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COURT	COURT OF QUEEN'S BENCH OF ALBERTA
JUDICIAL CENTRE	CALGARY
APPLICANTS	REBECCA MARIE INGRAM, HEIGHTS BAPTIST CHURCH, NORTHSIDE BAPTIST CHURCH, ERIN BLACKLAWS and TORRY TANNER
RESPONDENTS	HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF ALBERTA and THE CHIEF MEDICAL OFFICER OF HEALTH
DOCUMENT	**PRE-TRIAL REPLY FACTUM OF THE APPLICANT**
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PRE-TRIAL REPLY FACTUM OF THE APPLICANT REBECCA MARIE INGRAM

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PART I OVERVIEW

The fact remains that the response to the SARS-CoV-2 ("**COVID-19**") virus by the Respondents, Her Majesty The Queen In Right of The Province Of Alberta and The Chief Medical Officer of Health, has been without an analytical-based plan and illogical. The Respondents' actions have been reactive rather than proactive and usually delayed until the situation has gone out of control. The Respondents have abandoned and left our vulnerable seniors at various long-term care facilities to the care of an overwhelmed and understaffed work force. The Respondents ignored outbreaks at two meat processing plants until the situation was so dire the facilities had to be closed down temporarily to deal with the majority of the staff being infected. And in the midst of an already fragile healthcare system being the primary force dealing with the virus, the Respondents picked a fight with doctors, nurses and other healthcare aides in the name of "cost controls."

The Respondent's record is absent any evidence of planning, analysis, strategy and logical implementation of a carefully constructed plan before the promulgation of the voluminous CMOH Orders. Instead, they have launched a groundless attack at Ms. Ingram's religion contrary to established jurisprudence. This Court should be loath to reward the poor conduct of the Respondents in dealing with the COVID-19 virus and grant Ms. Ingram and her fellow Applicants the request they all request.

PART II FACTS

1. The Applicant Rebecca Marie Ingram ("**Ms. Ingram**") submitted for filing and served her Pre-Trial Factum[1] on September 1, 2021 (the "**Ingram Factum**"). Ms. Ingram adopts and repeats all nominations, references and authorities from her Pre-Trial Factum.

2. The Respondents, submitted for filing and served their Reply Factum on September 14, 2021 (the "**Respondents' Factum**").

3. On September 15, 2021, the Lieutenant Governor in Council proclaimed, via Order in Council 255/2021, a state of public health emergency.[2]

PART III SUBMISSIONS

4. No matter how the situation over the last year and a half is framed, this is a crisis of the Respondents' own creation. While the Respondents attempt to instill fear with statistics of allegedly high COVID-19 death and high infection numbers, they have failed to provide context. Yet the fact remains: this is not a public health crisis; it is a public health care **mismanagement** crisis.

5. On April 8, 2020, Premier Kenney promised to "increase ICU capacity by 1,081 beds for COVID-19 patients" by the end of April 2020.[3] Instead of doing as the Premier promised, he and Health Minister Shandro set out an attack to reduce the pay of doctors and nurses, devaluing their work while the pandemic was being used as an excuse to lock healthy citizens in their homes and shutter Alberta businesses.

6. After 18 months, it is evident that the Respondents still have no idea how to respond to a virus which has been endemic for over 12 months, nor do the Respondents have a plan of how to move forward.

7. Now as a direct result of the failure of the Government of Alberta to provide sufficient resources to doctors, nurses and hospitals, this lack of resourcing is being used as an excuse to force and coerce citizens of Alberta to be vaccinated against their will and to continue to promulgate so called public health measures that restrict businesses and infringe individual rights far beyond any powers contemplated under section 29 of the *Public Health Act*.[4]

8. Therefore, people across the province are suffering and have had their rights and freedoms abrogated due to the incompetence and inaction of the Respondents.

9. With respect to the education arguments that the Respondents have submitted, it is an attempt to avoid the issues pertaining to the CMOH interference with the education of children on the spurious technical ground that the children do not have standing. From the

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[1] Pre-Trial Factum of The Applicant Rebecca Marie Ingram [**Ingram Factum**].
[2] Order in Council 255/2021, **Tab A**.
[3] Government of Alberta, COVID-19 Modelling, April 8, 2020, **Tab A**.
[4] *Public Health Act*, RSA 2000, c P-37 [***Public Health Act***], in force between Dec 5, 2019 and Apr 1, 2020. This version is hyperlinked in the Ingram Factum List of Authorities.

perspective of the *Charter* issues, Ms. Ingram is the legal guardian and parent and therefore has standing. Also, from the perspective of the Court as the arbiter determining the level of overreach of the CMOH, these issues should be examined by this Court. Specifically, this Court should be presented with arguments that healthy school children are being forced to take protective measures with regard to a virus that presents negligible risk to them, and this Court should consider arguments as to the degree of infringements allowed and justified on parental rights with regard to being the sole arbiter of the psychological health of their children.[5]

10. On September 16, 2021, the CMOH promulgated CMOH Order 42-2021 which was followed two days later by CMOH Order 43-2021. Both of these orders introduce and detail the Alberta Restrictions Exemption Program, which essentially is a coercive measure to indirectly impose vaccine mandates. It is submitted that this coercive tactic is contrary to the World Medical Association Declaration of Geneva[6], which states that:

> The Physician's Pledge
>
> AS A MEMBER OF THE MEDICAL PROFESSION:
>
> I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;
>
> THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;
>
> I WILL RESPECT the autonomy and dignity of my patient;

11. It is plainly obvious that as a result of the lack of planning and inaction of the Respondents, that these coercive tactics are the only option that the Respondents have left themselves. It further supports that the COVID-19 public health care mismanagement crisis has been self inflicted by the Respondents.

i) Section 2(a) *Charter* Reply Arguments

12. The Respondents correctly identified the basic tenets of the law with respect to section 2(a) but omitted a significant number of nuances that the applicable law on the subject provides. Specifically, the Supreme Court of Canada case of *Syndicat Northcrest v Amselem* provides a myriad of legal guidance on section 2(a) and the whole passage is critical, not just what the Respondents have presented.

> 46 To summarize up to this point, our Court's past decisions and the basic principles underlying freedom of religion support the view that freedom of religion consists of the freedom to undertake practices and harbour beliefs, having a nexus with religion, in which an individual demonstrates he or she sincerely believes or is sincerely undertaking in order to connect with the divine or as a function of his or her spiritual faith, irrespective of

[5] Expert Report of Dr. Jay Bhattacharya, Schedule C, Section F, at 19-25 (59-65 PDF).
[6] WMA Declaration of Geneva, **Tab B**. https://www.wma.net/policies-post/wma-declaration-of-geneva/

whether a particular practice or belief is required by official religious dogma or is in conformity with the position of religious officials.

47 **But, at the same time, this freedom encompasses objective as well as personal notions of religious belief, "obligation", precept, "commandment", custom or ritual. Consequently, both obligatory as well as voluntary expressions of faith should be protected under the Quebec (and the Canadian) *Charter*. It is the religious or spiritual essence of an action, not any mandatory or perceived-as-mandatory nature of its observance, that attracts protection. An inquiry into the mandatory nature of an alleged religious practice is not only inappropriate, it is plagued with difficulties**. Indeed, the Ontario Court of Appeal quite correctly noted this in *R v Laws* (1998), 1998 CanLII 7157 (ON CA), 165 DLR (4th) 301, at p. 314:

> There was no basis on which the trial judge could distinguish between a requirement of a particular faith and a chosen religious practice. Freedom of religion under the *Charter* surely extends beyond obligatory doctrine.

48 This is central to this understanding of religious freedom that a claimant need not show some sort of objective religious obligation, requirement or precept to invoke freedom of religion. Such an approach would be inconsistent with the underlying purposes and principles of the freedom emphasizing personal choice as set out by Dickson C.J. in *Big M* and *Edwards Books*.

49 **To require a person to prove that his or her religious practices are supported by a mandatory doctrine of faith, leaving it for judges to determine what those mandatory doctrines of faith are, would require courts to interfere with profoundly personal beliefs in a manner inconsistent with the principles set out** by Dickson C.J. in *Edwards Books*, *supra*, at p. 759:

> The purpose of s. 2(a) is to ensure that society does not interfere with profoundly personal beliefs that govern one's perception of oneself, humankind, nature, and, in some cases, a higher or different order of being. These beliefs, in turn, govern one's conduct and practices. [Emphasis added.]

50 **In my view, the State is in no position to be, nor should it become, the arbiter of religious dogma. Accordingly, courts should avoid judicially interpreting and thus determining, either explicitly or implicitly, the content of a subjective understanding of religious requirement, "obligation", precept, "commandment", custom or ritual. Secular judicial determinations of theological or religious disputes, or of contentious matters of religious doctrine, unjustifiably entangle the court in the affairs of religion**.

51 That said, while a court is not qualified to rule on the validity or veracity of any given religious practice or belief, or to choose among various interpretations of belief, **it is qualified to inquire into the sincerity of a claimant's belief, where sincerity is in fact at issue**: see *Jones*, *supra*; *Ross*, *supra*. It is important to emphasize, however, that sincerity of belief simply implies an honesty of belief: see *Thomas v. Review Board of the Indiana Employment Security Division*, *supra*.[7] **[emphasis added]**

[7] *Syndicat Northcrest v Amselem*, 2004 SCC 47, at 46 – 51 [***Amselem***].

13. The arguments put forward by the Respondents are meant to cast doubt and judge Ms. Ingram's beliefs against the very principle that "the State is in no position to be, nor should it become, the arbiter of religious dogma."[8]

14. The Respondents' attacks are denigrating to Ms. Ingram's and her family's religion and religious life. It is submitted that such scurrilous attacks should attract enhanced costs regardless of outcome in the case.

15. If the Respondents do not understand Ms. Ingram's religious practices or wish to inquire into the sincerity of Ms. Ingram's belief and practice, they had every opportunity to ask questions during cross-examination, which they elected to forego. They therefore have accepted Ms. Ingram's affidavit as fact.

16. It is submitted that on the facts and the vast jurisprudence, there was a *prima facie* infringement of Ms. Ingram's section 2(a) rights.

ii) Sections 2(c)-(d) *Charter* Reply Arguments

17. The Respondents acknowledged and admitted that there was a *prima facie* infringement of Ms. Ingram's sections 2(c) and (d) rights when the Indoor Gathering Restrictions and Outdoor Gathering Restrictions prohibited her from hosting Christmas or other holiday events or barred her from celebrating with her mother on her birthday.[9]

18. However, the Respondents ignored the asserted section 2(d) infringement that is collateral to the breach of Ms. Ingram's freedom of religion.[10]

iii) "Any Limitations are Reasonable and Justifiable"

19. Ms. Ingram submits that the Respondents have not made the section 1 *Charter* justification test as the facts show that the limitations are not reasonable and justifiable.

Pressing and Substantial Objective

20. The Respondents claim that the "pressing and substantial objective is clear: to preserve life by stopping the spread of COVID-19"[11]. Such an objective is fundamentally unsupported by the facts or by the Respondents' evidence.

21. There is no evidence tendered by the Respondents that a "COVID-19 zero policy" has been pursued, which would be a policy to drive infections to zero and stop the spread of COVID-19. In actuality, Dr. Hinshaw and Premier Jason Kenney have on numerous occasions stated that we must "flatten the curve" or slow down the rate of infection such that the health care system can manage. In her open-letter titled "Learning to live with COVID-19", Dr. Hinshaw stated that the "extraordinary measures" were required to prevent "our

[8] *Amselem*, supra, at 50.
[9] Respondents' Factum, at 64.
[10] Ingram Factum, at paras 89-92.
[11] Respondents' Factum, at 257.

health care system from being overwhelmed."[12] She also stated that these measures "saved lives" but she did not state that "stopping the virus" was an objective.

Rational Connection

22. Ms. Ingram reiterates that on the facts, there is no rational connection between the measures and the objective.

23. In support of their assertion, the Respondents focus on the Expert Report of Dr. Kindrachuk who surveyed various articles regarding alleged COVID-19 spread in religious settings. The evidence does not support the argument of "substantial transmission" in religious settings and the articles tendered are rife with inappropriate comparative models and therefore not suited to comparison.

24. One of the articles included in Dr. Kindrachuk's expert report references a further study that identified 142 contacts resulting in three secondary cases[13], in Singapore. Not only is this not evidence of "substantial transmission" but considering Singapore's population density of roughly 8358 people per square km, and Canada's density of 4 people per square km, the basis for any comparison is hardly appropriate.

25. Nor have the Respondents provided what constitutes "substantial" or unacceptable transmission. Dr. Kindrachuk did not opine on, and conveniently ignored, the evidence of Ms. Simmonds that linked 533 cases to places of worship.[14] Considering the Respondents have adopted a strategy of allowing or living with some rate of COVID-19 transmission, is 533 cases out of a total of 246,665 cases in Alberta[15] (representing 0.22% of all cases) substantial enough to substantiate a rational connection? Ms. Ingram submits that it does not.

26. The Respondents also relied on the fact that COVID-19 is spread through close contact[16], a fact that possesses a mere aura of connection but not the rational connection required. The impugned measures imposed broad, arbitrary, and punitive restrictions that did not consider differentiating risks in various venues or provide for risk mitigation measures.

27. The impugned measures were also arbitrary and unfair. At the peak of the 'third-wave', on May 9, 2021, a total of 0.57% of Alberta's population had tested positive for COVID-19.[17] Conversely, on that date, 99.43% of Alberta's population was not infected or did not test positive for COVID-19.

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[12] Government of Alberta, Dr. Deena Hinshaw "Learning to live with COVID-19" (August 4, 2021), Book of Authorities of the Applicant Rebecca Marie Ingram [**Ingram BOA**], **Tab 48**, https://www.alberta.ca/article-learning-to-live-with-covid-19.aspx
[13] Expert Report of Dr. Jason Kindrachuk, pgs. 989 & 991.
[14] Affidavit of Kimberly Simmonds (Affirmed July 11, 2021), Exhibit B, pg. 17.
[15] Ingram Factum, at 149 – 150.
[16] Respondents' Factum, at 262.
[17] Pre-Trial Factum of The Applicant Rebecca Marie Ingram, at 14.

28. Therefore, the impugned measures were not "carefully designed to achieve the objective in question"[18]; they were a wrecking-ball when a chisel was appropriate.

29. The Respondents also relied upon the evidence of Dr. Hinshaw regarding the impugned measures being a "last resort" after voluntary measures allegedly "failed"[19]. The voluntary measures were essentially a mirror of the impugned measures, just less severe and not mandated by law. As such, the voluntary measures were obviously destined to fail. There was no careful crafting of any measures.

30. Ms. Ingram submits that even though there might be some semblance of connection, the connection that exists does not meet the criteria advocated by various jurisprudence, and therefore, does not meet the rational connection criteria.

Least Drastic Means

31. This step of the Oakes Test requires that the measures "should impair 'as little as possible' the right or freedom in question"[20] and various jurisprudence has required elements of "reasonably tailored" and "reasonably necessary".[21]

32. It is not reasonable to subject 99.43% of Alberta's uninfected population to punishing restrictions. It is submitted that restrictions that affect 99.43% of COVID-19 free individuals do not fall within a range of reasonable options.[22]

33. The Respondents' mischaracterization of Ms. Ingram's arguments could not be farther from the truth. She does not advocate for "doing nearly nothing and simply hoping for the best."[23] Ms. Ingram advocates for a scientific and analytical-based approach which would have produced a plan that was subsequently followed. There is not a single shred of evidence that such an approach was pursued.

34. Instead, Alberta imposed freedom and rights infringing measures, and hoped and waited until vaccines became available.

35. It is arguable that more people under the age of 60 died as an indirect result of the CMOH Orders than died from COVID-19 in 2020.[24]

36. In the "expert report"[25] of Scott Long, it appears that Mr. Long uses the 8 to 9 weeks of advance notice as an excuse for many of the Respondents' inadequacies, specifically for not developing a plan.[26] But even after 18 months of COVID-19's existence in Alberta, not

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[18] *R v Oakes*, [1986] 1 SCR 103 [***R v Oakes***], at 74, Ingram BOA**, Tab 27**.
[19] Respondents' Factum, at 263.
[20] *R v Oakes*, at 74, Ingram BOA**, Tab 27.**
[21] *R v Sharpe*, 2001 SCC 2, at 96.
[22] Ibid.
[23] Respondents' Factum, at 271.
[24] Government of Alberta, Leading Causes of Death, updated August 13, 2021, Ingram Factum, at para 25.
[25] While Ms. Ingram acknowledged that the report exists, she challenged the expert accreditation of Mr. Scott Long for want of independence.
[26] Expert Report of Scott Long, at pg. C-2, para 8.

even a draft COVID-19 pandemic plan exists nor has any real effort been made to create the promised 1,081 ICU COVID-19 beds. In direct rebuttal to any such excuse, Mr. Redman outlined how he was tasked with developing the Crisis Management Counter-Terrorism Plan within 8 weeks of the September 11, 2001, tragedies.[27] Mr. Long also stated that "process of developing a plan is more valuable than the actual plan itself"[28] yet had failed to present proof of a plan development process. Dr. Hinshaw made the assertion in her affidavit that "Alberta's response has included the careful weighing of costs and benefits throughout the course of the pandemic"[29] but it is important to remember that no proof exists of such an analysis.[30] Nor is any evidence provided as to what weight was assigned to the lives of people under the age of 60 that died as an indirect result of the CMH Orders or the radical interference or destruction of Albertan's lives or businesses.

37. There is simply no proof that the Respondents considered a "range of reasonable options to achieve the pressing and substantial objective."[31] Nor is it evident that any weight was assigned to societal impacts of such draconian and radical measures.

38. Finally, Ms. Ingram agrees with the jurisprudence the Respondents have chosen to bring to the Court's attention:

> There must nevertheless be a sound evidentiary basis for the government's conclusions.[32]

39. The Respondents have not disclosed what was before the CMOH, the provincial Cabinet and other decision makers when considering and promulgating the CMOH Orders. The vast amount of evidence tendered by the Respondents amounts to after the fact excuses and not constitutional justification. What is questionably absent is the data and analysis that formed the basis for the conclusions and recommendations resulting in the impugned measures. In actuality, this supports the claim that there was no analysis and no plan.

40. Therefore, the Respondents are incapable of satisfying the third part of the Oakes Test, that the limits are minimally impairing.

Proportionate Effect

41. The salutary effects presented by the Respondents[33] are an oversimplification of the issue. First, in an attempt to quantify a hypothetical number of "deaths avoided" the Respondents turn to the calculations of Dr. Kindrachuk who's estimated deaths numbers without any restrictions represent a rudimentary calculation that provides a very rough estimate only and cannot be afforded any weight. The calculation does not adjust for the various age

[27] Surrebuttal Report Of David Redman, at 12.
[28] Expert Report of Scott Long, at pg. B-1, para 2.
[29] Affidavit of Dr. Deena Hinshaw (Affirmed July 12, 2021), at 87.
[30] Ingram Factum, at 175.
[31] *R v Sharpe*, 2001 SCC 2, at 96.
[32] Respondents' Factum, at 267, quoting *Irwin Toy Ltd v Quebec (Attorney General)*, [1989] 1 SCR 927 at 999
[33] Respondent's Factum, at 272.

groups, their population proportionality and the corresponding risk and mortality rates[34]. The avoidance of theoretical deaths is not a salutary effect, as Ms. Ingram does not advocate for zero COVID-19 measures.

42. Second, Dr. Gordon's affidavit testified how the Alberta healthcare system has been "overwhelmed."[35] But any inundation of the healthcare system has been a direct result of the Respondents' failure to enact a plan to protect the most vulnerable, which Mr. Redman advocated for.[36] Any healthcare crisis has been the creation of the Respondents and saving the healthcare system is hardly a salutary effect in favour of the Respondents.

43. The tally of deleterious effects is not limited to those the Respondents have listed as many have been conveniently ignored.

44. Dr. Hinshaw has highlighted other deleterious effects that are a result of the impugned measures:

> These extraordinary measures were necessary and effective, but they also came with unintended consequences that harmed the health of Albertans in other ways.
>
> …
>
> That has come at the cost of not fully working on other threats, like syphilis and opioid deaths.[37]

45. Further, the Respondents have ignored the excess deaths due to indirect impacts of the pandemic that Statistics Canada has alluded to.[38]

46. Other deleterious effects that were highlighted in the Ingram Factum include: mental health deterioration, rise in suicides, substance abuse, economic collapse, and other collateral damage that cannot be currently measured or recorded.[39]

47. The deleterious effects clearly tip the scale in favour of the argument that the infringements enacted by impugned measures are not justifiable.

iv) The *Alberta Bill of Rights*

48. The Respondents have quoted and pointed to Professor Hogg's opinions with respect to the *Canadian Charter of Right and Freedoms*, arguments which they transpose to the

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[34] As presented in the Ingram Factum, at 9, Alberta's own data indicates no COVID-19 related deaths for those 19 and under in age; but for those over the age of 80, the COVID-19 mortality rate is approximately 20%. Without proper adjustments, the older age categories heavily skew the data.
[35] Respondents' Factum, at 272, quoting Affidavit of Deborah Gordon, at paras 52-74.
[36] Expert Report of David Redman, at para 31.
[37] Government of Alberta, Dr. Deena Hinshaw "Learning to live with COVID-19" (August 4, 2021), Book of Authorities of the Applicant Rebecca Marie Ingram [**Ingram BOA**], **Tab 48**, https://www.alberta.ca/article-learning-to-live-with-covid-19.aspx.
[38] Statistics Canada, *Provisional deaths counts and excess mortality*, The Daily, July 12, 2021, at 1, Ingram BOA, **Tab 55.**
[39] Ingram Factum, at paras 186-196.

Alberta Bill of Rights. While a respected scholar and likely the most quoted authority to not have sat on the Bench, Professor Hogg admits that this line of his arguments has never been considered or subject to a ruling by the Supreme Court of Canada.[40] Therefore, his arguments are not law and are not binding on this Court.

49. Ms. Ingram submits that the Respondents have glossed over and ignored the fact that the *Public Health Act* is clear and unequivocal in section 75 wherein it states that the *Alberta Bill of Rights* is paramount, and the *Public Health Act* is submissive.

50. The example provided by the Respondents of the 1900's smallpox endemic is not appropriate as it is wholly distinguishable. The Alberta legislature in 1908 did not have the benefit of today's modern medical technology, knowledge and medicines, nor did society possess today's sanitary ingenuities – it was a different time. Neither did society at that time possess the advancements of modern-day emergency crisis management. Finally, the legislature at that time was not bound by the *Charter* nor the *Alberta Bill of Rights*, or the vast jurisprudence on rights and freedoms that we are currently bound by. Therefore, the Respondents' argument must fail.

51. While the case of *The Queen v Beauregard*[41] is good law, it is distinguishable as in the case at bar the impugned measures are arbitrary or capricious as there is no basis to quarantine uninfected individuals when the Respondents have not taken sufficient action to protect the vulnerable.

52. Ms. Ingram agrees with the decision of this Court in *Peter v Public Health Appeal Board of Alberta*[42], that no *Charter* nor *Alberta Bill of Rights* infringements were made out. The difference from the case at bar is that in *Peter*, the Court's decision hinged on the well drafted and clear sections 59 and 60.

53. Finally, the Case Management Justice did strike claims as they relate to section 1(a) of the *Alberta Bill of Rights*[43], but the decision has been appealed and will be heard in 2022. As such, the Respondents have made arguments[44] that are before the Alberta Court of Appeal and are therefore not binding on this Court in the context of this hearing under the doctrine of *stare decisis*.

v) Interpretation of the *Public Health Act*

54. The Applicant submits that in addition to the built-in limits within the *Public Health Act* argued by the Respondents' counsel[45], and the arguments presented in the Ingram

[40] Peter W Hogg, *Constitutional Law of Canada*, 5th ed (Toronto: Thomson Reuters, 2007) (loose-leaf updated 2019, release 1) at p 35-2 (footnote 8), Respondents' Book of Authority, TAB 82.
[41] *The Queen v Beauregard*, [1986] 2 SCR 56
[42] *Peter v Public Health Appeal Board of Alberta*, 2019 ABQB 989 [***Peter***], at 86.
[43] *Ingram v Alberta (Chief Medical Officer of Health)*, 2021 ABQB 343, at para 19.
[44] Respondents Factum, at paras 242-248.
[45] Transcript of Proceedings, Court of Queen's Bench of Alberta, April 21, 2021, 6:16 – 7:16.

Factum[46], the courts have conveyed their interpretation of delegated discretionary power, specifically in the context of the *Public Health Act*.

55. The Alberta Court of Appeal in *Alberta Health Services v Wang*[47] considered the broad discretion provided to an executive officer to conduct inspections on public property and rental accommodations pursuant to sections 59 and 60 of the *Public Health Act*. The Alberta Court of Appeal found that the law limits discretionary powers in two ways.

56. First, the Alberta Court of Appeal held that any discretionary power must be exercised for the purpose it was granted:

> … the executive officer must exercise the discretion for the purpose for which it was granted. ""Discretion" necessarily implies good faith in discharging public duty; there is always a perspective within which a statute is intended to operate; and any clear departure from its lines or objects is just as objectionable as fraud or corruption": *Roncarelli v Duplessis*, [1959] 1 SCR 121 at 140.[48]

57. While the *Public Health Act* is drafted to address numerous matters and arguably contains multiple purposes, the purpose of central importance to the case at bar is the control of communicable diseases and the administration of public health emergencies.

58. Dr. Hinshaw has indicated on numerous occasions that one of the intentions of the impugned measures is to prevent "our health care system from being overwhelmed."[49] While a noble and an important goal, and possibly in her job description or in other legislation, it is not a supported purpose of the *Public Health Act*. As submitted in the Ingram Factum[50], nowhere does the *Public Health Act* provide the CMOH the powers to restrict the freedom and rights of 99.43% of uninfected Albertans[51], as such, this is not a "perspective within which" this "statute is intended to operate" and a clear departure from the CMOH's discretionary powers.

59. If the CMOH had the powers she imagines, then the CMOH could ban fast food, fatty foods, salty foods and sugary drinks, and cigarettes from Alberta's convenience stores and restaurants; all of which arguably kill more people that COVID-19. While the Respondents might argue that the CMOH powers are limited to communicable diseases, the fact that the CMOH claims authority over uninfected and otherwise healthy people shows the extent of the overreach.

60. Second, the Alberta Court of Appeal reiterated such discretion is subject to the *Charter*:

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[46] Ingram Factum, at 32 – 61.
[47] *Alberta Health Services v Wang*, 2018 ABCA 339 [***Wang***].
[48] *Wang*, supra, at 13.
[49] Government of Alberta, Dr. Deena Hinshaw "Learning to live with COVID-19" (August 4, 2021), Book of Authorities of the Applicant Rebecca Marie Ingram [**Ingram BOA**], **Tab 48**, https://www.alberta.ca/article-learning-to-live-with-covid-19.aspx
[50] Ingram Factum, at paras 32-61.
[51] Ingram Factum, at para 14.

> … the discretion is constrained by the *Charter of Rights and Freedoms*. "[A]dministrative decision-makers must act consistently with the values underlying the grant of discretion, including *Charter* values": *Doré v Barreau du Québec,* 2012 SCC 12 at para 24, [2012] 1 SCR 395. Of course, the weighing of *Charter* values, including privacy, has to be done on a case by case basis in the particular factual and statutory context of the exercise of the discretion.[52]

61. There is simply no evidence that the CMOH acted with the values underlying the *Charter* in promulgating the CMOH Orders.

62. Finally, the Alberta Court of Appeal in *Wang* noted that both sections 59 and 60 are subject to judicial oversight by way of section 61.

63. Curiously, section 29 of the *Public Health Act* does not possess any provisions for judicial oversight, even though it is argued by the Respondents to be the broadest and most intrusive discretionary power-bestowing section of the whole act. Zero legislative accountability and judicial oversight for a provision that allows an unelected officer the discretionary powers to lockdown the whole Alberta population and shut-down whole sectors of the provincial economy.

64. Ironically, section 30 of the *Public Health Act*, which provides very limited discretionary powers to temporarily shut-down a business, possesses a built-in judicial oversight provision.

65. It is notable that the Respondents have failed to address Ms. Ingram's submissions with respect to statutory interpretation and the limits of the discretionary powers afforded to the CMOH.

66. As submitted in the Ingram Factum, there is no support for the broad powers the CMOH has been purporting to operate under.[53] There is no evidence that the legislature intended to bestow the CMOH such grand and broad discretionary powers to isolate and lockdown healthy people and to shutter and destroy Alberta businesses absent judicial supervision.

67. In the case of *Wang*, the Alberta Court of Appeal found that the clear and unambiguous provisions conferred a broad discretion on an executive officer. This further supports Ms. Ingram's argument that if the Legislature desired to provide such alleged broad powers under section 29 of the *Public Health Act*, then law makers would have made the section clear and unambiguous. This did not take place and the section must be construed in a narrow manner.

68. *Wang* also strengthens the argument that the Business Restrictions are ultra vires section 29 of the *Public Health Act* and that the appropriate section when considering the closing of a public place or business is section 30.[54]

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[52] *Wang*, supra, at 14.
[53] Ingram Factum, at paras 32-45.
[54] Ingram Factum, at paras 55-61.

vi) Conclusion

69. It is very evident that the Respondents' conduct throughout their response to COVID-19 has been one of surprised reaction rather than being in charge and proactive. The lack of analysis, strategy and implementation of a plan has resulted in numerous infringements of Ms. Ingram's *Charter* and *Alberta Bill of Rights* protected rights and freedoms.

70. But Ms. Ingram and her fellow Applicants are not the only victims of these infringements. The whole Alberta population has suffered and many independent business have faced devastating consequences as a result.

71. Counsel for the Applicant, Ms. Rebecca Ingram, looks forward to its submission before this Honourable Court.

ALL OF WHICH IS RESPECTFULLY SUBMITTED this 21st day of September 2021.

DATED this 21st day of September 2021 in the Municipal District of Foothills, in the Province of Alberta.

Jeffrey R. W. Rath
Counsel for the Applicant Rebecca Marie Ingram

PART IV LIST OF AUTHORITIES

Legislation:

Tab	Case Law
-	Order in Council 255/2021
-	CMOH Order 42-2021
-	CMOH Order 43-2021

Case Law:

Tab	Case Law
-	*Syndicat Northcrest v Amselem*, 2004 SCC 47
-	*R v Oakes*, 1986 CanLII 46 (SCC), [1986] 1 SCR 103
-	*R v Sharpe*, 2001 SCC 2 (CanLII), [2001] 1 SCR 45
-	*Irwin Toy Ltd v Quebec (Attorney General)*, [1989] 1 SCR 927
-	*The Queen v. Beauregard*, 1986 CanLII 24 (SCC), [1986] 2 SCR 56
-	*Peter v Public Health Appeal Board of Alberta*, 2019 ABQB 989
-	*Ingram v Alberta (Chief Medical Officer of Health)*, 2021 ABQB 343
-	*Alberta Health Services v Wang*, 2018 ABCA 339

Other:

Tab	Order
A	Government of Alberta, COVID-19 Modelling, April 8, 2020
B	WMA Declaration of Geneva

COVID-19 MODELLING

Update

April 8, 2020

Introduction

- COVID-19 continues to spread rapidly across the globe.
- To date, Alberta has fared better than most.
- Albertans need to know what they can expect over the next 6 to 8 weeks:
    - How is COVID-19 expected to spread in Alberta?
    - What actions should Albertans take?
    - What is the Alberta plan?

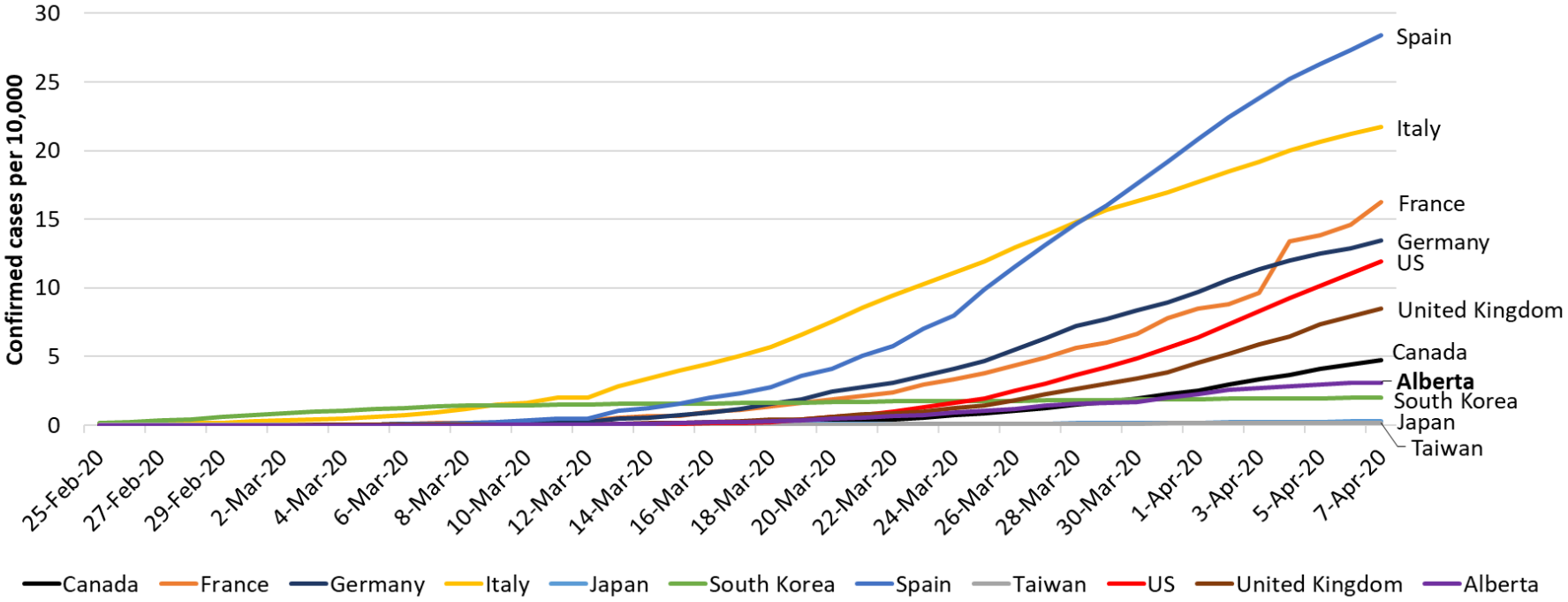
Alberta

Introduction

- Alberta continuously monitors the spread of COVID-19 – locally, across Canada and globally.
- Public health interventions that slow the spread have been developed based on what has worked elsewhere.
- Evidence gathered from other outbreaks informs the modelling of COVID scenarios in Alberta.
- The scenarios help the health system and Albertans plan for the potential impact of the pandemic and its peak.

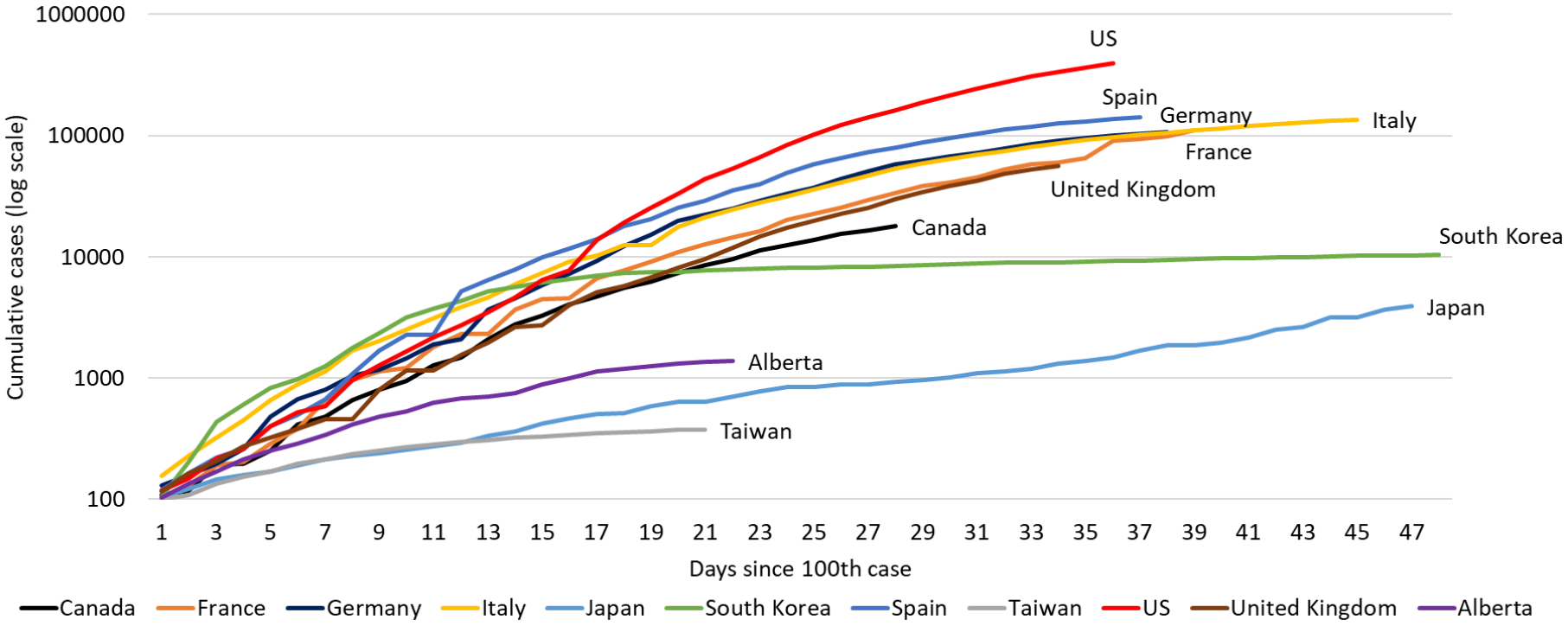
Current State

Comparison of Alberta to countries



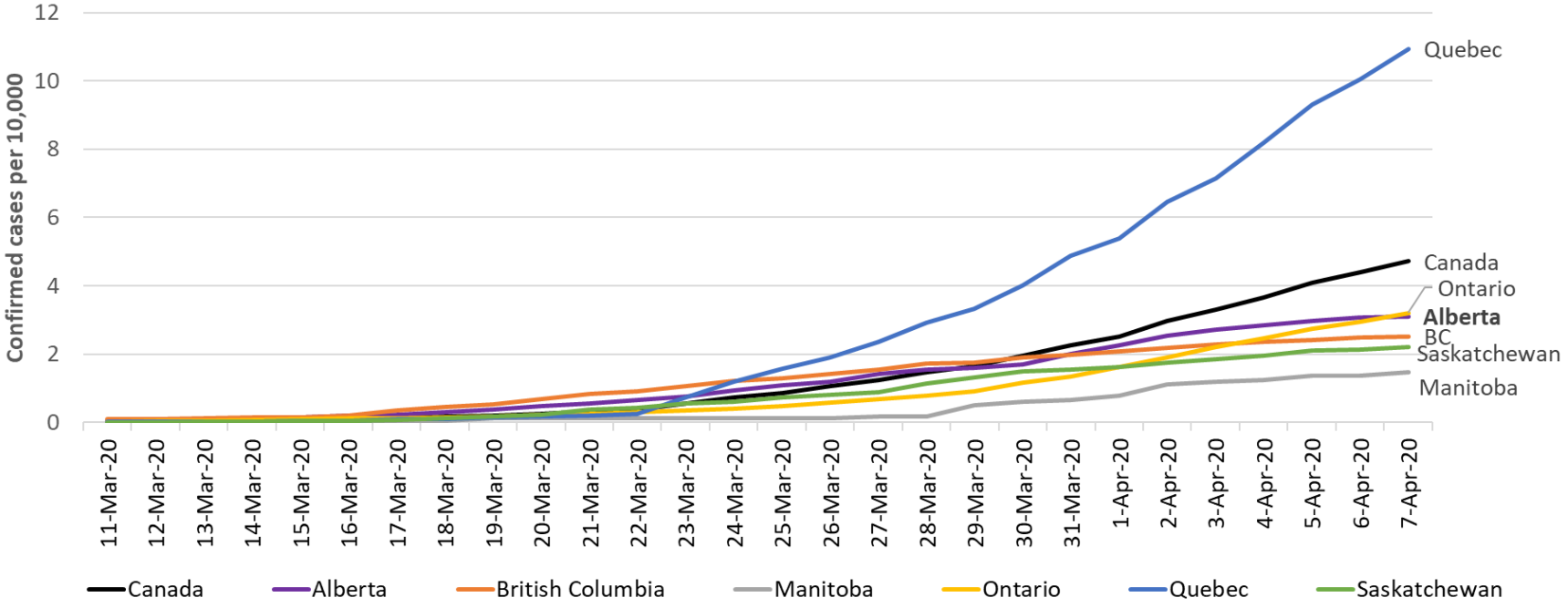
Data as of April 7, 2020, respective country websites. When not available Johns Hopkins CSSE github repository

Comparison of Alberta to countries (log scale)



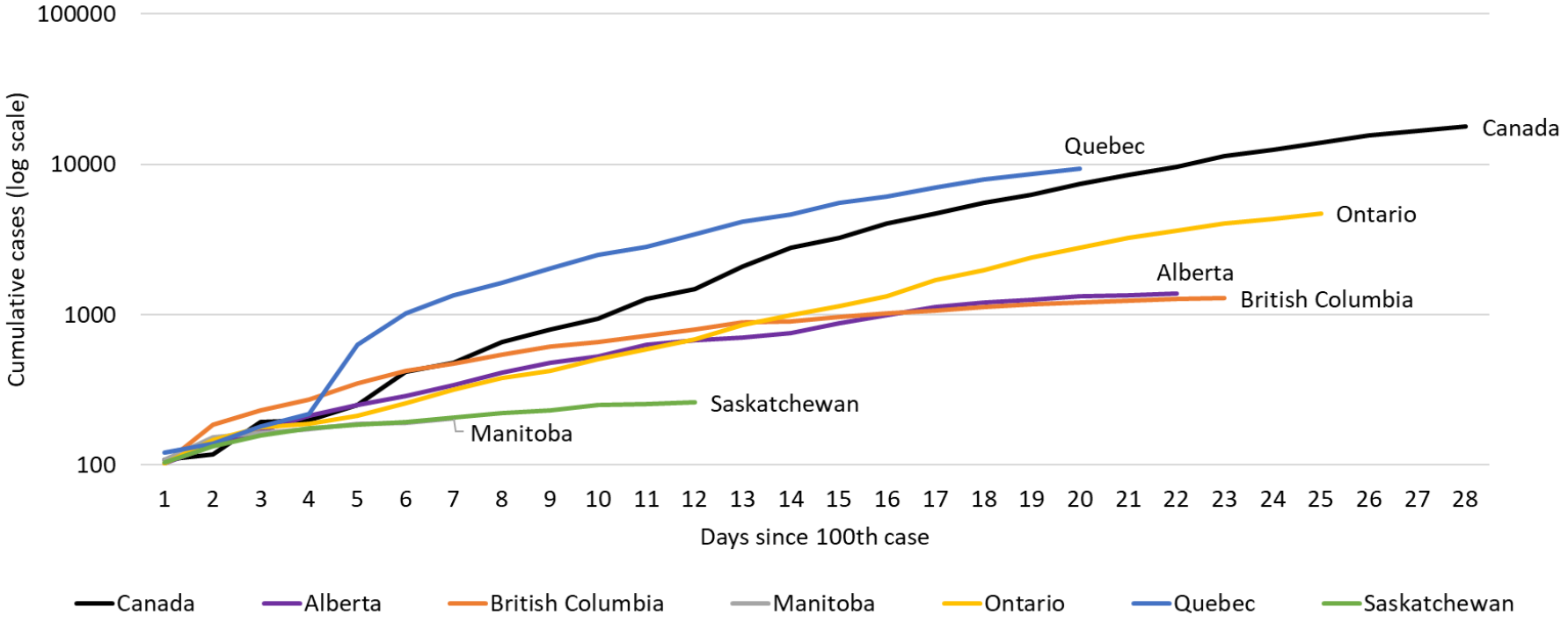
Data as of April 7, 2020, respective country websites. When not available Johns Hopkins CSSE github repository

Comparison of Alberta to other provinces



Data as of April 7, 2020, source PHAC: https://health-infobase.canada.ca/covid-19/

Comparison of Alberta to other provinces (log scale)



Data as of April 7, 2020, PHAC: source https://health-infobase.canada.ca/covid-19/

Confirmed cases, hospitalization, ICU, and deaths for Canada's 6 largest provinces

	Confirmed cases		Hospitalization		ICU		Deaths	
	# Cases	Per 10,000	# Cases	Per 10,000	# Cases	Per 10,000	# Deaths	Per 10,000
AB	1348	3.05	90	0.2	31	0.07	24	0.05
QC	9340	11.00	902	1.06	286	0.34	121	0.14
ON	4726	3.24	614	0.45	216	0.15	132	0.09
BC	1291	2.58	290	0.57	72	0.14	39	0.08
SK	260	2.21	4	0.03	2	0.02	3	0.03
MB	217	1.58	11	0.08	7	0.05	2	0.01

Data as of April 7, 2020, source PHAC :Epi summary, health-infobase.canada.ca and provincial dashboards
* Reporting of ICU, hospitalizations and deaths has a lag in Ontario, which would understate severity

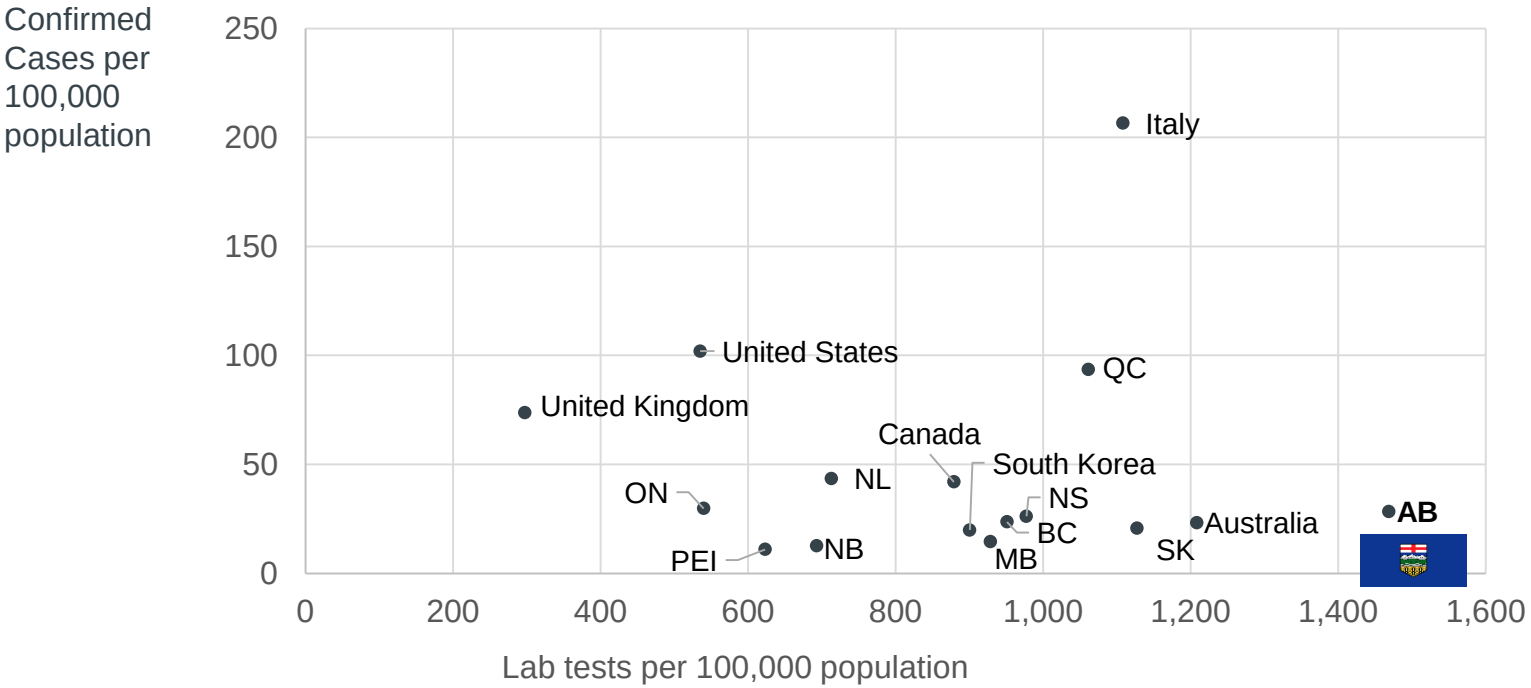
Alberta

Cases and deaths by age group in Alberta

Age Group	Cases	Death	Case Fatality Ratio
19 and under	149	0	-
20-39	446	2	0.45%
40-59	446	1	0.22%
60-79	256	4	1.56%
80+	76	19	25.0%
Total	1,373	26	1.89%

Data as of April 6, 2020, source https://www.alberta.ca/covid-19-alberta-data

Comparison of testing rates across jurisdictions



Data as of April 6, 2020, source https://ourworldindata.org/covid-testing

Modelling

Modelling

- Many jurisdictions use data from other countries, like China or Italy, to model the spread of COVID-19.
- Due to its extensive testing and surveillance program, Alberta case data is used to develop more accurate model scenarios.
- The modelling is updated as new data becomes available.
- Alberta has modelled two core scenarios – Probable and Elevated.

Scenarios

Probable Scenario

- For every case, 1-2 more people are infected.
- This scenario is comparable to the more moderate growth seen in the UK and countries that have had some success in “containing” growth.
- Given our early and aggressive interventions and contact tracing to limit spread, this is expected to be the most likely scenario for Alberta.

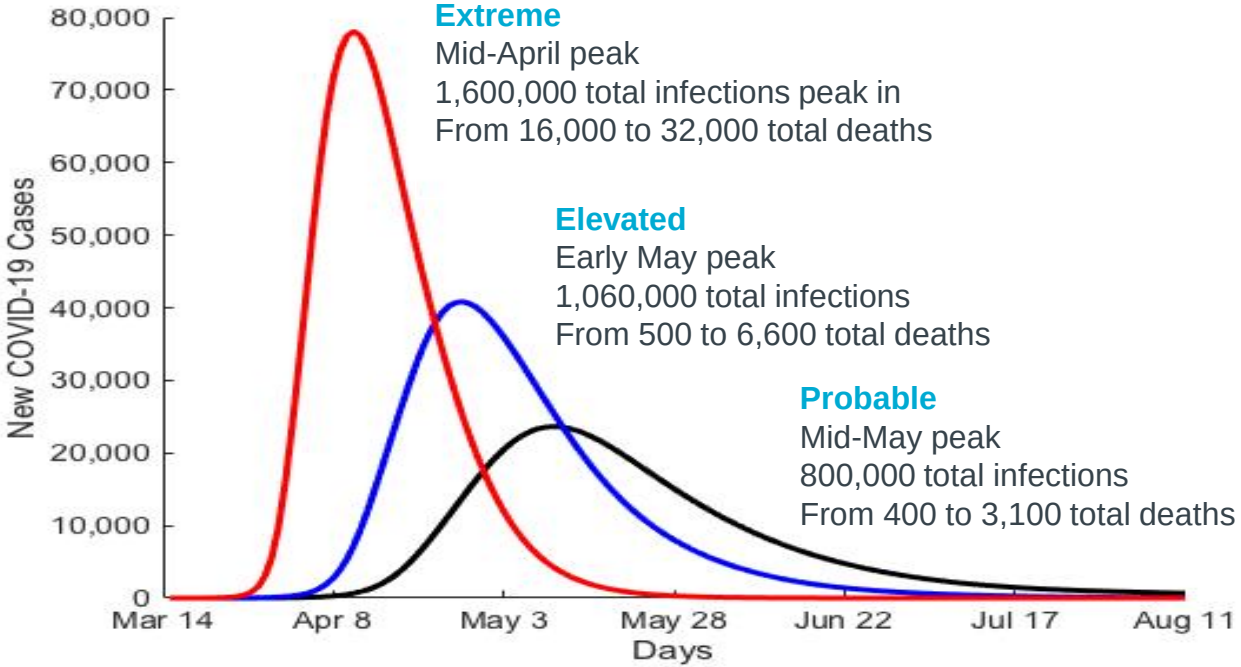
Elevated Scenario

- For every case, 2 people are infected.
- This is comparable to the more rapid growth initially seen in Hubei.
- Planning for this scenario is prudent and responsible given the catastrophic impacts should the health system become overwhelmed.

Extreme Scenario

- For every case, 3 more people are infected.
- This scenario assumes limited and late interventions so that COVID-19 rapidly spreads through the population.
- This scenario shows what would have happened if Alberta did not undertake early and aggressive interventions and contact tracing to limit spread.

Illustrative comparison of the scenarios

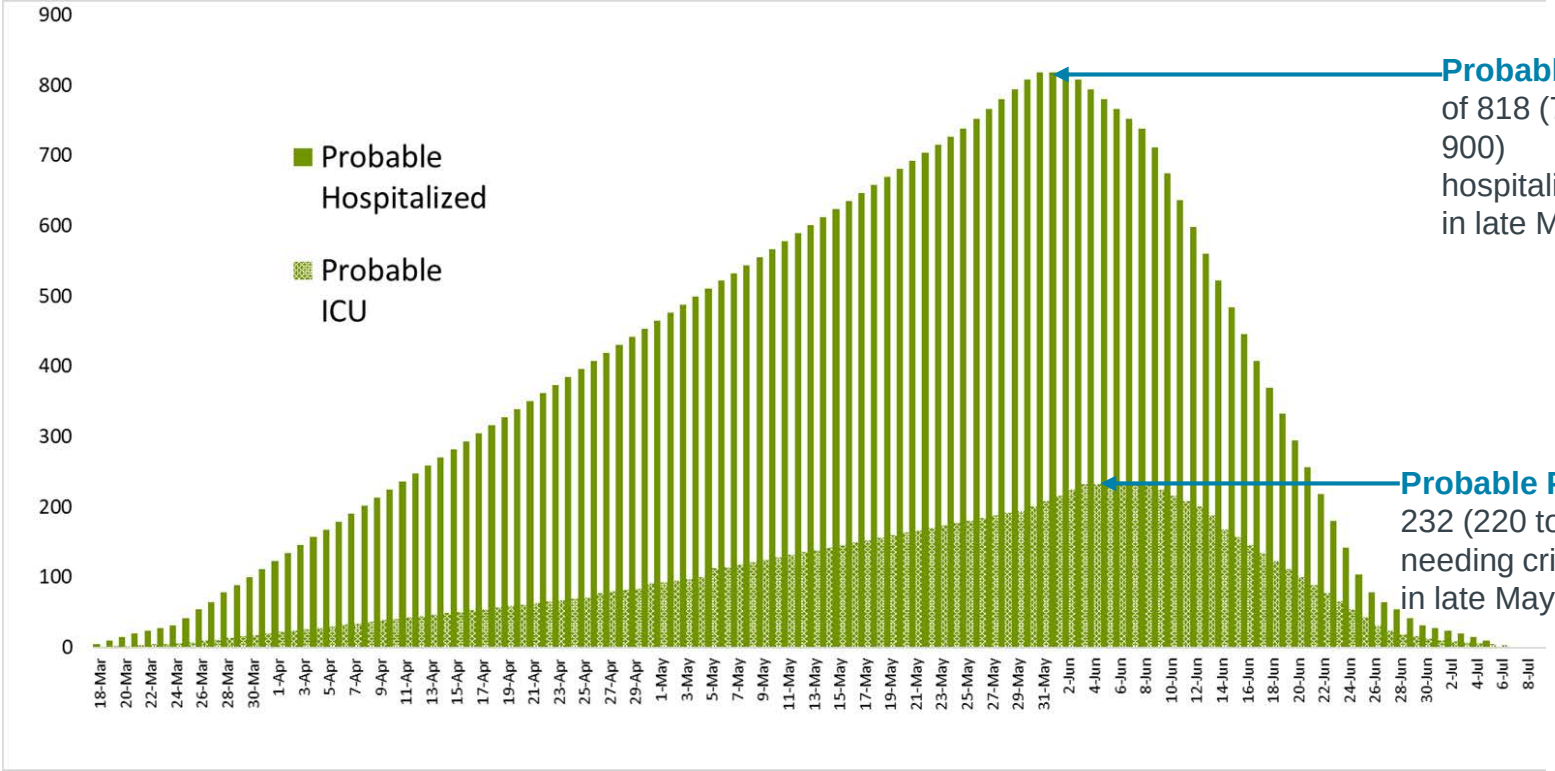


Extreme
Mid-April peak
1,600,000 total infections peak in
From 16,000 to 32,000 total deaths

Elevated
Early May peak
1,060,000 total infections
From 500 to 6,600 total deaths

Probable
Mid-May peak
800,000 total infections
From 400 to 3,100 total deaths

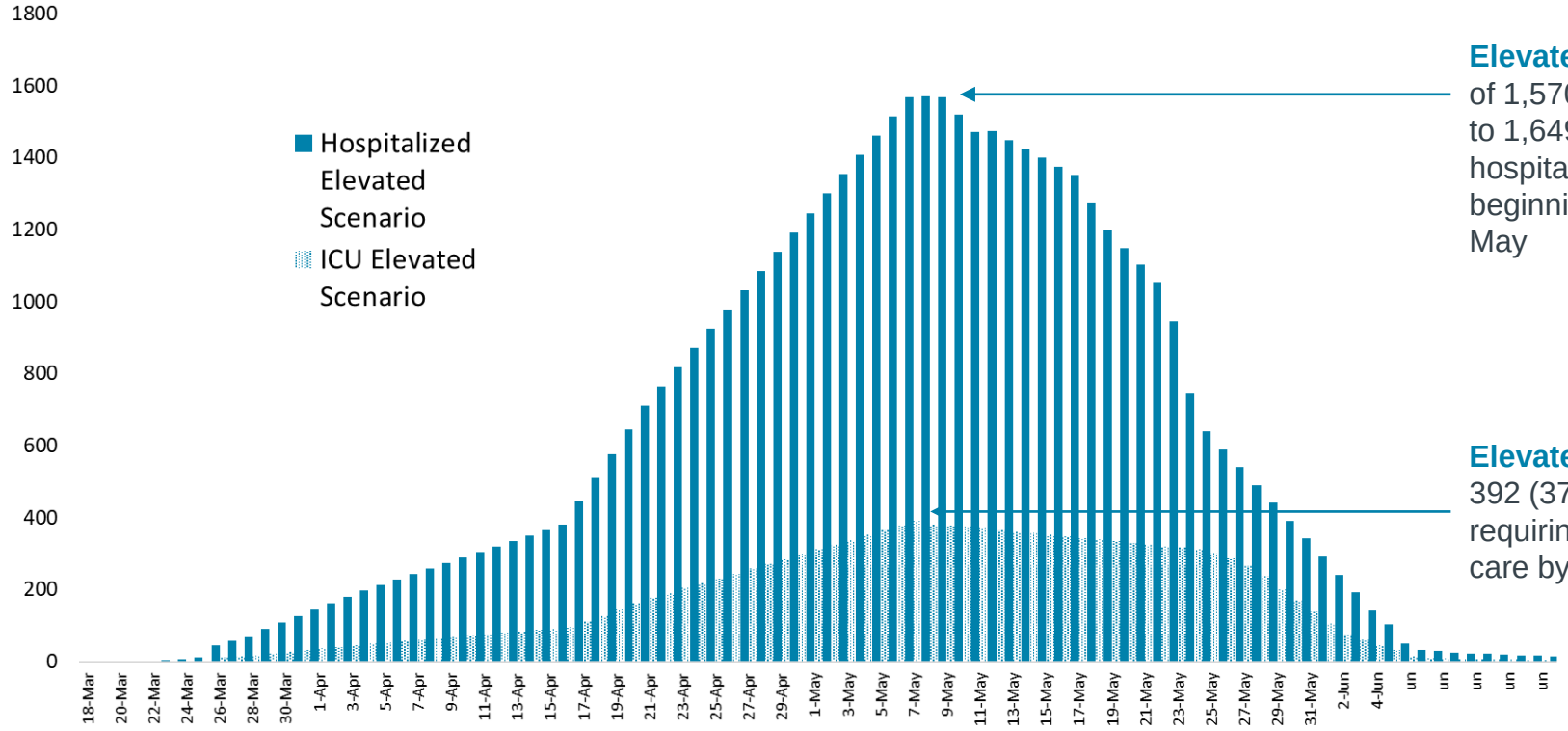
Hospitalizations and ICU - Probable



Probable Peak of 818 (736 to 900) hospitalizations in late May

Probable Peak of 232 (220 to 244) needing critical care in late May-June

Hospitalizations and ICU – Elevated Scenario



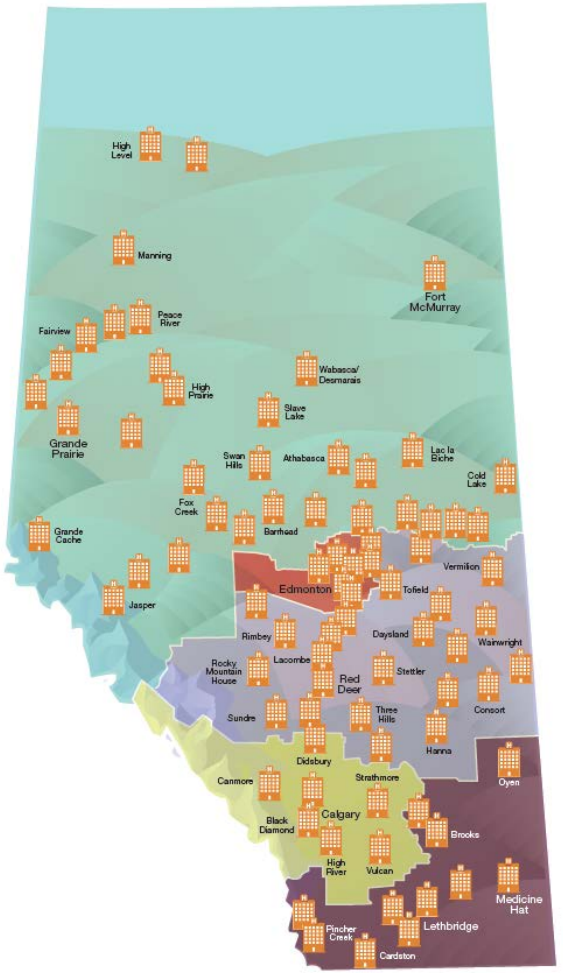
Elevated Peak of 1,570 (1,491 to 1,649) hospitalizations beginning of May

Elevated Peak of 392 (372 to 412) requiring critical care by early-May

Health System Capacity

Existing Capacity

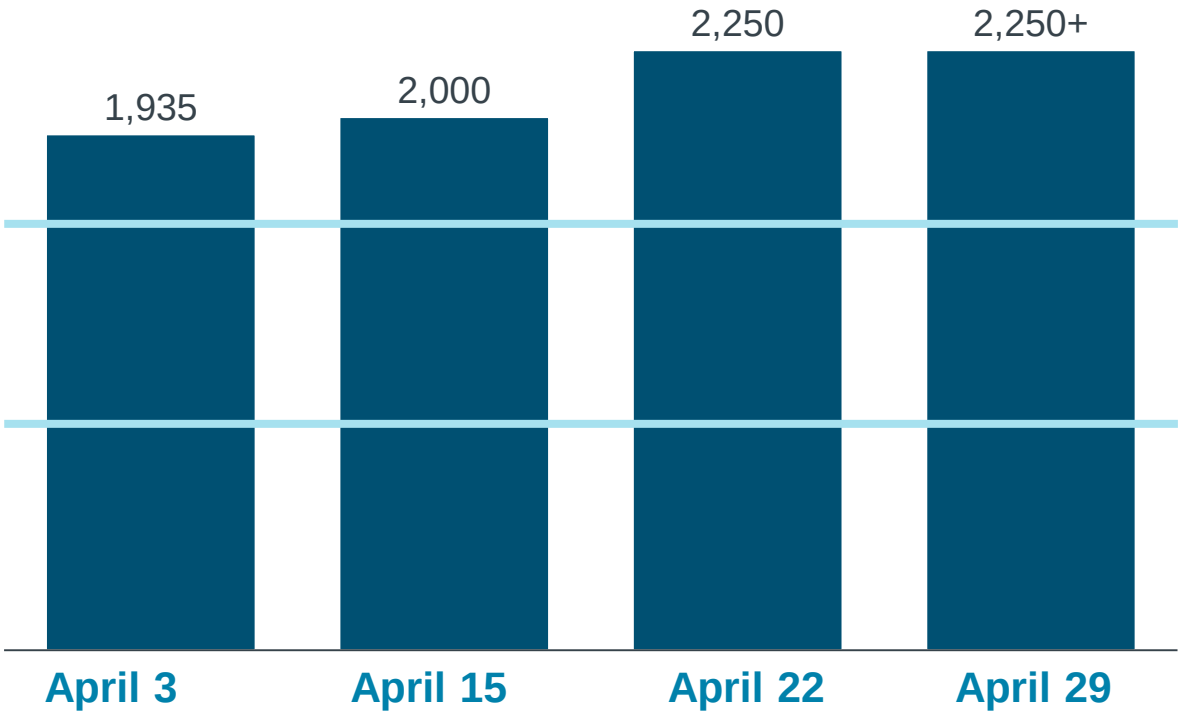
	North	Edm.	Central	Cgy.	South	Total
Hospitals	33	12	30	13	12	100
Hospital Beds	929	3,020	1,098	2,791	645	8,483
ICU beds	12	150	12	97	24	295
Ventilators	33	205	27	213	31	509



Building Acute Care Capacity

- **AHS plans to have 2,250 COVID-19 designated acute care beds by the end of April:**
  - As of April 3, 2020, 1,935 are available for COVID patients; and
  - New COVID dedicated spaces are being brought online.
- **COVID-19 acute care capacity is being achieved by:**
  - Postponing scheduled surgeries, tests and procedures while ensuring urgent, emergent and oncology surgeries continue;
  - Transferring patients who no longer require acute care to a community setting;
  - Increasing occupancy while maintaining physical distance between patients; and
  - Opening overcapacity, and new and decommissioned spaces.

Building acute care capacity



Peak of 1,570 (1,491 to 1,649) hospitalizations in **elevated** scenario, which is projected start of May

Peak of 818 (736 to 900) hospitalizations in **probable** scenario, which is projected late May

Building ICU Capacity

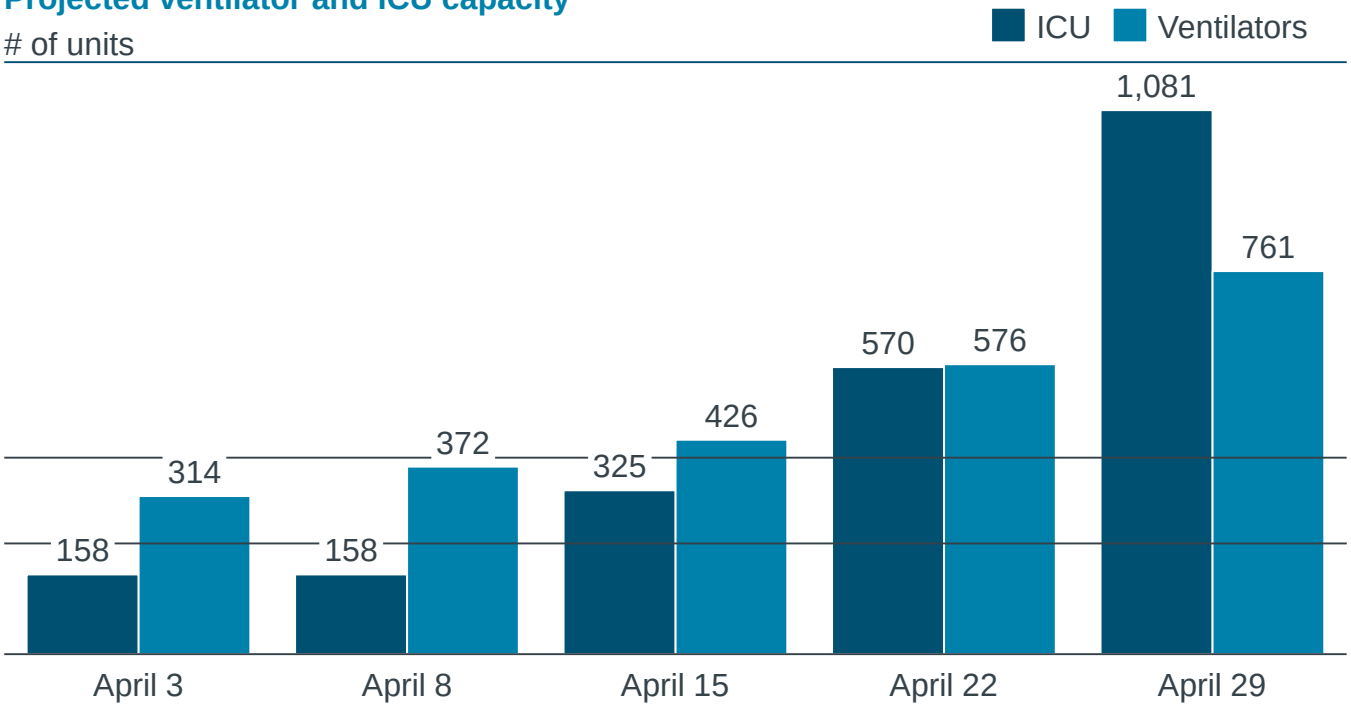
- **AHS plans to be able to increase ICU capacity by 1081 beds for COVID-19 patients by the end of April, if necessary.**
- **ICU capacity will be increased by:**
  - Adding ICU beds to existing ICU rooms;
  - Converting operating rooms and recovery rooms to ICU capacity;
  - Converting procedure and treatment rooms to ICU capacity; and
  - New models of care (e.g. more aggressive use of step down care).

Building Ventilator Capacity

- **AHS plans to have 761 ventilators available by the end of April for COVID-19 patients, if necessary, to respond to severe a scenario.**
- **314 ventilators are currently dedicated to COVID-19 patients and the capacity will be increased by:**
  - Purchased ventilators on order (35 that have arrived and another 30 in May);
  - Ventilators from NAIT and SAIT Respiratory Therapy program (40), STARS (6) and AADL Respiratory Outreach Program (25);
  - Repurposed from Chartered Surgical Facilities (30);
  - Alternative devices capable of mechanical ventilation including transport, anaesthetic and pediatric devices (305); and
  - Ventilators from Public Health Agency of Canada (6).

Building ICU & Ventilator Capacity

Projected ventilator and ICU capacity



Peak of 392 (372 to 412) needing critical care in **elevated** scenario, which is projected early May

Peak of 232 (220 to 244) needing critical care in **probable** scenario , which is projected May-June

Note: assumes that 195 of existing 295 ICU with ventilators are available to non-COVID cases

Workforce

- **Preparing for COVID-19 is about more than beds and equipment – it is about health care providers.**
- **To ensure Alberta has the highly skilled staff to respond to the pandemic the following is being developed:**
  - Accelerated training for ICU nurses;
  - New models of care to expand the reach of existing ICU nurses;
  - Working with the faculties of nursing to complete senior practicums to enable the nurses to enter the workforce;
  - Contacting former RNs with ICU experience and other recently retired staff; and
  - Redeployment of anesthesiologists, other physicians, other nurses, respiratory therapists, other allied health professionals and other staff with appropriate skills to work in a critical care environment.

Personal Protective Equipment (PPE)

	Forecast days of supplies inventory at end of April		Forecast days of supplies inventory at end of June	
Category of critical PPE	**Probable[1]**	**Elevated[2]**	**Probable[1]**	**Elevated[2]**
Face shields (single use)	12	5	-11	-13
Goggles	50	29	1	-5
Gowns/coveralls	39	19	19	7
Gloves	110	85	79	63
Procedural masks	76	51	26	15
N95 masks	32	7	-4	-12

Increasing PPE Stocks

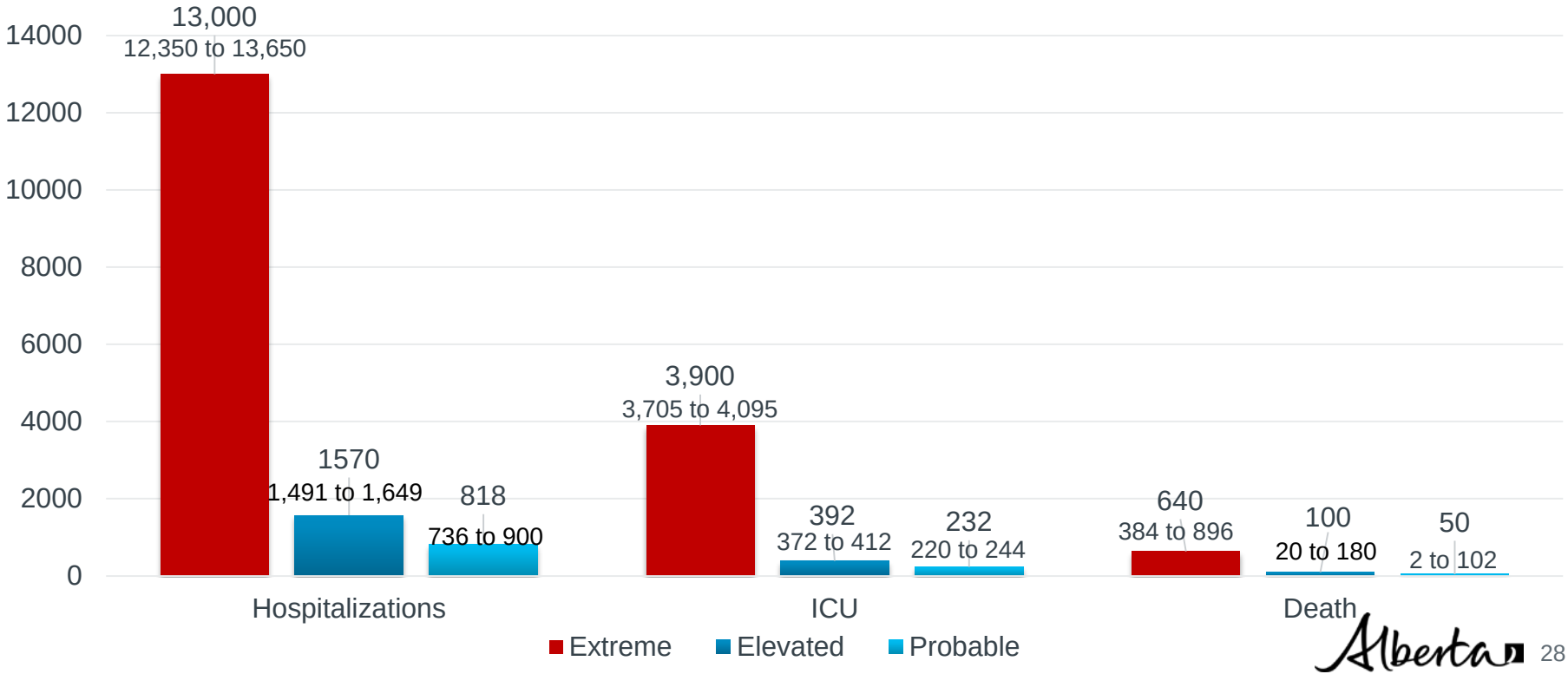
Demand levers

- Tracking PPE inventory and distribution across non-health sites
- Ensuring appropriate PPE according to recommended guidelines
- PPE reuse where safe and appropriate – e.g. sterilizing N95 masks for multiple use

Supply levers

- Increasing number of domestic and global suppliers to meet PPE demands
- Creating and working with local companies to increase production of supplies (e.g. face shields, scrubs, gowns and hand sanitizer)
- Virtual trade show April 8, 2020

Comparison of All Scenarios at the Peak



The Plan

Alberta’s Plan – the next 6 to 8 weeks

- World class testing and surveillance
- Aggressive contact tracing and containment
- Public health Interventions based on evidence of what works
- Supporting Albertans in pushing the peak down
- Supporting fellow Canadians in a time of crisis

What’s next?

- Relaunch Strategy
  - Aggressive system of mass testing, including serological testing
  - Strong tracing and tracking of contacts leveraging technology
  - Strong border screening
  - Use of masks

WMA DECLARATION OF GENEVA

Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948
and amended by the 22nd World Medical Assembly, Sydney, Australia, August 1968
and the 35th World Medical Assembly, Venice, Italy, October 1983
and the 46th WMA General Assembly, Stockholm, Sweden, September 1994
and editorially revised by the 170th WMA Council Session, Divonne-les-Bains, France, May 2005
and the 173rd WMA Council Session, Divonne-les-Bains, France, May 2006
and amended by the 68th WMA General Assembly, Chicago, United States, October 2017

The Physician's Pledge

AS A MEMBER OF THE MEDICAL PROFESSION:

I SOLEMNLY PLEDGE to dedicate my life to the service of humanity;

THE HEALTH AND WELL-BEING OF MY PATIENT will be my first consideration;

I WILL RESPECT the autonomy and dignity of my patient;

I WILL MAINTAIN the utmost respect for human life;

I WILL NOT PERMIT considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient;

I WILL RESPECT the secrets that are confided in me, even after the patient has died;

I WILL PRACTISE my profession with conscience and dignity and in accordance with good medical practice;

I WILL FOSTER the honour and noble traditions of the medical profession;

I WILL GIVE to my teachers, colleagues, and students the respect and gratitude that is their due;

I WILL SHARE my medical knowledge for the benefit of the patient and the advancement of healthcare;

I WILL ATTEND TO my own health, well-being, and abilities in order to provide care of the highest standard;

I WILL NOT USE my medical knowledge to violate human rights and civil liberties, even under threat;

I MAKE THESE PROMISES solemnly, freely, and upon my honour.