

British Columbia Health Professionals Challenge B.C. Government Regarding Covid-19 Restrictions

Open Letter to Dr. Bonnie Henry, Adrian Dix, and Premier John Horgan

By [Voices Of Silenced Okanagan Health Professionals](#)

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We are a group of extremely concerned health professionals in the Okanagan Valley, B.C. We have some critical questions regarding COVID-19, specifically about the current reporting of case numbers, statistics, and testing, and the restrictions imposed by your health orders. While discussion of adjunctive and alternative safe and effective treatments is being stifled, the policies of mandatory experimental vaccines and vaccine passports are being forced upon our province, our country, and many other countries worldwide.

Addressing Dr. Henry, Mr. Dix and Mr. Horgan: We—as healthcare practitioners and citizens—expect and deserve answers that address these concerns directly. Proclaiming that vaccine therapies are “safe and effective” is misleading and sloganistic. The reports of vaccine injuries are increasing every day, yet are being ignored. We are witnessing an increase in Covid illness occurring in fully vaccinated individuals and, irrationally, that is being followed by a promise of mandated boosters.[1] The lack of answers and the vague information being provided over the past 18+ months do not instill confidence in British Columbians.

This lack of transparency has resulted in unprecedented divisiveness amongst citizens, families and friends. There are individuals who are angry that some concerned citizens are not complying and are comparing our current circumstances to the Holocaust. While this may seem extreme, the Holocaust also began with the small removal of freedoms[2], just as we are seeing today. This historical atrocity started out as a slow and seemingly innocent removal of rights by the government, but quickly morphed into media control, divisiveness between groups of people, and limitations to what one select section of society could do. In this way, the ordinary citizen easily became an enemy of the state. Today a one-sided, politically-driven narrative, which is being fuelled by politicians and the media, is causing a similar divisiveness. When only one side of the story is made available to the public, it is

easy to understand how individuals can become disgruntled toward other citizens who are fighting to maintain their freedom and bodily autonomy. A political agenda is clearly being pushed here, and the refusal to address questions and concerns of healthcare practitioners and citizens of B.C. speaks volumes. We hope all of B.C. and Canada will carefully consider the information included in this document and join us in demanding clear, direct and truthful answers.

You must recognize and acknowledge the problems our country faces with our media and with our supposed leaders. We are on a dangerous trajectory and we must STOP —NOW! The media's control of information and the censorship of knowledgeable and experienced physicians, scientists, and lawyers are preventing access to the two sides of the story. The introduction of "Fact checkers"—who are wholly owned by Big Tech, Big Pharma, and Big Media — being paid to censor anyone who does not support the government narrative. The tools of intimidation, coercion, and bribery are being used to divide our society, and all of this is happening right in front of us. Obviously, this type of behaviour is not a reflection of good people with good ideas; to the contrary, it is criminal activity.

Groups of doctors are forming international networks to investigate public health measures and to raise questions and concerns.[3] We call on all Canadians to join the rapidly growing movement of ordinary citizens who are standing up against tyranny and violation of our human rights and freedoms!

Please answer the 12 questions below directly, clearly and truthfully, with references to the data from the scientific research on which you are basing your decisions and policies:

1.) DEATH PERSPECTIVE - There are currently ZERO deaths from COVID-19 for ages 12-19 in B.C., and 12 deaths in ALL children aged 0-19 in ALL of Canada

Question:

Why are you aggressively pressuring 12 through 19-year-old children to get the experimental COVID-19 vaccine when NO DEATHS have occurred in this age group due to COVID-19 in B.C. to date, according to the B.C. Centre for Disease Control?[4]

Background:

In general, we have observed extremely low mortality in B.C. and across Canada from COVID-19. As identified in the preceding link, only two COVID-19-related deaths have occurred in the past 18 months in the 0 to 11 age range in BC.

No deaths have occurred in the age range of 12 through 19. In these childhood deaths, the influence of comorbidities was not revealed.

On the BCCDC website[4], in the Situation Report listed below in the footnotes, these statistics can be viewed on page 9.

With only 2 deaths occurring in the 1 million children and adolescents aged 0 to 19 that reside in B.C., why are we even considering mandating vaccinations, masks, isolation, and restrictions at school?

B.C. has a population of 5.17M people. As of August 21, 2021, there have been a total of

1,804 deaths due to—or related to—COVID-19. These deaths occurred over the span of 18+ months dealing with COVID-19 in our province. Further calculation demonstrates that this represents a 0.023% COVID-19 yearly mortality rate for our entire B.C. population. Does an annual 0.023% risk of death, heavily skewed towards the elderly with comorbidities, justify a mandatory vaccine policy and a vaccine passport?

Moreover, in the age range of 0 to 59, there have been 127 deaths related to or from COVID-19 in the entirety of B.C across an 18+ month duration. Why is this information not being openly shared? Does this data not represent a very different reality than we are being led to believe in the media and in your press conferences?

The total number of people that the Government of Canada says died WITH COVID-19 (not necessarily FROM Covid- 19) since the beginning of the pandemic, is 26,873 as of September 3, 2021. You can view these numbers directly on the Government of Canada InfoBase website[5], using the link in the footnote (find Figure 7, and change the drop down to “deceased”). There you will find the breakdown of the 26,873 of total COVID-19 deaths by age group in Canada.

To see these numbers here, we show both the BC and CANADA total deaths, said to be WITH Covid-19, broken down by age, and the percentage of those deaths by age, over the past 18+ months:

● Age 0-19 =	2 (0%) BC	12 (0%)	Canada
● Age 20-29 =	0 (0%) BC	68 (0.3%)	Canada
● Age 30-39 =	2 (0%) BC	152 (0.6%)	Canada
● Age 40-49 =	16 (0.8%) BC	354 (1.3%)	Canada
● Age 50-59 =	30 (0.16%) BC	1,033 (3.8%)	Canada
● Age 60-69 =	77 (0.4%) BC	2,620 (9.7%)	Canada
● Age 70-79 =	178 (9.8%) BC	5,747 (20.5%)	Canada
● Age 80+ =	1,117 (62%) BC	17,160 (63.9%)	Canada
Total Deaths =	1,804 (100%) BC	26,872 (100%)	Canada
Total Population =	5,145,851 BC	38,067,903	Canada

It should surprise all Canadians that there has been a total of 12 children between the ages of 0 and 19 across the entire nation that have died WITH (not necessarily FROM) COVID-19 in 18+ months. Co-morbidities have not been made public. With this data, it is reasonable to ask why the government seeks to vaccinate all children to “protect” them? It is obvious that they do not need protection.

If we compare this to the number of 0-19 year olds in Canada who typically die from influenza (the flu) each year, the public health pressure on children to get vaccinated becomes even more troubling. The only breakdown shown for pediatrics (assuming age 0-16) in Canada showed that 10 children died of the flu in 2018 over a 12 month period.[6]

Data for deaths of children from the flu between the ages of 0 and 19 was not shown, which makes it difficult to precisely compare, but the figures are still telling. According to the Government of Canada, ten children 0-16 years old died from the flu in 12 months versus 12 children who died with COVID-19 over the last 18+ months (proportionately 8 children per 12 months). This means that COVID-19 is less dangerous than the flu for this age group.

Why then is the Government pressuring children to get vaccinated?

Given 84.3% of all people who are said to have died with COVID-19 are age 70 and over, and 94% of all people who are said to have died with COVID-19 are age 60 and over, how do you justify applying public health restrictions on the rest of the population?

2.) PCR TESTING - Invalid test used to create fear based on 90%+ false positives

Question:

Why are we still using polymerase chain reaction (PCR) tests to detect COVID-19 cases in B.C.?

Background:

The World Health Organization (WHO) originally stated that PCR tests were the “gold standard” for COVID-19 testing, recommending it as the universal test (as of March 21, 2020 laboratory testing strategy recommendations for COVID-19 interim guidance). Now the WHO admits what scientists have been saying since the beginning of the pandemic, that the PCR test is not an accurate diagnostic tool, and is in fact recommending a completely different testing protocol[7]. Also, the U.S. Centre for Disease Control (CDC) has said that it will ask the U.S. Food and Drug Administration (FDA) to withdraw its emergency use authorization (EUA) of the PCR test as of December 31, 2021[8].

The entire pandemic and associated restrictions are based upon the number of “cases”; however, the number of “cases” is based upon a positive PCR test result. These PCR tests are falsely inflating the “case” numbers of people who are sick with COVID-19. This creates fear and misleading statistics.

It is important to note that the inventor of the PCR test, Kary Mullis, stated many times that “PCR tests cannot be used to detect viruses”[9]. It is now admitted that the PCR cannot tell the difference between a common cold, the flu, or any virus or variant. Also, the PCR cannot differentiate between live and dead matter meaning whether something is infectious or not.

Additionally, former Pfizer Vice President and Chief Science Officer, Dr. Michael Yeadon announced “...this is nothing but fear-mongering based on junk science and fraud.”[10] He too claims that “almost all” of the tests being conducted for the Wuhan coronavirus (COVID-19) are “false positives”, a phenomenon that has been observed in Florida and around the world. Yet, we still continue to use PCR tests to manufacture fear and compliance.

Since speaking out, Dr. Yeadon has been censored and smeared in order to prevent the distribution of, and to discredit, the critical information he is sharing. He has risked his reputation, career, and his life to share this information. Dr. Yeadon has joined forces with a group of 160 doctors, who are in agreement with issues of regarding the COVID-19 narrative.[11] Why would these highly credentialed professionals willingly put themselves in this position, where there is so much to lose, and nothing to gain, other than trying to save people from harm?

Dr. Yeadon’s credentials are impressive and include: BSc (Joint Honours in Biochemistry and Toxicology) PhD (Pharmacology), Formerly Vice President & Chief Scientific Officer Allergy & Respiratory, Pfizer Global R&D; Co- founder & CEO, Ziarco Pharma Ltd.; Independent

Consultant (Scientist) (United Kingdom).

It is prohibited under the Genetic Non-Discrimination Act of Canada[12] to require someone to take a genetic test such as the PCR test as a condition of their employment or as condition of providing goods or services to that individual. It is also prohibited for any person to collect, use or disclose the results of a genetic test of an individual without the individual's written consent. Anyone involved in contravening this law is liable to a fine of up to 5 years in jail and up to a \$1,000,000 fine.

We note that all of your health orders contravene this law and that you are encouraging employers and business owners to do the same. Why aren't you advising the public of the legal responsibility and consequences under the GNDA?

3.) CASES - An overused term and count that means nothing in the actual diagnosis of disease

Question:

What actually constitutes a legitimate COVID-19 case?

Background:

You state a case is confirmed based on a positive PCR test; however, as per Question #2, we know these tests are shown to be inaccurate (90% false positives). Moreover, cycling of PCR tests (often in excess of 35+ amplifications) is being used incorrectly for the detection of this virus. With the knowledge of these inflated false positives, we absolutely should not be counting these as "cases".[13]

4.) SPREAD - Vaccinated individuals spread COVID-19 just as much—or more—than unvaccinated individuals

Question:

What science or information are you relying upon when you say in your health orders that unvaccinated individuals are at higher risk than vaccinated persons of being infected with and transmitting COVID-19, or that the presence of an unvaccinated staff member constitutes a health hazard under the Public Health Act?

Background:

Several studies as well as CDC data demonstrate evidence that vaccinated persons have high potential to spread the COVID-19 Delta variant[14]. It has been well documented that vaccinated people can—and do—spread the virus.[15]

A recently published medical study found that infection from COVID-19 confers considerably longer lasting and stronger protection against the delta variant than the current vaccines do.[16] Vaccinated individuals were found to be 27 times more likely to experience a symptomatic COVID-19 infection than those with natural immunity from COVID- 19.[17] Why are we discriminating against unvaccinated people, when the spread is clearly happening also amongst vaccinated individuals. Furthermore, those that have had a natural COVID-19 infection have been proven to have longer-term and more robust protection compared to those with the vaccine.[18]

5.) VARIANTS - Vaccines are causing the variants, and the vaccinated are more affected by variant strains than those with naturally conferred immunity

Question:

What source are you looking at when you declare that the variant(s) are being caused by unvaccinated individuals?

Background:

Dr. Byram W. Bridle (Professor of Viral Immunology at University of Guelph) explains that similarly to antibiotic resistance, COVID-19 variants are caused by not fully killing the virus, allowing for mutation.[19] Therefore, only individuals who are vaccinated can be creating the variants. As with any variant, as the CDC and WHO also state, mutations lead to a weaker and more transmittable viral strain. That is why the Delta will not have the same potential for causing deaths as the original COVID-19 strain. As evidenced by Dr. Bridle, the continual application of COVID-19 vaccinations, and furthermore boosters, will exacerbate the development of more variants. Finally, there is no current evidence that suggests that unvaccinated individuals are causing a rise in cases.[20]

6.) VACCINE EFFECTIVENESS - Exposing the true effectiveness rate of vaccines and approval concerns

Question:

Why is the inflated Relative Risk Reduction (RRR) of 94.0% utilized in reporting of vaccine effectiveness instead of the Absolute Risk Reduction (ARR) of less than 1.0%? What information are you relying upon when you say vaccines prevent or reduce the risk of infection with covid-19?

Background:

Promoting the RRR instead of the ARR misleads the general population, exacerbating the non-factual concept that these vaccines prevent getting and spreading COVID-19. The National Library of Medicine website linked below states "... the absence of the ARR in COVID-19 trials can lead to outcome reporting bias that affects the interpretation of vaccine efficacy." [21] Saying that vaccinations are 94.0-95.0% effective is very misleading, [22] as people often assume this means they have a 94.0% chance that they will not become sick from COVID-19. This is not true.

To explain how RRR and ARR works in layman's terms requires much detail. Simplifying this information, RRR signifies the risk of a health event occurring in a group of vaccinated individuals versus a group of unvaccinated individuals. This number is incorrectly interpreted to represent that 94 out of every 100 people vaccinated will be protected from COVID-19. Although this number is compelling, this is an incorrect statement regarding what that 94% means. This number does not tell you what your chances are of becoming sick if you get vaccinated.

The more valuable and accurate value that needs to be used is that of the ARR. The ARR represents the ACTUAL likelihood of disease risk between the placebo (non-vaccinated individuals) and treatment (vaccinated individuals) groups.

The ARR data directly from Pfizer and Moderna was calculated as 0.7% and 1.1% respectively. In contrast, the RRR calculated as 95.0% and 94.0% for Pfizer and Moderna, respectively. See the Abstract in this NIH document that presents the vaccine RRR/ARR data direct from Pfizer and Moderna.[23]

If individuals knew that the current vaccinations only confer a 0.7% to 1.1% reduction in chances of getting ill with COVID-19, would they have still have taken the vaccine given its risks?

It is imperative to clarify that the COVID-19 vaccines do NOT prevent COVID-19, nor do they stop the transmission of COVID-19. The vaccines have only been designed to reduce severity of symptoms in the individual who receives the vaccine. As previously discussed, the virus is still transmissible by both vaccinated and non-vaccinated individuals. Breakthrough cases are occurring regularly in fully vaccinated individuals at an increasing rate, which is pushing the requirement for booster vaccinations. The push by Government to require booster vaccinations at this early stage only serves to confirm that the original vaccine program being pushed is failing.[24]

7.) VACCINE SAFETY/INJURY STATS - Missing full details of the magnitude of Vaccine injuries and deaths

Question:

Where is the transparency for the current statistics and details regarding counts of B.C. vaccine-related injuries and deaths?

Background:

Adverse reaction statistics and data is imperative to ensure that British Columbians can exercise their constitutional right to free and voluntary informed consent. This information should be presented daily, alongside the Covid-19 “case” numbers, so people can decide whether they want to freely accept the experimental vaccinations.

The Government of Canada Vaccine Injury website states as of September 3, 2021 that 14,101 adverse reactions have been reported. Of those 14,101 reports of adverse reactions there are currently 3,768 reported as serious. “Serious” adverse reactions include death; however, death counts are not separately recorded on this database.[25] Why is there this lack of transparency?

Specifically, on Sept 3rd, a report quietly released by Public Health Ontario reported 106 youth, under the age of 25, were hospitalized with heart inflammation following mRNA vaccination.[26]

These vaccine injuries and deaths are not just in Canada, but all over the world:

- (EU Vaccine injury:1.9 Million, Vaccine deaths: 20,595)[27]
- (US Vaccine injury reported in VAERS: 650,075, Vaccine deaths: 13,911)[28]

yet the true numbers are not being disclosed accurately—if at all. Investigations show that very few vaccine injuries and deaths are actually approved and reported to government reporting agencies.[29] An article from Harvard states “manufacturers of vaccines must comply with the more expansive requirements of §600.80 of the C.F.R. Because VAERS is a

passive reporting system, many adverse reactions to vaccines may not be reported.”[30]

Lastly, the Harvard Pilgrim Study[31] states “Likewise, fewer than 1% of vaccine adverse events are reported. Low reporting rates preclude or slow the identification of “problem” drugs and vaccines that endanger public health.”

Dr. Patrick Phillips, an emergency room physician in Ontario stated that the forms are not easy to fill out, and that they are very cumbersome. Dr. Phillips also had a few reports returned to him marked as ‘invalid’.[32] It is critical to properly compare the risk of COVID-19 to the risk of vaccine injury knowing they are not fully disclosed. This is even more important when we see the pharmacies including more warnings on the Vaccines.[33]

A true clinical trial of this vaccine would include transparency where health officers would clearly provide vaccine injury details and fully track these occurrences without hesitation. Without this information and data, proper free and full informed consent cannot occur. The above included links are just some of the reporting systems, but the numbers are still very high and show much more injury than should be acceptable to any PHO or Government.

8.) PASSPORTS -Will NOT be temporary and soon the 2 shots will NOT be sufficient to obtain a valid passport

Question:

You have recently stated that vaccine passports will be temporary, expiring at the end of January 2022. However, with 1 billion dollars being offered as an incentive by the Government of Canada[34] for provinces who implement this system, it is hard to imagine this system will be scrapped by January 31, 2022, after only 5 months of use. It is difficult to rely on your statement given what you said on May 25, 2021 on television (see 2:52 into the video):

...there is no way that we will recommend inequities be increased by use of things like vaccine passports for services, for public access here in British Columbia, and that’s my advice and I’ve got support from the Premier and I have talked about this Minister Dix and others.”[35]

Prime Minister Trudeau made a similar commitment to Canadians on January 14, 2021 (see 3:30 into the same video).

Current studies (footnoted earlier) show that vaccinated individuals spread COVID-19 as well. This begs the question, if all people spread the virus why are we segregating people?

While it is understandable that fully vaccinated individuals are looking forward to getting their passport so life “can go back to normal” or so they “can travel”, they should be made aware that once a booster is mandated, their passport will no longer be considered valid until they are post 7 days after receiving a booster. Countries around that world that are implementing booster programs are already indicating that boosters will be needed to maintain a valid and up-to-date vaccine passport.[36] The booster system will ensure that this vicious cycle never ends and one will need regular boosters of the vaccine to keep their passport valid.

9.) TREATMENTS - There are better inpatient and at home treatments that can reduce illness severity and death

Question:

Why are we not using approved and well-researched antivirals like FDA approved Ivermectin?[26] Why are we providing no out-patient treatment for at home use when other doctors in many countries are successfully doing so?

Background:

Doctors are avoiding or being prohibited from prescribing pharmaceuticals that are known to help with COVID-19 symptoms that are safe, such as Ivermectin. The negative spin being put on Ivermectin by mainstream media, that it is only used in horses, is not true. These statements being made about Ivermectin are malicious and false as it has been safely and effectively used for years in humans.[37] In 2015 William C. Campbell, emeritus research fellow at Drew University in Madison, New Jersey and Satoshi Omura, professor emeritus at Kitasato University in Japan, jointly received one half of the Nobel Prize for their work with Ivermectin that was discovered in 1975 and approved for safe use in humans in 1987. In delivering his Nobel Prize lecture on December 7, 2015, Dr. Campbell confirmed the safety and effectiveness of using Ivermectin in humans, and noted that part of the ground breaking research was done in partnership with the WHO, the World Bank, and others.[38] It was noted that because of its excellent safety profile and broad spectrum of activity, Ivermectin was catalogued by the World Health Organization as an essential medicine and is regarded by many as a “magic bullet” for global health.[39]

On February 9, 2021, the chairman of the Tokyo Medical Association, Haruo Ozaki, announced that Ivermectin seemed to be effective at stopping Covid 19 and publicly recommended that all doctors in Japan immediately begin using Ivermectin to treat Covid 19.[40]

It is interesting to note that only since the covid-19 pandemic began has the WHO changed its stance on the effectiveness of Ivermectin. While the WHO still admits that Ivermectin is on its essential medicines list (and therefore safe), the WHO now simply says that the evidence to support using Ivermectin as an effective treatment for Covid 19 is inconclusive, and that the guideline development group that they convened did not look at the use of Ivermectin to prevent Covid 19. One can only speculate as to why this group was not asked to look at that essential question. The WHO only says that this question was outside the scope of the current guidelines.[41] It would seem that these much more expensive, experimental vaccines that were rushed to market under an emergency use authorization only, without proper testing and scrutiny, would be at least as inconclusive as the safe, tried and tested Ivermectin.

Additionally, Hydroxychloroquine is an approved and well-known treatment. Medical professionals have been coerced and forced to prescribe less efficacious, and even harmful, drugs. Deaths associated with adverse drug events (i.e. related to the use of Remdesivir[42]) should be considered as a separate count from COVID-19 deaths, as those deaths could have been avoided if these effective pharmaceuticals were implemented in a timely manner.

Simple home remedies such as zinc, vitamin D, vitamin C, N-acetylcysteine, and quercetin are also well known and effective at helping COVID-19 patients to recover[43]. Dr. Vladimir Zev Zelenko has led the way with these treatments. In contrast, many doctors are still sending patients with COVID-19 home without any of these treatment options.

Why have you not promoted other effective treatment apart from the experimental vaccines, or even healthy lifestyle choices and vitamin D, since it is clear that obesity, high blood pressure and inactivity were largely responsible for COVID-19 related deaths? The opposite has happened with your policies of lockdowns, closures of parks, gyms, and sports programs, and the creation of fear and anxiety through constant media messaging. These all lower the function of the immune system and increase blood pressure, which are undesirable outcomes.

10.) DEFINITION AND COUNTS OF THE VACCINATED VS. UNVACCINATED

Question:

Why have you made the definition of vaccinated and unvaccinated in your public health orders so misleading and contrary to common understanding? Why do use different definitions of what it means to be “vaccinated” in your different health orders that are still in effect?

Background:

In your August 20, 2021 provincial health order, which has already gone missing from the B.C. government website, you define “vaccinated” as any individual who is 14 days post receipt of the full series of a WHO approved vaccine, or combination of approved WHO vaccines. This means that anyone who is sick or hospitalized with COVID-19 within 13 days of their 2nd shot is considered “unvaccinated”. This is just like people who have had one shot, and are counted in the statistics that you put forth. These definitions are very misleading and help promote the false narrative that the unvaccinated are driving the upward trend of “cases”.

You alluded to the fact that boosters are likely to be required in B.C., at least for certain populations. As we are witnessing the rollout in other countries, we predict that the plan will be to require everyone to have a booster, or several boosters, eventually. Once 2 shots are no longer what is recommended as a full series of COVID-19 vaccines approved by the WHO, then no British Columbian will be considered “vaccinated” until a booster vaccine is taken.

Also, it has been noted that the WHO does not approve of mixing and matching vaccines. This is contrary to your definition of “vaccinated” in your current health order wherein you do approve of this practice. The WHO says this should not be done unless supportive evidence is available. What evidence are you relying upon to tell British Columbians that mixing and matching of COVID-19 vaccines is acceptable or safe? The WHO recommends that if someone has mixed and matched 2 different vaccines, no additional doses of either vaccine should be administered to that person.[44] Why are you ignoring this advice? What science are you relying upon?

Finally, Dr. Bonnie Henry, you quietly issued an additional health order on August 31, 2021[45], replacing the August 20, 2021 health order. The new order issued on August 31, 2021 removed some terms and added others which included changing the definition of “vaccinated” from 14 days post a full series of vaccination approved by the WHO, down to 7 days post-vaccination of an approved full series of WHO approved vaccines. Your September 2, 2021 Residential Care Staff Covid-19 Preventative Measures health order[46] uses the same 7 day period. What science are you relying on to justify this change, as you have previously stated that it requires 14 days for the vaccines to work?

11.) TESTING ONLY UNVACCINATED INDIVIDUALS —August 20, 2021, August 31, 2021 and September 2, 2021 Health Orders

Question:

In your public health order dated August 20, 2021—and now August 31, 2021 and September 2, 2021—you are only requiring unvaccinated individuals to undergo rapid antigen testing and PCR testing. In light of the evidence and scientific research showing that vaccinated individuals are significantly more likely to contract the Delta variant than unvaccinated individuals[47]. You also say in your September 2, 2021 health order that you will not allow any staff member to be hired after October 11, 2021 unless they meet your definition of “vaccinated”. What science are you relying on to justify this policy of testing and discriminating against unvaccinated citizens?

Background:

You continue to state that you are following the science, however, you have yet to provide ANY reference to the science you are following despite being asked for this information numerous times over the last 18+ months. We demand that you be transparent and honest with the public you serve by posting the scientific studies and data you are relying upon to support your policies and health orders on the BC government website alongside your public health orders so we can review this information.

12.) MASKS - under OATH Dr. Bonnie Henry admitted that there is scant evidence that masks are effective at preventing spread of the influenza virus but felt that can be an effective coercive tool when staff refuse to accept a vaccine

Question:

Where is the evidence that your mask mandates in your health orders actually work? You define “face coverings” in your September 2, 2021 health order[48] as including a medical mask, or a non-medical mask, or a tightly woven fabric but does not include a clear plastic face shield. Where is the evidence that a non-medical mask, or a piece of tightly woven fabric, is an effective means of preventing the spread of a virus?

Background:

Dr. Henry’s testimony under oath in 2015[49] in an arbitration hearing in Ontario as an expert witness for the Sault Area Hospital (SAH) and the Ontario Hospital Association (OHA) against the Ontario Nurses Association (ONA) is informative. The issue in that arbitration was that the hospital required healthcare workers to wear surgical/procedure masks each year throughout the 5 to 6 month flu season if they had not received the vaccination for influenza. The Nurses Union alleged that the policy was an unreasonable exercise of management rights and a breach of employee privacy rights. At the time that Dr. Henry advocated in favor of the policy, she was the Deputy Provincial Health Officer for British Columbia.

Dr. Henry’s testimony in that arbitration hearing is eerily similar to the narrative she has been telling British Columbians about the Covid 19 virus. Dr. Henry was a strong proponent that there was asymptomatic spread, that unvaccinated nurses and healthcare workers should wear masks, and supported mandating forcing employees to wear masks as a consequence of choosing not to get the vaccine.

On cross-examination Dr. Henry reluctantly admitted (at paragraph 161 of the arbitration decision) that there was not a lot of evidence to support the suggestion that asymptomatic shedding actually leads to effective transmission of the virus.

At paragraph 178 of the arbitration decision, the arbitrator notes that Dr. Henry concluded after admitting that “I am not a huge fan of the masking piece”, that “there is not a lot of evidence to support mask use...”

At Paragraph 219 Dr. Henry’s evidence is summarized in part as follows:

It is a challenging issue and we have wrestled with it. I am not a huge fan of the masking piece. I think it was felt to be a reasonable alternative where there was a need to do-to feel that we were doing the best we can to try and reduce risk. I tried to be quite clear in my report that the evidence to support masking is not as great and it is certainly not as good a measure.

In the arbitration, the Nurses Union submitted that Dr. Henry was instrumental in the introduction of the “vaccinate or mask” policy in British Columbia (paragraph 256) and therefore Dr. Henry’s objectivity was suspect. The arbitrator preferred the evidence of other experts over Dr. Henry and her colleagues’ evidence.

The arbitrator noted that Dr. Henry defended the vaccine or mask policies as a way of preventing transmission from unvaccinated healthcare workers to their patients before symptom onset, or in cases of asymptomatic infection (paragraph 287). However, the arbitrator also noted (at paragraph 294) that while Dr. Henry stated there was “some evidence that people shed prior to being symptomatic and some evidence of transmission” but “there is not a lot of evidence around these pieces”. Two other experts who testified on behalf of the hospital, one of whom Dr. Henry acknowledged her expertise, both admitted that the evidence of asymptomatic spread was “scant”.

The arbitrator held (at paragraph 297), while “bearing in mind the concessions made about the quality of the evidence by Dr. McGeer and Dr. Henry”, that the following opinion of another expert was more accurate:

Although symptomatic individuals may shed influenza virus, studies have not determined if such people effectively transmit influenza... Based on the available literature, we found that there is scant, if any, evidence that asymptomatic or pre-symptomatic individuals play an important role in transmission.”

The arbitrator held that the patient safety purpose and effect of masking was not established on the evidence and that the “vaccine or mask” requirement was reduced to a “coercive tool”, a situation that would be troubling if made out. The arbitrator also noted (at paragraph 326) Dr. Henry’s recognition that the wearing of a mask could be reasonably regarded as a “consequence” for failure to consent to vaccination.

The arbitrator concluded (paragraph 327) that the vaccine or mask policy did not provide a legitimate accommodative purpose for healthcare workers who conscientiously object to immunization, but rather more closely resembled an unacceptable Hobson’s choice (free choice). The arbitrator did not accept the argument that requiring unvaccinated staff to wear a mask may encourage truly voluntary immunization, nor did the arbitrator accept that the continuance of the minority employee group who choose to mask disproves the

effectively coercive aspect of a vaccine or mask policy. The arbitrator noted that one of the nurses told her managers that “I felt I was being publicly put on display for choosing not to get the flu shot. I told her I felt I was being bullied into it and harassed.”

The arbitrator concluded that the vaccine or mask policy was unreasonable and contravened KVP principles. Similar findings were made by another arbitrator in 2018 involving the St. Michael’s Hospital and the Ontario Hospital Association v. The Ontario Nurses Association.[50][51]

The vaccine or mask policy in issue in the Ontario Nurses arbitrations is very similar to what is going on in British Columbia with covid-19. Just as the arbitrator found that a masking policy amounted to a coercive tool that was troubling, your policies requiring rapid antigen testing, PCR testing, and masking as a condition of employment, is nothing more than a coercive tool to pressure people to accept the experimental vaccine. As the arbitrator held in 2015, a policy with this purpose is “troubling”.

You stated numerous times in your television briefings in 2020 that masks were not effective at preventing the spread of the Covid 19 virus.[52] Now you claim that masks do work and that you never said they did not. There is a glaring discrepancy between the statements that you made under oath in 2015, and in your television briefings in 2020, compared to what you are saying now in your current health orders in 2021.

Please refer to the additional published studies confirming masks are not effective.[53][54] Also, Dr. Byram Bridle’s video also demonstrates that wearing 5 masks do not stop droplets from escaping and certainly do not prevent the Covid-19 virus from passing through a non-medical mask or tightly woven clothing.[55]

Requiring people to wear masks harms the user by reducing availability of oxygen, increasing bacterial growth within the fabric of the masks, leads to social issues for individuals that cannot mask for medical reasons, creates waste of materials and money, and contributes to further pollution and negative environmental impact.

Please provide the evidence you are relying upon that prove masks work.

Call To Action:

Dr. Henry, Mr. Dix and Mr. Horgan, the citizens of this province call on you to answer to these questions, directly and truthfully. British Columbians will no longer tolerate the trampling of our rights, segregation, and division amongst neighbors and families. We respect different perspectives and opinions; however, everyone deserves to see the scientific evidence you are relying upon to justify your public health orders. All British Columbians thank you in advance for your much-anticipated response.

To our fellow British Columbians, you are our friends and family, and we need you to carefully consider the information above and be open to what is being said. We urge you to join us in fighting for the restoration of our freedoms and putting an end to the restrictions that have no basis in science and are designed only to promote fear and division and to give the government control over our lives.

Now is the time to take a stand, before it is too late.

Please share this with all your friends, family, media and everyone you can think of.

Sincerely,

Voices Of Silenced Okanagan Health Professionals

A concerned group of health professionals who choose to remain anonymous due to threats of discipline and termination, by our own various professional governing bodies, for all who dare to question the B.C. government narrative on COVID-19 policies.

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