Clerk's Stamp

COURT FILE NO.	2001-14300
COURT	COURT OF KING'S BENCH OF ALBERTA
JUDICIAL CENTRE	CALGARY
APPLICANTS	REBECCA MARIE INGRAM, HEIGHTS BAPTIST CHURCH, NORTHSIDE BAPTIST CHURCH, ERIN BLACKLAWS and TORRY TANNER
RESPONDENTS	HIS MAJESTY THE KING IN RIGHT OF THE PROVINCE OF ALBERTA and THE CHIEF MEDICAL OFFICER OF HEALTH
DOCUMENT	**WRITTEN SUBMISSIONS OF THE APPLICANTS REBECCA MARIE INGRAM, HEIGHTS BAPTIST CHURCH, NORTHSIDE BAPTIST CHURCH, ERIN BLACKLAWS, and TORRY TANNER RE: *C.M. v. ALBERTA***

ADDRESS FOR SERVICE AND CONTACT INFORMATION OF PARTY FILING THIS DOCUMENT	Rath & Company Barristers & Solicitors 282050 Hwy 22 W Foothills, AB, T0L 1W2 c/o: Jeffrey R. W. Rath Phone: [redacted] Fax: [redacted] Email : [redacted]	Justice Centre for Constitutional Freedoms #253, 7620 Elbow Drive SW Calgary, AB, T2V 1K2 c/o: Leighton B.U. Grey, K.C. Phone: [redacted] Fax: [redacted] Email: [redacted]
Counsel for:	Rebecca Marie Ingram	Heights Baptist Church, Northside Baptist Church, Erin Blacklaws and Torry Tanner

Contents

I. Applicants' Pleadings and Previous Written Submissions

1. These are the Applicants' supplemental written submissions in light of the recent decision of *C.M. v. Alberta*.[1]

2. On April 30, 2021, the Originating Application was amended by court order. The Amended Originating Application seeks, *inter alia*, a declaration that the Chief Medical Officer of Health ("**CMOH**") orders ("**CMOH Orders**") at issue were *ultra vires* the purpose of the *Public Health Act* ("***PHA***")[2] and a declaration that the business closure orders issued since March 2020 were *ultra vires* s.29 of the *PHA* and of no force or effect.

3. Throughout this case, the Applicants have argued that the CMOH Orders are *ultra vires* the *PHA* and an unlawful exercise of authority.[3]

II. The recent decision C.M. v. Alberta ("C.M.")

3. In *C.M.*, Justice Dunlop found that Dr. Hinshaw's CMOH Order 08-2022 was unlawful and unreasonable:

> I find that while the Order was issued by the Chief Medical Officer of Health, that order merely implemented a decision of a committee of cabinet, rather than being the Chief Medical Officer's own decision. *The Public Health Act*, RSA 2000, c. P-37, requires that decisions regarding public health orders be made by the Chief Medical Officer of Health, or an authorized delegate. . . [t]he Order was based on an unreasonable interpretation of the *Public Health Act*: that the Act left final authority for public health orders to elected officials. Consequently, the Order was unreasonable.[4]

4. The court also criticized Alberta's interpretation of s.29 of the *PHA* finding that it was unreasonable to read s.29 "with its repeated reference to what the medical officer of health "considers necessary" or "determines", to permit the Chief Medical Officer of Health to make orders at the direction of PICC or any other person or body."[5] During a public health emergency, the authority over public health orders is not with elected officials.[6] Further, Dr. Hinshaw could not delegate her authority under the *PHA* to PICC or anyone other than specifically identified possible delegates: the Deputy Chief Medical Officer or an employee of the Department of Health; neither delegate is an elected official.[7]

5. In finding CMOH Order 08-2022 unlawful, Justice Dunlop states:

> Dr. Hinshaw's interpretation of the *Public Health Act* as leaving decision-making authority for public health orders with elected officials is contrary to the *Public Health Act* and consequently is unreasonable. The Order was based on that unreasonable interpretation. Because the Order **slavishly** implemented PICC's decision, I conclude the Order was unreasonable."[8] [emphasis added]

6. A declaration was made by the court "for the benefit of the Chief Medical Officer of Health and other medical officers of health in considering future public health orders . . . that provides that the Order was unreasonable because it was based on an interpretation of the *Public Health Act* as giving final authority over public health orders to elected officials."[9]

III. The Evidence of Dr. Hinshaw in this case

7. Dr. Hinshaw's affidavit, affirmed on July 12, 2021, states at paragraph 29:

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[1] 2022 ABKB 716 ["***C.M.***"] **[TAB 1]**
[2] R.S.A. 2000, c.P-37.
[3] Pre-trail Factum of the Applicant Rebecca Ingram filed September 1, 2021, at paras 16,17,32-61; Pre-Trial Reply Factum of the Applicant Rebecca Ingram, filed September 21, 2021, at paras 65-68; Written Final Arguments of the Applicant Rebecca Ingram, filed June 10, 2022, at paras 2, 49-76.
[4] *C.M.*, *ibid,* at para 6.
[5] *C.M.*, *ibid,* at para 84.
[6] *C.M.*, *ibid,* at para 91.
[7] *C.M.*, *ibid,* at para 88.
[8] *C.M.*, *ibid,* at para 85.
[9] *C.M., ibid*, at para 132.

> **[U]nder the *Public Health Act* the Chief Medical Officer of Health is not the final decisionmaker**. Rather, the Chief Medical Officer provides advice and recommendations to elected officials on how to protect the health of Albertans. Those elected officials take that advice as one part of the considerations in the difficult decisions that they have had to make in response to COVID-19. The **final policy decision-making authority rests with the elected officials**, and these policy decisions are then implemented through the legal instrument of CMOH Orders. [emphasis added].

8. At the oral hearing in this case, Dr. Hinshaw testified extensively about her interpretation of the exercise of power as the CMOH and how CMOH Orders were implemented. She repeatedly affirmed that members of Cabinet were the "decision-makers" for her orders.[10] She testified that the exercise of power by the CMOH was not utilized prior to COVID. Therefore, in response to COVID, Alberta established a new process under s.29 of the *PHA* so that as the CMOH, Dr. Hinshaw "provided advice to elected officials who then took that into account [and] made policy decisions. . . those policy decisions were made by the representatives of the people and then as the individual responsible for that s.29 order, [Dr. Hinshaw] would take those decisions. . . [and] implement them through that order."[11]

9. Dr. Hinshaw repeatedly testified that: s.29 of the *PHA* enabled the decision-making to take place in the hands of elected officials;[12] the CMOH Orders were implemented at the direction of elected officials;[13] the CMOH Order decision-making body changed over time and was either the Cabinet committee, PICC or the Emergency Management Committee;[14] "elected officials are [in] the best position to make these decisions;"[15] and the CMOH Orders were the legal instrument to implement the policy decision of Cabinet.[16]

10. The particular process Dr. Hinshaw outlined in this case, is identical to the process revealed in Alberta's evidence in *C.M.* which led Justice Dunlop to find her order unreasonable.[17] Dr. Hinshaw testified in this case that: "the process that underpinned the orders and the recommendations that we put together from the perspective of managing COVID would go to Cabinet committee, and the record of decision from the Cabinet committee would inform the structuring of the order that would be the legal instrument to carry out the pandemic response tools that were being implemented."[18] When Applicants' counsel attempted to ask questions about that process, this Honourable Court prohibited those questions on the basis of cabinet immunity. Further, when the *C.M.* case provided clear evidence and court ordered disclosure of the documentation behind this process, this Honourable Court did not permit Dr. Hinshaw to be recalled by the Applicants.

IV. Argument

11. The principle of *stare decisis* was affirmed by the Alberta Court of Appeal in *R. v. Kostiuk.*[19] It applies to prior decisions of the same court in cases where: the prior decision is recent, the law has not evolved, and the decision has no "obvious flaw or simple easily-demonstrated" error.[20] The recent decision of *C.M.* must be followed by this Honourable Court.

12. It is clear when comparing the evidence in this case with the evidence in *C.M.* that Dr. Hinshaw implemented every CMOH Order at issue in exactly the same way: the final decision-makers were elected officials and not

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[10] Transcript of Proceedings, April 4, 2022, p. 8/8-26, p. 10/6-20, p.70/40-p.71/1-17, p.74/39-41, p. 75-77/1-11, p. 79/4-41, p.80/1-4, p.82/4-21**[TAB 3];** Transcript of Proceedings April 5, 2022, p. 78-80, p. 91-92/1, p.95-98/1-12 **[TAB 4];** Transcript of Proceedings, April 6, 2022, p. 83/25-41, p.84/1-5, p.99/3-38; p.115-117/24**[TAB 5].**

[11] Transcript of Proceedings, April 6, 2022, p. 117/12-24.

[12] Transcript of Proceedings, April 4, 2022, p. 8/8-26.

[13] Transcript of Proceedings, April 4, 2022, p. 71/6.

[14] Transcript of Proceedings, April 4, 2022, p. 75/18-20.

[15] Transcript of Proceedings, April 4, 2022, p. 82/4-5.

[16] Transcript of Proceedings April 5, 2022, p. 95/21-22.

[17] Amended Amended Certified Record of Proceedings in *C.M.*, in Written Reply of the Applicants, filed July 27, 2022, Secondary Source, TAB 24.

[18] Transcript of Proceedings, April 4, 2022, p. 76/2-7.

[19] 1995 ABCA 399 **[TAB 2]**.

[20] *R. v. Kostiuk*, ibid, at para 1.

Dr. Hinshaw. The facts regarding the implementation of CMOH Orders in this case and C.M. are indistinguishable.

13. Alberta implemented the CMOH Orders under s. 29 of the *PHA*. However, the evidence reveals that the process Alberta applied had the government actually operating as if it declared a "state of emergency" under s.18 of the *Emergency Management Act ("**EMA**"),*[21] rather than a "public health emergency" under s.52.1 of the *PHA*. Under the *EMA*, elected officials are the lawful decision-makers who are held accountable for their decisions by the electorate of Alberta. There are no such provisions in the *PHA*: the legislative intent was for powers under the *PHA* to be necessarily limited and narrow in scope and made by a medical professional, not elected officials. This is supported by the evidence of Col. David Redmond in this case.

14. During the cross-examination of Dr. Hinshaw, this Honourable Court allowed questions surrounding Dr. Hinshaw's understanding of her authority under s. 29 of the *PHA* while upholding objections to similarly phrased questions.[22] In *C.M.,* the court rejected Dr. Dr. Hinshaw's interpretation of her authority under s. 29 of the *PHA* as unreasonable and *ultra vires.*

15. The court in *C.M.* did not endorse Dr. Hinshaw leaving her medical decision-making role to the Premier and Cabinet on the basis that they were "elected officials". Justice Dunlop did not accept that non-medically trained politicians had any role in interfering in the medical decisions of the CMOH in a public health emergency under the *PHA*.

16. The purpose of the *PHA* is to have a medical doctor making medical decisions of a narrow scope. The *PHA* does not authorize "elected officials" to make political decisions[23] affecting the entire provincial economy and the individual rights of healthy citizens as if they were medical decisions. Further, Dr. Hinshaw is not authorized under the *PHA* to exercise the powers of Cabinet. It is respectfully submitted that this is what Justice Dunlop found to be unreasonable about Dr. Hinshaw's CMOH order in *C.M.*

17. Dr. Hinshaw's affidavit and repeated testimony under oath affirm that she was not the final decision-maker. This is completely determinative of the issue. Through the implementation of the CMOH Orders, Dr. Hinshaw was engaged in the unlawful exercise of her powers under the *PHA*. This process is akin to a Justice of the Court of King's Bench saying that they are not the final decision-maker, then having the Premier or Cabinet directing the court to issue a "final decision" in a form amenable to the Premier and Cabinet in a case where the Premier and Cabinet either were or could be potential litigants.

18. Time after time, Dr. Hinshaw affirmed that elected officials made the decisions for the CMOH Orders she issued. To the extent that the Crown attempts to reargue that Dr. Hinshaw maintained "decisive involvement" and therefore the CMOH Orders are *intra vires*, this argument was soundly rejected by the court in *C.M.*[24] There is no other way for the evidence in this case to be interpreted other than falling squarely within the ambit of the court's ruling in *C.M.*

19. The decision in *C.M.* bars this Honourable Court from rendering a judgment that would put the CMOH in a position of power and authority well beyond the contemplation of the legislature. It is respectfully submitted that it was for these reasons and the reasons outlined above that the court in *C.M.* used the strongest possible language to find the interpretation of the *PHA* adopted by the CMOH and Cabinet to be clearly "unreasonable."

20. Accordingly, every CMOH Order at issue in this case was implemented unlawfully and is unreasonable; each and every CMOH Order must be found to be *ultra vire*s the exercise of Dr. Hinshaw's authority under the *PHA* and *ultra vires* the purpose of the *PHA*.

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[21] R.S.A. 2000, c.E-6.8.
[22] Transcript of Proceedings, April 5, 2022, p. 95/26-41- p.98/14.
[23] *C.M.* supra, at para 85.
[24] *C.M.* supra, at para 87.

ALL OF WHICH IS RESPECTFULLY SUBMITTED THIS 9th day of November 2022:

Jeffrey R.W. Rath

Counsel for the Applicant, Rebecca Ingram

Leighton B.U. Grey, K.C.

Counsel for the Applicants, Heights Baptist Church, Northside Baptist Church, Erin Blacklaws and Torry Tanner

V. LIST OF AUTHORITIES

TAB	NAME AND CITATION
CASE LAW	
1.	*CM v. Alberta*, 2022 ABQB 716.
2.	*R. v. Kostiuk*, 1995 ABCA 399.
EXCERPRTS FROM THE TRANSCRIPT OF PROCEEDINGS	
3.	Transcript of Proceedings April 4, 2022, p. 8/8-26, p. 10/6-20, p.70/40-p.71/1-17, p.74/39-41, p. 75-77/1-11, p. 79/4-41, p.80/1-4, p.82/4-21.
4.	Transcript of Proceedings April 5, 2022, p. 78-80, p. 91-92/1, p.95-98/1-12.
5.	Transcript of Proceedings, April 6, 2022, p. 83/25-41p.84/1-5, p.99/3-38; p.115-117/24.

TAB 1

2022 ABKB 716
Alberta Court of King's Bench

CM v. Alberta

2022 CarswellAlta 3112, 2022 ABKB 716

C.M., Litigation Guardian for A.B., S.A., Litigation Guardian for F.S., C.H., Litigation Guardian for G.H., A.B., Litigation Guardian for J.K., R.L., Litigation Guardian for L.M. and Alberta Federation of Labour (Applicants) and His Majesty the King in Right of Alberta (Respondent)

G.S. Dunlop J.

Heard: August 17, 2022; August 18, 2022
Judgment: October 26, 2022
Docket: Edmonton 2203-04046

Counsel: Sharon Roberts, Orlagh O'Kelly, for Applicants
Gary Zimmermann, Steven Dollansky, Stuart Chambers, for Respondent

Subject: Evidence; Public
Headnote
Evidence
Health law

***G.S. Dunlop J.*:**

1. Overview

1 The applicants are children whose parents have been told their children are at heightened risk of severe outcomes if they contract COVID, and the Alberta Federation of Labour. The children's parents are their representatives in this action. The applicants challenge CMOH Order 08-2022 (the Order) by the Chief Medical Officer of Health, Dr. Deena Hinshaw and a statement by the Minister of Education, Adriana LaGrange (Minister LaGrange's Statement). Both the Order and Minister LaGrange's Statement deal with masking in schools:

- the Order rescinds a previous order requiring masking in schools for grades 4 through 12; and

- Minister LaGrange's Statement asserts that school boards may not impose masking requirements for students.

2 The applicants submit that the Order was *ultra vires*, made for improper purposes, and unreasonable. The applicants also argue that both the Order and Minister LaGrange's Statement violate sections 7 and 15 of the Charter.

3 CMOH Order 08-2022 is no longer in force. It was initially rescinded and replaced by another order. On June 30, 2022 Dr. Hinshaw rescinded all remaining public health orders.

4 There is no evidence before me that the Minister of Education has retracted Minister LaGrange's Statement.

5 The case turns on the reasonableness of CMOH Order 08-2022, the legal effect of Minister LaGrange's Statement, and whether the applicants have proven facts to support their *Charter* claims.

6 I find that, while the Order was issued by the Chief Medical Officer of Health, that order merely implemented a decision of a committee of cabinet, rather than being the Chief Medical Officer's own decision. The Public Health Act, RSA 2000, c

P-37 requires that decisions regarding public health orders be made by the Chief Medical Officer of Health, or an authorized delegate. I further find that the Order was based on an unreasonable interpretation of the *Public Health Act*: that the Act left final authority for public health orders to elected officials. Consequently, the Order was unreasonable.

7 I also find that, while Minister LaGrange's Statement on its face appears to prohibit school boards from imposing mask mandates, it does not do so, because the Minister can only do that through a regulation, and the statement was not a regulation.

8 Lastly, the applicants have failed to prove a *Charter* breach because the evidence before me does not establish that the applicant children, or any other children, are at increased risk of severe outcomes or complications from COVID.

9 Because the Order has been rescinded and Minister LaGrange's Statement had no legal effect, the appropriate remedy is a declaration that CMOH Order 08-2022 is unreasonable and that Minister LaGrange's Statement did not prohibit school boards from imposing mask mandates.

2. Definitions

10 In these reasons I refer to the respondent, His Majesty the King in Right of Alberta, as the Crown.

11 Some of the defined terms I used in previous decisions in this action have become confusing as the parties' positions became clearer. I previously referred to the statement by the Minister of Education as the Prohibition, but counsel for the Crown described it as "guidance" in their written submission filed August 12, 2022. Furthermore, in oral submissions on August 18, 2022, counsel for the Crown submitted that the Minister's statement did not prohibit school boards from imposing their own mask mandates. For greater clarity, in these reasons I refer to the February 8, 2022 statement by the Minister of Education as *Minister LaGrange's Statement*.

12 Similarly, in previous decisions I referred to CMOH Order 08-2022 as the Decision, but counsel for the Crown draws a distinction between a policy decision and the implementation of that decision. The question of who made the decision, as distinct from the order, has become central. To avoid confusion, in these reasons I refer to CMOH Order 08-2022 as the Order.

13 I will also use the following definitions:

Applicants	all of the applicants
Children	the individual applicants
Parents	the Children's parents, who are their litigation representatives
Dr. Hinshaw	Deena Hinshaw, MD, Chief Medical Officer of Health
Minister LaGrange	the Honourable Adriana LaGrange, Minister of Education
Minister Shandro	the Honourable Tyler Shandro, KC, Minister of Justice and Solicitor General for Alberta, Deputy House Leader and Member of Executive Council
PICC	Priorities Implementation Cabinet Committee
Initial Record	Dr. Hinshaw's Certified Record of Proceedings filed April 14, 2022
Amended Record	Dr. Hinshaw's Amended Certified Record of Proceedings filed June 1, 2022
Second Amended Record	Dr. Hinshaw's Amended Amended Certified Record of Proceedings filed July 12, 2022

3. Evidence

14 The material filed on this application consists of three certified records of proceedings, an *Evidence Act* certificate, twelve affidavits, three transcripts of questioning on affidavit and two sets of undertaking responses. The parties disagree about the evidentiary value of some of this material.

15 I addressed some of the evidentiary issues in my May 19, 2022 reasons: *CM v* Alberta2022 ABQB 357. Specifically:

• I postponed deciding whether to admit portions of the Applicants' affidavits that the Crown submits are inadmissible hearsay and opinion, leaving that decision to these reasons.

• I declined to admit into evidence in this action an affidavit sworn by Dr. Hinshaw on July 12, 2021 in another action, and which is attached as an exhibit to Gil McGowan's affidavit, filed by the Applicants in this action.

• I provisionally accepted into evidence portions of Mr. McGowan's affidavit and the Parents' affidavits containing information about COVID-19 available to Dr. Hinshaw before she issued the Order, subject to reconsideration in these reasons.

• I admitted into evidence Mr. McGowan's evidence regarding Minister LaGrange's Statement.

• I declined to admit into evidence in this action an Originating Application in another action.

• I declined to admit into evidence the portions of the Parents' affidavits which set out conclusions and argument.

16 The parties raise the following evidentiary issues:

• The admissibility of hearsay and opinion in the Applicants' affidavits.

• The admissibility of information about COVID-19 set out in the Applicants' affidavits, with respect to judicial review of the Order.

• The admissibility of Dr. Daniel K Benjamin's affidavit, the transcript of his questioning, and his responses to undertakings.

• The admissibility of Dr. Hinshaw's records of proceedings, with respect to the Charter issues

17 I raised another evidentiary issue myself: whether the contents of webpages hyperlinked in the material before me should be admitted into evidence.

3.1 Hearsay and Opinion in the Applicants' Affidavits

18 Five Children are Applicants. Each Child is represented in this litigation by a Parent. Four of the Parents filed affidavits. Each of the Parents' affidavits includes either what the Parent was told by their Child's treating physicians regarding their Child's vulnerability to COVID-19, or the Parent's understanding of their Child's vulnerability, without reference to advice from a physician. The Crown argues this is inadmissible hearsay. The Applicants respond that it is not tendered for its truth, but as evidence of each Parent's understanding regarding their Child's vulnerability to COVID-19.

19 I find that the Parents' understanding on this point is relevant to the Charter aspects of this action and admissible on that basis. The Children's physicians' advice is not admissible for its truth because those physicians have not provided affidavits and consequently the Crown had no opportunity to question them on their qualifications and their opinions. The Parents' understanding, where is it not attributed to a physician, is expert opinion evidence from a person who is not qualified to provide expert opinion evidence.

20 Consequently, there is no evidence before me that any of the Children are at heightened risk of severe complications should they contract COVID-19, although there is evidence that their Parents understand that to be the case.

3.2 Information about COVID-19 in the Applicants' affidavits

21 Dr. Hinshaw's Initial Record filed April 14, 2022, attaches two documents: her Record of Decision—CMOH Order 08-2022 and Minister Shandro's Evidence Act certificate. The Initial Record and the attachments total 19 pages.

22 Dr. Hinshaw's Amended Record, filed June 1, 2022, is 183 pages long. It attaches Minister Shandro's Evidence Act certificate and twelve other documents which the Amended Record describes as:

As of January 31, 2022	**Jurisdictional scan of masking requirements in other Canadian provinces and territories as well as other countries**
February 2022	Guidance for Schools (K-12) and School Buses
January 10, 2022	CMOH Order 02-2022
February 2, 2022	CMOH Order 04-2022
February 7, 2022	Alberta COVID-19 Immunization Program Report (Information as of February 7, 2022
February 7, 2022	Memo from Premier's Office Staff to Premier Kenney Re: Student Masking in School. Copy provided to Dr. Hinshaw
February 7, 2022	COVID-19 — COVID and Schools
February 7, 2022	Email from Scott Fullmer to Dr. Hinshaw and others Re: School Masking Evidence Summary
February 8, 2022	COVID-19 Situation Update — Epidemiology and Surveillance
February 8, 2022	Documents from Alberta Health Internal Dashboard — COVID-19 in Alberta, Analytics and Performance Reporting Branch, Epidemiology and Surveillance Unit.
March 2, 2022	Briefing Note — Advice to Honourable Jason Copping, Minister of Health — COVID-19 Measures in Schools — for information (plus attachments — COVID-19 Measures in Schools Alberta Data and COVID-19 Measures in Schools Literature).
May 31, 2022	Appendix 1 — summarizing context of COVID-19 and evidence relevant to masking in schools at the time of the decision

23 In compliance with my July 4, 2022 decision, Dr. Hinshaw's Second Amended Record, filed July 12, 2022, attaches two additional documents which the Second Amended Record describes as:

February 8, 2022	Power-Point presentation to Executive Council with information regarding the ongoing COVID-19 Pandemic.
February 8, 2022	The Official Record of Decision consisting of Cabinet meeting minutes arising from the February 8, 2022 meeting where ongoing public health orders were discussed and considered.

24 The Second Amended Record is 282 pages long.

25 The Crown submits that I should not consider the information about COVID-19 in Mr. McGowan's affidavit and some of the Parents' affidavits because of the additional material attached to Dr. Hinshaw's amended records. The Crown argues that the evidence on a judicial review should be limited to the record before the decision maker, in this case Dr. Hinshaw. I disagree for four reasons.

26 First, r 3.22(d) of the Alberta Rules of Court, (coming into effect in 2010) provides that the Court may admit additional evidence. The former *Rules of Court* (Alta Reg 390/1968) did not have a similar provision. The traditional categories of admissible additional evidence on a judicial review were based on the former rules. See Alberta Liquor Store Assn. v. Alberta (Gaming and Liquor Commission),2006 ABQB 904, per Slatter J (at para 41). These categories were later summarized in Swan River First Nation v. Alberta (Ministry of Agriculture and Forestry),2022 ABQB 194 at para 19:

> Traditionally, new or supplemental evidence on judicial review may be admitted to:
>
> a. address standing;
>
> b. show bias or a reasonable apprehension of bias where the facts in support of the allegation do not appear on the record;
>
> c. demonstrate a breach of the rules of natural justice not apparent on the record;

d. reveal the evidence actually placed before the decision maker where the decision maker provided an inadequate or no record of its proceedings.

27 Additional categories have been judicially recognized: *Swan River First Nation*, at para 59 ("information that was well-known to the parties 'in content and substance' and therefore should have formed part of the Record in the first instance"; Andres v University of Lethbridge, 2020 ABQB 223 at para 8 ("the content and substance of the documents was before the Committee and thus properly formed part of the Record"); Cold Lake First Nation v. Alberta (Tourism, Parks and Recreation),2012 ABQB 579 at para 27 (useful contextual information); Bergman v Innisfree (Village),2020 ABQB 661, at para 46, (to provide the necessary background and context to a judicial review application and to a related constitutional argument under the Charter).

28 Second, Dr. Hinshaw's Order was not the product of a hearing at which evidence and argument were presented by two or more parties, as is often the case when a decision-maker makes a ruling which is then brought before the Court for review. As contemplated by the *Public Health Act*, the Order was made by Dr. Hinshaw without any formal hearing at which opposing parties could present evidence and argument. Consequently, there is not a discrete and well-defined body of material available to the Court to assess the reasonableness of the Order. See Alberta's Free Roaming Horses Society v Alberta, 2019 ABQB 714 at para 25. In such circumstances, it may be necessary to reconstruct the record: Beaudoin v British Columbia, 2021 BCSC 512 at para 85.

29 Dr. Hinshaw acknowledges this fact in paragraph 2 of the Second Amended Record:

The following are parts of the notice to obtain record of proceedings that cannot be fully complied with and the reasons why:

Paragraph 1(b): The reasons given for the decision or act.	No reasons were given because the exercise of the authority to make a CMOH Order is a delegated legislative function given to medical officers of health, which includes the CMOH, under the Public Health Act.
Paragraph 1(c): The document starting the proceeding.	There is no such document. There is no commencement document that initiates a proceeding that results in the issuance of a CMOH Order. There is in fact no proceeding. Rather, section 29(2.1) of the *Public Health Act* sets out the conditions that must exist in order for the medical officer of health (which includes the CMOH) to take further action.
Paragraph 1(d): The evidence and exhibits filed.	None exist because the process does not allow for it. Although Dr. Hinshaw and her staff, along with staff from Health's Emergency Operations Centre, continually monitor and evaluate emerging scientific data regarding COVID-19 in Alberta, across Canada as well as around the globe to help inform policy options for CMOH Orders, evidence and exhibits are not filed with the CMOH as part of the decision-making process.

30 Third, Dr. Hinshaw acknowledges at the end of paragraph 2 of her Amended Record and Second Amended Record that the attached documents are not a complete collection of the material she reviewed before making the Order:

As noted, Dr. Hinshaw and her staff, along with staff from Health's Emergency Operations Centre, continually monitor and evaluate emerging scientific data regarding COVID-19 in Alberta, across Canada as well as around the globe to help inform policy options for CMOH Orders. It is not possible to reconstruct every record that may have been reviewed prior to the Decision being made. However, Dr. Hinshaw and her staff have made best efforts to identify and provide the documents and information that were most critical and directly relevant to the Decision.

31 While the additional material included in Dr. Hinshaw's First and Second Amended Records provides additional information about COVID-19 and government responses to it in Alberta, Canada, and the world, there are obvious omissions, like statements by Dr. Hinshaw and other Alberta government representatives, that are included in Mr. McGowan's and the Parent's affidavits, and which Dr. Hinshaw would have been aware of.

32 Lastly, the issues raised by the Applicants in their Originating Application include whether:

- Dr. Hinshaw or PICC made the decision to issue the Order,
- Dr. Hinshaw subdelegated her decision-making authority to PICC, and
- the Order was made for an improper purpose.

33 These are issues on which evidence outside the record may be relevant.

34 In particular, at the February 10, 2022 press conference, Dr. Hinshaw declined to answer questions about removing the school mask mandate and referred reporters to the Minister of Health. This evidence is relevant to the issues of who made the decision and subdelegation, and is set out in Mr. McGowan's affidavit.

35 Subject to the exclusions set out in my May 2022 reasons, the affidavits of the Parents and Mr. McGowan are admitted into evidence on both the judicial review and the Charter aspects of this action.

3.3 Dr. Benjamin's Evidence

36 I address the admissibility of Dr. Benjamin's evidence in section 6.2 of these reasons.

3.4 Dr. Hinshaw's Records of Proceedings as Charter evidence

37 Neither the Second Amended Record nor any of its attachments, is sworn. Most of the attachments do not indicate who authored them and they are rife with unattributed hearsay and opinion.

38 For example, Appendix 1 does not state who wrote it and includes the following statement:

> **Negative effects of mask-wearing for children (see TAB 6)**
>
> - Masks can disrupt learning and interfere with children's social, emotional, and speech development by impairing verbal and non-verbal communication, emotional signaling and facial recognition.

39 Tab 6 is a February 7, 2022 memo to Premier Kenney from "Premier's Office Staff". It includes the same statement quoted above from Appendix 1, without attribution. Later in that memo additional statements are made on this point with hyperlinks to webpages.

40 Because none of the material included in the Second Amended Record is sworn, the Applicants had no opportunity to question on it.

41 The Applicants submit that the records of proceedings are not admissible with respect to the Charter issues, because they are unsworn and mostly hearsay. The Crown submits that they are admissible, relying on *Beaudoin*. *Beaudoin* is distinguishable in at least two respects: first, the Charter issues were considered and decided with reasons by the Provincial Health Officer, and second the record was in the form of an affidavit, sworn by the Acting Deputy Provincial Health Officer: *Beaudoin* at para 56 and 90.

42 I agree with the Applicants that the Initial Record, the Amended Record and the Second Amended Record are not admissible on the Charter aspects of this case. It would be fundamentally unfair to permit the Crown to rely on evidence which the Applicants had no opportunity to challenge through questioning. This is particularly so with respect to unattributed hearsay and opinion evidence.

43 All parties agree that the Initial Record, the Amended Record and the Second Amended Record are admissible on the judicial review aspects of this case. I agree, because that is the scheme created by the *Rules of Court* for judicial review.

3.5 Hyperlinks

44 Both the Applicants, in their affidavits, and the Crown, in the attachments to the First and Second Amended Records, include hyperlinks to webpages. The contents of those webpages are not admissible evidence because they may not be static. A YouTube video available today may change or be deleted tomorrow. The same is true for any webpage. For a document or a recording to be admissible as evidence, at a minimum I must be confident that what I am looking at is what the person who swore the affidavit or Dr. Hinshaw was looking at. Similarly, anyone reviewing the record of this action in the future, including potentially the Court of Appeal, must have the same confidence. That is simply not possible with a hyperlink to the internet.

4. CMOH Order 08-2022

4.1 Standard and Scope of Review

45 The Supreme Court of Canada in Canada (Minister of Citizenship and Immigration) v Vavilov2019 SCC 65 clarified and simplified the law of judicial review, making reasonableness the general standard of review, subject to exceptions.

46 The Crown submits that the reasonableness standard articulated in *Vavilov* does not apply because the Order is a regulation or executive legislation. In support of this the Crown relies on Katz v Ontario (Health and Long-Term Care), 2013 SCC 64 (at para 24).

47 The Applicants agree the Order is executive legislation.

48 I agree that the Order is executive legislation, similar to a regulation, because it is an instrument of binding, general application that sets a norm or code of conduct (see JM Keyes, *Executive Legislation*, 3d ed (Markham: LexisNexis Canada Inc, 2021) (Keyes), at p. 31 citing *Reference Re Manitoba Language Rights (No 3)*, [1992] 1 SCR 212; Keyes at p. 33, citing *Re Grey* [1918] 57 SCR 150 at 170; and Keyes at p. 39, citing Northwest Territories Teachers' Association v. Northwest Territories (Commissioner)[1997] NWTJ No. 56, 153 DLR (4th) 80 (NWT SC) at par 48. Here, the Order was a mandatory order applicable to everyone in Alberta, setting out a code of conduct for dealing with the COVID pandemic.

49 I also agree that the legislative nature of the Order limits the scope of judicial review, but I do not agree that the standard of review is something other than reasonableness. As the Supreme Court of Canada wrote in West Fraser Mills Ltd. v British Columbia (Workers' Compensation Appeal Tribunal2018 SCC 22 at para 9:

> Applying this central teaching of ***Dunsmuir***, this Court has adopted a flexible standard of reasonableness in situations where the enabling statute grants a large discretion to the subordinate body to craft appropriate regulations: see ***Catalyst Paper Corp. v. North Cowichan (District),*** 2012 SCC 2, [2012] 1 S.C.R. 5, at paras. 13, 18 and 24; ***Green v. Law Society of Manitoba***, 2017 SCC 20, [2017] 1 S.C.R. 360, at para. 20.

50 Furthermore, as the Court of Appeal of Alberta wrote in Koebisch v Rocky View (County), 2021 ABCA 265, in the context of a challenge to county bylaws (at para 22):

> ***Vavilov*** did not change the applicable judicial review standard; if anything, ***Vavilov*** reinforced the proper application of the reasonableness standard of review: see also ***1120732 BC Ltd v Whistler (Resort Municipality)***, 2020 BCCA 101, para 51; ***1193652 BC Ltd v New Westminster (City)***, 2021 BCCA 176, para 60.

51 While the standard of review is reasonableness, the fact that the Order is delegated legislation limits the scope of judicial review to constitutionality or *vires*: *AB v* Northwest Territories (Minister of Education, Culture and Employment2021 NWTCA 8 at para. 45. As stated by the Ontario Superior Court of Justice (Divisional Court) in Hudson's Bay Company ULC v Ontario (Attorney General)2020 ONSC 8046 at para. 4:

> Absent a *Charter* challenge, the focus of judicial review of a regulation is narrow. It is not the role of the Court to decide whether s. 2(1)(3), Schedule 2, of O.Reg. 82/20 is effective, overly broad or unduly restrictive. These are policy choices made by the Ontario government during extraordinary times. The Court's role is limited to determining whether the provision at issue is authorized by the ROA [*Reopening Ontario (A Flexible Response to COVID-19) Act*], which it

clearly is. The purpose of the ROA is to balance public health and safety measures with economic concerns during the current pandemic.

52 I address the Applicants' Charter challenge to the Order in section 6, below.

53 On the judicial review aspect of this case, I am limited to considering the *vires* of the Order, that is, whether it is authorized by the *Public Health Act*. This process is described by Rothwell, J. in Auer v Auer,2021 ABQB 370 at paras 13, 15 and 16:

> A *vires* review while robust is also tempered by the legislative nature of the decision. Counsel will often use the analogy of peeling back the layers of an onion when encouraging a court to consider an issue. In a *vires* judicial review, the peeling occurs with the same care as an adjudicative decision; however, there are generally less layers to peel. Thus, application of the reasonableness standard in the context of a review for *vires* of a delegated legislation is different because there are no formal reasons issued by the administrative authority.
>
> . . .
>
> It is worthy of note that in ***Vavilov*** at para 66, the Supreme Court endorsed ***West Fraser Mills Ltd v British Columbia*** 2018 SCC 22 [***West Fraser Mills***], which involved a *vires* challenge to regulations passed by the Workers Compensation Board, pursuant to the *BC Workers Compensation Act*, RSBC 1996, c 492. Further, the Court endorsed ***Katz Group Canada Inc v Ontario (Health and Long-Term Care)***, 2013 SCC 64, which similarly considered a challenge to regulations promulgated by Ontario's Lieutenant Governor in Council under Ontario's pharmaceutical regulations that were aimed at improving the affordability of generic drugs: ***Vavilov*** at para 111.
>
> In ***Katz Group*** at paras 24-28, the Supreme Court enunciated the following principles regarding a *vires* challenge:
>
> • Regulations are presumed valid.
>
> • The onus of establishing invalidity rests with the challenger.
>
> • An interpretative approach that favours validity is favoured when possible.
>
> • The inquiry does not involve assessing the policy merits of the regulation to determine whether they are "necessary, wise or effective in practice."
>
> • The motives for promulgation are irrelevant.
>
> • The regulations must be "irrelevant," "extraneous" or "completely unrelated" to the statutory purpose in order to be struck down.

54 Some of the Applicants' submissions go to the merits of the Order. I have not considered those submissions because, as set out in *Katz,* I must not review the merits of executive legislation.

55 In Green v Law Society of Manitoba, 2017 SCC 20 the Supreme Court of Canada describes the application of the reasonableness test in the context of executive legislation (at para 20):

> A law society rule will be set aside only if the rule "is one no reasonable body informed by [the relevant] factors could have [enacted]": ***Catalyst Paper Corp. v. North Cowichan (District)***, 2012 SCC 2, [2012] 1 S.C.R. 5, at para. 24. This means "that the substance of [law society rules] must conform to the rationale of the statutory regime set up by the legislature": ***Catalyst Paper***, at para. 25; see also ***Katz Group Canada Inc. v. Ontario (Health and Long-Term Care),*** 2013 SCC 64, [2013] 3 S.C.R. 810, at para. 25.

56 I also note that the Manitoba Court of Queen's Bench applied the reasonableness standard in determining whether public health orders were *ultra vires* in Gateway Bible Baptist Church et al v Manitoba et al2021 MBQB 219 at para. 39 and 341.

4.2 Public Health Act

57 The starting point in considering whether the Order complies with the *Public Health Act* is, of course, the Act itself.

58 Part 3 of the Public Health Act deals with communicable diseases and public health emergencies. As defined in s. 1(hh.1), a public health emergency includes "an epidemic or pandemic disease ... that poses a significant risk to the public health". The existence of a public health emergency at the time of the Order is not in dispute.

59 When there is a public health emergency, s. 29(2.1) gives a medical officer of health (which includes the Chief Medical Officer of Health) the same powers as in s. 29(2) dealing with communicable diseases. Section 29(2) reads:

> **(2)** Where the investigation confirms the presence of a communicable disease, the medical officer of health
>
> (a) shall carry out the measures that the medical officer of health is required by this Act and the regulations to carry out, and
>
> (b) may do any or all of the following:
>
> (i) take whatever steps the medical officer of health considers necessary
>
> (A) to suppress the disease in those who may already have been infected with it,
>
> (B) to protect those who have not already been exposed to the disease,
>
> (C) to break the chain of transmission and prevent spread of the disease, and
>
> (D) to remove the source of infection;
>
> (ii) where the medical officer of health determines that a person or class of persons engaging in the following activities could transmit an infectious agent, prohibit the person or class of persons from engaging in the activity by order, for any period and subject to any conditions that the medical officer of health considers appropriate:
>
> (A) attending a school;
>
> (B) engaging in the occupation of the person or the class of persons, subject to subsection (2.01);
>
> (C) having contact with any persons or any class of persons;
>
> (iii) issue written orders for the decontamination or destruction of any bedding, clothing or other articles that have been contaminated or that the medical officer of health reasonably suspects have been contaminated.
>
> (underlining added)

60 Section 29(2.1) (b) also empowers a medical officer of health to:

> take whatever other steps are, in the medical officer of health's opinion, necessary in order to lessen the impact of the public health emergency.
>
> (underlining added)

61 Based on the above wording, the clear intention of the *Public Health Act* is that the orders of the Chief Medical Officer of Health be based on *that officer's* judgment. Further support for this interpretation is found in s 13 of the Public Health Act, which sets out specific qualifications for a Chief Medical Officer of Health. That person must be a physician with either a certificate, diploma or degree in public health or must have training and practical experience that the Minister considers to be

equivalent to a certificate, diploma or degree in public health. The Chief Medical Officer of Health must also be a fellow of the Royal College of Physicians and Surgeons of Canada.

62 Although not argued before me, I note for the sake of completeness that s 29(5) of the Public Health Act permits a medical officer of health issuing a s. 29 order to "incorporate, adopt or declare in force a code, standard, guideline, schedule or body of rules" including one "developed by the Minister". That does not apply here because there is no evidence of any such code, standard, guideline, schedule or body of rules, and because the Order makes no reference to anything being incorporated, adopted or declared in force.

63 Sections 13 and 57 of the Public Health Act permit the Chief Medical Officer of Health to delegate her powers, as follows:

> 13(3) The Chief Medical Officer may in writing delegate to the Deputy Chief Medical Officer any power, duty or function conferred or imposed on the Chief Medical Officer under this Act or the regulations.
>
> 57 The Chief Medical Officer may in writing delegate to an employee of the Department any of the powers, duties and functions conferred or imposed on the Chief Medical Officer by this Act or the regulations.

64 There are no other references to delegation of authority in the *Public Health Act*.

65 Other provinces give emergency powers to a minister or involve a minister in the exercise of the powers along with a medical officer. For example, in Saskatchewan s. 45 of the Public Health Act, 1994, SS 1994, c P-37.1, grants the Minister the power to direct the closing of public places, restrict travel, prohibit public gatherings, require immunizations, and impose quarantines. Under s 45(2.2) a medical officer of health, with the approval of the Saskatchewan chief medical officer of health, may make the same orders, but only if the medical officer believes there will be insufficient time for the Minister to make an order, and the medical officer's order terminates 48 hours after it is made unless the Minister extends it.

66 In Manitoba, under s 67 of the Public Health Act, CCSM c P210, the Chief Public Health Officer must obtain the Minister's approval before issuing a direction or order related to a suspected epidemic of a communicable disease.

67 The Applicants submit that Dr. Hinshaw did not exercise her own judgment in making the Order, particularly as it relates to removing the school mask mandate; rather she implemented a decision of PICC. As set out in the following section, the evidence before me supports that conclusion.

4.3 Who Made the Decision?

68 The Crown frames the removal of the school mask mandate as a policy decision for elected officials whereas the Dr. Hinshaw's Order operationalized that decision. As set out in Appendix 1 to the Amended Record and the Second Amended Record, under the heading "Decision making process":

> This process involved the CMOH providing advice and recommendations to elected official on how to protect the health of Albertans. Those elected officials took that advice as one part of the considerations in the difficult decisions that they had to make in response to COVID-19. The final policy decision-making authority rested with the elected officials, and those policy decisions were then implemented through the legal instrument of CMOH Orders. In making the CMOH Orders, the CMOH determined how to operationalize each policy decision.

69 In addition to Appendix 1, I have other evidence regarding who made the decision.

70 First, Dr. Hinshaw's initial record filed on April 14, 2022 referred to only two documents: a Power-Point presentation to cabinet and cabinet minutes (it later became clear the presentation and the minutes were actually to and of a committee of cabinet, PICC). This implies that those two documents, or the information in them, were the foundation for the Order.

71 Second, The Power-Point presentation includes at least two references to previous directions from PICC:

page 23:

Previous PICC direction on the following principles has informed the proposed approaches for easing public health measures.

page 25:

Per previous PICC direction, 3-step approaches to easing are proposed, with a focus on removing the Restrictions Exemptions Program and easing youth masking requirements.

72 These statements in the Power-Point indicate that the options presented were driven by previous directions of PICC.

73 Third, the Power-Point presentation sets out three options: Option 1 removes all school requirements including masking in Step 1 and Option 2 removes school masking in Step 2, and other school requirements removed in step 3.

74 The PICC minutes record a decision to direct the Minister of Health to implement Option 2, but vary Option 2 by removing the school mask mandate at Stage 1, specifically at 11:59 pm on February 13, 2022. Dr. Hinshaw's Order does exactly what PICC directed with respect to removing the school mask mandate, including the specific date and time of that removal.

75 Fourth, at a press conference on January 5, 2022, Dr. Hinshaw said:

The use of rapid testing and medical masks, in addition to the measures already in place, will help to protect students and staff as they return to the classroom. Given the current situation, I also want to note that I strongly recommend that students in all grades wear masks, including in kindergarten to grade 3.

76 At the press conference on February 10, 2022, when asked what had changed in the last month or so to make masking for children no longer necessary, Dr. Hinshaw answered: "I would defer to Minister Copping to answer that question." The fact that Dr. Hinshaw declined to explain why she was removing the school mask mandate when a month earlier she recommended that students in all grades wear masks, and the fact that she referred questions to the Minister of Health, who is a member of PICC, supports the conclusion that the decision to remove the school mask mandate was PICC's decision, not Dr. Hinshaw's.

77 Fifth, Dr. Hinshaw signed the Order on February 10, 2022 but she made it retroactive to February 8, 2022, the date of the PICC meeting.

78 Sixth, there is a subtle but substantial difference in the preamble to the Order (CMOH Order 08-2022), as compared to a previous order which Dr. Hinshaw includes in her Second Amended Record:

CMOH Order 02-2022, January 10, 2022

Whereas having determined that it is possible to modify certain restrictions while still protecting Alberta from exposure to COVID-19 and preventing the spread of COVID-19, I hereby make the following order (the Order):

CMOH Order 08-2022, February 10, 2022

Whereas having determined that certain measures are necessary to protect Albertans from exposure to COVID-19 and to prevent the spread of COVID-19, I hereby make the following order.

79 It is noteworthy the Dr. Hinshaw did not say in the preamble to Order 08-2022 that she had determined that any modification of her previous orders or reduction in restrictions was necessary or possible, which she did in the preamble to at least one of her previous orders. This implies that she did not make that determination herself.

80 Finally, there is no evidence that Dr. Hinshaw made the decision, other than the fact that she signed the Order. But, as Dr. Hinshaw makes clear in Appendix 1 to her Second Amended Record, in signing the order, she was implementing policy decisions of elected officials.

81 Based on the minutes, it appears that Dr. Hinshaw was present at the February 8, 2022 meeting of PICC, but the minutes do not disclose what anyone said at the meeting. The Crown submits that Dr. Hinshaw discussed, consulted, and collaborated with PICC, but there is no evidence before me to support that assertion. Even if consultations occurred and Dr. Hinshaw had input into the decision, it was not her decision. Her Order carried out PICC's decision to the letter. It was Dr. Hinshaw's Order, but not her decision. The evidence establishes, and I find as a fact, that PICC made the decision to remove the school mask mandate and the rest of the Order.

4.4 Reasonableness of Dr. Hinshaw's Interpretation of the Public Health Act

82 Dr. Hinshaw states in Appendix 1 to the Second Amended Record:

> The final policy decision-making authority rested with the elected officials, and those policy decisions were then implemented through the legal instrument of CMOH Orders.

83 The question for me is not whether that is a correct interpretation of the *Public Health Act*, but whether it is a reasonable interpretation. The issue is framed by the Supreme Court of Canada in *West Fraser* at para 10:

> The question before us is whether s. 26.2(1) of the Regulation represents a reasonable exercise of the Board's delegated regulatory authority. Is s. 26.2(1) of the Regulation within the ambit of s. 225 of the Act? Section 225 of the Act is very broad. Section 225(1) empowers the Board to make "regulations *the Board considers necessary or advisable* in relation to occupational health and safety and occupational environment". This makes it clear that the Legislature wanted the Board to decide what was necessary or advisable to achieve the goal of healthy and safe worksites and pass regulations to accomplish just that. The opening words of s. 225(2) — "Without limiting subsection (1)" — confirm that this plenary power is not limited by anything that follows. In short, the Legislature indicated it wanted the Board to enact whatever regulations it deemed necessary to accomplish its goals of workplace health and safety. The delegation of power to the Board could not be broader.
>
> (italics in original; underlining added)

84 I am mindful of the *Katz* principles, including that the Order is presumed to be valid and that I must take a broad and purposive approach to interpreting the Order and the *Public Health Act*. Nevertheless, and with respect, it is simply not reasonable to read s. 29 of the Public Health Act, with its repeated references to what the medical officer of health "considers necessary" or "determines", to permit the Chief Medical Officer to make orders at the direction of PICC or any other person or body.

85 Dr. Hinshaw's interpretation of the *Public Health Act* as leaving final decision-making authority for public health orders with elected officials is contrary to the *Public Health Act* and consequently is unreasonable. The Order was based on that unreasonable interpretation. Because the Order slavishly implemented PICC's decision, I conclude the Order was unreasonable.

4.5 Sub-delegation

86 The Applicants frame their argument, in part, as improper sub-delegation by Dr. Hinshaw to PICC of the authority of a medical officer to make public health orders during a public health emergency. In response the Crown cites the following statement in JM Keyes, *Executive Legislation* 2d ed (Markham: LexisNexis Canada Inc., 2010) at p. 276:

> Improper subdelegation is a different issue, which does not arise as long as delegates retain decisive involvement in exercising their authority and do not wholly surrender it to some other person or body.

87 In the Crown's submission the available evidence, including the recitals to the Order, establish that Dr. Hinshaw retained "decisive involvement" during the process leading up to the Order. If "decisive involvement" is the litmus test, it is not met here. As set out in the previous section of these reasons, Dr. Hinshaw was involved at least to the extent of being in attendance, but that involvement was not decisive because the decision was made by PICC.

88 The *Public Health Act* specifically permits the Chief Medical Officer of Health to delegate her powers in writing to either the Deputy Chief Medical Officer (s. 13) or an employee of the Department of Health (s. 57). An interpretation of the Act as permitting the Chief Medical Officer of Health to delegate her authority to a committee of Cabinet, is not reasonable. There is simply no way to interpret the Act as permitting delegation to anyone other than the specifically identified possible delegates. The *Public Health Act* did not authorize Dr. Hinshaw to delegate her powers to PICC.

4.6 Improper or Extraneous Purpose

89 The Applicants also submit that the Order was made for improper or extraneous purposes, including political considerations such as protests at schools and the blockade at Coutts, Alberta. They argue that those improper purposes can be inferred from the reference to those things in parts of the Second Amended Record, and the absence of any reason to end the school mask mandate at the time of the Order. I disagree.

90 The Second Amended Record is 282 pages. It includes references to protests at schools and the blockade at Coutts. It also includes detailed information about COVID-19 in Alberta including numbers of cases, hospitalizations and vaccinations and myriad other things that are central to the considerations in s. 29 of the Public Health Act. One of the documents is a February 7, 2022 memo to the Premier which includes a section headed "Harmful Effects of Mask Wearing on Children". Based on the extensive record, it is not possible for me to conclude that there was no reason to remove the mask mandate in February 2022, nor is it possible for me to conclude that the Order was made to address the protests and the blockade, and not for other reasons.

4.7 Conclusion on CMOH Order 08-2022

91 Both a reasonableness analysis as set out in *Katz* and *Green* and a sub-delegation analysis advanced by the Applicants turn on the interpretation of the governing statute, in this case the *Public Health Act*. Applying a broad and purposive interpretation to both the *Public Health Act* and the Order and starting with the presumption that the Order is valid, the Order was unreasonable because it was the implementation of PICC's judgment and decision, and not that of the Chief Medical Officer of Health. The Order was unreasonable because it was based on an unreasonable interpretation of the *Public Health Act* as giving ultimate decision-making authority over public health orders during a public health emergency to elected officials, specifically PICC.

5. Minister LaGrange's Statement

92 Counsel for the Crown submits that the Applicants sought only *Charter* relief with respect to Minister LaGrange's Statement, and that consequently the only remedy, if any, I should grant is a declaration based on *Charter* issues. This question was argued on May 17, 2022 and decided in my reasons issued on May 19, 2022: *CM v* Alberta2022 ABQB 357 at para 9 - 17. In summary, the Originating Application includes a claim for a declaration regarding Minister LaGrange's statement at large and not limited to *Charter* relief.

93 The relevant paragraphs of Minister Lagrange's Statement, dated February 8, 2022 read:

> As I shared in November, I must reiterate that every child in Alberta is entitled to have access to an education program as per Section 3(1) of the *Education Act*; this provision also existed in Section 8 of the previous *School Act*. To be clear, as of February 14, 2022 school boards will not be empowered by provincial health order or recommendations from the CMOH to require ECS — grade 12 students to be masked to attend school in person or to ride a school bus. At this time, prevention measures including cohorting, as well as enhanced cleaning and sanitization, will remain in school environments.
>
> As Minister of Education, I take very seriously the responsibility of providing access to education for all students in our province. School authorities cannot deny their students access to in person education due to their personal decision to wear

or not to wear a mask in schools. Individual family choices need to be respected and students should not be stigmatized for their choice related to masking going forward, similarly to their personal vaccination status.

(underlining added)

94 Six months' earlier, at a press conference on August 13, 2021, Minister LaGrange said:

Throughout the pandemic, we have trusted local school authorities to make decisions that work for their schools and their school communities. School authorities have the ability and the corresponding accountability for any additional local measures they may choose to put in place. This could include physical distancing, cohorting and masking requirements that may exceed provincial guidance."

(underlining added)

95 During oral argument, I asked counsel for the Crown whether Minister LaGrange's August 13, 2021statement, that school boards could impose mask mandates, was accurate in law at the time and whether that changed after Minister LaGrange's Statement in February 8, 2022. Counsel for the Crown submitted that the statement was accurate in August 2021, and that it did not change after Minister LaGrange's Statement on February 8, 2022, relying on sections 33(1)(d) and 33(2) of the Education Act, which state:

33(1) A board, as a partner in education, has the responsibility to

. . .

(d) ensure that each student enrolled in a school operated by the board and each staff member employed by the board is provided with a welcoming, caring, respectful and safe learning environment that respects diversity and fosters a sense of belonging,

. . .

(2) A board shall establish, implement and maintain a policy respecting the board's obligation under subsection (1)(d) to provide a welcoming, caring, respectful and safe learning environment that includes the establishment of a code of conduct for students that addresses bullying behaviour.

96 The Crown's submissions did not include an explanation why school boards continued to have the authority to impose mask mandates in schools, even after Minister LaGrange's February 8, 2022 Statement. In my view, the answer is in section 51(1) and (2) of the Education Act:

51(1) A board has the capacity and, subject to this Act and the regulations, the rights, powers and privileges of a natural person.

(2) With respect to any right, power or privilege exercisable by a board, the Minister may, by regulation,

(a) prohibit or restrict the use of the right, power or privilege;

(b) provide that the right, power or privilege is to be exercised subject to any terms or conditions prescribed in the regulations.

(underlining added)

97 Section 51(2) empowers the Minister of Education to restrict the powers of a school board, but that must be done through a regulation.

98 The Crown submitted neither evidence nor argument that Minister LaGrange's Statement was a regulation. On its face it was not a regulation. It is not called a regulation and it there is no evidence before me that it was published as the Regulations Act requires.

99 I agree with the Crown's submission that school boards have the authority under the *Education Act* to impose mask mandates and that Minister LaGrange's Statement did not change that. However, the following evidence establishes that many in Alberta, including some school boards and one senior government official, understood that Minister LaGrange had prohibited school boards from imposing mask mandates in schools:

- Minutes of a meeting of the Edmonton Public School Board Trustees on February 15, 2022 which include a resolution to "advocate to the Minister of Education to allow school boards, working with Alberta Health Services, the autonomy to put measures and resources, such as masking, in place based on our local context".

- A February 11, 2022 email from a school district to CH stating "As indicated in a recent letter from the Minister of Education. According to the province, school boards will not have the authority to require students to be masked while attending school or riding a school bus."

- A February 15, 2022 email from the same school district to CH stating "The guidelines created by the Government of Alberta state that masking during the school day remains a personal health choice for students and their parents/guardians."

- The evidence of Susan Novak, in an affidavit dated July 21, 2022, filed in this action by the Crown. Dr. Novak was the Planning Section Chief at the Department of Health Emergency Operations Centre of the Government of Alberta from November 8, 2021 to May 27, 2022. In paragraph 6 of her affidavit Dr. Novak provides this evidence:

> School boards were not prohibited from taking appropriate actions to protect school children, including following the guidance noted in paragraph 5 above. School boards were simply not permitted to deny in-person learning to students solely on the basis that the student was not masked.
>
> (underlining added)

100 Given the widespread misunderstanding of the legal effect of Minister LaGrange's Statement, it is appropriate for me to issue a declaration on that point.

6. Charter Arguments

101 The Applicants argue that the Order and Minister LaGrange's Statement breach s. 15 of the Charter by their adverse effect on the Applicant Children and other children with disabilities. They also submit that the Applicant Children and other disabled children are deprived of life liberty or security of the person by the Order and Minister LaGrange's Statement, contrary to s. 7 of the Charter. Fundamental to these claims is the Applicants' allegation that the Applicant Children and other disabled children are at increased risk if they contract COVID. As set out below, the Applicants have not proven that allegation.

6.1 The Applicant Children

102 Four Parents' affidavits establish that each recalls having been told by physicians that their child is at increased risk of severe illness and complications from COVID-19 or that they have that understanding. Each of those four parents goes on to describe how they and their family have responded to the Order and Minister LaGrange's Statement.

103 For example, CH states in their affidavit that they decided to send GH to school in January 2022, based in part on the mask mandate then in place. When the mask mandate was lifted pursuant to the Order and Minister LaGrange's Statement, CH initially kept all their children, including GH out of school. After five weeks of searching for an alternative, CH sent their children back to school. As CH states in paragraph 24 of their affidavit:

> Due to G.H.'s disability, I have been forced to risk their health to access public education. When there was just no other option left, we finally sent them back masked and they also go to school later than everyone else to avoid the crowds and then get let off early. They eat lunch alone. They don't participate in anything that requires mingling with other classrooms. Those were the only things we could really think of to protect G.H. and their siblings.

104 The evidence does not establish that any of the Applicant Children was in fact at heightened risk of any negative outcome should they contract COVID. That is a significant gap in the evidence. If the Parents were misinformed or misunderstood the advice they received or formed a false impression on their own, and their children are at average risk, then the Children have not suffered any adverse impact from the Order and Minister LaGrange's statement as compared to everyone else. Any harm suffered would be the result of the misinformation or misunderstanding.

105 In that case, the Applicant Children and their Parents had the same choices to make regarding masking and attending school and have been subject to the same risk as everyone else. Consequently, it is essential to the Applicants' claim of adverse effect discrimination, that they adduce evidence, not merely that the Parents have been told that the Children are at increased risk or that they think that, but that the Children actually are. Similarly, it is essential to the s. 7 claim that the Applicants prove a deprivation of life, liberty or security of the person flowing from the lifting of the mask mandate. This would require expert opinion evidence from one or more physicians who have examined the Children, or at a minimum reviewed their medical records. I have no such evidence before me.

6.2 Dr. Benjamin's Evidence

6.2.1 Threshold Admissibility

106 In addition to the affidavits of the Parents and Mr. McGowan, the Applicants also provided evidence from Dr. Daniel K. Benjamin, a physician and epidemiologist living and working in North Carolina. He does not practice medicine in Alberta and has no connection with the Applicant Children or other children in Alberta who may be at increased risk if they contract COVID.

107 Dr. Benjamin provided an 11-page affidavit with 601 pages of exhibits, including his 87-page *curriculum vitae*. He was questioned on that affidavit. The transcript of that questioning is 179 pages. Dr. Benjamin describes himself in the opening paragraphs of his affidavit as follows:

> I, DANIEL K. BENJAMIN, JR., a resident of North Carolina, in the United States of America, am a medical doctor (MD), epidemiologist (PhD) researcher (supported by the National Institute of Health to study transmission of SARS-CoV-2 in schools), scholar, and have experience in being qualified to give, and giving, expert opinion evidence, including with respect to the effectiveness of masks in reducing transmission of SARSCoV2, the virus that causes COVID-19. I make this affidavit and the opinions stated within it based on my education, training and expertise as a pediatric epidemiologist and a doctor of pediatric infectious disease medicine.
>
> > 1. In addition to being a board-certified pediatrician, I am a pediatric epidemiologist and a Distinguished Professor of Pediatrics at Duke University, being on faculty in the Divisions of Pediatric Infectious Diseases and Quantitative Sciences within the Department of Pediatrics at Duke University. I am also a Member in the Duke Clinical Research Institute and the Principal Investigator and Chair of the National Institute of Child Health and Human Development's Pediatric Trials Network and have several National Institutes of Health (NIH)-sponsored grants to study SARS-CoV-2 and over a dozen peer-reviewed publications related to SARS-CoV-2 transmission in K-12 public schools.
>
> (underlining added)

108 The Crown submits that I should either exclude Dr. Benjamin's evidence or give it very little weight for the following reasons:

- The Applicants refused to provide drafts of Dr. Benjamin's file including communications between the Applicants' lawyers and Dr. Benjamin and drafts of his affidavit;

• The Applicants' lawyers improperly influenced Dr. Benjamin;

• Dr. Benjamin is not an independent expert.

109 Dr. Benjamin's evidence is expert evidence, subject to rules of admissibility set out by the Supreme Court of Canada in R v Mohan[1994] 2 SCR 9 and White Burgess Langille Inman v Abbott and Haliburton Co2015 SCC 23. Admissibility turns on:

(a) relevance;

(b) necessity in assisting the trier of fact;

(c) the absence of any exclusionary rule:

(d) a properly qualified expert.

Mohan at para 17

110 Where an opinion is based on novel science, particular care must be taken to ensure it is reliable: *Mohan* at para 32; *White Burgess* at para 23.

111 The Crown's objections are directed at the fourth factor, a properly qualified expert, one aspect of which is that the expert witness be fair, objective and non-partisan: *White Burgess* at para. 46 and 53. The Supreme Court of Canada describes the evidentiary process on this point as follows:

> While I would not go so far to hold that he expert's independence and impartiality should be presumed absent challenge, my view is that absent such challenge, the expert's attestation or testimony recognizing and accepting the duty will generally be sufficient to establish that this threshold is met.
>
> Once the expert attests or testifies on oath to this effect, the burden is on the party opposing the admission of the evidence to show that there is a realistic concern that the expert's evidence should not be received because the expert is unable and/or unwilling to comply with that duty. If the opponent does so, the burden to establish on a balance of probabilities this aspect of the admissibility threshold remains on the party proposing to call the evidence. If this is not done, the evidence, or those parts of it that are tainted by a lack of independence or impartiality, should be excluded. This approach conforms to the general rule under the ***Mohan*** framework, and elsewhere in the law of evidence, that the proponent of the evidence has the burden of establishing its admissibility.
>
> This threshold requirement is not particularly onerous and it will likely be quite rare that a proposed expert's evidence would be ruled inadmissible for failing to meet it. The trial judge must determine, having regard to both the particular circumstances of the proposed expert and the substance of the proposed evidence, whether the expert is able and willing to carry out his or her primary duty to the court.
>
> ***White Burgess*** at para 47 - 49

112 In this case Dr. Benjamin did not testify in either his affidavit or his questioning that he recognizes and accepts his duty to the court to be fair, objective and non-partisan. Consequently, the burden remains on the Applicants to prove that fact.

113 The Applicants submit that I should find that Dr. Benjamin understands his duty as an expert witness to be fair, objective and non-partisan based on his affirmation of his evidence in his affidavit and on questioning, and the fact that he makes a living in this area in the context of this being a public case. In addition to those points, I find that the following evidence supports a finding that Dr. Benjamin understands his duty to be fair, objective and non-partisan:

• his professional qualifications set out in the opening paragraphs of his affidavit;

• the fact that he has been qualified to testify as an expert in previous court cases, including one in Canada; and

• his answers during the questioning on his affidavit, most of which suggest he was trying to provide information he thought would be helpful to me in deciding this case.

114 On the other hand, the following evidence casts doubt on whether Dr. Benjamin understood his duty to the Court:

• He testified that his affidavit was the product of a negotiation in which he and the Applicants' lawyer "came to terms and agreed to a document";

• He (or the Applicants) refused to provide his file on this matter, including earlier versions of his affidavit which he may have signed and communications between him and the Applicants' lawyer;

• He testified he minimized his time on this case;

• He responded sarcastically to a question about whether he had seen the Order;

• He was unable to provide the names of two cases in the United States in which he provided expert evidence about COVID;

• His testimony was combative and condescending, in response to a simple question about whether he had done any studies of COVID transmission in Alberta, asserting that "it's not like the virus passes through customs and is different between the two countries";

• He stated that "distance learning has been a disaster", which was not responsive to the question asked and which is outside his area of expertise;

• He failed to make a record of the Alberta guidance documents he reviewed before preparing his affidavit and consequently was unable to answer that question;

• Dr. Benjamin included (in paragraphs 38 and 39 of his affidavit) opinions about the impact of masking on learning and development, which are outside his expertise.

115 Given the low threshold at the admissibility stage of the *Mohan / White Burgess* analysis, I find that Dr. Benjamin does recognize his duty to the court to be fair, objective, and non-partisan. However, the points listed above are also relevant to the second stage of the admissibility analysis:

> Finding that expert evidence meets the basic threshold does not end the inquiry. Consistent with the structure of the analysis developed following ***Mohan*** which I have discussed earlier, the judge must still take concerns about the expert's independence and impartiality into account in weighing the evidence at the gatekeeping stage. At this point, relevance, necessity, reliability and absence of bias can helpfully be seen as part of a sliding scale where a basic level must first be achieved in order to meet the admissibility threshold and thereafter continue to play a role in weighing the overall competing considerations in admitting the evidence. At the end of the day, the judge must be satisfied that the potential helpfulness of the evidence is not outweighed by the risk of the dangers materializing that are associated with expert evidence.
>
> ***White Burgess*** at para 54

6.2.2 Masking Reduces COVID Transmission

116 Dr. Benjamin has researched whether masking reduces the transmission of COVID, particularly in schools, and he concludes that it does. At an interlocutory hearing in this action on May 17, 2022, the Crown was not prepared to concede this point, so I understand why the Applicants included this evidence as part of their case. However, by the time of the hearing in August 2022, the Crown admitted this point in its brief filed on August 12, 2022, at paragraph 42. Consequently, this fact is not in issue, which makes Dr. Benjamin's evidence on this point irrelevant.

6.2.3 Distance Learning and Impact of Masking on Learning

117 Dr. Benjamin offers his opinions regarding whether masking causes learning loss and whether distance learning has been effective. Both topics are outside his expertise. He is not a properly qualified expert in those areas.

6.2.4 Policy Options

118 Dr. Benjamin provides his opinions regarding whether and when Alberta should have lifted the mask requirement in schools. He also provides his opinion that decisions on masking in schools should be made by school boards rather that provincial governments. Those are opinions about policy questions, as distinct from opinions about facts. Opinions about policy questions, even when they are well-informed opinions, are not relevant.

6.2.5 Increased Risk of Severe Outcomes or Secondary Complications

119 Dr. Benjamin did not examine any of the Applicant Children, so he is not able to provide any evidence regarding whether any of them is at increased risk of severe outcomes from COVID-19. However, he does provide evidence regarding children generally. Specifically, he states at paragraphs 17, 24 and 35 of his affidavit:

> 17. We know and/or suspect that some children are at heightened risk if infected with SARS-CoV-2. In my opinion, this includes the risk of death and changes that result in a materially different quality of life for a patient after having contracted the virus.
>
> . . .
>
> 24. With respect to vulnerability and risk of severe outcomes for children, we know that "vulnerable" children can include, for example, those who have received solid organ and stem cell ("bone marrow") transplants, are those who are undergoing immunosuppressive treatments for cancer, and those with conditions putting them at elevated risk if they contract a respiratory virus like flu or SARS-CoV-2.
>
> . . .
>
> 35. Based on my research and clinical experience, it is possible to estimate the number of students within a general population who would be particularly vulnerable if they contracted COVID because they would be undergoing cancer treatments, or be a donated organ or marrow recipient. Using the population data referenced above, I would estimate that in or around early February 2022 when the CMOH Order and Prohibition were made, there would have been approximately 2,500 children with this kind of particular vulnerability in Alberta: this includes children who have had solid organ or stem cell transplantation, are receiving cancer chemotherapy, or taking other medicines that severely hinder their response to vaccine and/or mount an effective response to infection with SARS-CoV-2>. Admittedly, this is an estimate based on the information I currently have before me and it is possible not all such children are attending school. Whatever the actual number, however, the facts are that (a) these children are at a very high risk of severe outcomes or secondary complications; and (b) these very high risk children do not include children at modestly increased risk of severe COVID (e.g., children with severe asthma, poorly controlled diabetes, obesity, etc.).
>
> (underlining added)

120 Dr. Benjamin also made the following statement during questioning on his affidavit, at page 122 of the transcript:

> So what's unique about the solid organ bone marrow transplant, those kids, is that they have difficulty responding to the vaccine, whereas a child who has obesity, for example, although they're more at risk for severe COVID, those children can be unilaterally protected by their parents simply by vaccination.

121 Dr. Benjamin's phrase "know and/or suspect" in paragraph 17 of his affidavit implies uncertainty regarding the statement that follows: "some children are at heightened risk if infected with SARS-CoV-2". This is not surprising given that the COVID pandemic began in 2020 so the scientific study of the disease, while perhaps extensive, is still in its early stages. This engages the caution articulated by the Supreme Court of Canada in *Mohan* and *White Burgess* with respect to novel scientific evidence.

122 Furthermore, Dr. Benjamin does not appear to have expertise regarding which groups of children are at increased risk of severe outcomes should they contract COVID.

123 Dr. Benjamin testified at page 24 of his questioning transcript that, while he has an established track record of research over 20 years prior to the pandemic:

> COVID was really not — was not part of something that was part of my job description or title or anything that either or Duke ever anticipated having me do, so it was essentially extra add-on work.

124 Dr. Benjamin acknowledges that his studies of COVID in hospitals and in schools related to the probability of transmission and not to "what happens to the patient after they get sick". Specifically, Dr. Benjamin testified as follows at page 66 and 70 of his questioning transcript:

> Q Okay. And so that's in reference to transmissibility. You had indicated, though, that you were not — if I understood you correctly, you were not studying what happens when the people get sick. You were studying the probability of transmission versus the effect of transmission. Is that fair?
>
> A It's fair to say — let me make sure I understand — you and I make sure we understand each other.
>
> So we did not — once the kids or the adults in the school get COVID, we then — we do not then follow those people up to — then say, Okay. What fraction of those children or adults go on to become hospitalized? What fraction developed long COVID, et cetera? If that is your question, then yes, you are correct. We did not do that.
>
> . . .
>
> Q Okay. So if I understand correctly, then, your primary focus has always been on transmission, reducing transmission rates, but not necessarily the effects of the transmission once contracted. Is that fair?
>
> A Well, in the school environment and in the studies provided for this case, your statement's correct. But, you know, I've also done work on what's the efficacy of tests, that's the efficacy of therapeutics, what's — if you randomized a placebo versus product, you know, what's your — how long is your recovery; how soon do you get out of the hospital; proper dosing of COVID medicines for children.
>
> I hold the IND for the Active 1 protocol, which is about 2,000 patients, randomized a product after placebo, in which case a couple of the products actually reduced death in COVID. Our research group has described a lot of the therapeutics used for COVID in children.
>
> But for the articles that are referenced in this particular affidavit, it's limited to transmission, but that's not the limit of my research with COVID.

125 There is no evidence before me that Dr. Benjamin has done any research regarding whether some children are more likely to suffer severe outcomes if they contract COVID. Furthermore, Dr. Benjamin does not provide the basis for his statements in paragraphs 17, 24 and 35 of his affidavit that children undergoing cancer treatment or who have received organ transplants are at very high risk of severe outcomes or secondary complications should they contract COVID. This contrasts with his opinion that masking reduces COVID transmission in schools which is supported by peer reviewed journal articles, of which Dr. Benjamin was one of the authors and which are attached as exhibits to his affidavit.

126 Taking my concerns about Dr. Benjamin's understanding and acceptance of his duty to the Court, together with the novelty COVID research, Dr. Benjamin's lack of expertise regarding COVID outcomes for particular groups of children, and his failure to provide the basis for his assertions on this topic, I exercise my gatekeeping discretion to exclude Dr. Benjamin's opinion evidence that children undergoing cancer treatment or who have received organ donations or marrow transplants are at increased risk of severe outcomes or complications from COVID. Given that exclusion, Dr. Benjamin's evidence that there are approximately 2,500 such children in Alberta is irrelevant.

6.2.6 Conclusion Regarding Dr. Benjamin's Evidence

127 None of Dr. Benjamin's evidence is admissible. His opinion that masking reduces COVID transmission is irrelevant because the Crown concedes that fact. His opinions regarding distance learning and the impact of masking on children are outside his area of expertise. His opinions regarding policy questions do not bear on a fact in issue before me and are consequently irrelevant. The potential helpfulness of his evidence regarding the vulnerability to COVID of children who have received organ donations or are receiving cancer treatment, is outweighed by the significant frailties of that evidence. In that context, his estimation regarding the number of such children in Alberta is irrelevant.

128 I am not criticizing Dr. Benjamin's work or expertise or questioning his dedication to his profession. My decision is confined to applying the rules of evidence to his testimony in the context of this action.

6.3 The Absence of Evidence to Support the Charter relief

129 The Applicants have not proven that the Order or Minister LaGrange's Statement have any impact on them or any impact on other disabled children. This is fatal to their claim for *Charter* relief:

> Where a person challenging a law's constitutionality fails to provide an adequate factual basis to decide the challenge, the challenge fails. As Cory J. put it on behalf of the Court in ***MacKay v. Manitoba*** [1989] 2 SCR 357 (SCC), at p. 366, "the absence of a factual base is not just a technicality that could be overlooked, but rather *it is a flaw that is fatal to the appellants' position*" (emphasis added).
>
> ***Ernst v Alberta Energy Regulator*** 2017 SCC 1 at para 22

130 The Applicants' claim for *Charter* relief fails due to lack of evidence. It is consequently not necessary for me to do any analysis of the application of ss. 7, 15 or 1 of the Charter to this case.

7. Disposition

131 The Applicants' Originating Application seeks an order quashing and setting aside Dr. Hinshaw's Order. That aspect of this application is moot now because Dr. Hinshaw has rescinded the order herself. The Applicants also seek an order requiring either the existing Chief Medical Officer of Health or a "new and unbiased" Chief Medical Officer of Health to reconsider the matter and make a new decision. That would not be practical because public health orders must be made based on the situation at the time. The COVID-19 pandemic is at a different stage now than it was in February 2022.

132 The Applicants also seek declarations regarding both the Order and Minister LaGrange's Statement. For the benefit of the Chief Medical Officer of Health and other medical officers of health in considering future public health orders, I agree that I should make a declaration that provides that the Order was unreasonable because it was based on an interpretation of the *Public Health Act* as giving final authority over public health orders to elected officials.

133 I also declare that Minister LaGrange's Statement did not prohibit school boards from imposing mask mandates in schools. In my view that declaration is warranted because of the widespread misunderstanding of the legal effect of Minister LaGrange's Statement, and the fact that, on the evidence before me, that statement has not been rescinded or retracted.

134 I dismiss the application for *Charter* relief.

135 If the parties are not able to agree on costs they may contact the Justice Seized Coordinator to schedule a one hour hearing on costs before me.

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TAB 2

1995 CarswellAlta 1246
Alberta Court of Appeal

R. v. Kostiuk

1995 CarswellAlta 1246, [1995] A.W.L.D. 1078, [1995] A.J. No. 951

Her Majesty the Queen, Respondent and Richard Donald Kostiuk, Applicant

Belzil J.A., Côté J.A., Lieberman J.A.

Heard: October 16, 1995
Judgment: October 16, 1995
Docket: Edmonton Appeal 9503-0513-A2

Proceedings: Leave to appeal refused, 187 A.R. 319 (note), 127 W.A.C. 319 (note) (S.C.C.)

Counsel: J. Watson, Q.C., for Respondent, Her Majesty the Queen
R.S. Prithipaul, for Applicant, Richard Donald Kostiuk

Subject: Criminal; Constitutional
Related Abridgment Classifications
Judges and courts
XVII Stare decisis
XVII.2 Prior decisions of same court
Headnote
Criminal law

***Côté J.A.*:**

1 In this case the first motion is for leave to reconsider the correctness of the *Lorincz* decision, in other words to get leave to argue that it was wrongly decided. That decision was only heard as recently as January 4 this year, so it is not a case where the law has evolved and society has changed, or something like that. It doesn't on its face have any obvious flaw or simple easily-demonstrated error. It is also a transitional case, because it only relates to a stay of some 20 or 21 days, and so once the cases affected have all worked themselves through the system, as many of them already must have, it will have no more effect. Therefore, we deny leave to reargue the correctness of the *Lorincz* decision.

2 The other motion in this case is an ordinary one for leave to appeal further from Queen Bench to the Court of Appeal in this summary conviction matter. One of the aims of the new Practice Directions saying that leave motions will now be heard separately, is to save judicial time. To have one panel of three judges hear such a motion in order to see whether a second panel of three judges should then hear the appeal seems to us the reverse of saving judicial time. These motions are heard Tuesdays, Wednesdays or Thursdays before whomever is the duty judge. So we will simply adjourn that second motion *sine die*, and either party can on notice or by private arrangement bring it on before a duty judge to hear on the merits.

End of Document

TAB 3

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

Defendants

H E A R I N G
(Excerpt)

Calgary, Alberta
April 4, 2022

Transcript Management Services
Suite 1901-N, 601-5th Street SW
Calgary, Alberta, T2P 5P7
Phone: (403) 297-7392
Email: TMS.Calgary@csadm.just.gov.ab.ca

Q Okay. Nor do you have any training in travel and tourism policy or governance?
A Again, similarly only as far as that would relate to public health.

Q Okay. You'd agree with me though that your orders, various orders, they really impact all of those different areas, don't they?
A Yes, the orders have many impacts.

Q Okay and we can agree that you're not an elected person, you're a person whose been selected by the elected government to fill the office Chief Medical Officer of Health, but you've never been elected by the -- by the voters of Alberta?
A That's correct and that's exactly why the process that informs the CMOH orders was structured the way it was, if you note point 29 of my affidavit talks about the decision-makers being elected officials who decided on the policy decisions that informed the CMOH orders and it is exactly because I am not elected, my role is to provide recommendations. Elected officials make the decision and then the instrument that was used because of the nature of the emergency we were facing was CMOH orders implemented at the direction of elected officials.

Q Right and I know that that's true, I don't doubt that, but the fact remains that these orders are your orders, these are not orders that the Premier or anybody else -- the orders that we're talking about are your orders, order of the Chief Medical Officer of Health?
A Yes, that's correct.

Q Okay.
A Again based on the process that was foundationally meant to enable the decision-making to take place in the hands of elected officials.

Q Okay. If I could refer you to paragraph number 16 of your affidavit, this is on page 5, so you see it reads there that as part of your training it says: (as read)

> The Royal College's training materials explain fulfilling these two overarching roles requires Chief Medical Officer to have developed foundational competencies in clinical medicine and the determinacies of health upon which are built further competencies in public health sciences including but not limited to epidemiology, biostatistics and surveillance, planning implementation and evaluation of programs and policies, leadership, collaboration, advocacy and communication.

So we're going to get into in the course of my questioning, some of your -- some of the things that you've said on the topic of epidemiology, but it's not my understanding that you've been produced as an expert in epidemiology, you clearly have some knowledge

manage the condition or suite of conditions that particular patient has. Many patients have multiple conditions and treating one condition may cause challenges in another area. So there's always a need for balancing all of the different components of health when creating a treatment plan for individual patients.

At a population level, the diagnostic and assessment tools that are used are surveillance, epidemiology, biostatistics, using the population level data to understand what the issues are that are facing that particular population. Again, looking at trying to balance all of the competing interests while creating the -- again from a population perspective, a treatment plan is contemplated not simply by a physician, but in contemplation with elected officials who are the proxy decision-makers given that they are elected by the people to make important decision.

Then just as an individual physician would consult with an individual patient about the pros and cons of different treatment options and approaches in a population level perspective at a province-wide level, those are the kinds of discussions that take place so that the public health physician makes those recommendations, has that discussion. The decision is made by the people's representatives and then that treatment plan is able to be carried out again balancing all of the different health issues that that population is facing.

Q Okay. I didn't ask you this, but it seems pretty obvious that you're a medical doctor?
A Yes.

Q Okay. So, in this metaphor if we can call it that of the people of Alberta being the patient, that would put you in the position of being their doctor; is that basically how you see -- how you see yourself? That's what you appear to be stating there.
A At a population level, yes. I --

Q Okay.
A -- I would be considered to be again providing recommendations for the benefit of the population of Alberta.

Q Okay. When you -- when you became a physician, did you take something called the Hippocratic Oath?
A I did.

Q Okay and does that not state, do no harm?
A That is a part of the bigger pictures and I think all physicians when discussing issues with their patients need to understand again the balance of issues. So, for example, a surgeon, part of the treatment plan sometimes involves harming the patient from the

Q And so I think you talked earlier, I think you mentioned Indigenous populations and the elderly, who else would've been included in that most vulnerable category? Who would've received early access to the vaccines?

A The earliest access was for those -- two populations beginning with those who lived in long-term care and designated supported living facilities, so residents in those facilities as well as the staff who worked in those facilities, who worked in COVID wards of the emergency department, in order to be able to protect those vulnerable individuals both directly by providing them a vaccine but also to form an additional layer of protection by offering vaccines to those worked closely with them on a daily basis. As well, the -- I believe it was 65 plus individuals in Alberta who were Indigenous, First Nations Metis or Inuit. The initial rollout in late January, early February for First Nations and Metis peoples was specifically those who were on reserve or on settlement. And then as we progressed into late February and March where we were moving into community dwelling seniors outside of congregate living facilities, as well as other levels of congregate living facilities in addition to the designated supported living and long-term care. In the next rounds, we also opened up whenever there was an Indigenous categorization of eligibility it would include both those living on and off that settlement and reserve. So there was sort of a staggered approach but the first three months it was really targeted, again, at those highest risk and then moving out to include additional levels of those who were at risk.

Q Okay. So within the language of public health, which is the one that you speak, isn't that -- wasn't that an example of focused protection?

A Well, I mean, I think it depends how you define focused protection. I think it was an example of prioritizing limited resources and making them available to those at highest risk. So if that's your definition of targeted protection, that was not a term that I would typically use, I would typically talk about kind of risk-based prioritization.

Q Right. Okay.

A But -- yeah.

Q Okay. Shakespeare would say a rose by any other name, but I get what you're saying. You decided -- you made a decision that a group of people were the most vulnerable and you wanted them to have the earliest access to the vaccines because that could do the most good to the greatest number of people because they were the most at risk from serious illness or death from COVID-19. And so, as you say, you rationalized resources and made those vaccines available to those -- to those people who fit within those high-risk categories. That's -- is that fair?

A Yes. I mean, it's important to ensure priority about process. So these decisions are made by elected officials. When we bring --

Q Yes.
A -- (INDISCERNIBLE) recommendations based on the Alberta Advisory Committee on immunizations. So I just want to be clear that I certainly made recommendations after taking into account recommendations from a broad group of people and then put that forward to, again, people who are elected to make decisions on behalf of the population. And so that was --

Q Right.
A -- the way it was rolled out.

Q Okay. No, I appreciate that clarification. But as you probably realize, from most Albertans you were the public face of, you know, COVID-19 pandemic; right? In terms of getting information and so on. So there is this perception that these decisions are coming directly from you. I know you appreciate this but I understand the clarification. If I could refer you next, please, to paragraph 75 of your affidavit.
A M-hm.

Q So here you're talking about COVID-19 and the evolving scientific knowledge. Here you state: (as read)

> Because COVID-19 is a new threat and we continue to learn new things about it, the best evidence with respect to COVID-19 has changed and evolved over the course of the pandemic.

And you've told us something about that process today.

> Throughout the pandemic we have sought to learn and adjust to the best evidence to allow Alberta to most effectively minimize both the risks of public health measures and the risks of COVID-19.

But it's also true that you were not paying much attention to certain types of information that were available about COVID-19 and I'm speaking specifically, for example, things like the Great Barrington Declaration. You did not put much stock in that.
A So I'm not sure it's accurate to say that I didn't pay much attention to it. I read it thoroughly, thought about it deeply, and as you can see (INDISCERNIBLE) went through a process of working out what would that mean in Alberta if we were to attempt to implement what was alleged to be a better way forward in that Great Barrington Declaration. So I did read it, I did consider it, and I did respond in a detailed way that was posted for public consideration.

Q And at paragraph 80 it lists some of the different types of people you had on your team. I want to ask you about, for example, at bullet point -- the second bullet point in paragraph 80 talks about epidemiologist, data analysts, and mathematical modellers as described in Dr. Simmonds' affidavit. Did you have someone who was an epidemiologist sort of on your staff, on your team giving you specific advice throughout the period that we're talking about in this case? Did you have sort of somebody who was your right-hand person who -- I realize obviously you have some background in epidemiology but did you have an epidemiologist advising you specifically during this timeframe?

A So our response is structured with an emergency operations centre and there was an entire surveillance and analytics section of the emergency operations centre that was led at different times by Dr. Simmonds and she left government and so there's been another person who's been in that role and who also worked with Dr. Simmonds while Dr. Simmonds was here. So that lead person is the person I would typically go to with questions but it is the whole team that works on the different aspects of epidemiology and then would provide the data in terms of what we were seeing in our own Alberta experience. So, again, there was a -- there's a team that's referred to in that second point, the EOC analytics team, they were all involved with different aspects of analyzing the data.

Q As you know, Dr. Kindrachuk has testified in this hearing as an expert specifically in the -- on the subject of virology. But he's -- he's from Manitoba. I take it Dr. Kindrachuk was not part of your team, he was not somebody who was providing you advice or expert information on an ongoing basis during the relevant timeframe that we're -- that we're talking about. He was somebody who came later as part of litigation but he was not part of your -- part of the team that's described at paragraph 80 of your affidavit.

A He was not. We did have others who fulfilled that role in Alberta in terms of, again, the virologists in the public health laboratory who provided -- I think Dr. Nathan Zelyas has been also one of the people who's provided evidence and so he and the rest of the team at the Alberta Precision Laboratories would've provided all of the laboratory specific virologic expertise. And we had others who were involved in evidence analysis, the scientific advisory group you'll see in bullet 4 was a very important part of getting evidence summaries on key topics and points and so they really served that purpose of when we had key questions they would provide literature review and analysis of the current state of the evidence on particular topics. So we had different groups and different individuals who served functions in Alberta, again, from those different topic areas.

Q One area -- one topic that seems to be missing from what's described in paragraph 80 is an economist who was giving you advice about the, you know, risk benefit of NPIs. Was there somebody on your team who was doing that? Someone who was an

economist who could give you advice about the relative benefits versus harms of NPI measures?

A The way that we structured our response, the EOC within Alberta Health was really focused on the health-related (INDISCERNIBLE) and when -- in terms of that decision-making process there were questions about economic impact and those types of analysis, those questions would've been referred to other ministries who had expertise in those areas.

Q Okay.

A So, again, that -- that wasn't, as what you clarified at the beginning, I'm not an economist and so we referred those questions to other ministries as they are in a better position to be able to answer them.

Q And so just to follow up on that question, so when you made those referrals to other ministries, and presumably to experts, did they report back to you about the relative risks or the loss versus benefit harm of these non-pharmaceutical interventions? Did you receive that kind of data from these other ministries?

A Again, it's really important to remember that the decision-making body was the Cabinet committee, at different times it was called the Priorities Implementation Cabinet Committee or the Emergency Management Cabinet Committee and so the content specific input would come to that Cabinet committee from the relevant areas of expertise. So the economists didn't report to me that, you know, we again prepared our recommendations from a health perspective considering and weighing out risks and benefits from -- from that health perspective knowing that there are health implications for some of these non-pharmaceutical interventions and so creating those recommendations and the economics input would have gone directly to that committee that was deliberating from the areas that had the expertise.

Q Okay. So, for example, the economic impacts of restricting the operation of certain types of businesses, that would be outside the scope of your knowledge as a Chief Medical Officer of Health and so you would not concern yourself with those impacts, you would just trust the information that was being received to you or by you from other ministries? In other words, you didn't concern yourself with that part of it even though that may have been part of your orders.

A I wouldn't say that I didn't concern myself with it. I would say that I didn't have the expertise to comment in detail on those aspects so others with that expertise were called upon to provide that detailed evidence to those that had to make the decision.

Q Okay. And so how would that then find its way into your orders because your orders all start, you know, I, Deena Hinshaw, Chief Medical Officer of Health, so they're your orders. So how would those, you know, for example, restrictions upon business, how

would those find their way into the -- into the order?
A As you'll recall earlier, I spoke about the process that underpinned the orders and the recommendations that we put together from the perspective of managing COVID would go to Cabinet committee, there would be deliberation and policy decisions were made by the Cabinet committee, and then record of decision from the Cabinet committees would inform the structuring of the order that would be the legal instrument to carry out the pandemic response tools that were being implemented.

Q Okay. Dr. Hinshaw, at paragraph 87, this is on page 27 of your affidavit, there's a heading here, "Consideration and weighing of the cost and benefits of Alberta's public health measures," do you see that --
A M-hm.

Q -- part of your affidavit? Okay. And so paragraph 87, the first sentence reads, "The Bhattacharya report," and here we're talking about the report that Dr. Bhattacharya submitted in this -- in this proceeding, implies that there was no weighing of non health-related implications to Alberta's pandemic response. I take it you -- you say that is simply wrong?
A Yes.

Q Okay. And are you saying that -- because we were just talking about these economic impacts, so to that extent it's true that there was no weighing of those impacts by you, that might've been done by somebody else. For example, the economic impacts of one of your orders. Let's say -- let's take one that -- restrictions on business -- certain business operations. You would not have weighed those economic impacts yourself, you presumed that somebody else in the government would've done that for you; correct?
A I wouldn't agree with the statement they would have done it for me. Again, the decision-makers were elected officials and so we made sure that where multiple inputs were needed the appropriate experts were providing that input to those who were making the decisions and those impacts were considered as a part of that decision. So, again, it's the role of elected officials to make policy decisions on behalf of the population and so, again, we collectively made sure as a whole government approach that the appropriate expertise was brought into discussions where needed so that a decision could be made considering all of those factors.

Q So, going back to what it says in the affidavit, it says that there was no weighing of non-health related implications to Alberta's pandemic response. You're saying that's not true but it is true that the non-health related implications, the weighing of them, was not done by you personally?
A So the determinates of health, as we've spoken about before, were certainly a part of

the considerations. So I, again, would not be able to comment on the specific economic implications of one type of business closure over another but considerations of the broad determinates of health impacts of non-pharmaceutical interventions were a part of my team's deliberations which again is why I commented on all of the health-related impacts which are beyond just COVID specific health related impacts. So this paragraph is talking about the underlying principles of multiple determinates of health recognizing that societal disruptions do have reverberations with respect to health and that was considered as a part of our discussions about what the appropriate recommendations were to bring forward. But specific economic detailed analysis is simply not something that we were resourced -- or, again, is within our expertise and therefore that was referred elsewhere to be a part of that overall decision-making.

Q All right. So just to follow that up, at the end of paragraph 87, this is on page 28, the last sentence of that says that: (as read)

> Thus, Alberta's response has included the careful weighing of costs and benefits throughout the course of the pandemic.

You said that there was this -- it says here that this was this intersectoral collaboration approach, are you aware of the existence of an actual report or study that was generated by the Government of Alberta concerning the risks versus benefit analysis of NPIs? Was there a specific report generated anytime that you're aware of?

A We were looking at the evidence that had been generated by other jurisdictions. There was work underway that looked at impacts of the NPIs and so, again, that's really what we were looking to is utilizing the evidence generated by other jurisdictions. In terms of a report, again, we were looking at the data that was available to us. I'm not sure, again, whether a formalized report was put together but we did certainly provide data that we had access to with respect to the trends that had been seen over the course of the pandemic. I believe that other bodies such as the Health Quality Council of Alberta did some reports based on some surveys throughout the course of the first year of the pandemic just looking at some impacts, for example, on self-reported mental health and some specific work on seniors. So there were, again, some bodies of work that were -- that were done and shared with the public and there were other pieces of work that really were put together to form the data portions of -- to inform the deliberations of Cabinet committees.

Q So, to your knowledge, there's no comprehensive report generated by the Government of Alberta or commissioned by some outside body reporting to the Government of Alberta on the harms that the -- the perceived harms, anticipated harms, from NPIs? That's not something that you've seen? If it exists, you're not aware of it?

A I believe it's perhaps been approached in some more of a sector-specific way. So, for

That seems to be the thought process that was going on, would you agree with that?

A No.

Q Okay. Let's look at paragraph 89 for example. So this, I suggest to you, is an example of this thought process that I just described. So here, and you've acknowledged and you've been very frank about this, you've acknowledged that these orders, these NPIs that restricted liberty, that they caused harm, and so here, as I read paragraph 89 which talks about providing $40 million in support to Alberta's opioid response, and $53 million to expand online phone and in-person (INDISCERNIBLE) and mental health supports to make it easier for Albertans impacted by COVID-19 pandemic to access information, support, and referrals from anywhere in Alberta during the pandemic, this, to me, looks like an example of exactly what I was talking about; okay? And I'll be very succinct about this. You made a decision to impose NPIs on Albertans and you knew that was going to cause harm to Albertans, you did it anyway, and then when the harms happened the response was we're going to throw money at the problem. That's what it looks like, Dr. Hinshaw. What do you have to say about that?

A I would just be clear that I made recommendations in different contexts. So I think we're talking specifically about the second wave and third wave. And, again, going back to the second wave, the recommendations that I made started out because I was aware that non-pharmaceutical interventions come with unintended consequences and harms, that if we could manage the pandemic with guidance, with recommendations, with voluntary measures, that that would be the best case scenario. And so over the course of the ensuing months from October through early December, we did our best to provide the recommendations to the decision-makers regarding the least intrusive options that potentially could've been successful. Unfortunately those were not successful and what we saw as a result was a steep escalation in burden on the acute care system resulting again in delayed access to care for other health issues, as well as the severe outcomes directly related to COVID. And so, unfortunately, given that all attempts to use the voluntary measures had not been successful in affecting the healthcare system that it was necessary to make recommendations with respect to mandatory measures and that because it was clear that those would have impacts again there was other work underway to try to mitigate the impacts of non-pharmaceutical interventions including funding for mental health supports, including, as I believe has been provided with other witnesses, financial support for businesses, financial support for those who needed to be in isolation or quarantine, to try to mitigate some of the impacts that those non-pharmaceutical interventions would have.

So, again, it's really important to remember that there was no approach that would have been an approach with no harms to anyone and that we did our best to move that voluntary approach as far a we could and unfortunately it was not successful and we were left with few options to protect the healthcare system. And, again, my

recommendation to the decision-makers as I put forward those recommendations was to move then towards mandatory measures in order to protect the healthcare system, protect the health of all Albertans, and to consider those mitigating interventions to minimize as best as we could some of those other unintended consequences.

Q Dr. Hinshaw, what you're describing and you described this previously in your evidence is how you say that your team and the Government of Alberta was sort of gradually adapting and responding to these different pressures and learning, and growing, and changing your approach. But on one view of the matter it looks like you go back to (INDISCERNIBLE) days to flatten the curve, we go from NPIs, arguably lockdown, loosening of restrictions, and then back into NPIs, and then we go back into voluntary compliance and then that doesn't work, and back into -- and then back into NPIs going into the latter part of 2020 and then all the way through until -- really until June or July of '21. So it looks like this -- I know you take -- the Premier takes offence to the word "lockdown" but it looks like, you know, we have this sort of lockdown, loosening, lockdown cycle so that your solution -- or the Government's solution to an uptick in cases or challenges to the healthcare system was always NPIs. That was the go-to move, that's where you always went. There does not appear to have been any consideration of pivoting and changing your approach, for example, the way Florida did or Sweden did. Why was that? Why was your government -- why were you so convinced that these NPIs were working because there doesn't seem to be a lot of evidence to support that? Why were you so convinced that these NPIs were working?

A I've spoken earlier about the really clear local example that we've all lived through that shows that non-pharmaceutical interventions had a very significant impact when we compare waves 1 and 2, that it's very clear we can see that the early introduction of non-pharmaceutical interventions had a dramatic impact on lowering -- and, again, cases are important simply because it's the cases that lead to those severe outcomes and not just the direct COVID harms - the deaths, the hospitalizations - but also the filling up of the healthcare system and the need, therefore, to limit access to other health services that can result in other harms. And what we saw in the first wave was that our non-pharmaceutical interventions applied early dramatically reduced the cases and hospital impact.

In the second wave, we saw that, again, unfortunately voluntary measures were insufficient and because of the timing of the implementation of the measures being once the community transmission had taken very solid hold, we did see a very significant impact on acute care. So, again, comparing waves 1 and 2 is a very clear piece of evidence with respect to how important the non-pharmaceutical interventions are. We thankfully have vaccine available to us and it is a very powerful tool to prevent severe outcomes, unfortunately in the third wave in the spring we had two issues - one was that we had the more infectious Delta variant taking over and becoming dominant in

pandemic Sweden had a 12 times higher deathrate than we had. As our deaths have increased, that difference has dropped; however, we still have -- or Sweden still has double the par capita deathrate that we have in Alberta. And so, ultimately, there is a trade-off debate that needs to take place. And, again, that is why elected officials are the best position to make these decisions because there are very difficult trade-offs that need to be wrestled with and that the more widely COVID spreads without interventions to minimize its spread the more harms that occur, the more people die and the more healthcare space is utilized, and the more we see other healthcare needs being deferred and delayed and some of those reverberations. So, as I've said, the interventions themselves have harms, as does COVID, and there is no single decision that will -- that will be without consequence.

Q Right. But when you say there wasn't another path, there was another path but you -- I think you told us why, you rejected it. There was another path to go but you thought that was not the best path for Alberta.

A Again, my recommendations to elected officials really we're looking at the impact on the healthcare system, our ability to care for patients with all healthcare needs, and the, again, impacts of COVID deaths. And so those were my recommendations that predicated on those very significant impacts and decision-makers had to weigh out the various options, the implications, the harms that would come from wider spread with more severe outcomes, weighing out against the harms of the interventions.

Q Dr. Hinshaw, at page 29 of your affidavit there's a heading, "Alberta's response to COVID-19 has been equitable", beginning at paragraph 93 and following. We talked about this a bit before. At paragraph 99, this is on page 30, states that: (as read)

> Within this framework and in furtherance of the public health objective in Alberta, we have strived to ensure all groups (INDISCERNIBLE) have equitable access to multiple ways to protect themselves from the transmission and from the potential repercussions of infection. If a group did not have this equality of opportunity, that was not because of the group's demographics, geography, or economics.

You seem to be using equality and equity interchangeable there which your own health policy discourages. What do you mean when you -- at paragraph 99 when you say equality of opportunity? What are you referring to there?

A So the, as we discussed earlier, the definition of health equity is to remove avoidable barriers to achieving health. So the reason that the word equality is used in the final sentence of that particular paragraph is if health equity is, again, the removal of avoidable differences that another way of stating that is to say that all of these different

TAB 4

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

Defendants

H E A R I N G
(Excerpt)

Calgary, Alberta
April 5, 2022

Transcript Management Services
Suite 1901-N, 601-5th Street SW
Calgary, Alberta, T2P 5P7
Phone: (403) 297-7392
Email: TMS.Calgary@csadm.just.gov.ab.ca

The Witness Cross-examined by Mr. Rath

Q MR. RATH: (INDISCERNIBLE) Dr. Hinshaw. Dr. Hinshaw, can you please turn up paragraph 22 of your affidavit?
A Yes.

MR. RATH: I'm sorry, page 7, paragraph 22, My Lady.

Q MR. RATH: In that paragraph, you're talking about your powers under section 29 of the *Public Health Act;* is that correct?
A Yes.

Q And it seems that you're indicating that the powers under section 29(2) are extremely broad and you state that section 29(2)(b)(i) has provided you: (as read)

> With the power to take whatever steps I consider necessary to suppress COVID-19 and those who have already been infected with COVID, to protect those who have not already been exposed to COVID-19, to break the chain of transmission and spread of COVID-19, and to remove the source of infection.

And then under 29(2.1)(b) that says:

> To take whatever other steps in my opinion are necessary in order to lessen the impact of the public health emergency.

That's correct?
A Yes. So just to be clear, as I mentioned to Mr. Grey, this particular paragraph is talking about the legal powers that are given to all medical officers of health in the Province of Alberta under the *Public Health Act* in general with respect to communicable diseases and public health emergencies. And this paragraph 22 is essentially translating the powers under the *Public Health Act* that apply to communicable diseases and then specifying them in the context of COVID. So, just to be clear, the *Public Health Act* does not explicitly state COVID-19, it is general to communicable diseases and public health emergencies.

Q No, that's right. But generally speaking, section 29(2.1)(b) gives you extremely broad almost omnipotent powers that you referred to as your legislative authority; is that correct?
A That section -- oh, sorry.

MR. PARKER: I'm going to object on the basis of, first of all, my friend's argumentative omnipotent powers. I appreciate -- the other basis is in terms -- well, I'll leave it at that. The objection is (INDISCERNIBLE) at this point. Thank you.

MR. RATH: I'm just trying to get to the bottom of the extent of her legislative power --

THE COURT: Okay. Okay. Mr. Rath, I am going to allow the question.

Mr. Parker, I appreciate what you are saying but Dr. Hinshaw I am sure recognizes the implication of that word.

Okay. Go ahead, Dr. Hinshaw.

I am sorry, what was the question? I think we have not had the question, have we?

Q MR. RATH: That was the question, that that section, to your mind, confers extremely broad legislative authority on you, Dr. Hinshaw.

THE COURT: Okay.

A That particular section confers broad legislative authority on those who are appointed as medical officers of health in the context of communicable diseases and the context of public health emergencies.

Q MR. RATH: Right. And that includes the power to shut down businesses; correct?

MR. PARKER: I'm going to object on the basis that he's asking the question for a legal interpretation of the statute and that is a matter for others.

MR. RATH: Well, she's issued orders shutting down businesses, I just want to confirm that that's her understanding that she can shut down businesses under that section. They're her orders, My Lady, I would think she would know what she's ordering and under what section she ordered them.

THE COURT: Well, your question was that the section gives you the power to shut down businesses; is that correct? That is my understanding of the question. That seems to me to be asking for a legal opinion so I uphold the objection.

MR. RATH: Well, My Lady, with the greatest of respect, the paragraph itself (INDISCERNIBLE) constitutes what appears to be a legal opinion. She states: (as read)

> Section 29(2)(b)(i) of the Act has provided me the power to take whatever steps I consider necessary.

I'm just trying to get to what the limits are on the powers, if any, and she's certainly been shutting down businesses in the Province of Alberta and I just want to know whether she's been shutting down businesses under section 29.

THE COURT: I am sorry, Mr. Rath, I made a ruling on this. She, meaning I guess Dr. Hinshaw, has said what she said in paragraph 22. If you would like to cross-examine her on what you believe are the limits of that power, let's see if you can come up with a question that does not call for a legal conclusion.

Q MR. RATH: Dr. Hinshaw, were the orders that you issued shutting down businesses in the Province of Alberta issued under section 29?
A Yes, all of the orders that I have issued have been issued under section 29.

Q Okay. And to your mind does that section give you the authority to bankrupt businesses in the Province of Alberta?

MR. PARKER: Objection.

THE COURT: I am sorry, is there an objection, Mr. Parker? I have not heard you.

MR. PARKER: Yes. My apologies.

THE COURT: Okay.

MR. PARKER: Oh, I'm sorry. Yes, the objection, again, the question was asking whether the section provided the authority to bankrupt businesses. That, again, is asking for a legal interpretation of the section of the *Public Health Act.*

THE COURT: Okay. Mr. Rath, do you want to respond to that?

MR. RATH: I'll withdraw the question and I'll ask it in a different way.

Q Fair enough. And in that regard, Dr. Hinshaw, with regard to your powers under section 29 of the *Public Health Act* to do whatever you, you know, whatever -- to order whatever is necessary to ameliorate the public health crisis, do you consider that your powers included ordering the Government of Alberta to put additional funds into the healthcare system to increase hospital capacity?

MR. PARKER: Again, this is asking for a legal -- objection, the question calls for legal interpretation of section 29 of the *Public Health Act.*

THE COURT: Mr. Rath?

MR. RATH: It seems to be within the scope, My Lady. This is cross-examination and I'm trying to determine the scope of what Dr. Hinshaw considered her powers to be.

THE COURT: I am going to allow the question. Dr. Hinshaw?

A Just want to be clear that, and you may recall that we spoke a little bit about the process earlier, so under legislation I have the responsibility to provide advice to the Minister and that the process, given that this was an unprecedented threat that we were facing, and that the section 29 powers were being utilized in ways they had not been utilized before, the process that was established to ensure that those policy decisions were being informed by representatives of the people as is appropriate, was that the policy decisions that were made were based on recommendations that I provided and then weighed and decisions made by elected officials to inform the outcome of the orders. So, with respect to the question of whether I would consider myself to be able to order the government to spend money on acute care, I -- because the decisions were made, again, by those policy makers, I would consider that the scope would fall under, again, public health management. And the management of acute care resource and acute care capacity certainly was part of the response but I wouldn't consider it to be part of my ability to write an order to order the government to spend money on something given the process that was set up really reliant on policy decisions from elected officials.

Q MR. RATH: All right. Thank you. Now, with regard to your role as a CMOH and your ongoing monitoring of the impacts of your various CMOH orders, did anybody ever advise you as to what the economic impact of your orders were on the Province of Alberta?

A The specific economic evaluation was done by experts in that area and, again, that was provided as information to elected officials as part of the decision-making process. So (INDISCERNIBLE) part of those conversations but, again, given where the decision-making roles were allocated it was appropriate for the economic experts to provide that

information in that forum. And, yes, I would have heard the information provided.

Q All right. And could you advise the Court as to how many billions of dollars your orders have cost the Province of Alberta since they were culminated, from an economic perspective?

A Again, to be clear, the information and the analysis was not done by my office, it was done by those who have expertise in economics. And I'm not sure if the question -- first of all, again, I don't have that information at my fingertips and, second, I'm not sure if it's about the timeframe in question or what that specific question is about.

Q Well, we're limited to the third wave, Dr. Hinshaw, so let's say from March of 2020 to the swearing of your affidavit on the 12th day of July 2021, did anybody ever advise you how many billions of dollars your CMOH orders have cost the economy of the Province of Alberta?

A I think it's not appropriate to assume that all economic impacts that happened in the province were solely as a direct result of orders. There was evidence that had been shared again at -- in conversations about the publications that had been done on economic impacts indicating that there were economic impacts that were seen when uncontrolled COVID spread was present in a community, in addition to economic impacts of orders. So, I think that, again, it would be very difficult, certainly I don't recall information being shared, that would have been able to distinguish between economic impacts of the pandemic and the economic impacts of the orders specifically.

Q Okay. So certainly as an Albertan you've seen all of the shuttered bars and restaurants that have closed down over the course of the pandemic, have you not? Dr. Hinshaw?

A So I'm aware there have been business closures throughout the pandemic. Again, it's difficult to be able to entirely differentiate the impact of the pandemic overall and the impact of the orders specifically. But absolutely, there have been business closures throughout the pandemic.

Q Right. And do you accept that to the extent that restaurants and gyms have gone bankrupt, that they could've been bankrupted as a result of your orders closing those businesses?

A I'm certain that the orders were a factor in, again, depending on the specifics of each individual location. I'm sure that the orders were a factor.

Q Thank you. And in that regard, has anybody provided you an estimate as to how many millions or hundreds of millions or billions of dollars could be attributed to losses directly caused by your orders?

MR. PARKER: I believe she's been asked and answered this

Services. And it's my opinion that no order that I could possibly have put together would have changed -- would have enhanced the ability of the healthcare system to expand beyond all the extraordinary measures they were already taking.

Q What about bringing in general practitioners and others from their practices in Calgary, Edmonton, and elsewhere in the province to buttress COVID care capacity and paying them more to do it? Would that not be possible?

A Again, the details of all of the different methodologies that were employed to expand the capacity of acute care would best be discussed by Alberta Health Services. It's my opinion that they were doing everything in their power to expand acute care capacity with all means at their available -- at their disposal. And I wouldn't be the right person to ask the specifics of managing acute care capacity.

Q Right. But in the context of issuing your CMOH orders, did you have these very specific and pointed discussions with Alberta Health Services about putting more money into increasing capacity as opposed to stripping Albertans of their civil liberties?

A Again, it's important to remember the process by which decisions were made. And Alberta Health Services was part of the discussions and certainly there were -- essentially no stone unturned to expand acute care capacity to facilitate expanded care and minimize the need for utilizing non-pharmaceutical interventions. And, again, it's important to remember that the orders were the legal instrument to implement the policy decisions of Cabinet and so there was a group of people who deliberated and who ensured again that everything that could possibly be done to expand acute care capacity was being done. And so that was all a part of the conversation.

Q Right. So, Dr. Hinshaw, is it your evidence then that these orders weren't your orders and that these were Cabinet orders that were being promulgated under section 29 of the *Public Health Act?*

A It's my evidence --

MR. PARKER: Objection.

A Oh, sorry.

MR. PARKER: Objection.

THE COURT: And the basis, Mr. Parker, the basis for your objection? Let's follow the process.

MR. PARKER: The basis, right, the basis for the objection is that the orders -- that's not her evidence. The orders say what they are, they're orders under

section 29, and the orders, each one of them, say the orders of the Chief Medical Officer of Health.

MR. RATH: That's the problem, My Lady, is that that what's the orders say but Dr. Hinshaw's testimony is something very different and I believe it's a live issue in these proceedings as to what -- and this was the evidence of David Redman, that those orders should've been promulgated under the *Emergencies Act* if they were orders of Cabinet. Now Dr. Hinshaw is actually swearing under oath that these are orders of Cabinet --

THE COURT: Okay. Hold on. I am sorry, Mr. Rath, I am going to stop you right there.

Madam clerk, would it be possible for you to please take -- Dr. Hinshaw, I am just going to ask you to go offline for just a few minutes while we deal with this objection? I do not know if that will cause you any difficulty in getting back online.

Madam clerk, can you just bring Dr. Hinshaw back to us when we have dealt with this objection?

THE COURT CLERK: I believe if she goes as a (INDISCERNIBLE) she'll still be able to hear. Perhaps if she doesn't mind (INDISCERNIBLE) a private chat, I can call her when we're ready to bring her back or send her an email.

THE COURT: Okay. Dr. Hinshaw, my clerk tells me, I am sorry, I am not aware of how we can handle this, but if you could just contact the clerk in a private chat, she will let you know when we are finished handling this objection and she can bring you back online. Is that satisfactory? Can you do that?

A Sure. Maybe Mr. Parker could just send me a quick email since he already has my -- I just don't know how to get a hold of the clerk.

MR. PARKER: We'll take care of it.

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

(WITNESS STANDS DOWN)

THE COURT: Mr. Rath, the reason that I asked Dr. Hinshaw to go offline is that you are making a number of statements about your understanding of her evidence. Certainly your understanding of her evidence will be a matter for argument but

that is -- can you just -- I understand Mr. Parker to say that the question is not a fair question because the orders say what they say. You have responded by saying that is not Dr. Hinshaw's evidence and I have to say I do not understand what you mean by that. I know that you have put forward a witness saying that they should have said that they were the orders of Cabinet, Dr. Hinshaw has only indicated what the process has been, that she provided recommendations to Cabinet and then she issued orders. So maybe you can respond on your response to Mr. Parker's objection.

MR. RATH: That's what I'm trying to get to the bottom of, My Lady. It seems to me that she's repeatedly said that the process is that she makes recommendations to Cabinet and then Cabinet tells her what to do. So obviously there's the concern that we have with regard to the fettering of her discretion under section 29 of the *Public Health Act,* and if we are dealing with a situation where Cabinet is telling her what to do, we have some real concerns from a credibility perspective with regard to her (INDISCERNIBLE) where she's claiming to act in a medical capacity as the physician or doctor for every citizen in the Province of Alberta. Because it seems to be a very strange medical process to go through where somebody is supposed --

THE COURT: Mr. Rath, you are going way beyond. So I understand your response is that you are trying to find out from Dr. Hinshaw whether her evidence is that she made recommendations to the Cabinet and then Cabinet told her what to do; is that correct?

MR. RATH: That's correct.

THE COURT: Okay. Mr. Parker, do you want to respond to that?

MR. PARKER: I'm sorry, I was just asking Mr. Trofimuk to locate the amended originating application because I didn't, my apologies, I didn't get to state the full basis for the objection. There's a basis of -- the objection is also on relevancy because the issues that my friend is now raising, fettering discretion, have not been raised in the pleadings and so I wanted to get the amended originating application to raise the issue of where is this issue raised in the pleadings. So it's -- my response is to what I've heard that this issue is not relevant.

MR. RATH: This is a new issue, My Lady, that came directly from her testimony and it also goes to her credibility because she's stating that she was the one making the orders under the *Public Health Act,* her testimony (INDISCERNIBLE) all that into question by indicating that she's nothing more than a (INDISCERNIBLE) for Cabinet which is not contemplated by the statute.

THE COURT: I am sorry, Mr. Rath, your characterization of what you believe Dr. Hinshaw's -- you are entitled to your own characterization of what you believe Dr. Hinshaw's evidence has been, I am not necessarily agreeing at this point in time with your characterization. What I think we will do then, because this seems to me to call for a more measured response from both of you with perhaps some reference to the transcript of what Dr. Hinshaw has said, since we are not going to be finished today I want this question put aside and dealt with after you both are able to give me just some points with respect to whether or not this is actually raised by the pleadings and how you support your characterization of what you say you believe Dr. Hinshaw's evidence to be; okay?

MR. RATH: Thank you, My Lady.

THE COURT: Okay. And we will deal with that at the appropriate time tomorrow.

MR. RATH: My Lady, if I may, I was planning to proceed in a much more measured and orderly fashion.

THE COURT: I understand.

MR. RATH: (INDISCERNIBLE) afternoon because of the circumstances arising involving my friend, Mr. Grey. So perhaps -- I know we were planning on going to 5 today but perhaps this would be a good place to break for the day so that I could regroup and try to put things into some sort of order that's less perturbing to everyone.

THE COURT: Okay.

MR. RATH: So, I would appreciate that.

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

Mr. Parker, do you have any objection if we adjourn at this time?

MR. PARKER: No, Justice Romaine, we all want to get done. It would be great to get done and this isn't going to be helpful to that process but I'm -- we're in your hands of course. We appreciate everybody's --

THE COURT: Okay. Okay. And given the circumstances, I was hoping to get as much use out of the time as we could but I agree with Mr. Rath, it is a little

TAB 5

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

Defendants

H E A R I N G
(Excerpt)

Calgary, Alberta
April 6, 2022

Transcript Management Services
Suite 1901-N, 601-5th Street SW
Calgary, Alberta, T2P 5P7
Phone: (403) 297-7392
Email: TMS.Calgary@csadm.just.gov.ab.ca

> subject to oversight within the democratic structure of the Government of Alberta.

Now, with regard to your appointment as Chief Medical Officer of Health, you were initially appointed under the Notley government; correct?

A I was appointed in January of 2019.

Q Right. By the Rachel Notley government?

A Yes. I was appointed after having been serving as the Acting Chief Medical Officer of Health for the bulk of the year and a half preceding my appointment.

Q Okay. And when you say that you serve at the pleasure of the Minister of Health, what do you mean by that exactly?

A The Act that designates the person as the Chief Medical Officer of Health is a ministerial order. So the Minister has the ability to remove that designation or terminate the contract of the Chief Medical Officer of Health, or both.

Q At any time; correct?

A Yes, that's right.

Q And for any reason; correct?

A Well, if it's without just cause there's severance built into the contract. But certainly it can be terminated at any time and for any reason.

Q Right. And the reason I'm asking those questions, you were stating earlier that, in essence, that you don't -- you weren't the one making the Chief Medical Officer of Health orders, you make recommendations to Cabinet and then they would either accept or reject your recommendations; is that fair?

A Yes. You'll see paragraph 29 on page 9 of my affidavit lays out clearly the process that was put in place given as has been established that the nature of this virus was a novel and significant threat, and so the response was structured such that the elected members of Cabinet would make policy decisions and those policy decisions would inform the orders of the Chief Medical Officer of Health so that there was a working together of elected officials and my role as the Chief Medical Officer of Health. So I would provide recommendations. You'll see at paragraph 29: (as read)

> The Chief Medical Officer of Health is not the final decision-maker, rather, the Chief Medical Officer provides advice and recommendations to elected officials on how to protect the health of Albertans. Those elected officials take that advice as one part of the considerations in the difficult decisions they've had to make in

response to COVID-19. The final policy decision-making authority rests with elected officials and these policy decisions are then implemented through the legal instrument of CMOH orders.

So, again, that's the process that was established in the response to COVID-19.

Q Right. But not necessarily within the *Public Health Act;* correct?
A The *Public Health Act* -- oh, sorry.

MR. PARKER: Objection. It's asking for a legal interpretation of the *Public Health Act.*

THE COURT: Okay. Mr. Rath?

MR. RATH: Well, I'm just trying to clarify what process we're under. The process that Dr. Hinshaw's described doesn't appear to be set out in the *Public Health Act.* I was just asking her to confirm that.

THE COURT: No, that is asking her for a legal opinion so I uphold the objection.

MR. RATH: Okay.

Q MR. RATH: Dr. Hinshaw, with regard to recommendations you were making to Cabinet, is there any recommendations -- can you tell us what recommendations you made to Cabinet that were either ignored or where you were given instructions opposite to your recommendations?

MR. PARKER: We're going to object to that.

MR. RATH: On what basis, Sir?

MR. PARKER: The basis is public interest immunity. It's Cabinet-privileged information.

MR. RATH: Well, she's not acting as an officer of Cabinet, My Lady. She's acting as the Chief Medical Officer of Health. The Act clearly sets out that they're to be her orders. She's now told us that rather than making orders herself that she's being told what to do by Cabinet and I think we're entitled to ask which of her recommendations were being overruled by Cabinet. Like, as an example, and maybe I'll just ask this question.

THE COURT: Dr. Hinshaw?

A Thank you. So when I was speaking about this to Mr. Grey, I articulated that as a medical doctor for the population, of course with the volume of people in Alberta it's not possible to interact with each one of them individually and so when there is a province-wide decision to be made it is the elected representatives of the population in a democratic government who make decisions on behalf of that population. And so it's my job as the, again, in this particular position as the doctor for the population of this province, to provide my recommendations to those who are the peoples' representatives and then to use their policy decisions to inform the subsequent orders to manage the COVID-19 pandemic.

Q MR. RATH: Let's regard the specific orders as to who to lock down, when to lock them down, how to lock them down, et cetera, et cetera, would you agree that those aren't policy decisions, Doctor, that those are public health decisions that are -- that are advised by data and information that you would obtain as the Chief Medical Officer of Health?

MR. PARKER: Objection. This is asking for a legal interpretation, whether the power's exercised under the *Public Health Act* or not.

THE COURT: Okay. Mr. Rath?

MR. RATH: I didn't mention the *Public Health Act.* I'm simply asking whether she agrees that (INDISCERNIBLE) decisions with regard to who to lock down, where to lock them down, when to lock them down, et cetera, aren't policy decisions, that they're public health decisions. As an example, locking down a nightclub versus locking down a school or locking down a school as opposed to locking down a restaurant.

THE COURT: I will allow Dr. Hinshaw to answer that question.

A I don't think that's an appropriate distinction. Clearly the decisions that have been made with respect to intervening and spreading the -- stopping the spread of COVID-19 are policy decisions that are of course also public health interventions. The two, in my mind, are intertwined because of the impacts that these particular decisions have. So I wouldn't distinguish between the public health intervention which is a policy decision because of how broad the impacts are, as we've discussed over the past several days.

Q MR. RATH: Now, Dr. Hinshaw, in your affidavit at paragraph 11, you reference part of your role being the improvement of health and the well-being

Q But you -- that's fine. Thank you. Now, Doctor, at paragraph 28 you discuss your advisory role I believe to the EOC; is that fair? I'm sorry, your advisory role with regard to elected officials. In your mind, do you distinguish between your advisory role and any role that you play in promulgating orders under section 29 of the *Public Health Act?*

A I'm not sure I understand your question.

Q Well, as Chief Medical Officer of Health, do you -- you would agree that you have numerous different roles that you play within the government; correct?

A Yes, that's accurate.

Q And you would agree that some of those roles are advisory; correct?

A Yes.

Q And that some of those roles may, pursuant to the *Public Health Act,* may in fact be as a decision-maker; is that fair?

A Yes, within the context of, again, how that would be informed by the other roles. So, yes, it's accurate that in some of the context I would make decisions, in other advisory. However, I think it would be important to see how those intercept with each other.

Q All right. But let me give you an example. Like with regard to a decision under section 30 of the *Public Health Act* to shut down an individual business, that would be -- you wouldn't seek guidance from Cabinet on the shutting down of an individual business; correct?

MR. PARKER: Object on relevance. Section 30 is not an issue in this litigation.

MR. RATH: Just trying to get the nature of the decision-making roles that she takes under the *Public Health Act* as distinguished from her advisory roles, Madam Justice. I could ask the same question with regard to section 29.

Q MR. RATH: If you're shutting down an individual business under section 29 of the *Public Health Act,* would you (INDISCERNIBLE)?

MR. PARKER: Objection. Speculation.

THE COURT: I did not even hear the question. I am sorry.

MR. PARKER: Apologies.

THE COURT: Mr. Rath, can you repeat the question?

MR. RATH: Well, the first question was, and I don't think we had a ruling on the objection, if she was making a decision under section 30 of the *Public Health Act* to shut down an individual business, would that be something that she would consult Cabinet on in an advisory basis or would she be acting as a decision-maker.

THE COURT: Well, there was an objection and you advised me that you could ask the question with respect to section 29. So I am asking you what was your question under section 29?

Q MR. RATH: With regards to section 29, if you were quarantining an individual under section 29 as opposed to the entire population, would you seek the guidance of Cabinet or would you simply be acting as a decision-maker under section 29?

MR. PARKER: And my objection was on speculation. It's calling for speculation of a matter that's not before the Court.

MR. RATH: I'm asking to clarify her role that she speaks to in paragraph 28. "In my role, I'm not directed by elected officials what advice to give," and it seems to me that she talks about advisory roles and she talks about other roles, I'm just trying to define what her roles are and (INDISCERNIBLE) Cabinet or not.

THE COURT: Okay. Dr. Hinshaw, I will ask you to answer the question of in the case of whether if you were proposing to quarantine an individual under section 29, would you seek guidance from Cabinet?

A It's important to understand the context of all of the different officers appointed under the *Public Health Act.* So with respect to the powers under section 29, those are powers that are granted to all medical officers of health. There are some medical officers of health in the ministry of health, there are -- most medical officers of health in the province work for Alberta Health Services and are appointed under the AHS Board. And so, typically, individual quarantines or individual businesses, those kinds of responses would be from a local public health person. So, again, there's executive officers and medical officers of health who exercise powers under the Act. Routinely, it's part of my job as the Chief Medical Officer of Health to monitor how those powers are utilized but historically it would be highly unusual for the Chief Medical Officer of Health to be intervening in individual matters. Typically, again, the Chief Medical Officer of Health is operating as an advisor to the Minister of Health and to regional

health authorities and other medical officers of health. So I think, in terms of the question, typically an individual order would not be done by the Chief Medical Officer of Health, it would typically be done under the powers that the local medical officer of health would have that are, again, it's the same section.

Q MR. RATH: But if you were, as the Chief Medical Officer of Health, to issue such an order, you'd be issuing that order as a decision-maker and not in an advisory capacity; correct?

A I guess my point is that I don't really see a situation where I would be doing that. It's not typically a part of the role.

Q So your evidence then -- so if you're issuing an order under section 29(2.1)(b) that you can do whatever you want to ameliorate a public health crisis, is it your evidence that you're not acting as a decision-maker when you do that?

A It's my evidence that the exercise of that power by the Chief Medical Officer of Health was an exercise that had not been utilized previously and, therefore, a process was set up to ensure that decisions made under that section were, again, as the paragraph 29 on page (INDISCERNIBLE) states, that I provided advice to elected officials who then took that into account, made policy decisions. And so certainly section 29 gives me as a medical officer of health authority to take action and because of the extraordinary nature of this particular response that process through Cabinet was put in place to ensure that again those policy decisions were made by the representatives of the people and then as the individual responsible for that section 29 order I would take those decisions and with the team implement them through that order.

Q You'd agree wouldn't you, Dr. Hinshaw, that this so-called Cabinet process that was developed was not done by an amendment to the *Public Health Act* or an amendment to the legislation?

MR. PARKER: Objection.

MR. RATH: It's relevant to the exercise of her powers under the statute, My Lady, would be my view.

MR. PARKER: It's asking for (INDISCERNIBLE).

THE COURT: I am sorry, I did not hear the basis of your objection, Mr. Parker?

MR. PARKER: Sorry, I was just going to say that, Justice Romaine, it's asking for this witness' understanding of the legislative process to amend the

Public Health Act. I don't think it's an appropriate question for this lay witness or for someone who is not legally trained.

THE COURT: Okay. Mr. Rath?

MR. RATH: Well, she's -- she stated that she's exercising powers under a section of a statute that appears to have been modified by Cabinet without an amendment to the legislation. I'm just asking her to confirm if that's her understanding.

THE COURT: No. You are asking --

MR. PARKER: I think -- sorry.

THE COURT: You are asking for her opinion on a legal issue. That is a matter of argument.

Q MR. RATH: Dr. Hinshaw, would you agree that at the start of the pandemic in March of 2020 that healthcare in Alberta was undergoing some tension as a result of announced cuts to doctor salaries and nurses' salaries?

A There certainly was some tension at that time. I can't recall which announcements had been made at what points in time but I believe that certainly there was tension with physicians at that time. I'm sorry, I can't recall specifically with nurses.

Q All right. And in that regard, at the start of the pandemic, are you aware, and onward, are you aware as to whether or not the province was losing physicians as a result of these cuts in (INDISCERNIBLE) physicians?

A That's not something that I was involved in so I wouldn't feel prepared to comment on that.

Q So you're not aware as to what degree cuts to physicians' pay could've affected hospital capacity, ICU capacities, and so on?

MR. PARKER: Objection. Relevance.

THE COURT: Mr. Rath, how is this relevant to what we are to decide here?

MR. RATH: All of her previous evidence -- what's that?

THE COURT: How is this relevant to what we are to decide here? How is it relevant to what we are to decide here?