Action No.: 2001-14300
E-File Name: CVQ22INGRAMR
Appeal No.: _____

IN THE COURT OF QUEEN'S BENCH OF ALBERTA
JUDICIAL CENTRE OF CALGARY

BETWEEN:

REBECCA MARIE INGRAM, HEIGHTS BAPTIST CHURCH,
NORTHSIDE BAPTIST CHURCH,
ERIN BLACKLAWS and TORRY TANNER

Plaintiffs

and

HER MAJESTY THE QUEEN
IN RIGHT OF THE PROVINCE OF ALBERTA
and THE CHIEF MEDICAL OFFICER OF HEALTH

Defendant

H E A R I N G
(Excerpt)

Calgary, Alberta
February 24, 2022

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TABLE OF CONTENTS

Proceedings taken in the Court of Queen's Bench of Alberta, Courthouse, Calgary, Alberta

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February 24, 2022	Morning Session
The Honourable Justice Romaine	Court of Queen's Bench of Alberta
J. R. Rath (remote appearance)	For R. Ingram
L. B. Grey, QC (remote appearance)	For Heights Baptist Church, Northside Baptist Church, E. Blacklaws and T. Tanner
N. Parker (remote appearance)	For Her Majesty the Queen in Right of the Province of Alberta and The Chief Medical Officer
N. Trofimuk (remote appearance)	For Her Majesty the Queen in Right of the Province of Alberta and The Chief Medical Officer
B. LeClair (remote appearance)	For Her Majesty the Queen in Right of the Province of Alberta and The Chief Medical Officer
M. Palmer	Court Clerk

THE COURT: Okay. Good morning, everyone.

MR. PARKER: Good morning, Justice Romaine.

Ruling (Admissibility of Madewell 2 and Rasmussen Studies)

THE COURT: I'd like to start off by giving you my decision on the admissibility of the Madewell 2 and Rasmussen articles.

Okay. There are four issues that must be considered in determining whether to allow the Madewell 2 and the Rasmussen articles as exhibits in this hearing for the truth of their contents. First, in the ordinary course, as set out in *R. v. Marquand,* [1993] 4 SCR 223, at para. 55.

THE COURT CLERK: I apologize, My Lady, but (INDISCERNIBLE)

THE COURT: Okay. Sorry, we'll have to wait until ...

(ADJOURNMENT)

MR. RATH: Fine. That'll give me a chance to say good morning, My Lady.

THE COURT: Good morning. Okay.

THE COURT CLERK: I think we're okay.

THE COURT: Did you get the beginning of it, madam clerk?

THE COURT CLERK: Yes (INDISCERNIBLE)

THE COURT: Okay. I was quoting paragraph 55 of *Marquand*. I should let you know that, if you want a transcript of this, I'll put in the citations, but I'm not intending to read out the full citations as I give my decision.

> The proper procedure to be followed in examining an expert witness or other expert opinions on other expert opinions found in papers or books is to ask the witness if he or she knows the work. If the answer is no or if the witness denies the work's authority, that is the end of the matter. Counsel cannot read from the work since that would be to introduce it as evidence. If the answer is yes and the witness acknowledges the work's authority, then the witness has confirmed it by the witness' own testimony. Parts of it may be read to the witness and, to the extent they are confirmed, they become evidence in the case.

The transcript of February 14th, 2022 indicates that Dr. Bhattacharya was not aware of either of the articles in issue. My notes of February 22nd, 2022 indicate that, while the doctor answered questions about Madewell 2, he did not adopt it. However, even if he confirmed parts of the study, and I am not saying that he did without further resort to transcripts that are not yet available, this is not a normal case where the date the reports were published are not an issue.

Secondly, as noted in *Gateway Bible Baptist Church v. Manitoba,* 2021 MBQB 219, this hearing is not an inquiry or a post-mortem on the aspects of Alberta's response to COVID-19. It will not be either a validation or a second-guessing of Alberta's policy choices. My task is to evaluate whether the impugned restrictions have infringed the rights of the applicants and, if so, whether they are constitutionally defensible and whether they are legally impregnable on administrative law grounds.

As the Court in *Gateway* reminds us, I must take care not to conflate the constitutional assessment, whether the impugned provisions infringed the fundamental rights of the applicants, and if so, whether they are constitutionally justifiable as reasonable limits under section 1 of the *Charter*, with a post-mortem inquiry. In the section 1 analysis, the question is whether there is a sufficiently sound and credible evidentiary basis even in light of any opposing evidence for Alberta's position that the limitations and restrictions imposed were valid policy approaches that were reasonably justified and constitutionally defensive at the time these limitations and restrictions were imposed.

As noted by Chief Justice McLachlin in Hutterite Brethren:

> Section 1 of the *Charter* does not demand that the limit on the right be perfectly calibrated, judged in hindsight ...

Therefore, the Madewell report and the Rasmussen report are inadmissible as full exhibits on the basis of relevance.

The third factor to be considered is the procedure set out in the oral hearing order of August 6, 2021. That order sets out clear deadlines for the filing of any records. While the respondents have applied for leave to file the reports at issue as full exhibits, that application comes very late during the hearing despite the respondents' acknowledgement that they knew of the existence of the Madewell report in September of 2021. As noted by the applicants, the respondents made a strategic choice to present the studies to Dr. Bhattacharya during cross-examination. They must live with that choice.

Finally, I agree with the applicants that treating these reports for the truth of their contents is essentially accepting them as expert evidence, without their adoption by Dr. Bhattacharya, in the absence of them being presented by a qualified expert and subject to cross-examination and response in accordance with proper advance notice. This is improper procedurally and prejudicial to the applicants.

For all of those reasons, I dismiss the application to have these reports entered as full exhibits. Counsel may certainly refer to the answers of Dr. Bhattacharya and Dr. Kindrachuk with respect to the two studies at issue, subject of course to the issue of relevance of hindsight evidence in this case.

Okay. I went through that at breakneck speed, but are there any questions? Any comments?

Discussion

MR. RATH: Just -- just a quick question, My Lady. I take it from your ruling then that my friend's examination-in-chief of Dr. Kindrachuk on Madewell 2 yesterday afternoon that was the subject of my objection is, in fact, struck from the record?

THE COURT: Well, what I'd like to happen there, in light of my ruling, Mr. Rath and Mr. Parker, would you please go through that section of the examination-in-chief and advise whether any of it need not be struck. That's all.

MR. RATH: Ah. My Lady, I paid very careful attention. My view is that it would be stuck -- struck in its entirety and it's simply on the basis of fairness. We weren't accorded that same procedure or provision with regard to the John (sic) Hopkins study and on that basis alone that examination and that evidence should be struck from these proceedings from -- from the standpoint of fairness.

THE COURT: Okay. Well, if you're not willing to confer with Mr. Parker on it, what I will do is I will go through and give you my decision on whether it's struck entirely or any of it survives. Okay.

MR. PARKER: And could I just clarify -- thank you for your decision, Justice Romaine. I didn't catch it all and we look forward to reviewing the transcript. The -- what you said about the counsel may refer to the evidence of Dr. Bhattacharya and you said -- I believe you were referring to Dr. Kindrachuk, I just wanted --

THE COURT: Oh, I'm sorry.

MR. PARKER: -- to clarify what that relates to, focussing on this question, which is again Dr. Kindrachuk's evidence on Madewell 2, and I heard you say that that could be referred to.

THE COURT: Well, that's why I'm reluctant to just say right now that the whole of that can be struck. Dr. Bhattacharya was questioned and gave answers on Madewell. Dr. Kindrachuk did so also. What I've said is that the reports cannot be admitted as full exhibits, but I'm not sure that it follows that all of the answers of Dr. Kindrachuk should be struck and I'll have to review that. I was hoping that counsel would be able to confer on that, but if it looks like that's not likely, what I'll do is I'll go through it and let you know.

MR. RATH: Madam --

MR. PARKER: And -- sorry, just -- I'm just not finished, Mr. Rath, if I could just finish my question, sir.

MR. RATH: Madam (INDISCERNIBLE)

MR. PARKER: So --

THE COURT: Mr. Rath --

MR. RATH: (INDISCERNIBLE)

MR. PARKER: (INDISCERNIBLE) my friend --

THE COURT: Mr. Rath. Mr. Rath.

MR. RATH: Yes.

THE COURT: Please stop and let Mr. Parker finish.

MR. PARKER: Thank you so much, Justice Romaine. Yes. I think we should try to discuss it among counsel and, again, that applies to the answers given by both Dr. Bhattacharya and Dr. Kindrachuk on both the Rasmussen study and the Madewell study.

THE COURT: Yeah. I mean Dr. Bhattacharya answered questions, I believe, without objection.

MR. PARKER: M-hm.

THE COURT: Am I wrong on that? I'd have to go back in the transcripts. So it's there in the evidence --

MR. PARKER: Okay.

THE COURT: -- but I'll check both of them. I'm sorry, Mr. Rath, now do you want to respond to Mr. Parker?

MR. RATH: It wasn't (INDISCERNIBLE) simply trying to tell the Court and my friend, except he's always happy to talk over people, that I -- you

know, that I -- I'm happy to confer with counsel. So this entire colloquy was unnecessary but for my friend speaking over me and letting -- not letting me advise the Court. But in any event, we're happy to confer with my friend. Thank you.

THE COURT: Okay. Mr. Rath and Mr. Parker, I have to say that both of you are guilty of that particular sin. It's particularly difficult when we're on Webex and I understand that, but I'm sorry, Mr. Rath, you both have a tendency to speak over the other.

Now, I haven't asked Mr. Grey what his position is and I will now.

MR. GREY: Sorry, Mr. Parker, go ahead. You finish your thought.

MR. PARKER: No, no, you know what, I am trying to be courteous. I was trying to be courteous yesterday when I said, do you want me to speak to the exhibits. I didn't know we were going to launch into your application. I'm trying my best, I think Mr. Grey's trying his best, I am not sure Mr. Rath is making any effort on this and I will continue to do -- try my best. Mr. Grey communicated to counsel at the end of last week and suggested we all try to behave more cordially and, you know, I think that that is a good piece of advice. But, you know, the transcript will say what it says and Mr. Rath, and I know you're not going to point fingers at just one person, but he continues to make comments that I think are unwarranted and, you know, that's all I'm going to say. Thank you for listening to me.

THE COURT: Okay.

MR. PARKER: Go ahead, Mr. Grey, I appreciate it.

THE COURT: Mr. Grey --

MR. GREY: Thank you.

THE COURT: Mr. Grey, before you do --

MR. GREY: Sure.

THE COURT: -- thank you very much for your conversation with Mr. Rath and Mr. Parker. I certainly echo the sentiment that it would be far better if you could be more collegial and professional as a group. And, Mr. Parker, I do understand what you're saying. I have made mention to Mr. Rath a couple of times when I found that

he had made inappropriate comments. I'm glad to hear that you're going to do your best not to talk over other people and I hope Mr. Rath does the same. So, Mr. Grey, what would you like to say?

MR. GREY: Well, first of all, I have to say in all honestly I haven't always walked my talk with (INDISCERNIBLE). I was a little cranky yesterday morning and I accept full responsibility for that, that was regrettable. Coming back to your point, though, I think that you have an excellent suggestion. I would welcome the opportunity to try and work through what use can be made of the answers that were given. My recollection is the same as yours, that Dr. Kindrachuk provided some answers under cross-examination concerning Madewell number 2. I also recall that Dr. Bhattacharya was asked by me under redirect about Rasmussen so I think -- I agree with your process and I'll do my best to work through it with my friends to see what use -- what is the proper use to be made of that evidence and hopefully we can work through that so that you don't -- you don't have to do that all on your own, but I'll certainly make my best efforts.

THE COURT: Okay.

MR. GREY: I hope that answers your question.

THE COURT: It does. And thank you, Mr. Grey, and what I'll do then is wait until I hear from counsel about whether or not you can work this out among the three of you. Okay. Thank you.

Are we ready then to --

MR. PARKER: Sorry, Justice Romaine, I just wanted to indicate that sometimes during this Webex process we've been in over the last couple of years, judges have said please put your hand up if you want to make comments and so I have tried that. I know Mr. Grey thought it was -- I think he said a grade 9 move, which again was one of those comments that I'm sure he regrets, and I do. So I don't know if that's something we should be doing. I mean I don't like to just jump in. It's very tough, as you know, but I do like to be given the opportunity to speak to it if I think it's appropriate. So I don't know if that's something that's helpful or you'd rather we just interject and try not to interrupt.

THE COURT: I think that's an excellent suggestion. There is a function on Webex where you can sort of put up your hand, but I can't always be checking that. So, you know, even if it is a little bit, you know, undignified --

MR. PARKER: (INDISCERNIBLE) grade school.

THE COURT: Undignified. Perhaps everybody could follow that. Okay. Okay.

MR. PARKER: Excellent. Thank you.

THE COURT: Thank you. Okay. Can we proceed then with the next witness?

MR. PARKER: Dr. Simmonds is in the waiting room, so she's ready to be cross-examined, Justice Romaine.

THE COURT: Okay.

MR. PARKER: She's not being put up as an expert witness and so there was no plan to go through any of her qualifications.

THE COURT: Okay.

THE COURT CLERK: My apologies, what's her first name?

MR. PARKER: It is Kimberley. Dr. Kimberley Simmonds.

THE COURT CLERK: Thank you. I have admitted Ms. Simmonds. I believe I got the right person.

Ms. Simmonds, this is the clerk. Are you able to hear me?

DR. SIMMONDS: Yes, I can hear you. Now I can unmute myself as well.

THE COURT: Okay. Great. Okay. Mr. Grey, Mr. Rath, who is going to conduct the cross-examination first?

THE COURT CLERK: May --

MR. GREY: I was going to start, Madam Justice.

THE COURT: Okay. Mr. Parker?

MR. GREY: Oh, Mr. Parker has his hand up.

THE COURT: Yeah. Mr. Parker? Mr. Parker, we can't hear you.

MR. PARKER: Just noting we cannot see Dr. Simmonds, on my screen at least. I don’t know if anyone else can see her.

THE COURT: Oh. I just --

MR. GREY: Yeah, I can't -- I can't see her either, Madam Justice.

THE COURT: Okay.

MR. GREY: I could hear her though.

DR. SIMMONDS: Video settings, I'm not sure how to change this. Okay. Here? Video?

THE COURT: Madam clerk, can you help Dr. Simmonds? There should be something that says video on, video off, on your screen. We can --

DR. SIMMONDS: I ...

THE COURT: Yeah.

DR. SIMMONDS: Yeah, I don’t have in this -- this is a different Webex than I've previously worked with, so.

MR. PARKER: Maybe I could suggest we -- my apologies for this, Justice Romaine and counsel. Maybe we could --

DR. SIMMONDS: Sorry.

MR. PARKER: -- take 5, 10 minutes and I could check in with Dr. Simmonds and see if we can assist. I think the issue might be at her end.

THE COURT: Yeah.

DR. SIMMONDS: Sorry.

MR. GREY: That's -- that's fine. That's a good suggestion, Madam Justice --

THE COURT: Okay.

MR. GREY: -- however, if you're content -- as long as Professor Simmonds can -- can hear me, I would be content to -- to proceed without the video if we have to, but I think Mr. Parker has a good suggestion.

THE COURT: Okay. Thank you, Mr. Parker. I think we'll take you up on that. So, what, 10 minutes?

DR. SIMMONDS: My ...

MR. PARKER: Yes, please.

THE COURT: Thanks.

DR. SIMMONDS: My sincerest apologies for this.

THE COURT: No. No problem. Thank you.

MR. GREY: Oh, that's fine. Yeah.

THE COURT: Yeah. Okay.

MR. PARKER: Dr. Simmonds, we'll give you a call shortly. Thank you.

THE COURT: Okay.

DR. SIMMONDS: Okay.

(ADJOURNMENT)

THE COURT: Okay. Thank you. Dr. Simmonds, we can see you now. Madam clerk, would you please swear the witness? Thank you.

KIMBERLEY ANNE SIMMONDS, Affirmed, Cross-examined by Mr. Grey

THE COURT: Okay. Mr. Grey, are you ready?

MR. GREY: Yes, I am, Madam Justice.

Q MR. GREY: All right. Dr. Simmons, it's Leighton Grey. Can you hear and see me okay?

THE COURT CLERK: Mr. Grey, sorry -- sorry.

MR. GREY: I'm sorry.

MS. LECLAIR: We look like we've lost Mr. Rath and I'm just concerned --

MR. GREY: Oh, okay.

MS. LECLAIR: -- in that respect. Sorry to interrupt.

MR. GREY: Right. Oh, yes.

THE COURT: Oh, my.

MR. PARKER: Thanks for noticing that.

THE COURT: Okay.

MR. PARKER: Oh, I believe he's back.

THE COURT: Madam clerk, do you have him back?

MR. RATH: We seem to be back online now. Thank you. Sorry for the interruption, Madam Justice.

THE COURT: No problem. Okay. Okay. Go ahead, Mr. Grey.

MR. GREY: Thank you.

Q MR. GREY: So obviously you can hear me okay, Dr. Simmonds?
A I can.

Q All right. So, as you probably gathered, I'm a lawyer -- I'm one of the lawyers for the

applicants in the case and so it's my job to ask you some questions today. To start off with, as you probably know, we've had some very highly educated people give evidence in this proceeding so far. Some of them are medical doctors, some of them are not. For the sake of sort of keeping it straight on the record, I see that you're obviously some person of very high academic distinction and that you have a PhD in epidemiology and that you teach at the University of Calgary School of Medicine, but that you're not a medical doctor; is that correct?

A That is correct.

Q Okay. So just to keep things straight, if you don't mind, what I'd like to do is refer to you as professor. Is that okay?

A That's fine.

Q All right. So I see, professor, that you are a person who's part of Alberta's emergency operations centre as the lead for analytics and modelling, or at least you were from March 2020 to March 2021; is that correct?

A That is correct.

Q And are you still engaged in that capacity?

A No.

Q Okay. But as part of that, were you part of the -- sort of the team that was led by Dr. Hinshaw to address the COVID-19 pandemic in Alberta?

A I was.

Q Okay. And you state in your -- in your report -- or, actually, I should state in your affidavit, and this is from the -- it was affirmed on the 11th of July, 2021.

A That is correct.

Q Do you have a copy of that? Do you have a copy of that before you so you can refer to it?

A Yes.

Q Excellent. Okay. So at -- at paragraph 4 --

A Yes.

Q -- you talk about the fact that you -- you're an applied epidemiologist --

A M-hm.

Q -- and that you have experience in working in Alberta managing outbreaks and meeting (phonetic) infectious disease surveillance in the province over the past 15 years; is that

right?
A That is -- that is correct.

Q Okay. So, in addition to serving as a professor at the University of Calgary, is it accurate to state that you have also been concurrently employed by the Provincial of Alberta?
A That is --

Q Do I have --
A -- in fact correct.

Q Okay.
A That is correct.

Q Okay. And are you still, today, employed by the Provincial of Alberta?
A I no longer am employed by the Province.

Q Okay. And did your employment with the Province cease back in March of 2021?
A Yes.

Q Okay. So is it a situation where you're now a full-time professor at the university?
A No. I went to work in the private sector to go do work across the country.

Q Okay. Are you -- are you still teaching at the U of C, though?
A Yeah. I teach intermittent courses, but at this time I'm not teaching.

Q Okay. So, sorry, where are you employed now?
A I work for Ernst Young. It's an accounting firm.

Q Oh, okay. But still in the field of epidemiology?
A Actually, I do more healthcare and system designs but, yes, there is --

Q Okay.
A -- epidemiology involved.

Q All right. So, as a -- as a teacher, as a professor of epidemiology, I take it you're familiar with the work of Dr. Jay Bhattacharya?
A I'm familiar with what he submitted, yes.

Q Okay. So did you have the opportunity to read the -- the report that he submitted to the Court in this proceeding?

A I did.

Q Okay. And one of them is from the -- from January of 2021, have you had a chance to read that one?
A I don't know if there's more than one.

Q Okay.
A The only one I have is January 2021.

Q Okay. So did you first become aware of Dr. Bhattacharya through the course of this -- this case or --
A Yes.

Q -- had you heard of his work previously?
A No.

Q Okay. So --
A I had not previously heard of his work.

Q Okay. In -- in his report there's attached there a curriculum vitae. Have you seen that?
A Yes.

Q Okay. And he's given evidence in this proceeding to the effect that he's published in excess of 150 peer reviewed articles.
A Yes.

Q Okay. Have you reviewed or read any of those?
A No.

Q Okay. But you've read, I take it, his -- his expert report?
A Yes.

Q And in it there's a document called the Great Barrington Declaration --
A I am familiar.

Q -- are you familiar with that?
A Yes.

Q Okay. So this Great Barrington Declaration has become something of a controversy in -- in the science of COVID-19, hasn't it?
A Yes.

Q Yeah. And in particular, I take it you take an interest in it as an epidemiologist?
A Correct.

Q Okay. So the -- what's in the Great Barrington Declaration is the -- the assertion by Dr. Bhattacharya and the authors that, really, the most effective way to deal with COVID-19 is what they call focussed protection.
A M-hm.

Q Okay. Is that a yes?
A Yes. Correct.

Q Okay. Professor, have you given evidence in court before?
A No.

Q Okay.
A When I was 10, I did. Someone --

Q Okay.
A Yeah. And I -- and I went to law day every day for several years so I'm very familiar with Goldilocks and other sort of court proceedings, but from a law day perspective.

Q Okay. So I'll just tell you, and -- and don't take this as a criticism, but in common conversation we often nod our heads and we say m-hm, uh-huh, but we have a recording that's taking everything down --
A Right.

Q -- and there will be a transcript generated so it's very important that you give, you know, answers, yes, no, you know, that type of thing. So it's a little bit artificial, but we want to make sure we get your answers accurate, so. Okay.
A Thank you.

Q Okay. All right. So coming back to the Great Barrington Declaration, you agree with me that basically what it asserts is that the best way to deal with the COVID-19 pandemic -- which, by the way, Dr. Bhattacharya has described in this proceeding as a terrible pandemic, I expect you to agree with that.
A Yes.

Q Yes. But he says -- or it says in the Great Barrington Declaration the best way to deal with that is just focussed protection. From what you have submitted in your affidavit, it appears that you disagree with that; is that fair?

A That would be an oversimplification.

Q Okay. Okay. Do you agree with that in part?
A Yes, in -- in part I do agree that we should protect our most vulnerable. Obviously, there's feasibility considerations and defining vulnerable can vary based on the population that we're considering so, in part, I do.

Q Okay. Do you agree -- and the comment that you just made, does that -- do they apply specifically to the situation in Alberta with which you're very familiar?
A Yes. There's feasibility considerations. So there are academic considerations, which the Great Barrington Declaration takes into account, and then there's the reality and the feasibility of this and -- and the -- the social and other context that you need to consider in addition to simply looking at the data. Further, I would say the Great Barrington Declaration was an interesting idea when we didn't have very much information but, since then, we've had several months of evidence and data from around the world and I would assert it's become less and less a possibility to do things the way in which they described or wanted things to happen.

Q In terms of reaching epidemic equilibrium or herd immunity, is that what you mean?
A Exactly. Yes.

Q Okay. Okay. Just coming back to the controversy, are you familiar with Dr. Anthony Fauci?
A Yes.

Q Okay. So he's a very -- again, a very -- somewhat controversial, but very -- now a very famous person and my understanding, he's the head of the NIH in the United States. Is that your understanding as well?
A Yeah. And the CDC previously.

Q Right. Thank you. He -- he had described the -- the work of the -- of the experts who produced the Great Barrington Declaration, including Dr. Bhattacharya, as fringe -- fringe epidemiologists. Based on what you've read of Dr. Bhattacharya, I take it you would not agree with that assessment?
A So there are spheres of expertise that exist. So, while I'm not a medical doctor, I understand a bit about virology and I can speak to it. But at my core, my training and expertise is as an epidemiologist. Dr. Bhattacharya, in contrast, is a medical doctor by training and has additional epidemiologic training to support his expertise. So I would say fringe is a bit of an unfortunate term to use, however, I would say it's -- from people who -- who misunderstand some of the nuanced details of epidemiology and overexert their expertise and so many of the people on the Great Barrington Declaration are very,

very smart in their field of -- and their sphere of expertise, but they may have overstretched themselves just a bit. I will, however, concede that at the time we had been collecting new evidence every day and I can certainly understand the perspective from which they came. Do I think they're correct? No.

Q Right. So, really, what we're --
A Fringe is --

Q -- what you're --
A Fringe is a very rude term. I would not call someone fringe.

Q Okay. Thank you for -- for -- you know, for -- for clarifying that -- that answer. So what you're really -- what you're saying, I think, is that you disagree with much of what is in the Great Barrington Declaration, but it -- it sounds as though you respect that the authors of it are -- are trying to assert a certain position in what is let's say a very salient scientific debate --
A Correct.

Q -- is that a fair characterization? Okay. Thank you. So coming back to your affidavit, professor, at paragraph 7 it says that you have experience in infectious disease epidemiology --
A M-hm.

Q -- and mathematical modelling of infectious diseases and policy. That's correct?
A That is correct.

Q Okay. And so -- and that you were asked to support Alberta's emergency operations centre as the lead for analytics and modelling for the COVID-19 response.
A Correct.

Q Okay. So, as part of that, were you asked to give input about appropriate non-pharmaceutical interventions or what are commonly called lockdown measures? Was that part of the advice that you gave to Dr. Hinshaw and the -- the -- Alberta's emergency operations centre?
A To some extent. The -- the --

Q Okay.
A -- primary role that we served was to provided data and analytics and to work with the policy team under Dr. Hinshaw to assess the quantitative value of various non-pharmaceutical interventions, but I was not the policy lead for the non-pharmaceutical interventions component, simply the data.

Q Okay. So -- so in that context, are there any particular non-pharmaceutical interventions that you recommended to Dr. Hinshaw and your team?
A I don't provide recommendations to Dr. Hinshaw.

Q Okay. Okay. Who were you providing your -- your data and your modelling to then? What --
A So to -- to Dr. Hinshaw.

Q Yeah.
A If I may maybe describe it to help you understand. The policy team would be interested in a particular policy lever that they would like to implement, some particular non-pharmaceutical intervention. They would ask the modelling team to quantify what that would do in terms of cases, hospitalizations, et cetera, and then we would provide that information back. But we did not recommend a particular intervention over another. Dr. Hinshaw would assess the data and evidence and then make that determination with her team.

Q Okay. Thank you. That's -- that clarifies that point for me. I understand, though, from your -- from your affidavit that you had some involvement with development of contract tracing.
A Yes.

Q Or contract tracing model. Okay. So -- and this is -- my understanding from your affidavit is that it's your -- your evidence that this contract -- sorry, contact tracing that was implemented by the Government -- by the Government of Alberta was somewhat effective.
A Yes. And it was implemented by Alberta Health Services.

Q Okay. All right. Thank you for that clarification. For the sake of clarity, I'll just say Alberta.
A Okay.

Q How's that (INDISCERNIBLE)? So this is one of the points that Dr. Bhattacharya disagrees with Alberta about and I want to get your -- your take on this. He -- he states that Alberta relied on contact tracing programs as a means to try to control the spread of COVID-19 disease. Now, I expect you agree with that?
A Yes. At --

Q Okay.
A -- at various points, yes.

Q Right. He -- he says that contact tracing programs require people to have been identified as COVID-19 cases and divulge to public health officials all the people with whom they have been in contact with during their illness, as well as the location they may have visited.
A Yes.

Q Is that your understanding as well?
A Correct.

Q Okay. And that health officials basically asked people to install a phone application that aides in contact tracing by providing officials information about the locations where a person has frequented. Is that your understanding as well?
A No, that's incorrect.

Q Okay. Could you clarify that? How was that incorrect --
A So there --

Q -- in terms of the Alberta example?
A Yeah. So there was a contact tracing app that was developed and rolled out. It had limited uptake and so was not a primary part of contact tracing. The primary way that contact tracing works is, once you are either identified as a contact of a case or you have a positive lab result, if you develop symptoms as contact, you would be contacted and further, if you have a positive lab report, you would be contacted by public health.

Q Okay.
A So it -- the app was something that existed, but it -- there were very, very few instances where it was used.

Q Were you involved in the development or the use of the app?
A No.

Q Okay. So we'll stay away from that -- that part. Was it your experience, though, with contact tracing, though, that there was some resistance to it because there was a privacy concern on the part of -- of the public? Wasn't that sort of a weakness of the -- of the -- of contact tracing in terms of its rollout?
A So that's a great question and we get that all the time. So having led outbreaks even pre-pandemic, you would expect people would not want to divulge their information, but contact tracers, specifically skilled contact tracers, are able to build confidence with the case and work to extract a whole bunch of information and I would say that specifically in the first 12 months of COVID, people were very keen to be helpful and

share whatever information they could to try and stop the spread. However, I would agree with you that as time went on and people became more and more polarized, there became less and less of an interest in sharing that information and contact tracing lots its purpose -- lost its ability to deliver on what we were looking for. But I would wholeheartedly say at the beginning it was a fantastic way to stop the spread of COVID and have people share information that led us to understand the epidemiology of COVID in Alberta.

Q Yes. And -- and Dr. Bhattacharya points out -- he points to a government report in the UK that concluded there was no clear evidence that COVID -- or, sorry, that contact tracing had accomplished much despite the expenditure of about 37 billion pounds over a 2 year span. You're talking there about sort of after things became polarized. Is that what you mean?

A Yeah. So after things --

Q Okay.

A -- became polarized, contact tracing was less effective. (INDISCERNIBLE) we look at other jurisdictions and their experience. We have been doing contact tracing for infectious diseases such as measles and pertussis for years and we have highly skilled contact tracers who are able to work with people who have these diseases who might be from a marginalized unvaccinated or -- or specific population, so we have that experience in Alberta. I wouldn't be able to say that bringing the UK experience over would be a fair comparison.

Q Okay. You raise a good point, though, and one that I wanted to get to with you and that is Dr. Bhattacharya, his contention is that, while contact tracing is a useful public health technique for diseases where the location of the disease spread is readily identifiable and he uses the example of sexually transmitted disease, but there are others perhaps like the kind that you just described. But he said it's less efficacious for diseases like COVID-19 when a moment of disease transmission is much harder to identify. Would you agree with that?

A No, I would not.

Q Okay. Okay. Why not? Isn't it true --

A So --

Q -- that we don’t really know -- we don’t really know where and how and at what time COVID-19 entered Canada or entered the province, so we can't really trace COVID-19 back to the original person who -- who brought it into the -- into the province or the country, can we?

A The goal of contact tracing was not to trace it back to the index case of the world. The

goal of the -- of contact tracing was when a case is identified in Alberta to further prevent the spread and understand the source of it so that we could identify potential high risk settings or potential high risk activities or simply to identify outbreaks and contain them before they got too big.

Q Okay. But it is true also, though, that another problem with contact tracing is that a large fraction of COVID-19 cases involve no symptoms at all, so that's a -- that's one of the problems with contact tracing that's particular to COVID-19, that's true, isn't it?

A There is a large number of people who have minimal or asymptomatic infection. This is not that different than other respiratory diseases for which we have experience doing contact tracing.

Q Okay. So would you agree with me, though, that since asymptomatic disease spread is much less efficient than symptomatic disease spread, that it renders contact tracing methods less likely to succeed?

MR. PARKER: I'm going to object. This is argumentative. He has not established -- well, I'll object on argumentative and then I think you want to hear from me, is that the ...

THE COURT: Yes. Go ahead, Mr. Parker.

MR. PARKER: I don't think he's established the foundation for the question as to the transmissibility of the symptomatic individuals and that's the objection, it's argumentative.

THE COURT: Okay. Mr. Grey?

MR. GREY: Well, it is cross-examination. I am permitted to suggest an answer to the witness. She does not have to suggest that. Clearly, this is a very knowledgeable person in epidemiology. She obviously has already demonstrated a significant knowledge and clear understanding of contact tracing so I don't quite see how the -- how this is unfair to the witness. However, I'll take the Court's direction if you want the question rephrased.

THE COURT: No, that's fine. I will allow the question. I don't find it to be unduly argumentative. Okay. Thank you. Dr. Simmonds --

Q MR. GREY: Would you -- would you like me to repeat that? Sorry (INDISCERNIBLE)

A Please. Please repeat the question. Thank you.

Q All right. Okay. And, you know, I'm happy to do that anytime or if you find that my questions are -- are not clear, I invite you to tell me so so I can make them clear. So what I asked you about is that, since asymptomatic disease spread, which we were talking about earlier, is much less efficient than symptomatic disease spread, that this renders contact tracing efforts less likely to succeed.
A It is easier --

Q Would you --
A -- to do contact tracing when everyone is symptomatic and displays severe symptoms, that is true. Contact tracing is one of the tools and so no tool alone should be used to solve the epidemiologic puzzle that is COVID-19. It does render it more difficult, however, it doesn't make it impossible to do --

Q Right.
A -- contact tracing.

Q Right. And I wasn't suggesting that it was impossible, but you agree with me it makes it more difficult to do contact tracing --
A Sure.

Q Yeah. Okay. Thank you. So -- so, when we bring in then errors in PCR testing, this -- this can render, really, us unable -- or people like you unable to distinguish a COVID-19 patient who is highly infectious from a patient who is -- who has recovered from the disease but still has non-infectious viral fragments detectible and is no longer a threat to spread the disease, so this -- this -- in that scenario, that could almost contact tracing efforts less likely to succeed, do you agree with that?
A I would consider that a gross oversimplification of the --

Q Okay.
A -- situation, however, what you're talking about, the number of people that are infectious, the people who continue to carry virus who might be positive on PCR but who are no longer infectious, represent a small fraction of individuals. And when we're looking at 4.5 million people in the population, it's a rounding error at that point.

Q All right. Dr. Bhattacharya had referenced a study in response to some of the evidence that was given by the witnesses for Alberta. This is a comparison between California and Florida respecting the reduction of transmission and prevention of deaths from COVID-19. Are you familiar with this comparison?
A I am somewhat familiar with the comparison.

Q Okay. Well, I'd like to ask you a few questions about it and, as I said, if you're -- you can tell me if you're not comfortable answering, that's fine.
A Okay.

Q But Dr. Bhattacharya --

MR. PARKER: Sorry, I don't want to interrupt, but I just did want to note that Dr. Simmonds' evidence is she did not review Dr. Bhattacharya's surrebuttal report and so I just wanted to note that for the record here because that's where I think a significant amount of this evidence comes from. Thank you.

THE COURT: Okay.

MR. GREY: That -- that is true. That is true.

THE COURT: Thank you for that and it's noted on the record. Thank you, Mr. Parker. Go ahead, Mr. Grey.

MR. GREY: Thank you, Madam Justice. And I'll be -- I'll be very careful and fair to the witness in this regard. I take Mr. Parker's objection.

Q MR. GREY: So, Professor Simmonds, in a study that was referred to by Dr. Bhattacharya he refers to a case study contrasting COVID results in California which you probably know had implemented extended lockdowns, including mandatory stay at home orders, curfews, school, church and business closures, among other strategies, and Florida, which you probably know is demographically similar to California, according to Dr. Bhattacharya, but is -- did not implement harsh lockdowns since May of 2020. So that's the context of -- of what Dr. Bhattacharya was talking about in his case study. So he says that through March 28, 2021, 8.9 percent of all Californians had been identified as COVID cases, or 3.6 million cases. And he said that since most infections are not recognized as cases, a much larger fraction of the population had been infected with COVID, that through March 31st, nearly 58,000 people had died in California with -- with COVID. In sharp contrast to California, Florida had partially lifted its lockdown in May 2020 and then further relaxed restrictions in September 2020 and the -- the conclusion that Dr. Bhattacharya drew from this, and I'm going to ask you about this, that most Florida schools and universities were open for in-person instruction since the fall, nor most human activities, sports, churchgoing, visits to the park occurred with regularity and businesses were -- remained open. And despite these dramatically different policies, the infection control result in Florida looked remarkably similar to California, in some ways better. So in the context of what -- what you are saying in your affidavit about -- and, of course, the -- and the

policy that was instituted by Alberta, how do you -- how do you reconcile this with what Alberta did? In other words, the case study that was found by -- that -- that Dr. Bhattacharya referred to was that, really, all these restrictions that were in place in California didn't make any appreciable difference and yet in Alberta we've had -- we've had similar restrictions to California. How do you -- how do you respond to that -- to that criticism, given what you've said about the Great Barrington Declaration?

A I think it's unfortunate that the case study was selected with the US healthcare system underpinning it. The way that testing and healthcare access is in the United States is vastly different than in Canada. The way that their hospitalization rates are for other infectious disease is completely different. It's unfortunate that there was a selection of a US example. A better example would have been to look at, for example, Quebec or Ontario in -- in comparison to Alberta where I think he would have much more of an accurate grouping. So I personally would not characterize Alberta's measures as being, you know, similar to California or Florida. We would need to go line by line on that, and I haven't been able to do that.

Q All right.

A But I do think it's unfortunate to pick a US example. They are just such a different healthcare system to ours.

Q Okay. Fair enough.

A And contact tracing and cases and testing, I mean, it's just -- it's unfortunate.

Q All right. Dr. -- but in terms of just the context of non-pharmaceutical interventions --

A M-hm.

Q -- Dr. Bhattacharya describes these as -- as a form of trickle down epidemiology in the sense that -- and his evidence in the hearing was that COVID-19 affects the poor the most --

A M-hm.

Q -- but he also said that lockdowns, non-pharmaceutical interventions also have a severely impact -- or the severest impact on the poor so that -- he says that these -- these lockdown restrictions that -- that Alberta imposed, too, that these have a trickle down effect because they hurt the economy, they hurt the people who are the poorest the most. Would you -- would you agree with that?

A Somewhat. The -- what we found in Alberta was that individuals who, when people were asked to work from home, individuals who worked in lower-paying service industry jobs or frontline workers in low paying positions still had to go out and work under conditions of a novel virus spreading, which put them at greater risk of becoming ill, so that would be our Alberta experience during -- for certain measures, that's what

the data would show.

Q All right. But on the -- on the subject of focussed protection which we had referenced earlier when I was asking about the Great Barrington Declaration, isn't it true that the proportion of COVID-19 deaths in nursing homes dropped sharply during the second wave of COVID-19 infections as facilities adopted better policies to protect elderly residents and, of course, then that was improved even more when we had the focus on vaccinations for the elderly, so -- so those are examples of focussed protection that seemed to really work as opposed to these broad public restrictions that really restricted almost everyone in the province?

A Focussed measures for the most vulnerable, those in long-term care as an example, vaccines were proven to be the most effective intervention to be able to prevent the spread, that's true.

Q Okay. Dr. Bhattacharya's evidence was that COVID-19 impacts persons over the age of 60 with multiple comorbidities particularly and -- and he -- and this is why his view is that no lockdown is necessary for reducing hospitalization and deaths from COVID as long as the older population is prioritized for vaccination. Would you agree with that? Especially in the context of, really, the very high success that Alberta had with rolling out the vaccine, would you agree with Dr. Bhattacharya in that respect?

A No.

Q Okay. Why not?

A So risk is a relative measurement and, while I do agree that those over 60 are definitely at the highest risk of mortality from COVID, that is true. When we initially were introduced to a novel virus, COVID-19, it was considered to be a respiratory disease. As evidence has evolved, we have seen additional information that it's really an inflammatory disease and so we are seeing, especially with the new variants of concern, there have been increasing hospitalization rates amongst younger people and then, in addition, other unintended consequences that weren't foreseen when we first experienced COVID back in the spring of 2020. So, while I would assert that with the original wild type, Dr. Bhattacharya might be right, but I would assert further that, as we learned more and more, we have learned that this disease is not what we thought it was and it does impact younger people differently. And so over time we've seen increasing rates of hospitalization and ICU admissions among those who are in their -- their 30s, 40s and 50s and even deaths amongst all age groups.

Q Right. But the -- the statistics for deaths in Alberta for people under age 30, for example, are still vanishingly low. I'm speaking just --

A Absolutely.

Q -- particularly with deaths.
A Yes.

Q Okay.
A Yes.

Q But I understand what you're saying. You're saying that that doesn't exclude the -- the incidence of younger people, let's say people under the age of 50, to use your -- what you said, that they could have, let's say, severe health outcomes or I think what you were describing earlier was long COVID. Is that what you were saying --
A It could be --

Q -- is that what you're describing?
A -- long COVID or just non-traditional presentation.

Q Okay. And that's -- that's really, though, a function of COVID-19 being a new virus that we're really just learning about since let's say the end of -- the end of 2019; correct?
A Correct.

Q Okay. Professor -- one moment. I just want to find ... Professor, can I please refer you to paragraph number 17 of your affidavit.
A Yes. Modelling.

Q Right. And -- and in that paragraph there's a sentence that I think is the second to last one on page number 5. It beings with the word "history".
A M-hm.

Q Okay.
A Yeah.

Q So it says: (as read)

> History has shown that infectious diseases are cyclical and unable to achieve consistent endemic equilibrium.

And I think what you're saying there is that, there, you're coming back to what you described as the -- as the failure or the incorrectness of the approach that was in the Great Barrington Declaration; am I correct?
A Yes.

Q Okay. And then you go on to say in the next sentence: (as read)

> Historical data from Alberta shows a cyclical pattern of outbreaks from measles, rubella, polio and smallpox prior to widespread vaccine availability and then subsequent herd immunity.

So the way I read that sentence is you're saying that, in relation to, for example, smallpox, if herd immunity was achieved, historically that was through herd immunity. Is that your understanding?

A Maybe I'm not understanding the question.

Q Okay. Okay. What I'm asking you is that are you saying in that sentence that -- that the way that endemic equilibrium was achieved in relation to outbreaks from measles, rubella, polio and smallpox was as a result of widespread vaccine availability?

A Widespread vaccine uptake. So --

Q Okay.

A -- for smallpox, 97 percent of the population had to be immunized.

Q Okay.

A And --

Q So -- sorry, go ahead. Sorry to interrupt you.

A Oh, I was just going to say at the time of this affidavit in the summer of 2021, we weren't sure about long-term immunity from COVID and now we have additional information that -- that indicates that, unlike measles where you have lifetime immunity, people can become reinfected with COVID and so, even more so, there would need to be measures in addition to vaccines and other things that would be able to bring us to a herd immunity state.

Q Okay. So -- so let's take, for example, smallpox. I did a little bit of research on this and I want to challenge you on this point about vaccines, uptake being -- being the answer. I understand that in the 1880s there was a worldwide smallpox epidemic. Is that your understanding? Do you know about this?

A To be fair, I only know back to 1905 when Alberta was created --

Q Okay.

A -- and I went through the records. So if we can start at 1905 --

Q Okay.

A -- that'll be better for me.

Q Well, unfortunately, I -- I would have to go back further, so maybe I'll just leave off that -- that point and I won't ask you to -- to comment on it, but maybe what I'll do is I'll -- I'll put it to you this way. I -- I did some research on what happened in -- in England and, if you're comfortable to -- to comment on this, that's fine, but I -- I want to put this to you. My research shows that -- that back in 1885, there -- there was a worldwide smallpox epidemic and I found some very interesting coincidences between what's -- the way that the world was dealing with smallpox at that time and the way the world was now dealing with COVID.

For example, at that time, it was thought that universal vaccination was the answer and there actually were vaccine mandates and, in fact, in 1885, in the city of Leicester, there were huge public protests about this and, in fact, what happened was the way that -- that smallpox was -- was managed and ultimately, let's say not defeated but brought under control, let's say they'd reached endemic equilibrium, was not through universal vaccination, but through focused protection, and this was despite the advice that was coming from, with greatest of respect, people like yourself, the experts.

And the process that people were -- went into is that, when there was an outbreak, and you talk a lot about outbreaks in your affidavit, that they'd go in and clean, let's say there was an outbreak in a school or a home, they would go in and sanitize, deal with the individuals who were infected in this sort of focused protection way, and that, ultimately, this turned out to be much more effective than -- than universal vaccination or lockdown measures for dealing with the -- with the outbreak of smallpox, and that -- that process that happened in the city of Leicester in England actually was adopted throughout the world, that's what my research indicates.

Now, you said you haven't researched this, but are -- are you shocked to hear that or is -- is that a surprise to you, given that you're a professor of epidemiology?

MR. PARKER: I'm going to object to the questions, Justice Romaine. I appreciate Mr. Grey has to do some set up for these questions, I had to do the same with Dr. Bhattacharya, it's the nature of what we're dealing with, but just -- excuse me, Dr. Simmonds, Professor Simmonds, has indicated that she has not looked at the 1880 smallpox pandemic that Dr. -- sorry, that my friend is referring to and so I think that this is an area that I'm going to object to on that basis.

THE COURT: Okay. Thank you, Mr. Parker.

MR. RATH: My Lady --

THE COURT: Wait a minute. Thank you, Mr. Parker.

Mr. Grey?

MR. GREY: Oh, I -- I don't want to ask this witness to speculate on something that's outside of her knowledge, but I -- I did -- I thought that was interesting and I wanted to get her comments on it but I -- I take the objection. And, as I said, I don't want to put the witness in a situation where it's unfair to ask her -- ask her the question, so I'll -- I'll withdraw that -- that question --

THE COURT: Okay.

MR. GREY: -- if the witness is -- is uncomfortable answering it.

THE COURT: Okay. Thank you.

MR. GREY: Okay.

Q MR. GREY: Just give me a moment, professor. I just have a few more questions.
A M-hm.

Q If I could please refer you to paragraph 23 of your affidavit? This is on page 7.
A Yes.

Q So here you're referring to what was occurring in Alberta in November of 2020 --
A Yeah.

Q -- and you were saying that, "as expected", when you say "as expected" there, was that based upon modelling that you had done?
A No, that --

Q Okay.
A -- that's based on cases lead to hospitalization. So when we see a rise in cases, you will see a concurrent rise in hospitalizations.

Q All right. You say that -- there that: (as read)

> Hospitalizations began to rise rapidly as case growth leads to hospitalization growth but as a lagging indicator as it takes time to get sick enough to require hospitalization.

And then you say in this -- this next sentence, you say: (as read)

> A key characteristic of COVID growth is that it can turn from manageable to exponential in a matter of days to weeks.

So that -- that's a very grand statement and I -- I couldn't find any data to support that -- that statement. What -- what data are you relying upon to say that there was an exponential outbreak of COVID-19 in Alberta?

A Exponential growth. So I said that it can turn from manageable to exponential growth, and case growth did become exponential and then, obviously, it couldn't -- it didn't continue down that trajectory because measures were put in place or some other host, agent, environment interaction.

So if you will look at Exhibit, I think 'F', you can see in the fall -- in the fall, this is what the projected numbers were and I should have given you the actual numbers, but you can look them up on line as well, what you can start to see is there is a significant growth after Thanksgiving weekend and Halloween and we think that it was the -- the confluence of those two events in a -- in a short couple of weeks that led to a huge number of exposures and then the subsequent number of cases.

And so, yeah, you have to, sorry, look it up on line, but you can actually see where we go from a slow growth rate and then it just starts to go up at a -- a more significant rate and then you can further see that, obviously, as voluntary measures are put in place or any kind of change to host, agent, environment have made -- made a change in a trajectory of the cases.

Q And isn't it true that during that particular timeframe that the -- the number of -- that the percentage of Albertans who were negative for COVID was somewhere between 85 and 95 percent?

A Yes.

Q Okay. So -- so that means that -- that only about 15 percent, between 10 and 15 percent of the population, was infected with COVID-19 based upon testing?

A So "only" I think might be a misnomer. If -- if I told you that 15 percent of the population had cancer, people would be gob smacked. I think it's a measurement of risk, right. At no other time in the history of Alberta have I know of 15 percent of the population to be infected with a disease. Further -- and I think that was laid out in one of the exhibits that we had about modelling, Exhibit E, where we talk about the -- the case identification -- the cases that are identified to the true infection ratio and how big that is. So you're correct, but I would -- I would surmise that 15 percent of the

population infected with anything would be, obviously, maybe because of my background, terrifying.

Q Okay. But you're -- you're not -- you're not seriously equating COVID-19 with cancer?
A So this I think probably is not going to take us down a long path, but there are obviously cancers that are very benign and get it cut out and cancers that are very serious and kill. And so, like all diseases, there is a scale from not such a big deal to, Oh, my God, you're going to die. And so within that sort of frame, 15 percent of the population infected when we know that some percentage of them are going to die, some percentage of them are going to be forever impacted because of their visit to the ICU or other inflammatory things that happen because of COVID, I would consider, and a reasonable person I think, would consider that to be a significant risk.

Q Well, you say "some percentage". In November of 2020, that percentage was known and that percentage, from my understanding, is less than .03 -- roughly, .03 percent of the population was --
A We use about .05 --

Q Okay.
A -- so if we have 4.5 million people in the province and we're going to eliminate .5 percent of them plus then consider in the number who have severe illness, that would be equivalent to essentially wiping out a town the size of Red Deer in terms of morbidity and mortality. I -- I --

Q (INDISCERNIBLE).
A -- personally consider that a significant risk.

Q Well, okay. But you were comparing COVID-19 to cancer. My understanding is I'm -- I'm not aware, and you're the epidemiologist historian, I can't remember Alberta being locked down because of cancer, that's never happened.
A Have we ever had 15 percent of the population at one time infected with something?

Q Well --
A I mean, it's not my decision to make, I'm -- I'm sure --

Q Okay. Okay.
A -- that Mr. Parker probably wants to object at this point, but -- but the reality is -- is that I can't speak to policies about lockdown, I can only speak to data and evidence --

Q Right.
A -- and if -- and if 15 percent of people are at risk of something, that would be considered

maybe something to take caution and pause for.

Q Right. But when we're talking about 15 percent, we're talking about infection.
A Yeah.

Q That's the infection rate; right?
A Yes. Yes.

Q Not -- not cases, not people sick with COVID.
A Okay.

Q And we also know --
A Maybe I'm unclear.

Q Okay. Well, when I say --
A Did --

Q Okay. Go ahead.
A Fifteen percent of people who are infected.

Q Right.
A Okay.

Q So -- so when we're saying that -- to -- to use your numbers, let's say 4.4 million people in the province of Alberta; correct?
A M-hm.

Q That's a yes?
A Yes, correct, sorry.

Q Okay. It's okay. And -- and what I'm saying to you is, at any given time, let's say 15 percent of them are infected with COVID-19, right.
A Okay.

Q But not all those -- not all those people are sick, they're not cases, right.
A How are you defining cases versus infected?

Q Someone who's -- someone who's sick with -- with COVID. That's my understanding of how we've been distinguishing between infection and cases.
A And --

Q A -- a case would be someone who's symptomatic with COVID-19.
A Oh, okay. As per your definition, okay, yes.

Q It's not -- yeah, I don't think it's mine, I think -- that's my understanding of how the experts have come before you in this hearing have -- have identified that, but if I'm mistaken, I'm sure Mr. Parker's going to --

THE COURT: Mr. Parker? I'm sorry, Mr. Parker, were you -- I can't really see if you have your hand raised or if you were objecting.

MR. PARKER: No, I'm sorry.

THE COURT: Okay.

MR. PARKER: I'm just on guard, but --

THE COURT: No.

MR. PARKER: -- yeah, no, I haven't. Sorry.

THE COURT: Okay. Thank you.

MR. GREY: Okay.

THE COURT: Go ahead, Mr. Grey.

Q MR. GREY: I'm not -- sincerely, I'm not trying to trick the witness, I'm just trying to clarify this.
A No, no, I agree.

Q So let's go back --
A Yes, cases are those --

Q -- let's go back --
A -- we identify and infections are those that may have disease that we may or may not have identified through lab testing and whatever other mechanism.

Q Right. And -- and they -- they could also be -- infections could also include cases of -- of persons who have been tested and that tested positive for the PCR test but, because the PCR test is -- is fallible, they actually are not positive for COVID and so we include -- within that number, within that 15 percent, there's a certain percentage, we don't know

how many, Dr. Boehlert (phonetic) says it's as high as 56 percent --
A We're now out of my --

Q -- so we don't know how many.
A -- area of expertise.

Q Okay. Fair enough. Fair enough.
A I am not a virologist.

Q Okay. Fair enough. That's fair enough.
A I -- I know enough, but not enough to -- to speak to this in a courtroom.

Q Okay.

MR. PARKER: And I was going to object on argumentative and terms of --

MR. GREY: Yes. Thank you.

Q MR. GREY: Okay. So my point is we can agree, though, you do agree, and we're talking about that 15 percent would be infections but not necessarily people who are sick with COVID; right?
A Correct.

Q And -- and of that percentage, I think you said .05 percent are at risk of dying?
A Correct.

Q But that risk, that risk that we're talking about, to you, that would justify non-pharmaceutical inventions that -- or interventions that would apply across the board to restrict basically every Albertan --
A Outside of my --

MR. PARKER: I'm going to object.

A -- area of expertise again.

Q MR. GREY: Okay.
A I -- I don't make policy like that.

Q All right.

MR. PARKER: And I -- sorry, I was going to object on that basis. Thank you.

MR. RATH: My Lady, this is Mr. Rath. Can we clarify for the record, I didn't believe that this witness had been tendered as an expert. She keeps referring to her area of expertise, but I -- I thought she was here as a lay witness.

THE COURT: Well, yes, but she's here as someone who has a PhD in epidemiology. Dr. Simmonds is just referring to her scope of knowledge.

So go ahead, Mr. Grey.

A Should I use a --

MR. GREY: All right.

A -- different term? I -- I could use a different term, like my area of -- scope of knowledge. Is there a better term to use for the Court?

THE COURT: No, no, no, no. Dr. Simmonds, don't worry.

MR. RATH: I'm fine, I just wanted to clarify that. Thank you, My Lady.

THE COURT: Yes. Yes. Okay.

MR. GREY: Okay. All right.

THE COURT: Mr. Grey?

MR. GREY: All right. Thank you, Madam Justice.

Q MR. GREY: So just to -- to clarify, you would regard the -- the risk of an infection from COVID-19 to be as serious to public health as cancer being -- as -- as a disease? You regard COVID-19 as the equivalent disease to cancer?
A No.

Q Okay. I just want to clarify that. So, professor, could I please refer you to paragraph 29, it's the last paragraph in your affidavit, it's on page 9?
A M-hm. Yes.

Q Okay. So at 29(c) --
A Yeah.

Q -- this is a paragraph that kind of -- that summarizes your -- your evidence and -- and it says, "In summary, in responding to the COVID-19 pandemic", and then at sub (c) it says: (as read)

> Every time COVID-19 transmits from one person to another and the virus replicates, there is an increasing likelihood of a new variant.

Correct?
A Correct.

Q Okay. And -- and you say, based on your evidence, that that is consistent with the data that you analyzed during your time, during your involvement, in your study of COVID-19 in Alberta?
A Correct.

Q Okay. And then you say, "Therefore, public health measures attempt to stop or slow transmission". And so this gets back to my earlier point that Mr. Parker objected to, so when you say public measures attempt to stop or slow the transmission, what are you referring to? What are public health measures?
A Great question. When we talk about disease transmission, we talk about the host, so humans in this case, the agent, COVID virus, and the environment. So public health measures attempt to control things related to the environment, right, and there's a several suite of those that have been attempted to try and control that. So what would public health measures be? That might be things like wearing a mask, not having contact with a lot of people, exposing yourself outdoors, things that change the environment in which the -- the virus can transmit. In terms of which public health measures do a better job, that, again, is outside of my scope of influence, but there are obviously several measures that we were asked to look at and try and quantify the difference when Dr. Hinshaw and elected officials were making their decisions.

Q All right. So when you're talking about public health measures, you are talking about some type of non-pharmaceutical interventions?
A Correct.

Q Okay.
A In this context --

Q All right. And --
A -- because vaccines would also be added, but we didn't have widespread vaccination by wave 3.

Q Okay. And so -- and so it is your evidence that -- that you -- you think that these public health measures are effective to stop and slow transmission?
A Various public health measures have various levels of efficacy in different populations to prevent the spread of any infectious respiratory disease, including COVID.

Q Okay. Okay. Well, let's take -- let's take personal hygiene, right, washing of hands, right, (INDISCERNIBLE), right. I'm -- I'm not aware of any outbreak among -- with the homeless people, street people, who do not have access to changes of clothing, let alone a wash basin or a shower or things of that nature. Has there been an outbreak in homeless people with COVID-19 that you're aware of?
A I am not aware of any of the shelters having widespread outbreaks due to the -- the strong control measures put into place.

Q Okay. But -- but what I'm talking about in terms of personal hygiene, that -- that would -- that would confront or fly in the face of the -- the belief, or the assertion, that personal hygiene, washing of hands, wearing a mask, doing those things, that -- that that somehow prevents transmission of COVID-19.
A So when COVID was initially identified, we thought it was primarily spread through big droplets, so when you sneeze and spray that, which then get on your hands and then you touch your mucus membranes and become infected. As evidence developed and more information became available, and especially with the variants, they are much more likely to be transmitted through very small droplets that hang in the air for longer, some would even say airborne, this is a discussion in the literature. Handwashing, although very important and a great public health measure, will not prevent transmission of very small droplets or airborne transmission. So --

Q What about -- okay.
A Yeah. So -- so handwashing wouldn't really be effective because you're using the wrong public health tool for the problem at hand.

Q What about -- what about social distancing, staying 2 or 3 metres apart? Isn't it so that -- that this virus can be transmitted in droplets that could travel up to 30 metres?
A So, again, it goes to that host, agent, environment that we talked about, so it would depend on the environment that you're in, so outdoors versus indoors, proper ventilation, all of those kinds of things. I -- I don't think I could specifically say, and it's not my area of expertise in terms of -- or scope of influence or practice to know how far it spreads in -- in specific settings.

Q Okay. Are you -- are you comfortable with stating, however, that the risk of -- of outdoor spread of COVID-19 is much, much lower --
A Yes.

Q -- than --
A Yes.

Q -- indoor?
A Yes.

Q Okay.
A The Alberta data was unequivocal on that. That was a point that we -- that I think no one contests.

Q Okay. But notwithstanding that, you're aware that Alberta placed restrictions on outdoor gatherings?
A Yes, I believe so. Again, I did not follow every single policy decision that was made mostly because I was working 24 hours a day on the data.

Q Okay. Fair.
A So --

Q Okay. I hope you got some sleep during that timeframe.
A Not really.

Q Okay. All right. You also state at paragraph (c), at 29(c), that wave 2 allowed for uncontrolled spread.
A Yeah.

Q So, first of all, what I'd like to -- we've -- we've heard a lot about -- about wave 2 and about when different waves started and ended, so when you're talking about wave 2, can you be more specific about what timeframe you're talking about there?
A So, really, when we saw the biggest spread, and that goes back to your previous question about the exponential growth, was at the end of October and beginning of November within -- there's sort of about a month there when measures I believe were voluntary, I'll have to refer to -- yeah, so in paragraph 19, some of the voluntary measures were put in and those proved to be ineffective, that was in September, and then, really, things started to go crazy, as noted in paragraph 21 and 22, in that October time period.

Q Okay. So what you've done there is you formed a connection, I think, perhaps you're

doing this in an epidemiological way, that's what I want to clarify, you formed a connection between removal of some of the mandatory public health measures and what you've described as an uncontrolled spread which caused wave 3; is that right?

A I -- I don't know if we removed any precautions. As I'm aware, precautions were lifted May 14th and then again on June 12th of 2020 and then I don't believe any measures were implemented before the voluntary -- voluntary measures were introduced in end of September.

Q Okay. So -- so -- but what I'm getting at here is it sounds as though you're saying that wave 2 allowed for uncontrolled spread because there was a relaxation of public health measures, mandatory public health measures; is that what you're saying?

A I'm -- I'm saying that I don't know that there were public health measures to relax --

Q Okay.

A -- during that time period.

Q All right.

A So -- so maybe if I rephrase it to make you happier, limited public health measures which then led to the ability to have uncontrolled spread in -- in October.

Q Okay. So to -- to put a finer point on this, you see a connection between what you describe as uncontrolled spread, or -- and -- and you see that as being caused by an -- an absence of public health -- mandatory public health measures; is that correct?

A Sure.

Q Okay.

A Yes.

Q I submit to you that -- that is a -- that's a -- a subjective --

A Yes.

Q -- correlation --

A Yes.

Q -- as opposed to what Dr. Kindrachuk had described for us previously as -- as something that is provable to a scientific certainty on the basis of causation.

A Absolutely.

Q Okay.

A And -- and I'm very familiar with the epidemiologic causation criteria --

Q Okay.
A -- and -- and I completely understand. In a perfect world, you would do a randomized control trial or a whole bunch of other study designs. Unfortunately, during the pandemic, we don't have the opportunity to randomize people to exposed and unexposed in a controlled environment. That would be unethical and wouldn't be safe.

Q Right. So -- so it -- it is conceivable, I'm not saying probable, but it is conceivable that -- that none of the public health measures that you're describing had any impact on reduction of the spread of COVID-19 or reduction of deaths.
A So when we look at the causation criteria, there's a whole list of those and so one of them -- so you're right, correlation versus causation, when we look at causation, some of the things we talk about are things like biological plausibility, so is it biologically plausible what we're talking about? Or time dependency, right. So did the event precede the outcome?

So, in this particular case, and those are just two examples, in this particular case, when we put measures into place, we saw a decrease in cases, so there's that timeliness, right. In addition, there's biological plausibility in that we know disease is spread person -- this disease is spread person to person and, when you eliminate the number of interactions with people, then it's biologically plausible.

So while we can never say anything with a hundred percent certainty, I would feel quite confident that there is an impact from public health measures to reducing disease transmission based on the classically described causation criteria for epidemiology.

Q Okay. Well, let's follow that through just a bit further. So, at various times, and -- and I noticed in your affidavit it says that you helped to prepare certain data --
A Yeah.

Q -- for Dr. Hinshaw that she would then disclose to the public, right?
A Correct.

Q So -- so I take you saw many of those, let's call them press conferences --
A Yes.

Q -- where Dr. Hinshaw would go on television and would give a public update about the status of COVID-19 in Alberta, you saw those?
A Correct.

Q Okay. So at -- at various times, Dr. Hinshaw would go on and she would say, Well, cases are down, infections are down, hospitalizations are down, and deaths are down

and, therefore, this is an indication that everybody's doing a good job, everybody's following the science, they're following the public health measures; right? Good so far? Do -- do you recall that happening?

A I -- I do recall this happening.

Q Okay. Okay. And then, at other times, Dr. Hinshaw would go on --

MR. PARKER: Sorry, I'm going to object --

MR. GREY: I'm sorry?

MR. PARKER: -- and if my friend could be more specific in when and what Dr. Hinshaw is saying, I think that that would be fair to the witness.

THE COURT: Okay. Mr. Grey?

MR. GREY: I -- I could do that, but we'd have to take a break and I'd -- I'd have to come back and -- and, you know --

THE COURT: Okay. I think --

MR. GREY: -- I'd -- I'd have to get the other materials, but.

THE COURT: Yes. I think it's time for our morning break, anyway, so we'll take 15 minutes --

MR. GREY: Okay.

THE COURT: -- to 11:30. Okay. Thank you.

MR. GREY: Thank you.

(ADJOURNMENT)

THE COURT: Okay. Thank you.

Mr. Grey, were you going to rephrase your question? Is that the stage that we're at?

MR. GREY: Is Professor Simmonds there? I don't see her.

THE COURT: Well, do we have Dr. Simmonds back yet?

THE COURT CLERK: She is online. I think she was supposed to unmute her microphone and turn on her video.

A Hi. Can you see me and hear me? I was trying to click the button. I clearly am not the technological expert.

THE COURT: It's okay.

Q MR. GREY: I can -- I can hear you now, professor.

THE COURT: Okay. And I can see you. Yes. Okay.

Okay. Mr. Grey, you were going to rephrase your question. Go ahead.

MR. GREY: Actually, Madam Justice, I made good use of the -- of the break and I went back through my notes and what I've decided to is, rather than put statements of Dr. Hinshaw to this witness, I'm going to save this for when we have Dr. Hinshaw before the Court. I think it might be unfair to Professor Simmonds and so I'm simply going to conclude my cross-examination and thank Professor Simmonds for her testimony today.

THE COURT: Okay. Thank you, Mr. Grey.

Mr. Rath, do you have cross-examination?

MR. RATH: I do, My Lady. Thank you.

THE COURT: Okay.

The Witness Cross-examined by Mr. Rath

Q Good morning, Professor Simmonds. How are you?
A (INDISCERNIBLE).

Q All right. And I was just curious, with regard to your previous law day experience, do you recall, was Goldilocks convicted or acquitted of breaking and entering?
A I think she was convicted that year.

Q Good to know. All right. So with regard to your CV, Dr. Simmonds, you would acknowledge that your PhD dealt with staphylococcus resistance and wasn't focused on

SARS or any respiratory type illness?
A Correct.

Q Okay. And you'd agree that with regard to all of your published papers, very few of them dealt with respiratory infections; is that fair?
A Incorrect.

Q Well, several dealt with -- well, some of them dealt with pertussis, some of them dealt with the flu --
A Yeah.

Q -- none of them dealt with COVID; is that fair?
A Correct.

Q And with regard to the affidavit that you provided, you acknowledge that that was not prepared or tendered as an expert affidavit or expert report?
A Correct.

Q Thank you. And in your paper, and it's one of the points that I'd like to clarify with regard to your evidence, and I'll refer you specifically to paragraph 28.
A Okay.

Q Do you have it in front of you?
A Yes.

Q And it begins: (as read)

> As with previous waves, targeted measures were implemented at first. On April 29th, it was announced that schools would close in areas with more than 350 active cases.

Is -- do you see that?
A Yes.

Q Okay. And by "active cases", do you agree that those are simply people that tested positive by PCR tests?
A Correct.

Q Okay. And you acknowledged, I believe in response to questions from my friend, Mr. Grey, that you're now aware of studies that have shown that the PCR tests are incapable of distinguishing between people that have active infectious COVID and people that

have recovered from COVID?
A Correct.

Q Okay. And in that regard, are you now aware that the indications are that as much as -- there's -- there's evidence from Manitoba that said as much as 56 percent of people that test positive for COVID were COVID recovered as opposed to active COVID, but is it fair to say that you accept that as many as 50 percent of the people who test positive for COVID on a PCR test may, in fact, not have COVID, active COVID, infectious COVID?
A I couldn't speak to the -- the rate of -- of recovered patients who still have viral particulate matter.

Q Right. But with regard to your modelling, do you agree that it would have been relevant to know what percentage of people testing positive on a PCR test were either infective and infectious or had simply recovered and you were looking at -- you know, looking at numbers potentially as much as 50 percent lower with regard to COVID cases in the context of your modelling?
A So in order to be recovered, one has to have previously been infectious by definition of recovered. So when we consider for the modelling whether or not they are now recovered or were previously infectious is -- is irrelevant and so that's why I submitted the exhibit that outlines the different methods for looking at the -- the case detection ratio so that we do account for obviously all kinds of factors that change whether or not cases are identified, including criteria. So when you had to be symptomatic in order to obtain a case, like in order to obtain a test, that was considered as well as when asymptomatic testing was available. So whether or not it's 50 percent inaccurate, which I -- I cannot speak to, we do account for that when we look at our transmission and when we fit the model.

Q Right. But with regard to your models, were any of your models determined to be accurate plus or minus 50 percent?
A They were always accurate within 50 percent for what they were being asked to do, and there's a variety of models, so --

Q Right. But --
A -- we (INDISCERNIBLE).

Q -- you'd -- you'd agree that an accuracy of a model plus or minus 50 percent means that it's a fairly inaccurate model, would you not?
A I would.

Q Okay. Thank you. And with regard to the evidence that you provided, you'd agree with

me, wouldn't you, that given your role in analyzing data on behalf of the government that -- that all of your evidence largely pertains to, you know, let's call it a 30,000 foot view of the pandemic as opposed to what was actually going on directly on the ground in individual cases?

A No, I would say that's incorrect.

Q Okay. On what basis would you say that's incorrect?

A So I had the opportunity to review every single death that was reported to assess comorbidities for reporting, so I looked at each one of those cases individually. I was involved in outbreaks, specific outbreaks, where they required my additional experience and scope of practice. And so, while I wasn't involved in every case management, obviously, I was certainly involved with certain aspects at very detailed levels for specific -- for example, counties, outbreak locations, and events, depending on the requirement for my expertise.

Q Right. But as -- as an example, you never actually attended at Ms. Ingram's gym, as an example?

A No, I don't live in Calgary, so that would be very difficult.

Q Right. But -- but the answer is, regardless of where you live, you never attended at Ms. Ingram's gym; correct?

A I did not.

Q Good. Thank you for that. Now -- and with regard to that, did you ever make any determination that any cases had arisen as a result of contact tracing that were traceable to Ms. Ingram's gym?

A I'm not aware of any cases.

Q Right. And with regard to the -- you'd attached as an exhibit to your affidavit a -- a diagram indicating that there were two facilities -- two -- two fitness facilities that were involved in super spreader events. Do you recall that?

A Correct.

Q Right. And did you personally inspect either one of those facilities?

A Oh, I'm not a public health inspector, so, no, I did not.

Q Right. And with regard to either one of those facilities, are you aware as to whether either one of those facilities were closed down as a result of the determination that they were involved in super spreader events under section 30 of the *Public Health Act*?

A Was I aware that they were closed down?

Q Do you know one way or another whether -- whether section 30 of the *Public Health Act* was invoked with regard to those facilities?
A I am not.

Q And are you aware as to whether or not section 30 of the *Public Health Act* was ever invoked with regard to Ms. Ingram's facility?
A I am not.

MR. PARKER: This is a question I think that's a legal question and I'm going to object on that basis. I appreciate she answered it.

THE COURT: Mr. Rath?

MR. RATH: Well, it's certainly relevant to the scope of the evidence that this witness is providing. I'm simply asking her what her knowledge is with regard to the public health care management of these facilities. Her affidavit speaks generally to public health measures that were imposed across society, so I'm simply asking her whether she has any specific knowledge with regard to Ms. Ingram's facility, which, apparently, she doesn't, that's the only answer I required.

THE COURT: That's fine. I have to agree with Mr. Parker that asking the witness whether there were closures pursuant to a statutory provision is not appropriate but, as you say, you have now established that Dr. Simmonds did not attend Ms. Ingram's gym.

MR. RATH: Thank you.

Q MR. RATH: Now, in paragraph 20, you state that: (as read)

> Data from Alberta and worldwide showed household transmission of COVID-19 was higher than in other settings.

Do you recall providing that evidence?
A Correct.

Q Okay. Where is that data? Is it attached to your affidavit?
A I think I attached the households with variants of concern. If not, that information is available. Let's double check. Yeah, so if you look at Exhibit H, we did specifically look at the variants of concern and increasing transmission within the household, but it does apply also to the wild type households are a high risk setting.

Q Right. So that's -- in paragraph 20, that's a fairly general comment. You would say that, then, that the data from Alberta in regard to later variants of concern showed household transmission; is that fair?
A Correct.

Q Okay. And with regard to that data, on what basis was it thought to be sound public health policy to have people who were infected with active cases of COVID-19 isolate in their homes where they could infect other people?

MR. PARKER: Objection. I think that's beyond this witness's scope of expertise --

MR. RATH: All right.

MR. PARKER: -- scope of knowledge based on the affidavit.

THE COURT: Yes. Yes. Mr. Rath?

MR. RATH: That's -- I'll -- I'll take my friend's objection, My Lady.

THE COURT: Okay.

MR. RATH: If the witness can't answer this question, she can't answer this question. That's fine.

THE COURT: Okay. It is not that she can't answer the question, it's that the question is not a proper question to put to this witness.

MR. RATH: Thank you, My Lady.

Q MR. RATH: Now, in paragraph 23 of your affidavit, you state that: (as read)

> Key -- a key characteristic of COVID growth is that it can turn from manageable to exponential in a matter of days to weeks.

Do you recall that?
A Correct.

Q How do you define manageable?

A Where we are able to have contact tracing in place and other measures to make sure that that individual can understand their risk and also there's the ability to have sufficient hospital capacity broadly, which is not in my scope, but basically that the system is able to manage those cases, but primarily contact tracing and being able to call those -- those individuals and get some information and make sure that they are aware of their status to prevent further spread.

Q Right. So that's -- when you talk about manageable, the -- the only management tool you're speaking of there is contact tracing; is that correct?
A And, broadly, system's ability to manage the hospitalizations and ensuing medical requirements.

Q Right. So would you -- have you reviewed Deborah Gordon's affidavit in these proceedings?
A I have not.

Q Okay. But are you generally aware in the context of the work that you are doing that, in June of 2020, a decision was made to reduce surge capacity in the hospitals from 2,250 beds to 500 beds?
A I am not.

Q Or I'm -- I'm sorry, I misspoke, I'm referring to a document dated June 3rd, it says, "COVID-19 surge capacity has been at a thousand beds since May 2020 for better recovery time". And then it was reduced to 500 from a thousand. Do you consider the reduction of hospital bed capacity for COVID beds to be good management of -- of our hospital system during the pandemic?

MR. PARKER: I'm going to object again. That is outside of this witness's scope of knowledge.

THE COURT: Okay. Mr. Rath?

MR. RATH: I'll -- that's fine, I'll do -- I'll ask another question, My Lady.

THE COURT: Okay.

Q MR. RATH: So with regard to your use of the words "manageable growth", would you agree that when you talk about manageable growth, that would include the number of hospital beds available for -- for COVID patients?
A As one component, yes.

Q Right. And would you agree that the reduction in surge capacity in hospitals and that the reduction in hospital beds available for COVID patients would, in fact, reduce the ability to "manage growth" of COVID cases in Alberta?

MR. PARKER: Objection. The witness was already asked if she knew about this evidence and she said she did not.

MR. RATH: I'm just asking her generally in the context of her use of the words "manageable growth", My Lady. The --

THE COURT: Okay. I'm going --

MR. RATH: -- the (INDISCERNIBLE) --

THE COURT: Excuse me, Mr. Rath. I am going to allow the question because I'm quite confident that Dr. Simmonds is capable of accepting or rejecting the premise behind the question.

Dr. Simmonds?

A Could you repeat the question one more time so I'm clear?

Q MR. RATH: Within your discussion of manageable growth of COVID cases in Alberta, would you agree that a reduction in hospital beds and surge capacity in hospitals would make the management of the growth of COVID cases in Alberta more difficult?

A If there's a reduction of hospital -- hospital space at the time when cases are growing, that would be nonsensical. It is my understanding based on the data provided for us when we were doing our modelling that beds were -- they had an agile approach and that beds were increased as cases increased and reduced as it wasn't -- as they weren't required so that other things in the system like surgeries could happen, but after that I can't speak to anything else, really.

Q Okay. And your evidence would be that the reduction of available bed capacity in the middle of a pandemic would be nonsensical; is that your evidence, doctor -- or, professor?

MR. PARKER: Well, she's -- she's just answered this question in more detail and now my friend is following up with a less detailed question on something that she's already answered, so there's an objection on that basis.

THE COURT: Okay. Mr. Rath?

MR. RATH: I'll -- I'll let you rule against me, My Lady. I thought it was an appropriate question under the circumstances.

THE COURT: Okay. I have to agree that you're putting words in the witness' mouth.

MR. RATH: My Lady, just in fairness, I wasn't putting words in her mouth, I was asking her a question, she could agree or disagree, but if that's -- if -- if that's the ruling on the objection, I'll move on to my next question. Thank you.

THE COURT: Okay.

MR. RATH: Thank you, My Lady.

Q MR. RATH: Now, Professor Simmonds, paragraph 29 of your affidavit, you say that, "Wave 2 to allowed for uncontrolled spread which led to wave 3 driven by variants".

A Correct.

Q So is your -- on what basis do you make that statement?
A So when we -- when we have a wave of COVID or any disease, we need cases, the number of active cases, people who can spread disease, to decrease to a -- a level that, when new cases come in through like the variants of concern through travel, that the system is able to identify and -- and manage, as I used before that. In the case of wave 2, the cases didn't get low enough in January such that when we found out that new variants, specifically the Alpha, also known as B.1.1.7 was introduced, it set the stage so that cases could rapidly rise for wave 3. Had we not had wave 2 at such a high peak, we wouldn't have been in the same situation for wave 3.

Q So you're not saying, then, that under wave 2 that -- that whatever measures were in place in Alberta at that time contributed to mutations of the virus or anything of that nature?
A No, that's -- you're correct.

Q Okay. I just wanted to clarify that. Thank you.
A It's my first affidavit. Now I know next time to be more clear.

Q Thank you, Professor Simmonds. I think that might be an issue you want to take up with your legal counsel, so. In paragraph 27, you speak in -- if we turn to paragraph 27, you speak in broad strokes about the third wave and how it was driven by variants and how younger and healthier people were impacted; is that fair?
A Correct.

Q Okay. Is it not true that during this period that deaths attributed to COVID-19 decreased dramatically?
A I believe that to be correct.

Q Okay.
A Dramatically, I think I wouldn't use -- I -- I prefer to use quantifiable terms, but -- but they did decrease to a measurable amount.

Q Yeah, they -- they decreased measurably. And you've neglected to provide this important point in your affidavit. Was there a reason for that?
A Yeah, I consider mortality to be a crude and measure and so when we look at diseases that are of significance, for example, polio and COVID, morbidity is a much more significant issue for the health of the population, but I do agree, mortality did go down in a measurable amount and that was partly because of the beginning of the introduction of vaccines in our older population and in our health care worker.

Q Right. And mortality across the population has been going down throughout; isn't that fair?
A Correct.

Q Okay. Now, in paragraph 29, you state: (as read)

> Every time COVID-19 transmits from one person to another, the virus replicates and there's an increasing likelihood of a new variant, therefore, public health measures attempt to stop or slow transmission. Wave 2 allowed for uncontrolled spread, which led to wave 3 driven by variants.

As far as that goes, isn't it true that, as we extend the timeline of the virus and allow the virus to perpetuate itself within society, you're giving any particular virus more time to mutate?
A So every time the virus transmits from one person, it has that opportunity to have a misstep in its replication and make a new variant, that is correct.

Q Thank you. And you -- you stated earlier that household transmission was the largest

component of COVID transmission; is that fair?
A Yes, at various stages.

Q Right. And with regard to household transmission, were you ever involved in doing any modelling which would have -- would have looked at providing quarantine hotels or quarantine facilities for everybody infected with COVID to keep them out of their households and going back and reinfecting others in the -- in the household? Were you ever involved in doing any of that modelling?
A We didn't do official modelling on that, but we did look at -- at what the reduction in transmission might be broadly with the provision of quarantine hotels.

Q And what was the -- what was the result of that modelling?
A It was mixed and it depended on the population. So, simply put, it depends. For individuals who could rapidly be identified and then quarantined, like offered the opportunity to stay in quarantine hotel, the preliminary data looked like it might be effective. Unfortunately, as often is the case, by the time someone was identified as a case, their -- their family had already been exposed. So it was very dependent on the nature of the household structure, the time that the individual was identified as infected, and where -- where it was in the course of the -- the outbreak within the household.

Q Right. But -- so would you agree that the lockdown measures themselves may have -- may have contributed to household transmission and infection?
A So the virus has to get into the house somehow and -- and so, as a result, there needs to be a way for you to bring it into the home, whether that be through work or school or activities or whatever that might be, and so when we talk about that -- that policy lens of which I am not privy to, one of the things that needs to be considered is feasibility and so, you know, I think it's not feasible to have people individually in a house without their family members. So -- so we didn't look at, you know, locking people inside of rooms inside of their house, I don't know how that would work logically.

Q Well, I -- I wasn't suggesting that people locked inside of their rooms or locked inside of their house, I was -- I was suggesting that -- to the extent that people were required to stay in their homes that -- that this would contribute to infection and the number of cases in the province of Alberta that were active.
A Oh, it's my understanding that isolation within the home is intended to be within a room separate from your family. When I looked at the contact tracing information, that's what was asked specifically by contact tracers, Do you have a place in your home in which you can isolate and be away from the rest of your family?

Q You -- you agree that COVID is transmitted by aerosols?
A So, yes, by small aerosol particles or by small droplets, which doesn't make it go

through the ventilation systems, which is why we don't see apartment outbreaks, right, where there might be ventilation between units.

Q Right. And did you consider how unrealistic it is that anybody would actually isolate in their bedroom and not go to the kitchen for a cup of coffee or -- or any -- or come in contact with their family members while these measures were being imposed on them?

MR. PARKER: Objection. It's calling for speculation.

MR. RATH: Well, all of -- all of this witness's evidence, My Lady, is based on speculation, it's based on modelling. We're just --

THE COURT: That is an unfair comment, Mr. Rath, that you may be arguing that later, but I don't accept that premise. Do you wish to directly address the objection?

MR. RATH: No, there's -- there's no need, My Lady, I'm -- I'm -- I'll move on. Thank you.

THE COURT: Okay. Thank you.

MR. RATH: Those are all my questions. Thank you.

THE COURT: Okay. Thank you, Mr. Rath.

Mr. Parker, do you have anything in response?

MR. PARKER: I just have one question in redirect, Justice Romaine. Thank you very much.

The Witness Re-examined by Mr. Parker

Q Dr. Simmonds, do you remember being asked about -- by Mr. Grey being asked about outdoor transmission and being much, much lower?
A Correct.

Q And do -- I believe you referred to the data -- the data for that -- for that information. Do you know what I'm talking about, the basis of that --
A M-hm.

Q -- the data on which that was based?

A Yes.

Q When was that data prepared and when did it come to your knowledge, specifically on this outdoor transmission you've referred to?

A Yeah. So in the summer of -- of 2020, we were carefully monitoring what was happening because we were allowing activities to happen outdoors and so there was careful monitoring of the data coming from cases to see where things might be transmitted and, broadly speaking, it was very low, I would have to go look at the numbers. The exception to that is when there were some gatherings like picnics that were indoor and outdoor or where people were in very close proximity and -- and eating together and stuff but, generally, outdoor transmission was really low and I -- I was specifically monitoring it because my children participate in outdoor activities. So I -- I do recall that it was quite low.

MR. PARKER: Thank you very much, Dr. Simmonds. Those are my questions arising.

THE COURT: Okay. Thank you.

Thank you very much, Dr. Simmonds, for your testimony today. We can now let you go. If you can turn off your sound and your video now? Thank you.

A Awesome. Thank you so much. Have a nice day.

(WITNESS STANDS DOWN)

THE COURT: Thank you.

MR. PARKER: I think you could just leave us and you don't have to do that, Dr. Simmonds.

THE COURT: No, I'm just joking. I apologize. Okay.

Okay. We have another witness, it's 12:01, would this be an appropriate time to take the lunch break for an hour or do you want to start with the other witness?

MR. RATH: I'll be -- I'll be leading off with Ms. Gordon, My Lady, so I think this would be an appropriate point for a break. Thank you.

THE COURT: Okay. Well, then let's take a break until 1:00. Thank you.

MR. PARKER: Thank you.

PROCEEDINGS ADJOURNED UNTIL 1:00 PM

Certificate of Record

I, Michelle Palmer, certify that this recording is the record made of the evidence in the proceedings in the Court of Queen's Bench, held in courtroom 1702, at Calgary, Alberta, on the 24th day of February, 2022, and that I was the court official in charge of the sound-recording machine during the proceedings.

Certificate of Transcript

I, Carla Novello, certify that

(a) I transcribed the record, which was recorded by a sound-recording machine, to the best of my skill and ability and the foregoing pages are a complete and accurate transcript of the contents of the record, and

(b) the Certificate of Record for these proceedings was included orally on the record and is transcribed in this transcript.

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