vitamin C or D, zinc, or melatonin might help in the fight against COVID-19. While there's no proof yet that they do, additional research could show a benefit in certain situations, or with a different dose or formulation of the supplement. So it's worth keeping an open mind."

Context: Fox LA: Studies suggest 4 vitamins to lower risk of severe cases of COVID-19
December 23, 2020
https://www.foxla.com/news/studies-suggest-4-vitamins-to-prevent-severe-cases-of-covid-19?fbclid=IwAR13jwdzB7LldK1DUwaJfLMGppuiGCfoGtkuerxE4tssbYJQX9sOH1SrjBY

> "He [Dr. Peter Osborne] also says the most recent studies show that nine out of 10 COVID-19 deaths could be prevented if people had adequate Vitamin D levels."

7.3.2.1 Records relating to the number of vitamin D test requests which were rejected in 2018, 2019, 2020, 2021 & 2022.

7.3.2.2 Records of communications regarding rejecting vitamin D test requests between September of 2019 – present.

7.3.2.3 If different from the above, records of communications involving the Roy Romanow Provincial Lab and rejecting vitamin D test requests between September of 2019 – present.

7.3.3 Records relating to the use of fluvoxamine for early treatment, either by itself or in combination with other drugs, including the evidence which was relied on.

Context: https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(21)00448-4/fulltext

> "Treatment with fluvoxamine (100 mg twice daily for 10 days) among high-risk outpatients with early diagnosed COVID-19 reduced the need for hospitalisation defined as retention in a COVID-19 emergency setting or transfer to a tertiary hospital."

7.3.4 Records relating to the use of Ivermectin for early treatment, either by itself or in combination with other drugs, including the evidence which was relied on.

Context:
https://journals.lww.com/americantherapeutics/fulltext/2021/08000/ivermectin_for_prevention_and_treatment_of.7.aspx

> "Conclusions:
> Moderate-certainty evidence finds that large reductions in COVID-19 deaths are possible using ivermectin. Using ivermectin early in the clinical course may reduce numbers progressing to severe disease. The apparent safety and low cost suggest that ivermectin is likely to have a significant impact on the SARS-CoV-2 pandemic globally."

7.3.5 Records relating to the use of Remdesivir for early treatment, either by itself or in combination with other drugs, including the evidence which was relied on.

Context: https://www.forbes.com/sites/williamhaseltine/2022/01/10/the-challenges-of-treating-covid-19-lessons-from-gileads-remdesivir/?sh=7d3b7aa070df

> "In a recent study published in the New England Journal of Medicine, researchers at the Baylor University Medical Center in Dallas, TX and affiliated institutions found that a three-day course of remdesivir lowered the risk of hospitalization by 87.5% in symptomatic, non- hospitalized COVID-19 patients."

7.3.6 Records relating to the use of monoclonal antibodies for treatment, either by itself or in combination with other drugs, including the evidence which was relied on.

Context: We note that as of November 1, 2021 monoclonal antibodies have been endorsed. According to a Nov. 3, 2021 article by the CBC entitled, "Sask. has treated 6 people with monoclonal antibodies for COVID-19, despite hundreds of available doses" (https://www.cbc.ca/news/canada/saskatchewan/6-people-treated-monoclonal-antibodies-1.6235694) it states:

> "[The] SHA is aiming to treat five to seven patients a day with monoclonal antibodies, but it hasn't reached that number yet largely due to a recent decrease in COVID-19 cases and limited eligibility…
>
> …there is no cost to the province for the treatment because it's being provided by the federal government."

7.3.6.1 Records relating to the extent which monoclonal antibodies were/are being used to treat patients.

7.3.6.2 Records relating to any changes to the number of hospitalizations, including the ICU, since monoclonal antibodies were authorized to treat patients.

7.3.6.3 Records relating to a lack of training for hospital staff resulting in monoclonal antibodies not being used to treat patients.

7.3.6.4 Records relating to why the implementation of this treatment was delayed for nearly a year.

Context: Monoclonal antibodies were approved for use under the Emergency Authorization process in November of 2020 (See https://www.canada.ca/en/public-services-procurement/news/2020/11/government-of-canada-signs-new-agreement-for-a-covid-19-antibody-therapy0.html).

7.4 Records relating to why the approved COVID-19 "vaccines" were promoted, and continue to be so promoted, to the virtual exclusion of all other options.

Context: For example, January 22, 2022 opinion piece in the Globe and Mail by Dr. Norman Doidge:

> "Vaccines are a tool, not a silver bullet. If we'd allowed more scientific debate, we would have realized this earlier - More than two years since COVID-19 emerged, our kit of solutions – and the mindset needed to use them – is too small. It's time to listen to the science in a broader way"
>
> (https://www.theglobeandmail.com/opinion/article-vaccines-are-a-tool-not-a-silver-bullet-if-wed-allowed-more-scientific/)

and

> Scientists who express different views on Covid-19 should be heard, not demonized
> April 27, 2020
>
> "When major decisions must be made amid high scientific uncertainty, as is the case with Covid-19, we can't afford to silence or demonize professional colleagues with heterodox views. Even worse, we can't allow questions of science, medicine, and public health to become captives of tribalized politics. Today, more than ever, we need vigorous academic debate."
>
> https://www.statnews.com/2020/04/27/hear-scientists-different-views-covid-19-dont-attack-them/

7.4.1 Records relating to how the pharmaceutical companies, such as Pfizer & Moderna, and/or their lobbyists/agents, influenced COVID-19 policies.

7.4.2 Records relating to whether policies regarding COVID-19 vaccination are based in part on studies/research funded by pharmaceutical companies.

7.4.3 Records relating to identifying and addressing potential conflicts of interest in the studies/research which ultimately inform our COVID-19 policies.

7.4.4 Records relating to the policy on vaccination of children and net benefit to risk ratio.

7.5 Records relating to potential partnering with the University of Saskatchewan and/or the University of Regina to develop improved protocols to any of the above 4 "pillars of pandemic response".

7.6 Records relating to the pandemic response plan that was in place prior to January of 2020.

Context: According to a July 8, 2021 article in the Medicine Hat News: "Former head of Alberta Emergency Management Agency blasts governments and 'lockdowns' in webinar" (https://medicinehatnews.com/news/local-news/2021/07/08/former-head-of-alberta-emergency-management-agency-blasts-governments-and-lockdowns-in-webinar/), David Redman states:

> "Each province and territory in Canada has a pandemic response plan, Redman added. "And they're written on the hard lessons learned – that we learned from all the previous pandemics and from other experiences in responding to emergencies." "

On this website dated Sept. 16, 2009 (https://www.saskatchewan.ca/government/news-and-media/2009/september/16/saskatchewan-releases-updated-pandemic-plan) it states:

> SASKATCHEWAN RELEASES UPDATED PANDEMIC PLAN

There is a link (file:///C:/Users/Louis/Downloads/Pandemic%20overview%20(2).pdf) to a 2 page document entitled:

> SASKATCHEWAN HEALTH PANDEMIC INFLUENZA PREPAREDNESS PLAN: AN OVERVIEW
> September 2009

7.6.1 Records relating to the implementation, if any, of the pre-existing pandemic response plan.

7.6.2 Records identifying whether emergency management agencies or public health has been in charge of Saskatchewan's pandemic response.

Context: David Redman further states:

> "[E]mergency management agencies should have been placed in charge to develop concepts and plans, Redman said, "we handed it to health."

7.6.3 Records relating to the role, if any, which Saskatchewan's emergency management agencies played in responding to the COVID-19 pandemic.

7.6.4 Records identifying the person in charge of Saskatchewan's emergency management agencies who has been engaged in responding to the COVID-19 pandemic, as opposed to public health officials.

8. Risk stratification

8.1 Records relating to risk stratification, and how risk stratification was used to develop policies for Saskatchewan's varied people and workplaces.

Context: As reported in a Dec. 13, 2021 CTV article, according to Dr. Peter Jüni, the head of Ontario's Science Advisory Table, "Age is the most important risk factor…"
-See https://toronto.ctvnews.ca/ontario-needs-to-address-myth-that-omicron-is-mild-head-of-science-table-says-1.5705025

Therefore, risk stratification must be applied with every single inference we make in the pandemic. However, we have the same one-size fits all policy recommendations for people working with young people as we do for people working in long-term care facilities.

8.2 Records relating to minimizing the infringement on people's rights by differentiating higher risk versus lower risk environments.

Context: For example, how do the guidelines differ for people who work with seniors versus people who work with children and youth aged 5 – 18 years old?

9. Free Speech & Integrity of Evidence

9.1 Records relating to ensuring Saskatchewan's doctors spoke only in a manner consistent with the established narrative regarding COVID-19, and did not spread "misinformation".

Context: Were memos sent out to Saskatchewan's physicians advising as to consequences for deviating from the narrative? Was access to resources, such as operating rooms, leveraged to ensure compliance with the established narrative? Were other "carrots" & "sticks" leveraged?

There are multiple reports in the mainstream media of doctors being disciplined, pressured, coerced, etc. for deviating from the established COVID-19 narrative, including Saskatchewan's own Dr. Francis Christian.

-See https://www.jccf.ca/surgeon-fired-by-college-of-medicine-for-voicing-safety-concerns-about-covid-shots-for-children/
-https://www.cbc.ca/news/canada/british-columbia/bc-doctors-misinformation-covid-19-1.6021489
-https://northernontario.ctvnews.ca/englehart-ont-doctor-sanctioned-for-disgraceful-conduct-related-to-covid-19-1.5603594
-https://edmonton.ctvnews.ca/regulatory-group-warns-several-alberta-doctors-about-sharing-covid-19-misinformation-1.5596182
-https://www.thestar.com/news/gta/2021/09/28/restrictions-imposed-on-doctor-accused-of-spreading-covid-misinformation.html
Etc.

9.1.1 Records relating to communications with the College of Physicians and Surgeons of Saskatchewan to ensure that doctors would not spread "misinformation" about COVID-19.

9.1.2 Records relating to the definition of "misinformation" and how it was determined that any duly licensed doctor's medical opinion is "misinformation".

9.1.3 Records relating to communications with doctors regarding granting medical exemptions with respect to COVID-19.

9.1.3.1 Records relating to communications with doctors regarding granting 90 day exemptions from testing after a person recovers from COVID-19.

9.1.3.2 Records relating to changes to access to PCR tests to reduce 90 day exemptions from testing for people who recovered from COVID-19.

9.2 Records relating to ensuring that COVID-19 policies are based on the best and most comprehensive information available, including the full spectrum of genuinely held medical opinions by doctors.

Context: In light of the above, some doctors may not feel comfortable expressing their true medical opinions about various aspects about COVID-19. What, if anything, is being done to ensure that doctors are free to share their genuine medical experiences and opinions about COVID-19, even if they differ from the accepted narrative, to ensure that our policies are based on the best and most comprehensive data?

9.3 Records relating to ensuring that COVID-19 policies are based on the best and most comprehensive information available, including the full spectrum of studies and research.

Context: Further to the above, there is some evidence that publishers are refusing to publish scientific papers/research which are contrary to the established COVID-19 narrative.

For example, according to The American Journal of Cardiology's website (https://www.ajconline.org/article/S0002-9149(14)01767-6/pdf#%20) Dr. Peter McCullough's medical bio includes:

> "In October 2002, he returned to the Detroit area and to William Beaumont Hospital as a Consultant Cardiologist and Division Chief of Nutrition and Preventive Medicine--where he remained until August 2010, when he became the Chief Academic and Scientific officer of the St. John Providence Health System, also in Detroit. In February 2014, Dr. McCullough joined Baylor Scott & White Health as Vice Chief of Internal Medicine at BUMC, Chief of Cardiovascular Research of the Baylor Heart and Vascular Institute, and Program Director of the cardiovascular disease fellowship program at BUMC."

HeartPlace is a cardiology medical facility located in Dallas, Texas and according to their website (https://www.heartplace.com/dr-peter-a-mccullough):

> Dr. Peter McCullough is board certified in internal medicine, cardiovascular diseases, and clinical lipidology…
>
> Dr. McCullough has broadly published on a range of topics in medicine with > 1000 publications and > 600 citations in the National Library of Medicine… Dr. McCullough is a founder and current president of the Cardiorenal Society of America, an organization dedicated to bringing cardiologists and nephrologists together to work on the emerging problem of cardiorenal syndromes. His works have appeared in the New England Journal of Medicine, Journal of the American Medical Association, Lancet, British Medical Journal and other top-tier journals worldwide. He is the editor-in-chief of Reviews in Cardiovascular Medicine and senior associate editor of the American Journal of Cardiology. He serves on the editorial boards of multiple specialty journals. Dr. McCullough has made presentations on the advancement of medicine across the world and has been an invited lecturer at the New York Academy of Sciences, the National Institutes of Health, U.S. Food and Drug Administration (FDA), and the European Medicines Agency. He has served as member or chair of data safety monitoring boards of 24 randomized clinical trials.

However, despite Dr. McCullough's impeccable qualifications, extensive experience and internationally recognized expertise, he stated the following according to LifeSiteNews on Nov. 16, 2021 (https://www.lifesitenews.com/blogs/dr-mccullough-sues-medical-journal-for-refusing-to-publish-papers-showing-covid-shot-risks-in-children/):

> "According to McCullough, the journal, "Elsevier," originally published the study, but scrubbed it just days before the FDA met to discuss approval for the injections to 5-11 year olds.
>
> "This is an overt act of censorship," he said. "We will be launching a full scale lawsuit against Elsevier, and it's going to be for breach of contract." "

9.3.1 Records relating to potential publication bias regarding the studies & research which are informing our COVID-19 policies.

9.3.2 Records relating to how the Ministry is addressing this potential publication bias, to ensure that our COVID-19 policies are based on the best and most comprehensive studies & research, not just those which reinforce the established narrative.

9.4 Records relating to the potential corruption of the scientific integrity of studies & research which are informing our COVID-19 policies.

Context: According to the Informed Consent Action Network ("ICAN")'s website (https://www.icandecide.org/ican_press/ican-demands-cdc-authors-withdraw-rigged-natural-immunity-study/):

> On October 29, 2021, 53 authors put their name on a paper that they should be, at best, deeply ashamed of and, at worst, held liable for. Seventeen of those authors were members

of CDC's COVID-19 Response Team. ICAN sent them a letter detailing the gross scientific misconduct evidenced in the paper and demanded that they withdraw their names from the study.

The non-peer-reviewed paper titled Laboratory-Confirmed COVID-19 Among Adults Hospitalized with COVID-19–Like Illness with Infection-Induced or mRNA Vaccine-Induced SARS-CoV-2 Immunity — Nine States, January–September 2021 purports to compare the risk of infection between those who previously tested positive for SARS-CoV-2 and those who received a COVID-19 vaccine.

It misleadingly concludes that the unvaccinated have more than a 5x greater risk of becoming infected with COVID-19 than those who are vaccinated. If this strikes you as absurd based on the dozens and dozens of peer-reviewed studies that show the opposite result, and based on everything we know about natural immunity, that is because it is.

9.4.1 Records relating to the Ministry's awareness of this potential corruption of the scientific integrity of studies & research which are informing our COVID-19 policies.

9.4.2 Records relating to how, if at all, this potential corruption is being addressed to ensure our COVID-19 policies are based on the best and most comprehensive studies & research, not just those which reinforce the established narrative.

9.5 Records relating to changes to the COVID-19 "Dashboard", and other public data, in order to support a policy objective as opposed to reflecting accurate data.

9.5.1 Records relating to emphasizing any data at the expense of other data to advance a policy objective, as opposed to reflecting accurate data.

9.6 Records relating to whether any of the components of the current vaccine trials have been peer-reviewed by independent bodies bearing no conflicts of interest and no reporting bias.
9.7 Records relating to the FDA's and Pfizer's attempt to conceal critical information for 75 years.

Context: According to several online news websites, the US Food and Drug Administration had "asked a federal judge for permission to make the public wait until the year 2096 to disclose all of the data it relied upon to license Pfizer's Covid-19 vaccine.

That is not a typo. The FDA wanted court approval to have up to 75 years to publicly disclose this information."

(See https://news.bloomberglaw.com/health-law-and-business/why-a-judge-ordered-fda-to-release-covid-19-vaccine-data-pronto)

Given the importance of transparency regarding all aspects of the COVID-19 vaccines, what is the Ministry's position and response to the FDA's and Pfizer's attempt to conceal critical information for 75 years?

9.8 Records relating to meetings with the Saskatchewan Union of Nurses ("SUN") regarding grievances between October – December of 2021.

9.8.1 Records relating to meetings with SUN, CUPE, SGEU, SEIU between September of 2019 – present, regarding COVID-19.

10. Privacy

10.1 Records relating to collecting, tracking, using or analysing any data from the mobile phones of Saskatchewan citizens and/or residents.

Context: The Public Health Agency of Canada is collecting data from millions of mobile phones without consent.
-See https://nationalpost.com/news/politics/opposition-mps-call-for-committee-tolaunch-emergency-probe-of-use-of-mobile-data

10.1.1 Records relating to the collection, use and disclosure of personal health information relating to COVID-19 and *The Health Information Protection Act* (Sask)("HIPA").

10.2 Records relating to whether the e-health mobile app tracks a person's movement.

10.3 Records relating to whether the e-health mobile app provides any information to the Ministry, or any other person or entity, without the phone owner's consent.

10.4.1 Records relating to how the "careful consideration" test has been addressed.

Context: On May 19, 2021 Canada's Federal, Provincial and Territorial Privacy Commissioners issued a joint-statement regarding COVID-19 vaccine passports (See https://www.priv.gc.ca/en/opc-news/speeches/2021/s-d_20210519/).

Therein, our privacy commissioners stated:

> Page 1: At its essence, a vaccine passport presumes that individuals will be required or requested to disclose personal health information – their vaccine/immunity status – in exchange for goods, services and/or access to certain premises or locations. While this may offer substantial public benefit, it is an encroachment on civil liberties that should be taken only after careful consideration…
> (Underlining added)
>
> Vaccine passports must be developed and implemented in compliance with applicable privacy laws. They should also incorporate privacy best practices in order to achieve the highest level of privacy protection commensurate with the sensitivity of the personal health information that will be collected, used or disclosed.

> Page 2: Above all, and in light of the significant privacy risks involved, the necessity, effectiveness and proportionality of vaccine passports must be established for each specific context in which they will be used.
> (Underlining added)
>
> • **Necessity:** vaccine passports must be necessary to achieve each intended public health purpose. Their necessity must be evidence-based and there must be no other less privacy-intrusive measures available and equally effective in achieving the specified purposes.
> • **Effectiveness:** vaccine passports must be likely to be effective at achieving each of their defined purposes at the outset and must continue to be effective throughout their lifecycle.
> • **Proportionality:** the privacy risks associated with vaccine passports must be proportionate to each of the public health purposes they are intended to address. Data minimization should be applied so that the least amount of personal health information is collected, used or disclosed.
>
> The necessity, effectiveness and proportionality of vaccine passports must be continually monitored to ensure that they continue to be justified. Vaccine passports must be decommissioned if, at any time, it is determined that they are not a necessary, effective or proportionate response to address their public health purposes.

10.4.2 Records relating to the "privacy best practices" considered in developing or advising on the vaccine mandate "in order to achieve the highest level of privacy protection commensurate with the sensitivity of personal health information that will be collected, used or disclosed."

10.4.3 Records relating to the "Necessity" requirement, including how the vaccine mandate was/is necessary to achieve each intended public health purpose.

10.4.4 Records relating to the specific intended public health purposes which drove/driving the vaccine mandate.

10.5 Records relating to the evidence which was/is being relied upon to justify the necessity of a vaccine mandate in any work environment.

Context: Given that "the necessity must be evidence-based", please provide the evidence upon which the Ministry was/is relying to justify the necessity of the vaccine mandate in any work environment.

Further to the above section on "Transmissibility", in a September 28, 2021 study entitled, "No Significant Difference in Viral Load Between Vaccinated and Unvaccinated, Asymptomatic and Symptomatic Groups Infected with SARS-CoV-2 Delta Variant" the Abstract states:

> We found no significant difference in cycle threshold values between vaccinated and unvaccinated, asymptomatic and symptomatic groups infected with SARS-CoV-2 Delta. Given the substantial proportion of asymptomatic vaccine breakthrough cases with high viral levels, interventions, including masking and testing, should be considered for all in settings with elevated COVID-19 transmission.
> (See https://www.medrxiv.org/content/10.1101/2021.09.28.21264262v1)

In other words, both vaccinated and unvaccinated spread COVID-19 and testing therefore should not be imposed only on the unvaccinated.

Further, in a September 2, 2021 Freedom of Information Act request by ICAN (Informed Consent Action Network) which is a US not-for-profit organization "whose mission is to raise public awareness about vaccine safety and to provide the public with information to give informed consent.", ICAN's request to the American CDC stated the following:

> Documents reflecting any documented case of an individual who: (1) never received a COVID-19 vaccine; (2) was infected with COVID-19 once, recovered, and then later became infected again; and (3) transmitted SARS-CoV-2 to another person when reinfected.

The CDC's November 5, 2021 response was:

> A search of our records failed to reveal any documents pertaining to your request. The CDC Emergency Operations Center (EOC) conveyed that this information is not collected.
> (See https://aaronsiri.substack.com/p/cdc-admits-crushing-rights-of-naturally)

In other words, after formal demand, the CDC conceded it did not have proof of a single instance of a naturally immune individual spreading the virus.

In order for people to give informed consent to any vaccine mandate, they require that the evidence which is being relied upon for the "necessity" criterion address these 2 issues, ie. (i) that vaccinated people have similar viral loads as unvaccinated, and (ii) that naturally immune people may spread the virus less than vaccinated people.

10.6 Records relating to the analysis of the "other less privacy-intrusive measures" which were found to be inadequate.

10.7.1 Records relating to the "Proportionality" requirement, and specifically those relating to the due diligence to ensure the privacy risks associated with the vaccine mandate were/are proportionate to each of the public health purposes they are intended to address.

10.7.2 Records relating to how "Data minimization will be applied so that the least amount of personal health information is collected, used or disclosed."

10.8 Records relating to how the necessity, effectiveness and proportionality of vaccine passports were/are continually monitored to ensure that they were/are be justified.

Context: Our Privacy Commissioners stipulate that, "The necessity, effectiveness and proportionality of vaccine passports must be continually monitored to ensure that they continue to be justified." (Underlining added)

10.9 Records relating to the threshold when vaccine mandates were no longer a justified encroachment on our civil liberties.

10.10.1 Records relating to the requirement to "decommission" vaccine passports.

Context: Our Privacy Commissioners stipulate that, "Vaccine passports must be decommissioned if, at any time, it is determined that they are not a necessary, effective or proportionate response to address their public health purposes."
(Underlining added)

10.10.2 Records relating to the definition of "decommission".

11. Informed Consent

11.1 Records relating to who was/is authorized to administer the COVID-19 "vaccines".

11.2 Records relating to what guidelines were/are in place to determine informed consent, and whether this has changed since January of 2020.

11.3 Records relating to what information was/is provided to the people administering said "vaccines" to assist them with getting informed consent.

11.3.1 Records relating to whether this information was/is updated as new information becomes available.

11.4 Records relating to what information is supposed to be provided by the people administering the "vaccines" to the people receiving said "vaccines", both orally and in the form of documentation in order to obtain informed consent.

11.4.1 Records relating to whether this information was/is uniform across all the people administering the "vaccines".

11.4.2 Records relating to any audit system(s) and/or any other quality controls in place to ensure accurate and consistent information was/is being provided by the people administering the "vaccines" to the people receiving the "vaccines".

11.4.3 Records relating to whether there is FULL disclosure of ALL the potential side effects and risks by the people administering the “vaccines” to the people receiving the “vaccines”.

11.4.4 Records relating to what side effects and risks are supposed to be communicated by the people administering the “vaccines” to the people receiving the “vaccines”.

11.4.5 Records relating to whether recipients of said “vaccines” are being advised that they are part of the Phase III clinical trials.

11.4.5.1 Records relating to whether prospective recipients of a “vaccine” have to first consent to being a subject in a clinical trial.

11.4.5.2 Records relating to whether prospective recipients of a “vaccine” are informed in the same way that drug trial participants have traditionally been informed, ie. adhering to all the rules and regulations which are incumbent in such trials.

11.4.5.3 Given the speed with which the COVID-19 vaccines have had to be developed, records relating to what has changed regarding the information which is provided to participants in the Phase III clinical trials, versus that which is normally provided.

11.4.6 Records relating to when a person experiences an adverse event from a dose, whether they are provided with any additional information regarding successive doses and their informed consent for same.

11.5 Records relating to what is in place to ensure that a person is psychologically stable, cognitively mature and free from any form of duress, so as to ensure they can adequately provide informed consent.

11.5.1 Records relating to how often proxies have been used to provide informed consent for an approved COVID-19 “vaccine”.

11.5.2 Records relating to what processes are in place to ensure that said proxies are duly vetted and authorized to provide said informed consent for another.

11.6 Records relating to whether the Patient Advocate is involved if an adverse event occurs.
11.6.1 Records relating to ensuring the independence of the Patient Advocate in such cases.

11.6.2 Records relating to whether Patient Advocates receive any payments and/or other incentives for anything relating to COVID-19.

11.6.3 Records relating to whether Patient Advocates have provided any feedback and/or recommendations regarding COVID-19 protocols.

11.6.4 Records relating to whether any of the COVID-19 policies were changed as a result of Patient Advocates.

11.7 Records relating to whether anything is in place with the School Boards to address potential concerns of parents/students regarding "vaccines".

11.8 Records relating to material risks associated with the approved "vaccines" which people should know about.

11.8.1 Records relating to special or unusual risks associated with the approved "vaccines" which people should know about.

11.9 Records relating to material risks associated with the approved COVID-19 tests which people should know about.

11.9.1 Records relating to special or unusual risks associated with the approved COVID-19 tests which people should know about.

11.9.2 Records relating to whether any components of any of the COVID-19 tests are known to be carcinogenic.

11.9.3 Records relating to whether there are recommended limits on the frequency or duration for testing.

For example, if a person tested every day for 6 months are there any known risks associated with that?

11.10 Records relating to COVID-19 and s. 6 of HIPA.

Context: 6(1) Where consent is required by HIPA for the collection, use or disclosure of personal health information, the consent:

(a) must relate to the purpose for which the information is required;
(b) must be informed;
(c) must be given voluntarily; and
(d) must not be obtained through misrepresentation, fraud or coercion.
(Underlining added)

Saskatchewan citizens were required to show proof of vaccination to gain access to many businesses, including restaurants, movie theatres and in many cases to be able to continue working without regular testing. This involved the collection, use and disclosure of personal health information (via an app in many cases), ie. a person's vaccine status.

11.10.1 If different from above, records relating to COVID-19 and consideration of and compliance with s. 6(1)(a) of HIPA.

11.10.2 If different from above, records relating to COVID-19 and consideration of and compliance with and s. 6(1)(b) of HIPA.

11.10.3 If different from above, records relating to COVID-19 and consideration of and compliance with and s. 6(1)(c) of HIPA.

11.10.4 If different from above, records relating to COVID-19 and consideration of and compliance with s. 6(1)(d) of HIPA.

12. Pregnancy/Breastfeeding/Family Planning

12.1 Records relating to how COVID-19 policies regarding pregnant and lactating women were developed, given that pregnant and lactating women were/are excluded from the vast majority of clinical trials.

Context: In an article published on the John Hopkins University website, dated June 28, 2021 entitled, "Global policies on COVID-19 vaccination in pregnancy vary widely by country according to new online tracker - Johns Hopkins project provides worldwide snapshot of policies influencing access to COVID-19 vaccines for pregnant and lactating people", the following is stated:

> …countries around the world vary widely in their policies on COVID-19 vaccination in pregnancy…
> …
> "The variability in policy positions is in part a consequence of the absence of evidence on vaccines in pregnancy, because pregnant and lactating people are excluded from the vast majority of clinical trials. As a result, public health authorities and recommending bodies are developing guidance on COVID vaccines and pregnancy with far less evidence than they have for most other populations," said Ruth Faden, founder of the Johns Hopkins Berman Institute of Bioethics.
> (-https://hub.jhu.edu/2021/06/28/tracker-map-of-vaccine-policies-for-pregnant-women/)
> (Underlining added)

12.2.1 Records relating to any long-term safety data regarding the approved "vaccines" and pregnancy.

12.2.2 Records relating to any adverse events for pregnant women and/or unborn children associated with the approved "vaccines".

12.3 Records relating to any long-term safety data regarding the approved "vaccines" and breastfeeding.

12.3.1 Records relating to any adverse events for breastfeeding women and/or breastfeeding children associated with the approved "vaccines".

12.4 Records relating to whether the approved "vaccines" have any effect on fertility for pregnant women.

12.4.1 Records relating to whether the approved "vaccines" have any effect on the fertility of an unborn child when injected into his or her pregnant mother.

12.4.2 Records relating to whether the approved "vaccines" have any effect on men's fertility.

12.5.1 Records relating to the number of monthly miscarriages from January of 2018 – present.

12.5.2 Records relating to any correlation with an increase in the number of miscarriages and the roll-out of the approved "vaccines".

12.7 Records relating to any additional material risks associated with the approved "vaccines" which pregnant and/or breastfeeding women should know about.

12.7.1 Records relating to any special or unusual risks associated with the approved "vaccines" which pregnant and/or breastfeeding women should know about.

12.8 Records relating to any additional material risks associated with the approved COVID-19 tests which pregnant and/or breastfeeding women should know about.

12.8.1 Records relating to any special or unusual risks associated with the approved COVID-19 tests which pregnant and/or breastfeeding women should know about.