Court of King's Bench of Alberta

Citation: Ingram v Alberta (Chief Medical Officer of Health), 2023 ABKB 453

Date: 20230731
Docket: 2001 14300
Registry: Calgary

Between:

Rebecca Marie Ingram, Heights Baptist Church, Northside Baptist Church, Erin Blacklaws and Torry Tanner

Applicants

\- and -

Her Majesty the Queen in Right of the Province of Alberta and The Chief Medical Officer of Health

Respondents

Reasons for Judgement of the Honourable Justice B.E. Romaine

I. Introduction

[1] This application involves challenges to certain orders enacted by the Chief Medical Officer of Health for Alberta (CMOH), Dr. Deena Hinshaw, with respect to the Covid-19 pandemic (the "impugned Orders"), both on a constitutional basis and on the basis that the orders were *ultra vires* the *Public Health Act* RSA 2000, c. P-37.

[2] I find that the impugned Orders were *ultra vires* the *Public Health Act*.

[3] The *Public Health Act* requires that decisions with respect to public health orders must be made by the CMOH, or her statutorily- authorized delegate. The final decisions implemented by the impugned Orders in this case were made by the cabinet of the government of Alberta or by committees of cabinet. While the CMOH made recommendations and implemented the decisions of the cabinet and committees through the impugned Orders, she deferred the final decision making to cabinet.

[4] Although, Dr. Hinshaw was maligned during the pandemic and afterwards as the symbol of the restrictions, she was not in fact the final decision-maker. The delegation of her final decision-making authority to cabinet is not permitted by section 29 of the *Public Health Act*.

[5] However, had the impugned Orders been validly enacted by the CMOH, they would not have been unconstitutional. While they may have infringed certain of the Applicants' rights under the *Canadian Charter of Rights and Freedoms*, being Schedule B to the *Canada Act* 1982 (UK), 1982, c 11 and the *Alberta Bill of Rights*, RSA 2000, c A-14, these limitations were amply and demonstrably justified as reasonable limits in a free and democratic society pursuant to section 1 of the *Charter* and that they were enacted pursuant to a valid legislative purpose.

II. The Hearing Order

[6] On August 6, 2021, the case-management Justice, Kirker J, as she then was, granted an Oral Hearing Order for this application that, among other provisions, set out the following directions:

A. The type or nature of the application to be heard at the oral hearing is an Originating Application for the following relief:

i. a declaration that all provisions of Alberta's CMOH's orders as described in Schedule "A" of the Originating Application are of no force and effect as they offend sections 1(a), 1 (c), 1 (e) and 1 (g) of the *Alberta Bill of Rights* and are accordingly *ultra vires* the CMOH and the Alberta Legislature pursuant to section 2 of the *Alberta Bill of Rights*;

ii. a declaration that the CMOH orders as described in Schedule "A" are unlawful and are of no force and effect absent the Alberta Legislature passing that the *Public Health Act* is notwithstanding the *Alberta Bill of Rights*;

iii. a declaration that all provisions of the CMOH orders are *ultra vires* the purpose of the *Public Health Act*;

iv. a declaration pursuant to section 24(1) of the *Charter* and rule 3.15(1) of the Alberta Rules of Court (the *Rules*) that the CMOH orders are unreasonable because they disproportionately limit:

1. section 2 of the *Charter*;
2. section 7 of the *Charter*; and
3. section 15 of the *Charter*;

v. In the alternative, declarations pursuant to section 52(1) of the *Constitution Act, 1982* that the CMOH orders are of no force of effect because they unjustifiably infringe:

1. section 2 of the *Charter*;
2. section 7 of the *Charter*; and
3. section 15 of the *Charter*; and

vi. a declaration that the CMOH orders issued since March 2020 regarding business restrictions imposed due to Covid-19 are *ultra vires* section 29 of the *Public Health Act* and of no force or effect.

[7] The hearing order summarized the specific issues on which oral evidence would be necessary in Schedule A to the order, the supplementary particulars dated June 9, 2021. These particulars set out the Applicants' complete listing of their *Charter* claims at the time were as follows:

a) Private Residence Restrictions: prohibition that one is not allowed to have a non-resident enter one's own home (CMOH Order 02- 2021, part 2, section 3): [A] person who resides in a private residence must not permit a person who does not normally reside in that residence to enter or remain in the residence.

b) Indoor Gathering Restrictions: the requirements and prohibitions on “indoor gatherings”, where only 10 people are allowed in an indoor public or private place (CMOH Order 02-2021, Part 3, section 16) along with the following restrictions:

i. only a maximum of 10 people are allowed at a wedding (CMOH Order 02-2021, Part 3, section 14);

ii. only a maximum of 20 people are allowed at a funeral service (CMOH Order 02-2021, Part 3, section 15);

iii. wedding and funeral receptions are banned (CMOH Order 02-2021, Part 3, section 16).

iv. requirement that “faith leaders” limit attendance at worship services to 15% of the total operational occupant load capacity restrictions at a place of worship (CMOH Order 02-2021, Part 4, section 18)

v. requirement that individuals maintain 2 meters physical distance from each other, including when attending worship services, weddings or funerals (CMOH Order 26-2020, sections 1 and 2); and

vi. requirement that individuals cover their face, including when attending worship services, weddings or funerals (CMOH Order 02-2021, Part 5, section 23).

c) Outdoor Gathering Restrictions: the prohibitions on “outdoor gatherings” where only a maximum of 10 people are allowed at an outdoor private place or public place (CMOH Order 02-2021, Part 3, section 13), along with the following restrictions;

i. prohibition on outdoor group physical activities, including hockey, where 2 meters physical distance from each other person at all times is not possible and more than 10 people (CMOH Order 02-2021, Part 3, section 57);

ii. prohibition on outdoor group performance activity with more than 10 people (CMOH Order 02-2021, Part 3, section 69); and

iii. requirement that individuals maintain 2 meters physical distance from each other (CMOH Order 26-2020, sections 1 and 2).

d) Isolation, Quarantine and Visiting Restrictions: the mandatory isolation and quarantining measures that prohibit contact with other people, rely on PCR testing to determine if a person is a confirmed case for when these isolation and quarantine measures are imposed, and the requirement that health care providers are required to ensure compliance with the Order and guidelines, including:

i. mandatory isolation of at least 10 days for:

- a “confirmed case” of Covid-19 (not defined in the Order, but guidelines indicate that a confirmed case of Covid-19 includes a positive PCR-Test result with no clinical diagnosis) that requires a person to remain at home two meters apart from others, not attend work, school, social events or any other public gatherings, and not take public transit (CMOH Order 05-2020, sections 1, 2); and

- a person exhibiting the following symptoms not related to a pre-existing illness or health condition: cough, fever, shortness of breath. runny nose, or sore throat (CMOH Order 05-2020, section 7);

ii. mandatory quarantining for 14 days of a person who is a close contact of a person with a confirmed case of Covid-19;

iii. requirement that individuals maintain 2 meters physical distance from each other (CMOH Order 26-2020, sections 1 and 2);

iv. requirement that individuals cover their face while attending an indoor public place (CMOH Order 02-2021, Part 5, section 23).

v. the banning of visitors except for a single essential visitor (unless resident is at the end of life) (CMOH Order 09-2020, sections 1, 3, 5, 7 and 8); and

vi. the imposition on health care facilities to limit visitors and carry out the requirements of an Order via visitation standards in guidelines (CMOH Order 09-2020, section 3, CMOH Order 14-2020, section 1; CMOH Order 29-2020, section 1; CMOH Order 32-2020, sections 1, 9).

e) Business Closure Restrictions: the broad interference, prohibition, restrictions, or mandatory closures of business or whole sectors of the economy, specifically the forced restrictions or closures of gym and associated services, listed in Appendix B.

f) Primary or Secondary School Restrictions: the blanket prohibition, restrictions or mandatory closures of primary or secondary schools based on grade level or age of students. (CMOH Order 01-2020, sections 1-4; CMOH Order 18-2020, sections 6-9; and CMOH Order 19-2020, section 14).

Schedule A includes a summary of the *Charter* rights alleged by the Applicants to have been infringed, together with the following allegations of infringement:

a) Torry Tanner

The Private Residence Restrictions, Indoor Gathering Restrictions, and Outdoor Gathering Restrictions interfered with Ms. Tanner's freedom of religion, freedom of peaceful assembly and freedom of association and liberty and security interest *Charter* rights. These restrictions prohibited her from having her children and extended family over to her house to celebrate Christmas, a religious celebration for her. This was a prohibition on the gathering together of her family for religious reasons and had a profound impact on her core lifestyle choices and fundamental relationships. These restrictions were also state action that had an impact on Ms. Tanner's mental state.

The Outdoor Gathering Restrictions also interfered with Ms. Tanner's freedom of expression, freedom of peaceful assembly and freedom of association, and liberty and security interest *Charter* rights as they prohibited gathering in large groups to protest government action, an activity that Ms. Tanner strongly believes in. The exposure to censure, restrictions, and prosecution, such as contempt, triggers the violation of these rights.

b) Heights Baptist Church (HBC)

The Private Residence Restrictions and Indoor Gathering Restrictions interfered with HBC's freedom of religion, freedom of expression, freedom of peaceful assembly and freedom of association *Charter* [rights]. These restrictions prohibit HBC members from acting in accordance with their religious beliefs in a manner that was more than trivial or insubstantial and therefore infringed their freedom of conscience and religion. These restrictions prohibited them from physically gathering all together in one geographic place according to their religious belief. They also prohibited HBC members from participating in religious practices, such as baptism, serving the Lord's Supper to one another, and laying of hands on people during times of prayer and

commissioning. They also prohibited the gathering together in one's home to show hospitality, which is a religious belief.

The Indoor Gathering Restrictions severely limited a funeral service size and banned a funeral reception; at the time of a death, mourning together as a church while simultaneously celebrating that person's life with a service and a reception afterwards is a practice that was prohibited.

The masking requirement of the Indoor Gathering Restrictions was an interference with HBC members' ability to express themselves at a religious service.

The Isolation, Quarantine and Visiting Restriction interfered with HBC members' freedom of religion, freedom of expression, freedom of peaceful assembly and freedom of association as they required physical distancing, the covering of one's face and the banning of visitors in long term care or heath care facilities except for a single essential visitor.

c) Northside Baptist Church (NBC)

The Indoor Gathering Restrictions interfered with NBC's freedom of religion, freedom of peaceful assembly and freedom of association *Charter* [rights]. These restrictions prohibited NBC's members from acting in accordance with their religious beliefs in a manner that was more than trivial or insubstantial and therefore infringed their freedom of conscience and religion. They could not physically gather all together in one geographic place as their religious belief mandates, they could not participate in religious practices, both structured and unstructured, such as fellowship through mutual edification, participation in ordinances, corporate prayer, corporate singing, and other religious practices that require physical touch among members.

The Indoor Gathering Restrictions also interfered with NBC's freedom of expression. The masking requirement was an interference with the members' ability to express themselves without interference at a religious service.

d) Erin Blacklaws

The Indoor Gathering Restrictions interfered with Mr. Blacklaws' freedom of peaceful assembly and freedom of association, and his liberty and security interest *Charter* rights. Under these restrictions which limited funeral size and banned a funeral reception. Mr. Blacklaws was unable to hold a funeral for his father that would accommodate all the friends his father had and allow them and Mr. Blacklaw to have a funeral for his father that properly allowed them to collectively grieve, pay their respects and say good-bye.

e) Rebecca Ingram

The Indoor Gathering Restrictions interfered with Ms. Ingram's freedom of religion, freedom of peaceful assembly and freedom of association, and her liberty and security interest *Charter* rights. Ms. Ingram was not able to attend Christmas and Easter services at her place of worship; nor was she able to celebrate Sunday service with her church community. The Indoor Gathering Restrictions and Private Residence Restrictions resulted in Ms. Ingram not being able to celebrate Christmas and Easter in her home with extended family and friends. These prohibitions on religious gatherings of her family and friends had profound impacts on her core lifestyle choices and fundamental relationships.

The Indoor Gathering Restrictions and Outdoor Gathering Restrictions interfered with Ms. Ingram's and her children's freedom of peaceful assembly and freedom of association, and their liberty and security interest *Charter* rights. Ms. Ingram and her children were forbidden from socializing with their family and friends, including but not limited to the celebration of various life milestones. These prohibitions on indoor and outdoor gatherings with her family and friends had impacts on her and her children's core lifestyle choices and fundamental relationships.

> The Primary or Secondary School Restrictions interfered with Ms. Ingram's or her children's freedom of expressions, freedom of peaceful assembly and freedom of association, their liberty and security interests, and equality *Charter* rights. The CMOH orders that prohibited certain schools from offering in-class lessons based on grade level or age of student interfered with Ms. Ingram children's equality rights. Ms. Ingram was barred from making core lifestyle choices for her children. Ms. Ingram's children were unable to obtain education in a manner beneficials to them, thus suffocating their freedom of expression, such as the inability to work in groups and express themselves in class, school projects and other educational mechanisms. Her children were unable to see their education friends and peers and were unable to attend gym class to the betterment of their health.
>
> The Business Closures interfered with Ms. Ingram's liberty and security of the person interests. The measures infringed on her ability to make "core lifestyle choices" in the manner she chose to run her business. Ms. Ingram is currently in possession of a "stranded asset" wherein she was prohibited from operating her business which is continually going deeper into debt. Ms. Ingram was unable to provide for herself and her family through her business and was forced to seek alternative methods of earning. Further, the Business Closures interfered with Ms. Ingram's security interests in that they had serious and profound effect on her psychological integrity as she was unable to operate her business, make a living to provide for herself and her family, and there was pressure from the mounting debt of her business.

[8] Each of the Applicants provided at least one affidavit. They were not cross examined on the affidavits, which were entered into evidence. A summary of each of the affidavits is attached as Appendix A to this decision.

III. Preliminary Observations

[9] In ***Ontario v Trinity Bible Chapel et al*** (2022 ONSC 1344), aff'd 2023 ONCA 134, appeal to SCC refused, a roughly analogous case focusing on the constitutionality of public health orders and regulations, Pomerance J began her analysis with certain preliminary observations. I found this method of setting the context to be helpful, and the following observations are equally relevant to this decision:

A. In this case, as was the case in ***Trinity***, there was considerable evidence from both participant experts and litigation experts with respect to the extent to which Covid- 19 posed an unprecedented threat to public health, including the extent to which the virus could be transmitted. While the individual and expert evidence is different in this case, as are the terms of the impugned Orders, I agree with Pomerance J that the role of the Court is not that of an "armchair epidemiologist". Like her, I am neither equipped nor inclined to resolve scientific debates and controversy surrounding Covid- 19. The question before this Court is not whether certain experts are right or wrong. The question is whether it was open to the CMOH or Alberta to act as it did in implementing the impugned Orders and whether there was scientific support for the precautionary measures that were taken: ***Trinity*** at para 6.

   As I indicated frequently throughout the process, this decision is not a public inquiry into every aspect of Alberta's handling of the pandemic, nor a challenge to every public health restriction related to the pandemic.

B. I agree that the actions of both the CMOH and the government are not to be judged through the lens of hindsight. The question is what was reasonably known and understood at the time each of the impugned Orders were enacted.

C. It is clear that the *Charter* confers on the judiciary the power to invalidate law that is inconsistent with the Constitution. I agree with Pomerance J that:

> ... this authority does not... transfer the legislator's pen into judge's hands. The judicial lens is one governed by deference, not blind or absolute deference, but a thoughtful deference that recognizes the complexity of the problem presented to public officials and the challenges associated with crafting a solution: ***Trinity*** at para 6.

D. Given the evidence, I do not doubt the sincerity of the beliefs asserted in this case, and I do not understand Alberta to do so. As noted by Pomerance J, judicial humility aids in understanding the Applicants' highly personal beliefs and concerns. I am not sceptical about what they, and all Albertans, suffered through the pandemic, including restrictions on normal, highly important personal autonomy and decision-making.

IV. Issues

[10] As the hearing progressed, the nature of the issues clarified. The main issues are as follows:

A. Are the impugned Orders *ultra vires* section 29 of the *Public Health Act*?

B. Do the impugned Orders engage and violate section 2 of the *Charter*?

C. Do the impugned Orders engage and violate section 7 of the *Charter*?

D. Can the infringement of the *Charter* rights by the impugned Orders be justified in a free and democratic society in accordance with section 1 of the *Charter*?

E. Do the impugned Orders offend the *Alberta Bill of Rights*. If so, does the *Alberta Bill of Rights* include an implicit internal limit similar to the limit order section 1 of the *Charter*?

V. Analysis

A. Are the impugned Orders *ultra vires* section 29 of the *Public Health Act?*

[11] Although submissions with respect to this issue are scattered and sometimes inconsistent, the Applicants submit in their final argument that the impugned Orders are *ultra vires* the purpose of the *Public Health Act* and are *ultra vires* section 29 of the *Public Health Act*.

[12] The submissions that the impugned Orders are *ultra vires* on the purpose of the *Public Health Act* is unpersuasive. The purpose of the *Act* is the regulation of public health emergencies, including the spread of communicable diseases. The CMOH has the power to manage the spread and impact of a communicable disease by imposing restrictions on businesses and individuals generally, regardless of whether the contamination has not spread to those businesses or individuals. This is the nature of efforts to contain and prevent the spread of disease.

[13] However, near the end of the hearing, the Applicants, particularly Ms. Ingram, raised a new argument. They submit that the impugned Orders are *ultra vires* section 29 of the *Public Health Act* because they are decisions made by the provincial cabinet and/or committees of cabinet and not by the CMOH. This argument became more focused following the decision of Dunlop J in ***CM v Alberta***, 2022 ABKB 716.

1. The decision in *CM v Alberta*

[14] On October 22, 2022, in a case challenging an order of the CMOH relating to masking in schools, Dunlop J decided 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." He found that the *Public Health Act* requires that decisions regarding public health orders be made by the CMOH or an authorized delegate, and that the order in question was based on an unreasonable interpretation of the *Act*: para 6.

[15] The applicants in ***CM*** alleged that the order was *ultra vires,* made for improper purposes and violated sections 7 and 15 of the *Charter*, because it rescinded a previous order requiring masking in schools for students in grades 4 through 12. The applicants submitted that the CMOH had acted unreasonably by lifting the masking restriction.

[16] It must first be noted that the issues in this litigation arise from a position antithetical to that of the applicants in ***CM***. In this case, the Applicants allege that the CMOH acted unreasonably by imposing certain unnecessary restrictions, in other words, by restrictions that were overly onerous and thus not reasonable.

[17] While the ***CM*** decision is not binding on this Court, it is persuasive reasoning. At paras 58-60, it sets out a useful analysis with respect to the issue of whether a specified order of the CMOH complies with the *Public Health Act*:

> 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.
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> When there is a public health emergency, s. 29(2.1) gives ... 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; ...
>
> 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. (emphasis added).

[18] Justice Dunlop found, based on this wording, that the clear intention of the *Public Health Act* is that the orders of the CMOH be based on the CMOH's judgment. He noted that further support for this interpretation is found in section 13 of the *Act* which sets out specific qualifications for a CMOH: para 61. 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 CMOH must also be a fellow of the Royal College of Physicians and Surgeons of Canada.

[19] With respect to delegation of these powers, Dunlop J noted at para 63 that sections 13 and 57 of the *Public Health Act* permit the CMOH 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.

[20] He noted that the public health legislation of other provinces give wider powers of delegation, but that this is not the case in Alberta.

[21] In ***CM***, Alberta submitted that the removal of the school mask mandate was a policy decision for elected officials, and that Dr. Hinshaw "operationalized that decision", quoting a Crown record as follows:

> This process involved the CMOH providing advice and recommendations to elected officials 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: para 68.

[22] On the basis of this and other evidence, including testimony from the CMOH, Dunlop J found that the Priorities Implementation Cabinet Committee made the decision to remove the school mask mandate.

[23] The Court in ***CM*** noted Dr. Hinshaw's statement that "[t]he final policy decision- making authority rested with the elected officials, and those policy decisions were then implemented through the legal instrument of CMOH Orders": para 82. Dunlop J also noted that the question before him was not whether this was a correct interpretation of the *Public Health Act*, but whether the order at issue represented a reasonable exercise of the CMOH's delegated regulatory authority. He relied on the following statement by the Supreme Court of Canada in ***West Fraser Mills Ltd v British Columbia (Workers' Compensation Appeal Tribunal),*** 2018 SCC 22, 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... 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...
>
> (emphasis added)

[24] The order at issue in ***CM*** was a "regulation" as defined in the *Regulations Act*, RSA 2000, c R-14 and the *Interpretation Act* RSA 2000, c I-8, as are the impugned Orders.

[25] Dunlop J acknowledged the principles set out in ***Katz Group Canada Inc v Ontario (Health and Long Term Care)***, 2013 SCC 64 with respect to interpreting a regulation, including the principle that regulations are presumed to be valid, but found that "it is simply not reasonable to read s. 29 of the *Public Health Act*... to

permit the Chief Medical Officer to make Orders at the direction of [a cabinet committee]": para 84. Thus, the order at issue was based on an unreasonable interpretation.

[26] The Court considered the issue of improper subdelegation. The Crown submitted that "improper subdelegation... 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", citing JM Keyes, *Executive Legislation* 2nd ed (Markham: LexisNexis Canada Inc., 2010) at p. 276: para 86.

[27] He found that the evidence before him indicated that Dr. Hinshaw did not meet the test of "decisive involvement".

[28] In conclusion, Dunlop J found that:

> [b]oth 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 [a cabinet committee'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 [a cabinet committee]: para 91.

[29] The decision in ***CM*** is under appeal.

[30] While the applicants in ***CM*** sought an order quashing the impugned order, Dunlop J noted that, as the order had already been rescinded, it would be moot to quash it. Therefore, he issued a declaration that the order was unreasonable: para 132. He noted at para 132 that "[f]or the benefit of the CMOH 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 order to elected officials."

2. Whether improper subdelegation has been pled

[31] In attempting to distinguish ***CM***, Alberta submits that, in order to argue improper subdelegation in this case, the Applicants would be required to amend their Amended Originating Application because the pleadings do not allege that Dr. Hinshaw improperly subdelegated her authority to cabinet to make decisions under s. 29 (2.1) of the *Public Health Act*. Alberta submits further that the Court should not allow an amendment at this stage of the proceedings, considering that all the evidence has been heard.

[32] Kirker J, the case management Justice, ruling on amendments to the Statement of Claim, made no finding on the issue of whether the pleadings supported a claim that the impugned Orders generally were inconsistent with the purpose of the *Public Health Act*, or the means designated to achieve its purpose.

[33] She allowed an amendment that alleges that the impugned Orders were *ultra vires* the purpose of the *Public Health Act* because they were based on flawed medical literature and they arbitrarily shut down certain businesses.

[34] As a result, Alberta submits that "the only administrative law ground pleading in the Amended Originating Application is that the CMOH Orders are *ultra vires* the purpose of the *Public Health Act* because they are "in both purpose and effect "mandatory (i.e. subject to penalty for non-compliance) "rules of general and universal application".

[35] Alternatively, Alberta submits that if improper subdelegation of authority with regards to the impugned Orders is allowed to be an issue, the evidence in this case does not establish such improper subdelegation. More specifically, Alberta argues that, unlike the situation in ***CM***, Dr. Hinshaw's evidence was not that cabinet made the public health decisions, but that Dr. Hinshaw provided recommendations to cabinet and then issued orders that were informed by cabinet's policy decisions.

[36] Alberta submits that the relevant context makes it clear that Dr. Hinshaw served at the pleasure of the Minister of Health, and that her statutory role was to provide advice and recommendations to the Minister. Thus, Alberta submits that Dr. Hinshaw's decision on moving forward with public health measures at the direction of elected officials makes sense. It adds that, in any event, there is no evidence that Dr. Hinshaw "slavishly implemented" cabinet's decisions (as concluded in ***CM***) nor that Dr. Hinshaw failed to retain decisive involvement in exercising her authority because the impugned Orders were based on her judgment. Relying on ***Ontario Federation of Anglers & Hunters v Ontario (Ministry of Natural Resources***) (2002) 2002 CanLII 41606 (ON CA), 211 DLR (4th) 741 (ONCA), leave to appeal to SCC refused 29237 (March 27, 2003), Alberta goes one step further to argue that, even if the Premier had directed Dr. Hinshaw to enact the CMOH orders, it would not be an error for her to comply since the Orders are executive legislation.

[37] Ms. Ingram takes the position that she is not arguing improper subdelegation or fettering, but simply stating that cabinet did not have authority to issue the CMOH orders and that they were thus *ultra vires* "within the plain meaning of that phrase".

[38] However, in an Amended Originating Application filed February 8, 2022, the Applicants seek declarations that all provisions of the CMOH Orders currently in force are *ultra vires* the purpose of the *Public Health Act*, and that the impugned Orders issued since March 2020 regarding business restrictions imposed with respect to Covid-19 were *ultra vires* section 29 of the *Public Health Act* and of no force or effect.

[39] This issue was partially addressed during case management. In paras 100 and 101 of her April 30, 2021 decision, Kirker J declined to strike the Applicants' application to amend by adding the words "section 29 of the *Public Health Act*" to a previously pleaded claim that the impugned Orders are *ultra vires*, noting, however, that this claim was limited to whether the Business Closure Restrictions imposed by the CMOH Orders fall within the delegated order-making authority conferred on medical officers of health by section 29 of the *Alberta Health Act*.

[40] She also permitted on associated plea for relief in the form of a declaration that the CMOH Orders issued since March 2020 are *ultra vires* and of no force and effect.

[41] Kirker J also noted at paras 77-78 of her decision at ***Ingram v Alberta (Chief Medical Office of Health)***, 2021 ABQB 343 that:

> I am unable to reach the same conclusion in relation to the claims that the CMOH Orders themselves offend s. 1(a) of the *Alberta Bill of Rights*. On a generous reading of the claims asserted in the Originating Application, there is an issue raised in relation to whether business restrictions imposed by the CMOH Orders fall within the delegated order-making authority conferred on medical officers of health by the legislation; that is, whether the impugned business restrictions are consistent with the purpose of the *Public Health Act*, and the means designated to achieve its purpose.
>
> If the challenged business restrictions are found to be within the broad order-making authority delegated to the CMOH by the Alberta Legislature when, by due process of law, it enacted the *Public Health Act*, the Applicants acknowledge that there will be no basis to conclude that the CMOH Orders offend s. 1(a) of the *Alberta Bill of Rights*. But, I am not satisfied, on the basis of the material before me, that I can fairly reach that conclusion now... I find I must dismiss the Respondents' application to strike the claim that the CMOH Orders offend section 5.1 (a) of the *Alberta Bill of Rights*.

[42] While this analysis refers specifically to the *Alberta Bill of Rights* and the Business Closure Restrictions issues, the broad issue of the delegation authority of the CMOH has been present throughout the litigation, at least with respect to the Business Closure Restrictions. Now, however, the Applicants seek to amend their pleading to encompass all of the impugned Orders. The proposed phrasing of the amendment to include all "CMOH Orders currently in place" must fail, however, given this Court's decision in 2022 ABQB 164 that CMOH Orders that have not been pled cannot be included in the scope of the hearing.

[43] Therefore, any amendment must be restricted to the impugned Orders.

[44] Alberta submits that this Court should not allow this amendment after all the evidence has been heard unless it is satisfied that all evidence possible on the new issue has been submitted, and that Alberta would not be prejudiced by the new pleadings.

[45] Both these conditions have been satisfied. The original application referred to section 29 of the *Public Health Act* in the context of whether the impugned Business Closure Restrictions infringed rights under the *Alberta Bill of Rights*, but the proposed new amendment would state in effect that the impugned Orders are *ultra vires* section 29 of the *Public Health Act*. This proposed amendment does not specifically refer to improper delegation, but it does address whether the impugned Orders are *ultra vires*. While Ms. Ingram's submissions did not become focused on the delegation issue until the decision in ***CM*** was released, the issue was addressed and fully argued before this Court, and thus no prejudice arises from the lack of specificity. Alberta was fully aware of the issue as it was recently raised in ***CM***. If there is any prejudice, it can be remedied by an order of costs.

3. Dr. Hinshaw's Evidence

[46] Dr. Hinshaw was completely candid in her evidence about the CMOH's role in the decision- making process.

[47] In her affidavit of July 12, 2021, she made the following comments:

a) While the [CMOH] plays a leadership role in Alberta's public health system within government and giving advice to Alberta Health Services, the [CMOH] is not an independent officer of the Legislature like the Auditor General or the Child or Youth Advocate. Rather, as I serve at the pleasure of the Minister of Health, I can be removed from my position at any time. I am therefore subject to oversight within the democratic structure of the Government of Alberta: para 9;

b) I have also had the responsibility to provide advice to the Premier and Cabinet, including the Priorities Implementation Cabinet Committee (PICC) and the Emergency Management Cabinet Committee (EMCC) on the need to declare a state of public health emergency in response to the Covid-19 pandemic and to discuss and finalize public health measures to address the threat caused by Covid-19. The Priorities Implementation Cabinet Committee includes the Premier, and the Ministers of Health, Treasury Board and Finance, Justice and Solicitor General, Energy, Transportation, Environment and Parks, Jobs, Economy and Innovation, and Children's Services. The EMCC includes the Premier, and the Ministers of Health, Treasury Board and Finance, Justice and Solicitor General, Transportation, Environment and Parks, Education, Indigenous Relations, Children's Services, Community and Social Services, and Member of the Legislative Assembly of Alberta Mickey Amery: para 22;

c) In my role, I am not directed by elected officials what advice to give, rather I give my advice as I am directed and required to do by the *Public Health Act*, and the advice that I give is always my best advice based on the best available evidence. As [CMOH], I have done my best throughout the pandemic to monitor the health of Albertans and provide advice and recommendations to protect their health based on the best evidence available: para 28.

d) While my office and the Ministry of Health and AHS have played a lead role in informing the Province of Alberta's strategy to respond to the COVID-19 pandemic, under the *Public Health Act*, 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 have 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 instruments of CMOH Orders: para 29, (emphasis added).

[48] Dr. Hinshaw testified that: s. 29 of the *Public Health Act* enabled the decision-making to take place in the hands of elected officials, the impugned Orders were implemented at the direction of elected officials; the impugned Orders decision-making body changed over time and was either the Cabinet committee. PICC or the EMCC; "elected officials are [in] the best position to make these decisions" and the impugned Orders were the legal instrument to implement the policy decisions of cabinet.

[49] Alberta does not dispute that the impugned Orders must be "based" on the CMOH's judgment but submits that the evidence before this Court establishes that the CMOH retained "decisive involvement". The Crown cited various parts of Dr. Hinshaw's direct examination and cross-examination in that regard, but they do not illustrate "decisive involvement", but rather the opposite:

a) "... paragraph 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": (emphasis added) trial transcript April 4, 2022 at page 8;

b) "... it's important to remember that the orders were the legal instrument to implement the policy decisions of cabinet...": trial transcript April 5, 2022 at page 95;

c) ... You'll see paragraph 29 of 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 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: trial transcript April 6, 2022 at page 83;

d) ... when I was speaking about this to [counsel for NBC]. 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 people's representatives and then to use their policy decisions to inform the subsequent orders to manage the COVID 19 pandemic: trial transcript April 6, 2022 at page 49;

e) 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, it is 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 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. (emphasis added): trial transcript April 6, 2022 at page 117.

[50] Dr. Hinshaw's evidence was corroborated by evidence of Mr. Long, who indicated that "decisions were made by the political leaders of the province."

[51] Dr. Hinshaw was a highly credible witness, calm and thoughtful in her evidence and unimpeached by the often intense cross-examination. It is clear what she thought her role was in the decision-making process.

[52] While that role was not in accordance with her delegation authority, she was consistent and transparent about the process that had been put in place. It is reasonable to assume that this process was decided by government. Dr. Hinshaw was clear, however that she stood by her recommendations, and that she did not sign Orders implementing cabinet decisions that were more restrictive than she judged necessary. She testified that she would sometimes outline a range of policy alternates to cabinet, all of which were acceptable to her as a matter of public health, but there is no evidence that the policy decisions made by cabinet were ultimately based on her recommendations. The only evidence is that elected officials did not direct her to impose more severe restrictions in the CMOH orders than she had recommended to them (see 2022 ABQB 311, and the negative answers to the questions that were read into the record). While this may be important for the *Charter* analysis, Dr. Hinshaw cannot be said to have retained "decisive involvement "in the process.

[53] Although the principles set out in ***Katz Group*** provide that an interpretations that presumes regulations are valid is favoured when possible, I agree with Dunlop J that it is not reasonable or in accordance with the principles of statutory interpretation to read section 29 of the *Public Health Act*, with its repeated references to what the medical officer of health "considers necessary" or "determines", to permit the CMOH to make orders at the direction of cabinet, the PICC or any other person or body not specifically authorized as a delegate under the *Act*.

[54] Alberta submits that in the context of this unprecedented pandemic, consulting with the Minister of Health, as well as cabinet, was clearly proper and essential given that it is for elected representatives to set high level policy. However, the only legislation that provides cabinet and elected officials with such authority is the *Emergency Management Act*, RSA 2000, c E-6.8, which was not used by Alberta in the pandemic.

[55] Alberta submits that the application of fettering to lawmaking powers recognizes that ministries have wide ranging responsibilities, and thus must be capable when acting to establish policy to do so on equally wide-ranging reasons, "notably those of a political nature". Thus, it submits taking into account the realities of politics and government is not fettering.

4. Conclusion

[56] While involvement of elected officials in these important decisions may be desirable and even necessary, this involvement should have been structured in such a way as to mitigate the risk of political priorities interfering with the informed and well-qualified judgment of the CMOH, as provided in the *Public Health Act*, without ignoring the underlying public interest.

[57] In conclusion, I declare that the impugned Orders were *ultra vires* of the *Public Health Act* because they were based on a interpretation of the *Public Health Act* that gave final decision making authority over public health orders to elected officials.

B. The *Charter* Issues

1. Introduction

[58] Ms. Ingram submits that if the impugned Orders are *ultra vires* the *Public Health Act*, it is not necessary for this Court to consider the *Alberta Bill of Rights* (*ABR*) and *Charter* issues. However, most of the hearing including nearly all the witness testimony, was directed to the *ABR* and the *Charter* issues, and it is important to consider these issues in the event that I am incorrect about the *Public Health Act* issue.

2. Previous Cases

[59] I have had the benefit of reviewing a number of thoroughly reasoned decisions with respect to similar constitutional challenges to public health orders enacted in other provinces, both at the application and the appeal level. While these decisions differ in various ways from the case before me, and while they are not binding on this Court, they provide useful analyses with respect to similar constitutional issues. The following is a summary of the issues decided in these cases that are relevant to the issues before me.

[60] To be clear, however, I have made decisions on the constitutionality of the impugned Orders on the basis of the specific impugned Orders, and on the basis of the evidence led by the parties before me, and not on the basis of any evidence led in the other cases.

a. *Gateway Bible Baptist Church et al v Manitoba et al*, 2021 MBQB 219

[61] On October 21, 2021 Joyal CJ of the Manitoba Court of King's Bench delivered a decision cited as 2021 MBQB 219. The background to this case was as follows:

> On March 20, 2020 a province-wide "state of emergency" was declared in Manitoba. From March 2020 into the early summer months of 2021, pursuant to the authority delegated to him under the *Manitoba Public Health Act*, Manitoba's Chief Public Health Officer Dr. Brent Roussin issued successive public health orders.
>
> The applicants challenged orders made in relation to gatherings in private residences and places of worship, alleging they violated their sections 2(a), 2 (b) and 2(c), 7 and 15 *Charter* rights.
>
> Commencing in March 2020, indoor and outdoor gatherings, including places of worship, were limited to 50 persons. Retail establishments remained open with physical distancing, but theatres and gyms were closed and restaurants and hospitality premises were limited to the lesser of 50 people or 50 per cent capacity. Gathering limits were reduced to 10 people on March 30. Starting April 1, businesses not listed in a schedule were closed except for online pick-up and delivery. Restaurants were restricted to delivery and take-out. The orders did not place any restrictions on the delivery of health care.
>
> Beginning May 22, 2020, the gathering restrictions were relaxed to allow 25 people indoors and 50 people indoors, including in places of worship. By June 21, gathering size restrictions generally increased to 50 people indoors and 100 people outdoors. Many businesses opened to 75 per cent capacity subject to physical distancing requirements. By July 24, businesses could generally fully reopen to full capacity with physical distancing, unless otherwise specified in the orders. Religious services were permitted up to 30 per cent capacity. These restrictions continued essentially in this form until fall.
>
> In fall 2020, the rising number of cases was threatening to overwhelm hospitals. Elective surgeries were delayed so staff could be redeployed. The impugned orders were intended as a "circuit break" to flatten the curve.
>
> In January 2021, restrictions began to ease. Places of worship could hold in-person services with up to 50 people or 10 per cent of usual capacity. At the time of the hearing by Joyal CJ, regular in-person religious services could have up to 100 people or 25 per cent of usual capacity.
>
> November 21, 2020, December 22, 2020 and January 8, 2021 orders prohibited gatherings of more than five persons at any indoor and outdoor public place. Places of worships were closed to the public. An exception was made for funerals, weddings, baptisms and similar religious ceremonies which were limited to five persons not including the officiant. As of December 11, 2020, places of worship were allowed to hold outdoor religious services in vehicles.

[62] Chief Justice Joyal found as follows:

i. Rights under sections 2 (a), (b) and (c) of the *Charter*, freedom of religion, expression, and peaceful assembly were violated (conceded by Manitoba).

ii. The restrictions on religious services at places of worship and the restrictions on gatherings at private homes did not interfere with the right to liberty or security of the person contrary to s 7 of the *Charter*. There was no evidence of serious psychological harm or suffering, and the impugned orders were limited to 13 weeks. With respect to principles of fundamental justice, he found that the restrictions were not arbitrary because gathering limits were meant to prevent spread and thus minimize death and illness. The restrictions were not overbroad because they did not encompass conduct that posed no risk of transmission. The orders restricted similar types of gatherings, whether religious, or secular. The restrictions were not grossly disproportionate as they were not out of sync with the important objectives of protecting the healthcare system, public health and vulnerable persons.

iii. The closure of places of worship did not discriminate on the basis of religion contrary to section 15 of the *Charter*. The distinction in question (between what was permitted to remain open and what must remain closed) was not based on religion.

iv. The violations under sections 2(a), (b), (c) were justified as reasonable limits under section 1 of the *Charter*.

[63] Chief Justice Joyal cautioned that "the courts should be wary of second guessing those who are managing a pandemic on the basis of their democratic responsibility or their properly delegated authority, particularly when there may be divergent opinions or schools of scientific thought": para 281. It is an often complicated and subtle task for a court to fulfill its role as protector of fundamental freedoms while providing a margin of appreciation to governments attempting to balance complex issues that involve a multitude of overlapping and conflicting interests.

[64] Chief Justice Joyal concluded that "a margin of appreciation" was warranted. He stated that "where a sufficient evidentiary foundation has been provided in a case like the present, the determination of whether any limits on rights are constitutionally defensible is a determination that should be guided not only by the rigours of the existing legal tests, but as well, by a requisite judicial humility that comes from acknowledging that courts do not have the specialized expertise to casually second guess the decisions of public health officials, which decisions are otherwise supported by the evidence": para 292.

[65] The applicants did not disagree that the protection of public health is a pressing and substantial objective.

[66] With respect to rational connection, Chief Justice Joyal stated that he had "no difficulty in concluding, based on logic, reason and a common sensical understanding of the evidence ... that the measures taken to limit gatherings, including in places of worship, are rationally connected to the goal of reducing the spread of Covid 19": para 297.

[67] On minimal impairment, he noted that "the menacing force and unpredictability of [the] pandemic did not provide public health officials with the 'parlour room luxury' of prolonged speculative debate nor the comfort of trial and error decision making, let alone the possibility of academic research projects that might confirm whether there existed 'significantly less intrusive measures' that might be "equally effective": para 304. Joyal CJ understood the applicants' proposal of focused protection (meaning only placing restriction on those over 60) as insufficient because vulnerable people are integrated throughout society, severe outcomes can occur across a wide spectrum of ages and there is troubling evidence of 'long haul symptoms' that persist in infected persons of all ages: paras 305-312. Further "the protection of vulnerable populations cannot occur without also reducing the extent of community transmission overall": para 314. As a result, Chief Justice Joyal found the impugned orders fell within a range of reasonable alternatives.

[68] Regarding proportionality, Joyal, CJ found that the restrictions in what was a dire and urgent situation were neither disproportionate nor out of sync with the critically important objections of the restrictions. Courts must consider the *Charter* rights of others when weighing the effects of the limitation: para 326. He noted the

restrictions were only in place as long as needed to alleviate the strain on hospitals. A 13-week closure did not cause harm that outweighed the urgent need to address the public health crisis.

[69] The decision referred to other issues not relevant to this case.

[70] On appeal, 2023 MBCA 56, the Applicants argued that the application judge had erred in finding that the impugned Orders constituted justifiable limits on the infringed rights under section 2 (a)-(c) of the *Charter*. An intervener in the appeal submitted that cumulative breaches of the *Charter* should be considered in the constitutional analysis, and that the principle of constitutional pluralism should form part of the section 1 analysis,

[71] Manitoba submitted that the appeal was moot, but the Court found that an adversarial context continues to exist, and the parties had fully argued the constitutional issues. The Court referred to the appellate decisions in ***Beaudoin*** and ***Trinity*** and concluded that the Court should exercise its decision and determine the appeal.

[72] The Appeal Court found no error in the applicant judge's application of the ***Oakes*** test.

[73] The appeal was dismissed.

b. *Ontario v Trinity Bible Chapel et al*, 2022 ONSC 1344

[74] This decision was released on February 28, 2022. The background context was as follows:

> On March 17, 2020, the Ontario cabinet declared a state of emergency and ordered the closure of "non-essential" businesses and institutions, including churches and other religious settings.
>
> The state of emergency ended around July 24, 2020 and the *Reopening Ontario (A Flexible Response to Covid-19 Act)*, 2020. S O 2020 c 17 (ROA) came into force. Pursuant to section 2 of the *Act*, certain regulations made previously continued, including restrictions on social, commercial, and religious gatherings.
>
> On April 27, 2020, the Framework for Reopening the Province was released, which set out criteria for loosening emergency measures. On November 3, 2020, the Keeping Ontario Safe and Open Framework was released, which introduced a modified tiered approach intended to scale restrictions up and down.
>
> On December 26, 2020, Ontario placed the entire province under a "shutdown" that severely restricted many of the activities of Ontarians, including their attendance at places of worship, which were limited to a hard cap of ten persons indoors. Retail businesses were granted exemptions, provided they limited the number of persons inside to 25 percent of their building capacity.
>
> On or about January 12, 2021, Ontario was once again placed under a state of emergency, which lasted until approximately February 9, 2021, and the provisions of both previous initial emergency directives and the ROA applied during this period. The ROA then continued in force, with various regions of the province moving in and out of certain "zones".
>
> Effective March 15, 2021, Ontario amended the regulation that imposed a ten-person cap and replaced it with a 15 percent capacity limit.
>
> On April 7, 2021, the Province declared a third state of emergency. On May 29, 2021, the Ontario government announced its three-step Roadmap to Reopen, and the province-wide stay at home order was lifted in June, 2021.

[75] Justice Pomerance opined that her role:

> ...is not that of an armchair epidemiologist. I am neither equipped nor inclined to resolve scientific debates and controversy surrounding Covid 19. The question before me is not whether

certain experts are right or wrong. The question is whether it was open to Ontario to act as it did and whether there was scientific support for the precautionary measures that were taken: para 6.

[76] Justice Pomerance found that:

i. the Ontario restrictions on the size of religious gatherings interfered with the fundamental guarantee of freedom of religion in section 2(c) of the *Charter*, but

ii. the limitations of freedom of religion were reasonable and demonstrably justified in a free and democratic society under section 1 of the *Charter*.

[77] She found that the measures should be upheld under section 1, stating that "[t]his mix of conflicting interests and perspectives, centred on a tangible threat to public health, is a textbook recipe for deferential review": para 128.

[78] On whether there was a pressing and substantial objective, Pomerance, J stated that "[i]t borders on the trite to observe that human life is sacred, and that public health and safety is important. Of similar import is the viability of the health care system relied upon by all residents in the province": para 132.

[79] On rational connection, she stated that "[b]ecause Covid 19 is transmitted from person to person, restricting person- to-person contact logically reduces the risk of transmission. The connection between religious gathering restrictions and the objective is fortified by consideration of the activities at religious services": para 136.

[80] On minimal impairment, Pomerance J highlighted that "Ontario is not required to justify its choices on a standard of scientific certainty. That would set an impossible burden, particularly where, as here, the social problem defies scientific consensus": para 144. She noted the precautionary principle is engaged in matters of public health: para 145. She found that Ontario acted on the best scientific information available, and a "precautionary stance was favoured over a 'wait and see' approach, lest lives be lost in the interim": para 146.

[81] Pomerance J. rejected any comparison to retail stores, "as the retail experience does not contemplate the same potential for infectious droplets to be passed from person to person": para 153.

[82] Ontario conceded that limiting religious gatherings to ten persons or less infringed section 2(a) of the *Charter*, however it argued that other less stringent restrictions did not.

[83] Justice Pomerance acknowledged that "for these claimants, there is a qualitative difference between a small and large religious service. The synergy of the religious service fuels a collective consciousness": para 104. She found it was "not for the court to dictate to the claimants how many attendees should suffice for a meaningful spiritual experience": para 112.

[84] Thus, Justice Pomerance "conclude[d] that the numerical or percentage capacity limits imposed on religious gatherings - either indoors or outdoors - did infringe section 2(a) of the *Charter* "and the existence of alternate methods for the delivery of religious services [did] not attenuate the infringement, given the religious significance of the collective in-person experience": para 113.

[85] She found it unnecessary to conduct separate analyses under subsections 2 (b), (c), and (d) as "[t]he interests protected by those subsections are in this case, wholly subsumed by the section 2(a) analysis": para 115.

[86] She further noted that Ontario never completely banned religious gatherings (neither did Alberta). At moments of highest risk "religious institutions were permitted to have upwards of ten persons together to facilitate virtual or drive-in services": para 155. She concluded the restrictions were within a range of reasonable alternatives.

[87] On proportionality, Justice Pomerance, like Chief Justice Joyal, noted that the interests and *Charter* rights of all Ontarians were implicated: para 160. "Covid 19 has its own communal character whereby individual choice can have community consequences": para 160. She asserted that "[t]he fact that people die every year from other conditions, such as influenza, does not set a bar of tolerable mortality": para 164. Pomerance J wrote:

> ...no one would rationally suggest that a certain number of preventable deaths should have been allowed in the name of religious freedom, or that the lives of certain individuals - those who are over 60 or have underlying health conditions - have less intrinsic value than religious observance. These are false dichotomies. The sanctity of human life is not reducible to crass comparisons. The salutary benefit flows from the prospect of saving lives and preventing serious illness, even if we cannot precisely quantify how many lives were saved: para 164.

[88] The Court added that the "deleterious effects of the gathering limits were mitigated by the fact that other means of religious expressions were available": para 167. Religious institutions were required to make sacrifices to protect public health, "but no more than was reasonably necessary and for no longer than was reasonably required": para 169. Full accommodation of religious freedom "would have represented a wholesale abdication of government responsibility to act in the public interest": para 172.

[89] In ***Ontario (Attorney General) v Trinity Bible Chapel***, 2023 ONCA 134, the Ontario Court of Appeal dismissed an appeal of the decision. Pomerance J's finding that section 2 (a), of the *Charter* was infringed was not appealed, but the appellants challenged her treatment of the expert evidence, her decision not to rely on "hindsight" evidence in evaluating the regulations, her decision not to consider the other alleged *Charter* breaches, and her conclusion that the regulations were justified under section 1 of the *Charter*.

[90] The Court found that Pomerance J was entitled to consider the evidence of a participant expert, the Associate Chief Medical Officer of Health. The Court found no reason to interfere with her weighing of the expert evidence, noting Justice Pomerance's comment that:

> As noted earlier, it is not my role to choose between dueling experts on the science of Covid 19. The question is whether it was reasonable for Ontario to do what it did, on the basis of the evidence available to it at the relevant time. The views expressed by Dr. McKeown and Dr. Hodge best reflect what was known and understood by Ontario when it made its decisions. (emphasis added): para 49.

[91] The Court found that Pomerance J did not err by declining to evaluate the challenged regulations through the lens of hindsight.

[92] She reiterated that the dispute before her related to the scientific and policy understandings at the time the regulations were enacted. Additionally, she was highlighting the importance of context in the analysis, particularly the absence of scientific certainty regarding Covid 19.: para 55.

[93] The Court referred to the British Columbia Court of Appeal's decision in ***Beaudoin v British Columbia*** with approval, which it noted adopted and amplified Justice Pomerance's perspective on hindsight evidence.

[94] The Court refused to find an error in the fact that Pomerance J declined to conduct separate analyses with sections 2(b) and (d) of the *Charter*. Sossin JA, writing for the Court, noted at paras 67 and 71 that:

> The alleged infringement of the appellant's s. 2 (a) rights accounted for their related rights to express their religious beliefs, assemble for the purpose of engaging in religious activity, and associate with others who share their faith. While the appellants also suggest that certain expressive activities took the form of political protest protected under s. 2(b), those activities were directly related to the government restrictions on religious gatherings. The motion judge noted that her finding that section 2 (a) was infringed accounted for these various manifestations of religious freedom, concluding "[t]here is no value added by repeating or repackaging the analysis under different constitutional headings...".
>
> Therefore, where an examination of the factual matrix reveals that one claimed s. 2 right subsumes others, it is not necessary to consider the other s. 2 claims (though of course, there is no bar to a judge doing so). I should add that this approach is particularly apposite in the s. 2 context where the rights are related fundamental freedoms, whereas it may have less application across rights (for example, as between ss. 2, 7 and 15 rights).

[95] He also disagreed with the submission that the ***Oakes*** test changes where there are multiple breaches of the *Charter*, noting that "no matter which s. 2 right is used to label the interference, all deleterious effects will be considered in the proportionality analysis", agreeing in this respect with the Court in ***Beaudoin*** that "it goes against the tide of jurisprudence that has declined to determine every alleged *Charter* breach": paras 76 and 80.

[96] The appellants argued that the motion judge was "excessively deferential" to Ontario in her ***Oakes*** analysis and erred at every step of the test.

[97] The Court did not agree, and cited conclusions on minimal impairment upheld by courts across Canada that have considered similar restrictions at the stage of the ***Oakes*** analysis: paras 121-125.

c. *Beaudoin v British Columbia*, 2021 BCSC 512

[98] This decision was released on Mach 18, 2021. The context of the decision was as follows:

> On March 18, 2020, the Minister of Public Safety issued a declaration of a state of emergency in British Columbia, which was extended and consistently kept in place to the date of the hearing.
>
> On March 16, 2020, the Chief Medical Health Officer Dr. Bonnie Henry issued the first Gathering and Events (G&E) Order, prohibiting gatherings in excess of 50 people. On March 17, 2020, Dr. Henry declared the transmission of the virus to be a regional event as defined by s. 51 of the *British Columbia Public Health Act*. The issuance of the Notice of Regional Event triggered Dr. Henry's ability to exercise emergency powers under Part 5 of the *Act*.
>
> By mid-October 2020, diagnosed case numbers began to accelerate rapidly. On November 7, 2020, Dr. Henry imposed further restrictions on gatherings in the Vancouver Coastal and Fraser Health regions. The surge of cases continued and on November 19, 2020, the November 7, 2020 restrictions were extended province - wide, resulting in a temporary ban on all in - person gatherings, including religious services.
>
> On December 2, 2020, Dr. Henry issued a written G&E Order that repealed and replaced her November 10, 2020 and her November 13, 2020 orders with respect to COVID-19 regional measures. The December 2, 2020 Order prohibited all events except those enumerated in the order. Weddings, baptisms and funerals were permitted, though with a maximum of 50 people and specific guidelines to reduce the risk of transmission. The December 9, 2020 Order reduced the maximum attendance for these events to 10 people and permitted individual attendance at a place of worship for the purpose of prayer or quiet reflection. This order also permitted drive-in events. Orders on December 15 and 24, 2020 extended these same restrictions, but specified that drive-in events could have no more than 50 vehicles present.
>
> The January 8, 2021Order maintained the prohibition on in- person religious services and the previous amended limitations.

[99] Chief Justice Hinkson dismissed a declaration sought by three churches and their spiritual leaders that time-limited orders imposed by the *Public Health Act* during the second wave of the Covid-19 pandemic that prohibited in-person gatherings for religious worship violated their freedom of religion, expression, assembly, association, liberty, and equality rights under section 2(a)-(d), 7, and 15(1) of the *Charter*.

[100] He found that, although the impugned orders limited the applicant's section 2 rights, those limits were justified under section 1 of the *Charter*. He found that the orders were not an unreasonable exercise of administrative authority and should not be quashed.

[101] Hinkson, CJ found that the impugned orders were based on a reasonable assessment of the risk of transmission of the virus during religious and other types of gatherings, and that Dr. Henry had turned her mind to the impact of her orders on religious practices and governed herself by the principle of proportionality.

[102] Chief Justice Hinkson held that "[i]n the areas of science and medicine, Dr. Henry is entitled to deference and the appropriate standard of review of such matters is that of reasonableness", rejecting the applicants' argument that the standard should be correctness given that the substance of the matter was a *Charter* challenge: paras 122-124.

[103] The respondents had conceded that the impugned orders engaged sections 2(a) (b) (c) and (d) of the *Charter*. With respect to section 7, the applicants argued that the right to life might be described as a depreciation in the value of the lived experience: para 180. Chief Justice Hinkson, agreed with the respondents that the right to life protected by section 7 does not extend as far as the religious petitioners suggested: para 184.

[104] Given the concessions of the respondents and his findings with respect to the religious petitioners' section 2 *Charter* rights, Chief Justice Hinkson found it unnecessary to expand the jurisprudence relating to section 7 and made no findings with respect to section 7.

[105] For the same reason, Chief Justice Hinkson found it unnecessary to make a finding with respect to section 15.

[106] Chief Justice Hinkson determined the *Doré* test should apply to his analysis, as the impugned orders were more akin to administrative decisions than a law of general application: para 218.

[107] Chief Justice Hinkson noted that "[t]he constitutional importance of combating the Covid-19 pandemic has been stated by courts across the country": para 224.

[108] He rejected an intervenor's submission that religious gatherings presented identical risks to school, gymnasium, support group or restaurant settings: para 226. The key distinguishing factors relied on by Dr. Henry in restricting religious gatherings included the ages of the participants, the intimate setting of religious gatherings, and the presence of communal singing or chanting: para 226. The Chief Justice concluded that "[a]s the religious petitioners concede that public health is a sufficiently important objective that it can justify limits on *Charter* rights. [There was] no basis upon which to find that the impugned G&E Orders are arbitrary in the broad sense": para 228.

[109] Applying ***Vavilov*** guidance on reasonableness review, the Chief Justice found that Dr. Henry's orders fell within a range of reasonable options: para 246.

[110] This decision was appealed, and the appeal was dismissed: ***Beaudoin v British Columbia (Attorney General)***, 2022 BCCA 427, leave to appeal requested.

[111] Mr. Beaudoin appealed the chambers judge's declaration that the impugned orders were of no force and effect to the extent they infringed the right to organize and participate in outdoor protests on the basis that the declaration did not go far enough. His appeal was dismissed as the issue had become moot.

[112] With respect to the church appellants, the Court of Appeal held that a *Doré* analysis was the appropriate framework in that case, that the chambers judge was not obliged to consider the section 15 claim in the circumstances, and that the ban on in-person gatherings for religious worship fell within a range of reasonable outcomes and proportionately balanced the appellants' freedoms with the attainment of critically important public health objectives. The Court found that the result would have been the same under an ***Oakes*** analysis.

[113] The Court of Appeal noted that "[i]t is important to extract from the record what was known by the [public health officer] when the impugned decisions were made", noting with approval the comments of Pomerance, J in ***Trinity*** with respect to hindsight analysis: para 68.

[114] The Court also cited with approval the comments of Joyal, CJ in ***Gateway*** and Pomerance, J in ***Trinity*** on the subject of judicial humility in the public health context, noting at para 150 that in that context, "courts have consistently acknowledged the specialized expertise of public health officials and the need to judicially review decisions with a degree of judicial humility."

3. Infringement of Rights

a. Concessions

[115] Alberta makes the following concessions with respect to whether the impugned Orders infringed any of the Applicants' *Charter* rights:

i. the HBC and the NBC have demonstrated infringement of their section 2(a) rights with respect to the Indoor Gathering Restrictions;

ii. the Private Residence Restrictions and the Indoor Gathering Restrictions infringed Ms. Tanner's section 2(c) and (d) rights;

iii. the Indoor Gathering Restrictions infringed the Churches' section 2(c) and (d) rights;

iv. the Isolation, Quarantine and Visiting Restrictions and the Indoor Gathering Restrictions violated Mr. Blacklaws' section 2(c) and (d) rights, and

v. the Indoor Gathering Restrictions and the Outdoor Gathering Restrictions violated Ms. Ingram's section 2(c) and (d) rights, except for the rights she claims on behalf of her children.

[116] The following analysis only addresses claims of infringement that have not been conceded by Alberta.

b. Do the impugned Orders engage and violate Section 2 of the *Charter* with respect to Ms. Tanner, HBC and Ms. Ingram?

i. Section 2 (a)

[117] Section 2 (a) of the *Charter* provides the right to freedom of conscience and religion. The purpose of this freedom is to allow every individual:

> ... [to] be free to hold and to manifest whatever beliefs and opinions his or her conscience dictates, provided *inter alia* only that such manifestations do not injure his or her neighbours or their parallel rights to hold and manifest beliefs and opinions of their own: ***R v Big M Drug Mart***, 1985 CanLII 69 (SCC), [1985] 1SCR 295 at 346.

[118] The party alleging infringement of such right must provide positive evidence linking a practice or belief with a sincerely held religious belief in order for the protection of section 2(a) to be invoked. The applicant must establish that the impugned action interferes with her or his ability to hold or manifest those beliefs in a manner that is more than trivial or insubstantial: ***Mouvement laique québécois v Saguenay (City)***, 2015 SCC 16 at para 86; ***Alberta v Hutterian Brethren of Wilson Colony***, 2009 SCC 37 at para 32.

[119] "Trivial or insubstantial interference" is interference that does not threaten actual religious beliefs or conduct: ***Hutterian Brethren*** at para 32.

[120] As noted by the Supreme Court in ***R v Edwards Books and Art Ltd***, 1986 CanLII 12 (SCC), [1986] 2 SCR 713 at 759:

> ... The Constitution shelters individuals and groups only to the extent that religious beliefs or conduct might reasonably or actually be threatened. For a state-imposed cost or burden to be proscribed by s. 2(a) it must be capable of interfering with religious belief or practice. In short, legislative or administrative action which increases the costs of practising or otherwise manifesting religious beliefs is not prohibited if the burden is trivial or insubstantial: see, on this point, ***R v Jones***, 1986 CanLII 32 (SCC), [1986] 2 SCR 284, *per* Wilson J. at p.314. [Emphasis added]

Ms. Tanner

[121] Ms. Tanner submits that Christmas is a sacred time of year, and also a time for a family gathering. She says that Christmas is the one time of the year when her entire family gathers together to celebrate the birth of Jesus, and that Christmas has become "a sacred tradition for her family where we can lean on each other for love, prayer and support."

[122] While Ms. Tanner does not assert directly that gathering with her family is part of a deeply held religious belief, she certainly implies that Christmas gathering is part of a sincerely held belief. While it is true that she refers to non-spiritual activities at Christmas, this does not derogate from her expression of Christmas as part of her religious beliefs. Her assertions are uncontested.

[123] Given, the nature of her assertions, the impairment of her religious freedom cannot be said to be trivial.

[124] I find therefore that impugned Orders infringed Ms. Tanner's section 2(a) *Charter* rights.

HBC

[125] Alberta has not challenged the standing of the Applicant churches to assert infringement of s. 2(a) *Charter* infringements.

[126] However, Alberta submits that, as HBC is a religious corporation or organization, and not a natural person, it does not have standing to assert a violation of section 2(a) with respect to Private Residence Restrictions on behalf of others.

[127] The Church's lead pastor, Mr. Schoenberg, submits that the Church "and its members believe in using our homes to offer hospitality to one another." As noted by Alberta, HBC does not have a private residence. This claim is therefore dismissed.

Ms. Ingram

[128] Ms. Ingram submits that, as a Christian, she sincerely believes that attending church, religious services like wedding and funerals, and religious celebrations such as Christmas and Easter, "are important sacramental milestones tied to her practice of Christianity". As religious services and celebrations were limited by the impugned Orders, Ms. Ingram says that she could not celebrate Easter and Christmas, and she says that she ceased attending church because of capacity restrictions.

[129] Ms. Ingram submits infringement of freedom of religion does not require prohibition of participation in religious ceremonies, only that her religious beliefs or conduct be threatened. Ms. Ingram submits that capacity restrictions on religious services interfered with her religious practice. However, as noted in ***Edwards Books***, the threat to religious conduct must be reasonable. At no point, did the impugned Orders entirely prohibit attendance at religious services.

[130] As noted by Alberta, Ms. Ingram does not assert that she was actually prohibited from attending religious services or that she was denied an ability to participate in either weddings or funerals. Nor does she provide evidence that attending Church with the entirety of her congregation forms part of her religious beliefs,

[131] She does not give evidence that celebrating with her extended family in her home forms a part of her sincerely held religious beliefs. Thus, Ms. Ingram's section 2(a) *Charter* claims lack factual foundation.

ii. Section 2(b)

[132] Section 2(b) of the *Charter* protects "freedom of thought, belief, opinion and expression, including freedom of the press and other media of communication".

[133] The Supreme Court noted in ***RWDSU, Local 558 v Pepsi-Cola Canada Beverages (West) Ltd.***, 2002 SCC 8 at para 32:

> The core values which free expression promotes include self-fulfilment, participation in social and political decision making, and the communal exchange of ideas. Free speech protects human dignity and the right to think and reflect freely on one's circumstances and condition. It allows a person to speak not only for the sake of expression itself, but also to advocate change, attempting to persuade others in the hope of improving one's life and perhaps the wider social, political, and economic environment.

[134] The Applicants Ms. Tanner, HBC, and NBC assert that their section 2(b) rights have been infringed.

[135] The first stage of a section 2(b) analysis is the definition of the activity at issue that connects with the alleged right: ***Irwin Toy Ltd v Quebec (Attorney General),*** 1989 CanLII 87 (SCC), [1989] 1 SCR 927.

[136] The second stage is to determine whether there has been a violation: Robert J. Sharpe & Kent Roach, *The Charter of Rights and Freedoms*, 7th edition (Toronto Irwin Law: 2017) at 180.

[137] The Supreme Court distinguishes between content-based restraints and restraints that have an incidental effect on limiting freedom of expression. There are no content-based restraints found within any of the impugned Orders. Accordingly, each individual claimant must demonstrate that the restriction impaired their right to engage in expressive activity that promotes one of the principles underlying freedom of expression: political debate, the marketplace of ideas, or autonomy and self fulfillment. ***Sharpe*** at 171.

Ms. Tanner

[138] Ms. Tanner attended a peaceful protest with respect to the CMOH Orders without any consequences. However, she submits that she was concerned about the police presence at a rally. There is no evidence that the police were intimidating or prevented the protest. Any infringement of her section 2(b) *Charter* rights was trivial, inconsequential and passing in nature and therefore does not call for a remedy.

HBC and NBC

[139] The Churches assert that the Private Residence Restrictions, Indoor Gathering Restriction and the Isolation, Quarantine and Visiting Restrictions infringed their section 2(b) *Charter* rights.

[140] HBC and NBC have no standing to assert section 2(b) *Charter* rights with respect to Private Residence Restrictions and the Isolation, Quarantine and Visiting Restrictions for the reasons set out in previously in this decision.

[141] With respect to the Indoor Gathering Restrictions, the Churches submit that the masking requirements limited their congregants' ability to express themselves. To the extent that this is accurate, it would be a trivial or insubstantial interference with autonomy, even if the churches had standing to assert infringement on behalf of its congregants: ***Amselem*** at para 62.

[142] The Churches submit that their section 2(b) rights to freedom of expression have been infringed by the masking requirement. They do not have standing to assert such a right on behalf of their congregants.

iii. Sections 2(c) and (d)

[143] Sections 2(c) and (d) provide the right to freedom of peaceful assembly and freedom of association.

[144] Section 2(c) protects the "physical gathering together of persons". ***Roach v Canada (Minister of State for Multiculturalism and Citizenship) (CA)***, 1994 CanLII 3453 (FCA), [1994] 2 FC 406.

[145] Section 2(d) of the *Charter* is intended to recognize and protect the "profoundly social nature of human endeavours and to protect the individual from state-enforced isolation in the pursuit of his or her ends". Freedom of association seeks to protect "not associational activities *qua* particular activities, but the freedom of individuals to interact with, support, and be supported by, their fellow humans..." ***Reference Re Public Service Employee Relations Act (Alta.)***, 1987 CanLII 88 (SCC), [1987] 1 SCR 313 at 365; ***Mounted Police Association of Ontario v Canada (Attorney General)***, 2015 SCC 1 at para 35.

[146] Alberta has conceded the infringement of sections 2(c) and (d) for all applicants except with respect to certain aspects of the claims of Ms. Tanner, and Ms. Ingram.

Ms. Tanner

[147] While Alberta concedes Ms. Tanner's claim with respect to the Private Residence Restrictions and Indoor Gathering Restrictions, it submits, and I agree, that given the nature of Ms. Tanner's evidence, her claim with respect to Outdoor Gathering Restrictions must be dismissed.

[148] Any infringement of Ms. Tanner's rights to peacefully assemble and to associate with like-minded individuals at protests or rallies was a trivial, insubstantial, and passing infringement. Ms. Tanner's evidence is that she participated in the rallies and faced no consequences for having done so.

Ms. Ingram

[149] While Alberta concedes that Ms. Ingram's sections 2(c) and (d) were infringed with respect to the fact that she could not host Christmas or other holiday events or celebrate with her mother on her birthday (the Indoor Gathering Restrictions and the Outdoor Restrictions), Alberta submits, and I agree, that Ms. Ingram does not have standing with respect to her allegations of infringement of her children's rights, They are not parties to the application. Ms. Ingram gives no evidence with respect to how the Primary or Secondary School Closure Restrictions infringed her section 2(c) and (d) rights, other than a bare allegation that these restrictions caused her children unspecified psychological damage.

c. Do the impugned Orders engage and violate section 7 of the *Charter*?

[150] Section 7 of the *Charter* states:

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

[151] None of the Applicants assert a violation of a "right to life". Ms. Tanner, Mr. Blacklaws and Ms. Ingram assert that their section 7 rights to liberty and security of the person have been infringed. While the HBC initially asserted that the impugned Orders infringed its section 7 rights, these rights only apply to natural persons. HBC has thus abandoned this claim.

[152] As noted by Alberta, the rights found in section 7 do not apply to economic or property interests nor do they protect the ability to generate business revenue by one's chosen means: Peter W. Hogg, Constitutional Law of Canada, 5th ed. (Toronto: Thomson Reuters, 2007) (loose-leaf updated 2019, release 1) at p. 47-50. pp. 47-11, -47-12, 47-18 to 47-19.

[153] The Ontario Superior Court of Justice in ***Doe v Canada (Attorney General)*** 2006 ONSC 1185 at paras 158-159, aff'd 2007 ONCA 11 concluded that section 7 does not encompass the choice of an individual to voluntarily assume the risk of contracting an infectious disease without state interference. Individuals do not have a section 7 right to engage in behaviour that increases the risk of contracting an infectious disease that puts others at risk and burdens the public health care system.

[154] Alberta acknowledges that some of the restrictions arising from the impugned Orders have restricted the movements of Albertans, for example restricting the locations that they could visit, the numbers of individuals that could attend events, and requirements of physical distancing from other individuals. Alberta submits, however, that the deprivations arising from such restrictions are clearly in accordance with the principles of fundamental justice.

[155] Given Alberta's concession, it is not necessary to analyze in detail the allegations of Ms. Tanner, Mr. Blacklaws and Ms. Ingram. Assuming that some of the impugned Orders violated section 7, the issue becomes whether the deprivations arising from the impugned Orders were contrary to the principles of fundamental justice: ***Canada (Attorney General) v Bedford***, 2013 SCC 72 at para 57.

[156] The onus rests on the Applicants to show that their rights have been denied contrary to an identifiable principle of fundamental justice.

[157] In ***Reference Re section 94(2) of the Motor Vehicle Act (BC)***, 1985 CanLII 81 (SCC), [1985] 2 SCR 486 at 495, Lamer J tied the principles of fundamental justice to "the basic tenets of our legal system" and the "domain of the judiciary as guardian of the justice system, rather than the realm of public policy."

[158] The principles of fundamental justice include prohibitions against unduly vague laws, laws that are arbitrary or bear no rational relation to their legislative objective, laws that are overbroad to their legislative objective and laws that are grossly disproportionate between their objective and the harms they impose: ***Sharpe*** at 274. A section 7 analysis is concerned with the qualitative relationship between the

infringement of a right and the objective of the law, not as ***Sharpe*** notes, "the law's effectiveness or how many people it affects."

[159] The impugned Orders cannot be said to be vague: they set out an intelligible standard of conduct. Laws are arbitrary if there is no rational connection between the measures that cause the deprivation and the purpose underlying them: ***Bedford*** at para 111. The purpose of the impugned Orders is clear: they were enacted to prevent, reduce, or eliminate the spread of Covid-19 in order to minimize death and serious illness, and the risk of overwhelming the healthcare system.

[160] As Hinkson CJ noted in ***Beaudoin***, the deprivation of a right will be arbitrary and thus violate section 7 if it bears no real connection to the law's purpose. The deprivation of a right will be overbroad if it goes too far and interferes with some conduct that bears no connection to its objective. The deprivation of a right will be grossly disproportionate if the seriousness of the deprivation is so totally out of sync with the objective that it cannot be rationally supported: para 179.

[161] It is irrelevant for the purposes of section 7 to compare the impugned Orders to other restrictions: ***Gateway*** at para 260. That is not the correct analysis. I agree with Hinkson CJ that the fact that some places of business were allowed to remain open subject to various restrictions does not negate the rational connection that exists between the impugned Orders and their objective.

[162] A law is overbroad where it prohibits some activities that have no rational connection to its purpose: ***Bedford*** at para 111. The question as it relates to the section 7 analysis is not whether the restrictions could be less stringent. It is whether the prohibitions under any specific impugned Order did not reduce or slow the spread of the virus. The Applicants have not established this.

[163] Finally, "[t]he rule against gross disproportionality only applies in extreme cases where the seriousness of the deprivation is totally out of sync with the objective of the measure": ***Bedford*** at para 120. As was clearly established by the evidence led by Alberta with respect to the transmission of the virus, the need to prevent its spread and the necessity of avoiding severe outcomes in terms of mortality and morbidity, the restrictions that Ms. Tanner and Ms. Ingram describe under the rubric of section 7 were not grossly disproportionate. No one doubts that the Private Residence Restrictions, the Indoor Gathering Restrictions and the Outdoor Restrictions were painful for many individuals and families, but the impugned Orders did not, as alleged by Ms. Tanner, "attempt to cancel Christmas".

[164] Ms. Ingram was not prevented from attending church services: she was prevented from doing so in her preferred way.

[165] The issue of whether Ms. Ingram is able to assert section 7 claims on behalf of her children has been discussed previously. They are not parties to this action.

[166] While Alberta acknowledges that Ms. Ingram may have a claim with respect to her parental rights, again, the limitations imposed by the impugned Orders cannot be said to be overbroad considering the risks to her children arising from the spread of the virus, and the corresponding risk of transmission to others.

[167] Parental rights are not absolute. Not every limitation on a child's *Charter* rights would engage parental rights under section 7. The state can justifiably intervene if it is necessary to safeguard the child's autonomy or health and to promote the best interests of the child: ***B(R) v Children's Aid Society of Metropolitan Toronto***, 1995 CanLII 115 (SCC), [1995] 1 SCR 315 at 372.

[168] There is no doubt that Mr. Blacklaws suffered from his inability to be with his father at his father's end of life, and his inability to hold a funeral for a group larger than that allowed by the impugned Orders. However, Mr. Blacklaws' submissions with respect to breaches of his section 7 liberty and security interest with disrespect to the Insolation, Quarantine and Visiting Restrictions must fail because, given the evidence with respect to transmission, these restrictions cannot be said to be arbitrary, overbroad or grossly disproportionate. Also, much of Mr. Blacklaw's evidence involved his interaction with the staff of the University Hospital, and not the impugned Orders *per se*. With respect to the Indoor Gathering Restrictions, and Mr. Blacklaws' inability to hold a sufficiently large funeral to accommodate all whom Mr. Blacklaws wished to invite, he was not

precluded from holding a smaller gathering. He has no standing to advance a section 7 claim on behalf of those individuals who could not attend a smaller service.

[169] I therefore conclude that Ms. Tanner, Mr. Blacklaws and Ms. Ingram's section 7 claims must be dismissed on the basis that the deprivations that are the subject of the claim were enacted in accordance with the principles of natural justice.

[170] In summary, the only *Charter* right that was infringed in addition to the rights conceded by Alberta was Ms. Tanner's rights under section 2(a) of the *Charter*.

d. Can the infringement of the *Charter* rights by the impugned Orders be justified in a free and democratic society in accordance with section 1 of the *Charter*?

i. Section 1 of the *Charter*

[171] Section 1 provides that the rights and freedoms guaranteed by the *Charter* are "subject only to such reasonable limits prescribed by law as can be justified in a free and democratic society".

[172] This provision encompasses both a formal (prescribed by law) and a substantive (the state's justification for the restriction and its means of doing so) element: ***Sharpe*** at pg. 71.

[173] The formal element of a limit prescribed by law is not at issue, assuming that I am incorrect with respect to my earlier analysis with respect to section 29 of the *Public Health Act*.

[174] The Supreme Court in ***Canada (Attorney General) v JTI-Macdonald Corp***., [2007] 2 SCR at paragraph 36, said of section 1 that it effects a balance between the rights of the individual and the interests of society by permitting limits to be placed on guaranteed rights and freedoms. "Most modern constitutions recognize that rights are not absolute and can be limited if this is necessary to achieve an important objective and if the limit is appropriately tailored, or proportionate".

[175] As noted in the seminal case of ***Oakes***, 1986 CanLII 46 (SCC), [1986] 1 SCR 103 at pg. 136, the values and principles that must guide the Court in applying section 1 include:

> ... respect for the inherent dignity of the human person, commitment to social justice and equality, accommodation of a wide variety of beliefs, respect for cultural and group identity, and faith in social and political institutions which enhance the participation of individuals and groups in society. The underlying values and principles of a free and democratic society are the genesis of the rights and freedoms guaranteed by the *Charter* and the ultimate standard against which a limit on a right or freedom must be shown, despite its effect, to be reasonable and demonstrably justified...
>
> The rights and freedoms guaranteed by the *Charter* are not, however, absolute.

[176] The Court in ***R v Oakes*** established the following steps for a Court to follow in analyzing whether a limit on a *Charter* issue right is "reasonably" and "demonstrably justified" beyond the prescribed by law requirement:

1. Is the legislative goal pressing and substantial? i.e., is the objective sufficiently important to justify limiting a *Charter* right?
2. Is there proportionality between the objective and the means used to achieve it?

The second branch of the test has three elements:

a. "Rational Connection": the limit must be rationally connected to the objective. There must be a causal link between the impugned measures and the pressing and substantial objective;

b. "Minimal Impairment": the limit must impair the right or freedom no more than reasonably necessary to accomplish the objective. The government will be required to show that there are no less rights-impairing

methods achieving the objective “in a real and substantial manner”: ***Carter v Canada (Attorney General)***, [2015] 1 SCR para 102; citing ***Hutterian Brethren***, 2009 SCC 37 (CanLII), [2009] 2 SCR 567 para 55;

c. “Final Balancing”: there must be proportionality between the deleterious and salutary effects of the law: ***Carter*** at para 122; ***JTI-Macdonald***, at para 45.

[177] This test is now well-established ***Egan v Canada***, 1995 CanLII 98 (SCC), [1995] 2 SCR 513 at para 182; ***Vriend v Alberta*** 1 SCR 493 at paragraph 108; ***Canada (Attorney General) v Hislop***, 2007 SCC 10 (CanLII), [2007] 1SCR 429 at para 44; ***JTI-Macdonald*** at para 35-36.

[178] The standard of proof under section 1 is a preponderance of probabilities, and the onus is on the Respondents.

[179] The next step is to address the evidence called by the parties relevant to the ***Oakes*** analysis.

[180] The Oral Hearing Order provided that the Respondents would provide affidavit evidence from Dr. Hinshaw, Dr. Kimberly Simmonds, Deborah Gordon, Patricia Wood and Scott Long. These witnesses would then be cross-examined at the oral hearing.

[181] The Applicants’ factual evidence would be tendered by affidavit evidence only, and is summarized in Appendix A.

[182] The Applicants were allowed to call three expert witnesses: Dr. Jay Bhattacharya, Dr. Martin Koebel and David Redman.

[183] The Respondents were allowed to call four expert witnesses: Scott Long, Dr. Nathan Zelyas, Dr. Jason Kindrachuk and Dr. Thambirajah Balachandra.

[184] The oral hearing Orders provided that the Respondents would provide affidavit evidence from Dr. Hinshaw, Dr. Kemberly Simmonds, Deborah Gordon, Patricia Wood and Scott Long. These witnesses would then be cross-examined at the oral hearing.

[185] The Applicants’ factual evidence would be tendered by affidavit evidence only, and is summarized in Appendix A.

[186] The Applicants were allowed to call three expert witnesses: Dr. Jay Bhattacharya, Dr. Martin Koebel and David Redman. Dr. Redman was not called, nor was he referred to in closing arguments.

[187] The Respondents were allowed to call four expert witnesses: Scott Long, Dr. Nathan Zelyas, Dr. Jason Kindrachuk and Dr. Thambirajah Balachandra.

ii. Evidence of the Applicants

Dr. Jay Bhattacharya

[188] Dr. Bhattacharya filed an expert report on behalf of the Applicants on January 24, 2021 and a surrebuttal report on July 30, 2021. He was qualified to give opinion evidence as an expert in the area of health and health economic, including a focus on epidemiology and infectious disease epidemiology and on the public health impacts of lockdowns.

[189] Dr. Bhattacharya is a professor in the School of Medicine at Stanford University, lately in the Department of Health Policy. He is one of three authors of the Great Barrington Declaration, an article released in September 2020, that is based on the premise that there is a steep age gradient in the risk profile for Covid-19 such that older people face much higher risk of severe disease and death upon infection with Covid-19, relative to younger people. The Great Barrington Declaration calls for a lifting of restrictions as a general matter so that younger people can live lives as close to normal as possible, and then a focussed approach to protecting older people from the disease, with more resources and more ingenuity put into protecting older people from exposure to the virus, followed by prioritization for vaccination once vaccines are available.

[190] Dr. Bhattacharya's profile on the Stanford website describes him as a health economist who focuses on vulnerable populations and aging. He conceded that his knowledge of immunology is based on his studies in medical school and the articles he has since read.

[191] In Dr. Bhattacharya's view, looking only at the potential benefits of a policy, while ignoring the costs, is "economic malpractice". There should be an investigation of all outcomes from a policy, looking at other health outcomes and not just Covid-19 outcomes. He suggested that Alberta had not done an adequate cost benefit analysis.

[192] Dr. Bhattacharya has received a certain amount of name recognition due to his public advocacy with respect to the efficacy of lockdowns and in support of the Great Barrington Declaration, which has included appearances on network TV and podcasts. His experience with viruses was minimal pre-Covid-19, and primarily limited to economics. However, since 2000, he has published peer-reviewed articles in medical journals on infectious disease epidemiology and policy, including with respect to HIV, H1N1, H5N1, antibiotic resistance, and Covid-19. He has published six peer-reviewed papers on Covid-19 relating to the extent of spread of Covid-19, the mortality rate of Covid-19, the fairness of placement of testing centres, the efficacy of non-pharmaceutical interventions in slowing the spread of Covid-19 disease and other related topics related to Covid-19.

[193] He has not been board-certified in public health and attributes his expertise in that area to papers he has published, but he acknowledged that he is not a specialist in that area.

[194] The gist of Dr. Bhattacharya's opinion is that Covid-19 does not pose a real or imminent serious threat to the heath of the population unless you are elderly or have comorbidities.

[195] His view was that Alberta should have followed the recommendations of the Great Barrington Declaration from the beginning of the first wave and throughout all subsequent waves. Dr. Bhattacharya also stated in his opinion that Covid-19 infected individuals who are asymptomatic are more than an order of magnitude less likely to spread the disease to even close contacts than symptomatic Covid-19 patients.

[196] However, he has changed his opinion about asymptomatic spread since the advent of the Omicron variant, and now thinks it very likely that asymptomatic spread of the virus is more important with that strain of the virus than it had been before. However, it remained his opinion that, in the first through fourth weeks of the pandemic, asymptomatic transmission of the virus was rare.

[197] With respect to the Great Barrington Declaration, Dr. Bhattacharya noted:

> ...the highest risk of being hospitalized [or being admitted to] ICUs is the older population. By implementing a policy of focussed protection, you can reduce the risk of hospitalizations and ICUs, without necessarily focussing primarily on community transmission. Community transmission is not the primary way, or the only way to address hospitalizations and ICUs.

[198] He is also of the opinion that NPIs that place restrictions upon the public generally do not do much to protect the most vulnerable. He opined that extending lockdowns has actually prolonged the process toward what he described as equilibrium, by which he appears to mean "herd immunity".

[199] Dr. Bhattacharya is strenuously opposed to mandatory health measures, testifying that in his opinion, mandates build mistrust in public health. He suggested that a better alternative was to work with people and give them the resources to help meet guidelines. His opinion is that mandates were not necessary in this pandemic.

[200] Dr. Bhattacharya was cross-examined for three and a half days.

[201] He denied that his main expertise pre-Covid-19 was in financial issues as they relate to patient care and outcomes, but a list of his publications pre-2018 belied this denial. Dr. Bhattacharya was defensive with respect to cross-examination in this area, declaring that his research was not just about financial matters, but about patient outcomes, in many cases referring to financial incentives in treatment.

[202] Dr. Bhattacharya supported vaccination as a good public health policy, particularly giving priority to elderly people, which Alberta did in January 2021.

[203] With respect to his opinion on the prevalence of asymptomatic transmission. Dr. Bhattacharya was taken to an article he and co-authors published on December 1, 2020, in which they said that "while there is a pressing need to better understand the prevalence of asymptomatic transmission, it is also becoming increasingly clear that it will likely take a long time until we can with full confidence deliver reliable measurements of this asymptomatic group".

[204] While Dr. Bhattacharya said that this reflected what he thought in December 2020, he also maintained that by, that date "we had started to have a much better view of the extent of the asymptomatic group". The article continues to note that, in the meantime, mathematical modeling can provide valuable insight into the tentative outbreak dynamics and outbreak control of Covid-19 for various asymptomatic scenarios. Dr. Bhattacharya conceded that this still represented his view, although he later appeared to suggest otherwise.

[205] Dr. Bhattacharya agreed that he had given testimony similar to what he was going to provide to the Court in the ***Gateway*** litigation, although he testified that he had not read the ***Gateway*** decision. In that case, Dr. Bhattacharya was qualified as an expert in health economics. The affidavit he provided in this case was in fact the affidavit he had sworn in Manitoba. His primary report was filed in Manitoba on January 5, 2021, and in Alberta on January 21, 2021. He conceded that the reports are very similar, although he made some alterations more specific to Alberta's situation, such as Alberta case numbers.

[206] Dr. Bhattacharya had little specific knowledge about the events and public health measures taken in Alberta.

[207] For example, Dr. Bhattacharya seemed unclear about what steps Alberta had taken to achieve its objectives in the pandemic. When it was pointed out that his expert report did not deal with the issue of reducing morbidity, he said he would have to look back, as he thought he did comment on morbidity in some of his reports. Dr. Bhattacharya was referred to a comment made by Chief Justice Joyal in the ***Gateway*** case involving a similar report that:

> In this regard, Manitoba is right to point out that Dr. Bhattacharya's evidence focusses almost exclusively on mortality with virtually no mention of the impact that widespread community transmission has on hospitals and ICUs.

[208] Dr. Bhattacharya's response was that the reference in his report to the Great Barrington Declaration answered that criticism, although his explanation of why that was so was unclear.

[209] Dr. Bhattacharya had not reviewed all of the affidavits filed by Alberta's witnesses. He had not recently re-read the expert reports he was rebutting.

[210] Dr. Bhattacharya conceded that he had not recently looked at Alberta forecasting, but his recollection was that it had the same problems as many other areas throughout the world, in that it tended to overstate the estimates relative to what had ended up happening. He conceded that this had happened everywhere in the first wave.

[211] Dr. Bhattacharya stated in his written opinion that influenza death and Covid-19 deaths are counted differently by Statistics Canada, resulting in artificially elevated death statistics due to Covid-19. He was cross-examined on this in reference to the expert report to the contrary provided by Dr. Patricia Wood, a Senior Mortality Classification Specialist with Statistics Canada. Much the same occurred when he was referred to the expert report of Dr. Thambirajah Balachandra with respect to reporting causes of death, and the opinion of Dr. Nathan Zelaya. He stubbornly refused to admit that his statement with respect to Statistic Canada method of counting Covid-19 deaths was inaccurate, suggesting that he would have to have a conversation with Ms. Wood before he would accept her opinion. Dr. Bhattacharya was reluctant to accept any evidence or opinion that may cast doubt on his opinions.

[212] Dr. Bhattacharya was cross-examined on an article he wrote that was citied in his opinion that he had characterized in the ***Gateway*** proceeding as the best study on assessing mandatory stay-at-home and business

closures on the spread of Covid-19, at least in May 2021. He conceded that the article had not been published until about January 2022.

[213] He conceded that he knew that Alberta did not have a mandatory stay-at-home order during the pandemic. He referred to business closures, but he could not recall the details.

[214] Dr. Bhattacharya conceded that there were many academic studies that came to a different conclusion at the time and after the publication of his article. He also conceded that there had been a number of criticisms of the article, including relating to small sample size and arbitrary selection, although he did not agree with them.

[215] Dr. Bhattacharya referred to a study called the Madewell study and gave an opinion on the basis of that study that it was unlikely if someone was simply asymptomatic, either pre-symptomatic or asymptomatic, that that person will spread the disease to someone in his or her own household even if that person was in close contact with them.

[216] On that basis, he suggested that intrusive lockdown policies could be replaced with less intrusive symptom checking.

[217] In his written opinion, Dr. Bhattacharya noted that the authors of the Madewell study analyzed 54 studies in coming to the conclusion that asymptomatic and pre-symptomatic spread in households was .7 percent. Dr. Bhattacharya conceded on cross-examination that, in actuality, this data had come from a sub-analysis of four studies with 151 individuals. Dr. Bhattacharya denied that the manner in which he expressed his opinion was misleading.

[218] Dr. Bhattacharya testified that the Madewell study "played an enormously important part in my thinking, or at least up until [his expert report]." He was cross-examined on a more recent update to the Madewell study, but as it was published after June 30, 2021, the update is hindsight evidence not relevant to the question at issue in this litigation.

[219] Dr. Bhattacharya was referred to a "Declaration" he had published in California, in which he gave the opinion that a lockdown "may be beneficial in limited situations where hospital overcrowding is predicted to occur, which might induce avoidable mortality".

[220] The declaration continued:

> The primary benefit of a lockdown is that it is limited in time, a delay in the incidence of cases to avoid a public health emergency, such as the unavailability of sufficient medical personnel in an area to care for Covid-19 patients.

[221] Dr. Bhattacharya sought to qualify this opinion by indicating that he was referring to theoretical benefits, and whether these benefits would actually occur was an empirical question. He said that, in other articles, he had offered the opinion that alternative policies could be followed, particularly the Great Barrington Declaration's policy of focused protection.

[222] Dr. Bhattacharya was referred to a study cited in his written report called the Saviors study. In his testimony in Manitoba, Dr. Bhattacharya had referred to the study as "[p]erhaps the best peer-reviewed study" but in his Alberta report, he referred to it as to "[a]nother study". On cross examination, he explained the change by referring to a dispute amongst academics after the paper was published. He said he looked into that afterwards "and I thought it was still a good paper, but no longer necessarily the best paper." He conceded that he aware that the article had been retracted by the editors of the Scientific Report on December 14, 2021, but he did not raise that fact until he was cross-examined on it.

[223] Dr. Bhattacharya was very defensive about this area of cross-examination, in effect accusing counsel of trapping him. He indicated that he disagreed that the criticism of the article that led to the retraction was warranted.

[224] Dr. Bhattacharya conceded that in July of 2021, it was an open question whether NPIs were not effective in decreasing mortality, although "the literature has moved on".

[225] He admitted that he has changed his opinion about some things, such as masking when outside the home and remaining six feet apart; that he remained in favour of hand washing frequently and staying home while sick. He was now less certain about masking and did not think that the six foot requirement was necessary.

[226] Dr. Bhattacharya had referred to Sweden as an example of good policy in his written report. When faced with data that indicates that, during a similar period, Alberta's death rate was about 15.2% of Sweden's death rate when relevant populations were taken into account, he testified that it was important to adjust for the age of the population, suggesting that the high death rate in Sweden was caused by the initial exposure of nursing homes to the virus without any measures for protection.

[227] He conceded that he had not conducted an age adjusted mortality difference between Alberta and Sweden, despite using Sweden as an example in his opinion. He then testified that " if you don't do age adjustment, you're essentially producing misleading information".

[228] Dr. Bhattacharya often did not answer questions directly, instead reverting to justifications for or overelaboration of his opinions.

[229] In the ***Gateway*** decision, Chief Justice Joyal noted about Dr. Bhattacharya's testimony that:

> While Dr. Bhattacharya's contrary and in some cases contrarian views are decidedly not a disqualification from an important role in what has to be a continuing and rigorous scientific conversation and method, the views of Dr. Bhattacharya need be seen as views and opinions that are not supported by most of the scientific and medical community currently advising on and formulating the ongoing public health responses to a pandemic that continues to threaten too much of the world's population.

[230] Dr. Bhattacharya submitted, however, that his views are increasingly in the mainstream. He blamed "an organized media campaign" that mischaracterized his view as "fringe". He however conceded that he may have agreed with the Chief Justice's comment that his views were not supported by most of the scientific and medical community at the time of the Manitoba hearing.

[231] Dr. Bhattacharya was cross-examined on an American case involving disabled children and the efficacy of masking Dr. Bhattacharya gave evidence to the effect that masks were not effective in reducing the spread of Covid-19, and that schoolchildren are not at high risk for infection. The judge in that case, Chief United States District Judge Waverly Crenshaw Jr., of the United States District Court, M.D. Tennessee, Nashville Division. The Court found Dr. Bhattacharya's expert testimony "troubling and problematic" for several reasons. Judge Crenshaw said:

> In short, the Court is not persuaded by or confident in, Dr. Bhattacharya's expert opinion. He over-simplified the conclusions of the Bangladesh study, suggesting he may have been apt to do so with other studies upon which he relied. He offered opinions regarding the pediatric effects of masks on children, a discipline on which he admitted he was not qualified to speak. His demeanour and tone while testifying suggested he is advancing a personal agenda.
>
> At this state of the proceedings, the Court is simply unwilling to trust Dr. Bhattacharya: ***R.K. v Lee***, 3:21-cu 00725, at pg. 13.

[232] The plaintiffs in that case were granted a preliminary injunction against the State Governor's executive order giving parents a unilateral right to opt their children out of temporary universal mask mandates imposed by the local school board.

[233] These, of course, were different cases and involved different testimony by Dr. Bhattacharya. However, on the basis of the testimony and cross-examination in this Court, I must agree that there is little in Dr. Bhattacharya's evidence that would cause me to doubt the evidence of Alberta's witnesses. For the reason I have outlined, Dr. Bhattacharya's evidence was indeed indicative of advancing a personal agenda, was contradictory with previous published opinions and as was not based on an analysis of events and health care initiatives as they actually unfolded in Alberta. He was primarily an advocate for the Great Barrington Declaration, despite conceding some of the practical problems that attempting to take the approach suggested by

that theoretical model would entail. Dr. Bhattacharya himself described the difference between his views and others as follows:

> I think that the scientific literature on the effects of Covid-19 policies like lockdowns on outcomes has generated quite a bit of controversy in the scientific literature. And then you characterize as camps, I think that's fair, that there are scientists on one side who very strongly believe, I believe have prior beliefs, that Covid-19 restrictions have lifesaving effects and other scientists who, looking at the evidence, disagree. And so what we're talking about, really, is a major scientific fight over the effects of these Covid-19 orders, these lockdowns, on outcomes.

[234] The Appellants submit that it was unfair for Alberta to cross-examine Dr. Bhattacharya on what he had said under oath during the ***Gateway*** litigation, on the basis that "the ***Gateway*** decision reads more like a political decision then a legal decision, in effect concluding that upon the mere incantation of the words 'public health emergency' the government can do no wrong, and courts should not play any supervisory role". While this is a grossly unfair and inaccurate characterization of the ***Gateway*** decision, I have reached my own conclusion with respect to the credibility and weight to be given to Dr. Bhattacharya's opinions based on his written and oral testimony before this Court.

David Redman

[235] Mr. Redman was qualified to give opinion evidence as an expert in emergency management.

[236] Mr. Redman was the Executive Director of the Alberta Emergency Management Agency (AEMA) from January 2002 until December 2005. He was responsible for leading the emergency management activities for the Government of Alberta, a management role, with responsibility for co-ordinating responses to an emergency and advising the Premier.

[237] Mr. Redman has had a lengthy and impressive career in emergency management both in the military and during his two years with AEMA. However, his opinions with respect to Alberta's response to the pandemic suffer from the fact that they stem from his personal opinions about choices made by Alberta in responding to the pandemic, rather than any real procedural difficulties with the response.

[238] Mr. Redman was of the opinion that Alberta's responses to Covid-19 were flawed in that they only dealt with one of the objectives of the Alberta Pandemic Influenza Plan of 2014. In his opinion, Alberta was wrong to focus on controlling the spread of "the influenza" (by which he apparently meant Covid-19) in that it failed to focus completely on the full goal of controlling the spread of the disease and reducing illness and death by "providing access to appropriate prevention measures, care and treatment". On cross-examination, Mr. Redman indicated that in his opinion, the response of Alberta in March and April of 2020 did not address a focussed protection for seniors over the age of 60 with severe multiple comorbidities, particularly in long-term care homes. He offered the opinion that "if we had actually followed goal number one and offered methodologies for protection for our seniors, we probably could have reduced even the number of deaths in that area and yet we didn't".

[239] In his opinion, the use of NPIs did not address the other three goals of the 2014 influenza plan, being mitigating societal disruptions through ensuring continuity and recovery of critical services, minimizing adverse economic impacts and supporting an efficient and effective use od resources during response and recovery.

[240] He testified that NPIs were "assumed to have no negative outcomes", but "[w]e knew then they would have negative outcomes". On cross-examination, Mr. Redman offered the unsupported opinion that the Business Closure Restrictions "did not stop the spread significantly", and asserted incorrectly that they were "used as a first resort" when the World Heath Organization had recommended that they be used as "a last resort in an extremely severe pandemic".

[241] On cross-examination, Mr. Redman noted that "one of the things that we're clear, particularly in the first wave, is that 8.9 million Canadians across Canada out of a workforce of 20.1 million, were at home on CERB. That's a massive impact and a destruction of our economic potential in our country". CERB, of course, was unrelated to the impugned Orders at issue.

[242] He indicated his disagreement with other programs, including "programs that provided employees to make back payments of wages while they restricted the number of employees or sent their employees home" was "a completely inappropriate" program. He was the opinion that "the entire program was aimed at justifying use of lockdowns when they actually had not been justified".

[243] He disagreed with the WCB premium deferral for small and medium businesses. He indicated that he considered some of these programs "in terms of the destruction of small businesses in our Province", and "their lack of effectiveness".

[244] With respect to his opinion that Alberta's response failed to address the 2014 plan goal of mitigating societal disruptions, that "we now have fear in our society that forces people to say that their children have to be masked and stay at home. That's societal disruption..."

[245] With respect to a question whether, in his experience, as a hazard unfolds, so does the response, he agreed but said:

> ... if there had been a written plan that was developed appropriately, the options would have been presented in the plan with why there may be a shift and what the triggers would've been to do it. What we saw in Alberta was no production of a written plan ever issued to the public or even an oral one. The entire response shifting on a constant basis, based in the use of fear. The whole focus of the discussions that I put in that report and the whole lines that go, you know, first we're going to flatten the curve, then we're going to ___ the curve, then you're going to kill your grandparents, then all people are at equal risk; is simply untrue. But those were the goalposts that were constantly used to justify the inappropriate use of non-pharmaceutical interventions.

[246] Mr. Redman was asked whether it was fair to say that one of the criticisms across his report was that the government failed to adhere to or at least follow the general outline of the 2014 Alberta Pandemic Influenza Plan. He responded:

> My criticism is, is that the Government of Alberta never developed a plan. That they ignored their existing plan is a part of that criticism, but the majority of the criticism is directed at the fact that we didn't assign the right aim: we never established a cross-society government task force and we did not develop a plan that would address all of the issues on the impact of the use of any of the options on all of society. Our aim constantly and it's repeated every night on the news to this day, is to protect the medical system, it is not what public health should be, which is to protect all of society.

[247] As evidence of the Respondents witnesses indicated, non of this hyper role is correct.

[248] He was asked whether one of the issues in his surrebuttal report to Mr. Long's response report was the notion that in Mr. Long's opinion the 2014 plan contemplated the pandemic response being led by health professionals, he agreed, but insisted that was not what the plan said.

[249] When taken to clear language in the 2014 plan indicating that the role of Alberta Health was to lead and co-ordinate the provincial pandemic influenza health planning response and recovery Mr. Reymond stubbornly refused to accept this, instead indicating that the plan needed to be read in conjunction with the Alberta Emergency Plan, and that its "general assumptions" indicated the efforts of and response to a pandemic influenza are not limited to the health sector.

[250] He gave the opinion that:

> ... if the Premier had established a task force that looked at all of society, not just protection of the medical sector, but protection of Albertans in all sectors, we would've have had an extremely different response.

[251] The evidence from Dr. Hinshaw, Ms. Gordon and Mr. Long is that such a task force was established.

[252] If it was clear from his cross-examination that, while his opinion suggests that Alberta was at fault for not following the 2014 plan, the issue was really that he disagreed with the decisions made by Alberta in

addressing the goals of that plan. Mr. Reymond is not an expert in medicine, economics, or statistics, but he gave opinions on cross-examination in relation to all those areas. While he is certainly entitled to his opinion, they were not within his area of expertise. His expert opinions with respect to emergency management were really a justification for his personal, non-expert opinions about the steps Alberta took to deal with the pandemic.

[253] The Applicants did not refer to Mr. Redman's opinion in final argument.

iii. Evidence of the Respondents

Dr. Hinshaw

[254] Dr. Hinshaw is a specialist in public health and preventative medicine. She was Alberta's CMOH for the duration of the pandemic. Dr. Hinshaw has been an active member of the College of Physician and Surgeons since 2006.

[255] Dr. Hinshaw described Alberta's Covid-19 public health objectives as follows:

> Alberta's objective, in common with all Canadian jurisdictions, has always been to use the least restrictive measures required to prevent or limit the spread of the virus, thereby minimizing the number of serious outcomes, in terms of both deaths (mortality) and illness (morbidity), while balancing the collateral effects of public health restrictions and minimizing the overall harm to society.

[256] She noted the importance of sharing knowledge on the evolving pandemic and how "[p]ublic health officials from Alberta, Canada and around the world have worked together to develop and share new information about how to best respond to the pandemic".

[257] Dr. Hinshaw described the ethical principles applicable to making public health decisions and noted that the objective of the measures has been to protect the community and prevent widespread transmission, while "where reasonably possible" allowing people to decide for themselves the risks they wanted to take as individuals. She testified that restrictive measures to control widespread transmission of Covid-19 were used as a last resort in the second and third waves of the pandemic when advice and voluntary guidance were not sufficient to stop rising case numbers and rising hospitalizations, ICU admissions and deaths due to Covid-19.

[258] Dr. Hinshaw noted that Alberta's approach was consistent with that taken throughout Canada and across much of the world. This opinion was corroborated by the descriptions of measures taken in British Columbia, Manitoba and Ontario as described in ***Gateway***, ***Beaudoin*** and ***Trinity***.

[259] Dr. Hinshaw explained in affidavit evidence that the approach taken globally by public health experts was to seek to limit the number and duration of contacts between people, particularly when indoors, in order to prevent or reduce transmission of the SARS-CoV-2 virus. The extent to which mandatory measures were implemented in Alberta depended on local metrics, including active cases rates, positivity rates, R-values, as well as hospital and ICU capacities. R-values are calculations for the average number of infections that each person may go on to cause.

[260] She noted that, as no single measure alone was sufficient to control the spread of Covid-19, Alberta attempted to control transmission by implementing a variety of voluntary and mandatory public health measures. The evidence during the second and third waves was clear that, without widespread immunization, restrictions on how people interact with others outside of their households were effective in reducing cases of Covid-19 by reducing the transmission of SARS-CoV-2.

[261] Dr. Hinshaw stated that, while Alberta's approach had always been to attempt to control the spread of the virus while protecting, as much as possible, an individual's ability to interact with others and participate in work, recreational, religious and social activities. As the number of Covid- 19 cases and related hospitalizations, ICU stays, and deaths increased, Alberta's public health measures in response also had to adapt.

[262] Dr. Hinshaw explained that "at the very beginning of the pandemic, a lack of scientific evidence on the effectiveness of the public health measures, including the degree of public compliance and the collateral effects, meant decisions had to be taken in circumstances of significant uncertainty".

[263] With respect to the first wave, Dr. Hinshaw indicated that the initial closure (March 17 to May 14, 2020) was to address the increasing number of cases in the province. Alberta eased most public measures in place in a step-wise fashion beginning with the May 14, 2020 relaunch. After May 14, 2020, Alberta used targeted measures only as required to keep spread manageable and to ensure that Alberta's health system was able to cope with demands.

[264] Following Alberta's initial closure between March 17 and May 14, 2020, Alberta pursued a strategic and accelerated relaunch to facilitate opportunities for individuals and businesses to recuperate from both a financial and well-being perspective. She noted that Alberta was among the first provinces in Canada to enter into the relaunch phase and was often at the forefront of safely reopening sectors.

[265] She commented that seasonality benefitted containment efforts during the spring and summer of 2020. During July and August, daily cases and corresponding hospital and ICU numbers remained stable.

[266] On November 24, 2020, Alberta declared a state of public emergency pursuant to section 52.1 of the *Public Health Act*. Dr. Hinshaw explained that on that day, 1,115 new cases of Covid-19 had been identified over the previous 24 hours, and there were 348 people in hospital, including 66 in ICU. She testified that it was in response to this growth, "and because of increasing community transmission with unknown source", that the province decided to make the declaration, she stated as follows:

> [N]ew restrictions along with increased enforcement were put in place to reduce the spread of Covid-19 in communities, protect hospitals, keep schools and businesses open as much as possible, and better protect vulnerable Albertans...Mask wearing became mandatory effective immediately... in all indoor workplaces in the Calgary and Edmonton areas, except when working alone in an office or safely distanced cubicle or [where] a barrier is in place... However, the case trajectory continued to accelerate through November.
>
> In spite of the mandatory restrictions put in place by December 2020, the sharp increase in unknown community transmission meant the effectiveness of contact tracing was greatly reduced. As the number of individuals testing positive for Covid-19 increased, the capacity of the healthcare system to contact cases, identify contacts and link cases was significantly limited. The capacity to identify and control the spread in a targeted way was severely curtailed. By December 18, 2020, 78% of all active Covid-19 cases had no identifiable source.

[267] Dr. Hinshaw explained that the very nature of exponential growth meant that even in areas with low numbers of Covid-19 cases, the number of cases could grow very quickly. Due to the exponential growth in the number of Covid-19 cases Alberta experienced during its second wave up to December 18, the health care system was under severe threat. She noted that the severe pressure on the healthcare system through the second wave necessitated further restrictions through late November and December in order to slow transmission and bend the curve in ICU cases and hospitalization.

[268] Dr. Hinshaw responded to written interrogatories. All of the questions asked were answered with the objection that they were beyond what was allowed by the Oral Hearing Order, which limited written questions to the source of information in Dr. Hinshaw's affidavit. This objection was justified.

[269] Dr. Hinshaw was cross-examined from April 4, 2022 through April 7, 2022 by the two counsel for the Applicants. None of this cross-examination affected her credibility.

[270] She agreed that some of the decisions made had caused harm to Albertans but noted that she had stated on numerous occasions that the measures required to manage Covid-19 had unintended consequences and sometimes disproportionate impact. She testified that this was why "we have done everything we can to balance the benefits and those unintended consequences" to the entire population.

[271] She agreed that some individuals may have a lower risk of severe outcomes from Covid-19, but noted that, even if their individual risk was lower, they were still able to spread the risk to others, to be part of a large chain of transmission. She noted that even individuals who do not have clear risk factors had severe outcomes, a hospital stay or long-Covid-19.

[272] In response to questions that implied that the impugned Orders impacted the liberty of "most" Albertans who were not at risk of serious illness (hospitalization) or death, Dr. Hinshaw noted that:

> It's really important... to remember that individuals who may themselves be at lower risk of having to have hospital care if they were to get infected with Covid..., they are still impacted negatively if the hospitals are overwhelmed and not able to cope with the number of Covid patients they have and therefore need to limit access to other treatments. And so it's really important to remember that we're not just talking about deaths, we're talking about the (INDISCERNIBLE) effects of that tremendous pressure on the acute care system and all of the other services that were not able to be provided even in our actual experience that would have been much worse if we had not intervened to minimize the spread of Covid.
>
> So even that individual who themselves may have recovered from Covid, could have a significant impact on their health if they're not able to access treatments for other conditions. So again, it's really important to look at that really big picture that everyone gets impacted by Covid, even if they as an individual don't need hospital care for Covid...
>
> I think that it's really interesting if you look at our own Alberta experience and you look at wave 1 and 2 and you look at the response to wave 1 which was to implement non-pharmaceutical interventions quite early to minimize the likelihood of transmission, where we had a very small wave and a moderate impact on our acute care. In wave 2, we took a different approach to encourage people to limit the number of people that they spent time with, we tried targeted geographic approaches and ultimately needed to resort to mandatory measures because these voluntary approaches didn't work.
>
> And so, if you look at our actual lived experience in Alberta, if you look at wave 1 and wave 2, it is crystal clear that the non-pharmaceutical interventions implemented in wave 1 dramatically reduced mortality and hospital impact, and that delaying the implementation of those measures until the wave was already significantly established in wave 2, again for very important reasons of ensuring that we were exhausting all other possible avenues of response before resorting to mandatory measures: the death toll of wave 2 was dramatically higher than wave 1. Wave 2 came very close to overwhelming our health care system even though our measures minimized the spread and minimized the overall impact, given that we did implement those to stop the worst of what would've happened.
>
> So, I actually think that it's very easy to look at our own lived experience in those two waves and see very clearly the impact that non-pharmaceutical interventions had, and I think we can also compare our own experience to neighbouring jurisdictions to be able to see the outcomes that were different based on when NPIs were introduced and to what degree.

[273] Dr. Hinshaw was clear that she did not direct Alberta Health Services in the utilization of their acute care resources, that that was within the purview of the Minister of Health.

[274] Dr. Hinshaw also made it clear that the initial use of NPLs in March 2020 was due to the very significant impacts that were being seen in jurisdictions that would be considered comparable to Alberta, as well as the speed of contagion in those comparable jurisdictions.

[275] Dr. Hinshaw testified that, with respect to protocols such as the two meter distance requirement, she and her team started with what they knew from analogous infectious diseases and then learned more about Covid-19 specifically over time. She indicated that at the time period of the impugned Orders, the two meter requirement was in accordance with scientific consensus that it would reduce risk. Dr. Hinshaw answered questions about the efficiency of masking, and about the risk of transmission outdoors knowledgeably and candidly, making the

point that her recommendations were based on the evidence she and her team had at the time based on multiple sources.

[276] The Church Applicants suggest that decisions that led to the Indoor Gathering Restrictions were "speculation". That was not Dr. Hinshaw's evidence: she related the decision to "a variety of publications" about what was known generally about the generation of respiratory particles and the activities that generate them, specific outbreaks and case reports, local observations, and foundational evidence based on what was known about aspects of transmission. Dr. Hinshaw testified in response to the criticism that some statements in research articles were not particularly strong for a scientist that:

> ... in my experience, scientists tend to not talk in absolutes but talk about what the evidence indicates at this moment in time, especially with Covid, knowing that we do continue to learn. It's not uncommon that the evidence would be portrayed in a way to say this is what the evidence suggests at this time, and we continue to study it. So, I think, again, especially with Covid, we often talk about the current state of evidence and what that current state of evidence is, kind of again, that summative look at all of the published evidence and what seems to be the best conclusion at that point in time.

[277] With respect to a criticism of evidence with respect to "modelling", Dr. Hinshaw testified that modelling is an important part of taking observations that she and her team, or others, had made and then making estimates about such things is the contribution of transmission, asymptomatic transmission and pre-symptomatic transmission to how the spread was happening in the community.

[278] Her affidavit explains that Alberta modelled two core scenarios: "Probable" and "Elevated". The "Probable Scenario" involved modeling where for every case, it was presumed 1-2 more people would be infected. This was comparable to the moderate growth seen in the UK. In the "Elevated Scenario", it as assumed that for every case, 2 people would be infected. This predicted growth was akin to what was initially seen in the province of Hubei in China. An "Extreme Scenario" was also modelled, which assumed 3 or more infected for every case. The Extreme Scenario showed what would have happened if Alberta did not undertake early and aggressive interactions. Dr. Hinshaw explained that Ontario, during the first wave, was equivalent to Alberta's modelled "Elevated Scenario". Quebec, during first wave, was equivalent to Alberta's "Extreme Scenario" with respect to its impact on the acute care system.

[279] Alberta's approach also prioritized the continuation of essential health care services, in part by relying on the modelling. Patients were triaged and some surgical procedures were cancelled. Plans were made to increase ICU capacity. Notwithstanding these increases, Alberta's main hospitals were operating at over 90% capacity for Covid-19 impatient care during the second wave. If Alberta's Covid-19 capacity had been significant exceeded, it could have resulted in the rationing of care for patients in need of critical supports. Dr. Hinshaw indicated that public health measures put in place in December 2020 reduced hospital capacity and ICU admissions before such a grievous scenario arose. During the third wave, the ICU was operating at a similar capacity.

[280] Dr. Hinshaw testified that Alberta had been activating a pandemic plan since January 2020 when the Covid-19 virus first emerged as a novel virus. The plan had been specifically for the pandemic influenza, but many parts were applicable to Covid -19. They utilized the lessons they had learned from the influenza pandemic of 2009 as well as the SARS experience of 2003. Alberta was preparing its skilled communicable disease teams for what they understood at the time.

[281] Dr. Hinshaw was asked "how many billions of dollars" her Orders have cost the province of Alberta. She answered that this analysis would have been done by those who had expertise in economics. She noted, however, that it is not appropriate to assume that all economic impacts that happened in the province were solely as a direct result of Orders. There were economic impacts that were seen when uncontrolled Covid-19 spread was present in a community, in addition to the economic impact of Orders, and it would be difficult to distinguish between economic impacts of the pandemic and the economic impacts of the Orders.

[282] As indicated previously, Dr. Hinshaw was a credible witness. She was calm, patient, well-informed and extremely professional, even in the face of somewhat abusive cross-examination. The cross-examination did not affect her credibility in any way. While she may have been mistaken with respect to her ability to allow elected officials to make final decisions under the *Public Health Act*, she testified that she had "done her best throughout the pandemic to monitor the health of Albertans" and provide advice and recommendations to protect their health based on the best evidence available. I find no reason to doubt this.

Dr. Kimberley Simmonds

[283] Dr. Simmonds is an applied epidemiologist with 15 years of relevant experience managing outbreaks and leading infectious disease surveillance in Alberta. Due to her expertise in infectious disease epidemiology, mathematical modelling of infectious diseases, and policy, she was asked to support Alberta's Emergency Operations Centre as the lead for analytics and modelling for the Covid-19 response. She was not called as an expert witness.

[284] In her affidavit evidence, Dr. Simmonds noted that modelling was used as a tool to assess the impact of Covid-19. The most common model that was used focused on breaking the population up into three groups: susceptible, infected and recovered. As Dr. Simmonds explained:

> At the start of an outbreak most of the population are susceptible, and as the infections spread through the population, more people are infected and subsequently, they recover or die. The probability that a susceptible and an infectious individual meet and the infection is passed from the infected to the susceptible is the effective transmission rate... In some circumstances a condition called endemic equilibrium occurs and the disease rate is maintained at some static rate... Unfortunately, for a respiratory disease like Covid-19, this does not occur if anything upsets the equilibrium.

[285] Dr. Simmonds evidence traced the work of Alberta's analytics team through the summer of 2020 into the second wave.

[286] In the summer of 2020, Dr. Simmonds' modelling work focused on the transmission dynamics of Covid-19 with the population back indoors in offices and schools in the fall. The short term projections were targeted to focus on the impact of Covid-19 on the acute care system to ensure health care capacity was not exceeded. Dr. Simmonds stated that "the goal was to protect those who are most vulnerable and to tailor public health measures to local needs and circumstances as much as possible."

[287] By September of 2020, cases had increased from the August average of 99 cases daily to 142, which resulted in an increase in Covid-19 hospitalizations. Edmonton had a higher level of disease transmission than other areas of the province so voluntary measures were implemented to minimize the risk of outbreaks and super-spreader events. About two weeks later, voluntary measures were implemented in Calgary.

[288] By October of 2020, daily cases continued to increase, and following Thanksgiving, the number of outbreaks rose steadily. Dr. Simmonds noted that in November, hospitalizations rose rapidly as expected. She noted that "[a] key characteristics of Covid growth is that it can turn from manageable to exponential in a matter of days to weeks". As the growth became exponential, a state of public health emergency was declared. Dr. Simmonds' modelling predicted a short-term peak of hospitalizations in the last week December. The actual ICU peak occurred on December 28, 2020, and the non-ICU hospitalizations peak occurred on December 30, 2020.

[289] Dr. Simmonds also provided an overview of outbreaks in Alberta between March 1, 2020 and May 15, 2021 associated with places of worship (35 outbreaks with 704 directly associated cases), and sports and fitness facilities (33 outbreaks with 501 directly associated cases).

[290] The Applicants submit modelling is speculative and has been shown to be unreliable.

[291] However, Dr. Simmonds explained that Alberta's modelling accurately predicted uncontrollable spread as observed in the real-world experience in wave 2 of the pandemic , as shown in Alberta's fall predictions.

[292] She noted that the estimated peak for cases was December 15, 2020, with 2023 cases and the actual was December 13, 2020 with 1875 cases. Hospitalizations due to Covid were estimated to peak at 648 on December 27, 2020. In fact, the peak was December 30, 2020 with 905 hospitalizations. Covid-19 related ICU admissions were estimated to peak at 168 cases on December 29, 2020 and the peak was December 28, 2020 with 154 patients in the ICU.

[293] In February and March 2021, the "third wave" of the pandemic, forecasting was revised to focus on the impact of the variants of concern and vaccinations on hospitalizations, particularly ICUs. The model estimated that 14-21 days were required to show the impacts of rapid immunizations, as that period of time is required to develop immunity. Dr. Simmonds testified that the data shows that approximately two weeks after restrictions were implemented on May 5, 2021, the number of people in ICU peaked and then began to decrease.

[294] As Dr. Simmonds further explained:

> The third wave began in March 2021 and was the result of the increasing variants, specifically [the alpha variant] B.1.1, which has impacted younger and healthier Albertans compared to the previous waves. At the same time, there was increasing non-compliance with following the restrictions and cases who declined to provide information to contact tracers.

[295] Dr. Simmonds summed up what this state of constantly evolving knowledge meant to her as Alberta's lead for modelling, noting that "[e]pidemiologists use evidence, both local and from other jurisdictions, to provide information to decision makers" and that the "evidence is constantly shifting". "What we thought in March 2020 is different than in 2021. Scientific knowledge is not static, rather it is constantly updating based on new data."

[296] Dr. Simmonds was a highly credible witness. None of her evidence was impeached by cross-examination.

[297] When cross-examined about the fact that at a particular point in time, about 15% of the population was infected with Covid 19 based upon testing, Dr. Simmonds pointed out that, within that percentage, some percentage of people would die. Some percentage would be impacted because of a visit to an ICU or other serious health outcomes would happen because of Covid-19. She considered that to be a significant risk.

[298] When she was questioned about the fact that in November, 2020, the percentage of people who were anticipated to be seriously affected would be about 0.5 percentage of population, she noted that:

> ... so if we have 4.5 million people in the province and we're going to estimate 0.5 percent of them, plus then consider in the number of who have severe illness, that would be equivalent to essentially wiping out a town the size of Red Deer in terms of morbidity and mortality. I personally consider that a significant risk.

[299] The Applicants submit that Alberta produced no data to support the theoretical models developed by Dr. Simmonds. However, Dr. Simmonds' evidence indicates that modelling accurately predicted the course of the pandemic in Alberta to a high degree.

[300] The Applicants also submit that there was a lack of validation testing. The response to this criticism is found in Dr. Kindrachuk's evidence about the possibility of validation testing during a pandemic. The Applicants also suggestion that "the entire concept of a "super spreader event" has no objective scientific basis. This was contradicted by Dr. Kindrachuk's evidence.

Deborah Gordon

[301] Ms. Gordon was the Vice President and Chief Officer Clinical Operations of Alberta Health Services during the pandemic. Her role as Chief Operating Officer changed beginning in January in 2020 as a result of Covid-19 with the activation of the AHS Emergency Coordination Centre. She also led the oversight and development of an Acute Care Capacity Plan.

[302] Ms. Gordon provided affidavit evidence and was cross examined. She was not called as an expert witness.

[303] Ms. Gordon's evidence was that there is no comparison between the threat to Alberta's healthcare system from seasonal influenza and that posed by Covid-19. When responding to other viral contagions such as seasonal influenza, surges in capacity to inpatient and ICU admissions are capable of being managed within the existing bed bases or with short-term opening of surge spaces.

[304] Over the past 5 years, the highest total seasonal influenza inpatient admission (2017-18) to Covid-19 capable units with influenza was 206 patients compared and that posed Covid-19 wave 2 admissions which at its peak saw 767 patients hospitalized at one time with Covid-19. This was a move than 350% increase in the number of peak admissions for Covid-19 patients compared to annual seasonal influenza admissions.

[305] Consequently, the demands of Covid-19 on ICUs during wave 2 were also unprecedented. in the five years prior to wave 2 the highest number of total seasonal influenzas admissions to the ICU were 31 patients in 2017/2018. Comparatively, wave 2 peak Covid-19 patient admissions in the ICU were 158 patients, an increase of more than 500% for admissions compared to the highest annual admission levels for seasonal influenza.

[306] Ms. Gordon noted that, fortunately, Alberta was spared widespread community transmission and did not experience a large number of cases during the first wave of the pandemic in the spring of 2020.

[307] Ms. Gordon explained the threat to Alberta health care system that the alpha variant posed during the third wave and how AHS responded.

> By the beginning of wave 3 in April 2021, Covid-19 variants of concern (viral mutations and genetic variants of the SARS-Co V-2 virus)...became the dominant strains of new cases in Alberta and cases requiring hospitalization. [SARS-CoV-2 is the virus that causes Covid-19]. Many members of our Clinical Operation teams along with ECC worked to assess and integrate into the AHS Capacity Plan the impact that the variants of concern would have on acute care capacity. As throughout the pandemic, the goal to increase acute care capacity was to ensure there was sufficient capacity to meet the demands as projected by the AHS EWS high scenario and projections developed by Alberta Health.
>
> We brought forward learnings and experiences gained through the first 2 waves. For example, we learned how long it would take to scale surge capacity up and down. We also knew that at the height of wave 2, when we had a total of 291 ICU beds open (including 118 net new surge beds) and staffed, that it put a tremendous stress on the health care system care system due to case distributions, which required a 30% reduction in usual surgical activity in the Edmonton zone. We further knew that having beyond 291 ICU beds open and staffed would be extremely difficult. Consequently, we were required to manage ICU capacity finitely and fine tune our ICU staffing plan for wave 3.
>
> By mid-April 2021, actual ICU cases with Covid 19 were once again tracking above the AHS EWS high scenario. Consequently, the demands of Covid-19 on hospital capacity and resources continued to be unprecedented, leading to an accelerated implementation of plans to increase surge capacity for Covid-19.
>
> Our Acute Care Capacity Plans from wave 2 as carried forward throughout wave 3 had previously identified additional surge capacity of up to 2 250 beds. Our experience in wave 2 had shown that the majority of those spaces could be made available within 72 hours notice.
>
> Of the additional surge capacity of wave 3, 320 net new spaces were available. That is the approximately equivalent to opening a new hospital such as the South Health Campus in Calgary or the Red Deer Regional Hospital Centre.
>
> Capacity planning for ICUs remained unchanged from wave 2, meaning we could accommodate up to 425 ICU beds for Covid-19 patients. Of that total, 118 net new spaces had been created in wave 2, however, as wave 2 subsided, the majority of those spaces were closed and staff was redeployed back to surgery or were assigned to other pandemic related functions such as

assisting with vaccinations. Reactivating those beds during wave 3 therefore required adjusting staff assignments and reducing capacity in other Covid-19 and non-Covid-19 related functions.

> For example, surgical reductions of 30%, approximately 1600 per week, would be required to add 120 of the 425 ICU beds. With another 187 additional beds necessary to reach maximum ICU capacity, would require further reductions in surgery, doubling up of occupancy in existing single patient rooms and using additional unconventional spaces such as operating rooms. Unconventional staffing models would also have to be considered.
>
> In total, a net new number of ICU beds during wave 3 was increased from wave 2 to a peak total of 126 net new beds. This unprecedented amount was approximately 73% more than our usual pre-pandemic capacity for ICU.
>
> On May 17, 2021 Alberta reached peak Covid-19 hospitalizations for wave 3 with 187 patients with Covid-19 in ICU. The overall ICU occupancy (Covid-19 and non Covid-19) patients was approximately 141% (244 Covid-19 and non Covid-19/173 baseline beds), without accounting for the 110 net new surge spaces or 86% including the net new surge spaces. On May 10, 2021, we hit a peak of 542 inpatient hospitalizations of patients with Covid-19. The overall inpatient occupancy (Covid-19 and non Covid-19) was approximately 86% without accounting for the 320 net new spaces or 85% including the net new surge spaces. Wave 3 active Covid cases peaked at 25, 159 cases provincially while hospitalization rates per million peaked at 30.9 in the North zone.

[308] The Applicants attempted to impugn Ms. Gordon's testimony on the basis that, although, AHS had developed a plan for the pandemic, this plan was not provided in evidence. This is an inaccurate and misleading characterization of Ms. Gordon's testimony. In response to a question of whether she had seen a 2014 emergency pandemic plan. Ms. Gordon responded that she was aware that the province of Alberta had a pandemic plan, that AHS used pieces of the plan for the pandemic response.

[309] When asked if she was aware of a similar plan to the 2014 provincial plan that was developed with AHS to deal with the Covid-19 pandemic, she replied that there were plans for epidemics like H1N1 that were groundwork for AHS to lever its response to Covid-19, but that those plans that existed were associated with previous emergency situations, and that they were able to be used as AHS developed specific plans for Covid-19. She testified that AHS developed the specific plan for the Covid-19 pandemic as they prepared for the pandemic and as they went through the pandemic, but she did not indicate that there was a written plan. In earlier cross-examination, in response to a question of whether there was any formal written plan that was guiding her decisions and involvement with the pandemic response, Ms. Gordon stated as follows:

> Well, we had never had a pandemic in Alberta before, so <u>we did not have a specific pandemic plan</u>. We did rely- - and your colleagues spoke about the H1N1 plans and we did look back at our H1N1 plans. We do have, as I mentioned, an emergency management system within the organization that we used in all emergencies and we used that system in response to this pandemic. <u>None of us had ever responded to a pandemic like this</u>. (emphasis added)

[310] Ms. Ingram also questioned Ms. Gordon's credibility on the basis that she claimed not to have knowledge regarding Covid-19 death statistics when she had attached such information to her affidavit. This is again inaccurate: Ms. Gordon was clear that she could not provide data about deaths as that was not something that fell within her realm of responsibility. She had attached an Alberta Government documents to her affidavit, which as she noted, merely provided death statistics as of May 14, 2020. Ms. Gordon's credibility was not impugned by cross-examination.

Dr. Kenneth Jason Kindrachuk

[311] Dr. Kindrachuk prepared an expert report in this matter that was filed on July 12, 2021. He is currently an infectious disease specialist and assistant professor at the University of Manitoba, where he was recruited in January 2017 as a Canada Research Chair in the molecular pathogenesis of emerging and re-emerging viruses.

[312] Dr. Kindrachuk currently teaches microbial pathogenicity and clinical virology, touching on epidemiology. Dr. Kindrachuk is undertaking significant research specific to SARS-CoV-2, including investigations on models of infection, and the effects of respiratory virus co-infections on disease outcome.

[313] Dr. Kindrachuk obtained an undergraduate degree in biochemistry, and completed his PhD in 2007, both at the University of Saskatchewan.

[314] In 2007, he began to focus on host pathogen interactions, mainly looking at bacteria and viruses. He spent two and a half years in a post-doctoral fellowship at the University of British Columbia. In 2009, he was recruited by the National Institute of Health in Bethesda, Maryland as a visiting fellow. Since 2009, he has been working as a virologist. From 2009 to October 2014, he changed from being a visiting fellow to a principal research scientist position at the Integrated Research Facility, transitioning in October 2014 to a staff scientist position with the National Institute of Health in the Department of Critical Care Medicine in Bethesda, where he remained until he joined the University of Manitoba.

[315] Dr. Kindrachuk was qualified to give opinion evidence as a virologist with expertise in:

a) current knowledge of Covid-19 cases and disease severity including Covid-19 clinical symptoms onset and diversity;

b) SARS-CoV-2 transmission and high risk activities;

c) whether non pharmaceutical interventions reduce SARS-CoV-2; transmission;

d) SARS-CoV-2 variants of concern;

e) herd immunity and vaccinations; and

f) ongoing and future research, including long-term complications in Covid-19 recoverees and reproductive health concerns.

[316] The Oral Hearing Order provided the following with respect to admissibility of expert reports:

> Other than as set out in subsection (k) above, [referring to Mr. Long], the Applicants have no objections under section 5.36 of the Rules to the admissibility of the Respondents Expert Reports.

[317] There were no objections to the surrebuttal reports. While counsel for Ms. Ingram attempted to challenge Dr. Kindrachuk's qualifications, the scope of his intended qualification was included in his report, and thus he was precluded by the terms of the Oral Hearing Order from doing so.

[318] Dr. Kindrachuk's report explains that SARS-CoV-2 is driven by respiratory droplets and aerosols. Respiratory droplets remain suspended for short periods of time and are transmitted over short distances depending on airflow. Small-particle aerosols can disperse quickly and remain airborne while travelling longer distances. Epidemiological data suggests that close contacts are a major driver for SARS-CoV-2 spread. Recent studies also suggest that aerosol transmission can occur during prolonged exposure in enclosed settings with poor ventilation. This is of particular importance given that these aerosol particles can accumulate in the air of enclosed spaces over time based on their physical characteristics and thus increase the potential for infection beyond proximal contacts at two meters or less in distance away.

[319] Extensive investigation between "biological risk factors" and Covid-19 severity reveals that older age, race/ethnicity, gender and socioeconomics status are all associated with severe disease, ICU admission and even death. As Dr. Kindrachuk explains:

> While older age is convincingly linked to severe Covid-19, the outlined risks are not limited to those in high age groups. Factors strongly linked to severe disease in adults include cancer, chronic kidney disease, COPD, cardiovascular disease, obesity, pregnancy, sickle cell disease, smoking, organ transplantation and type 2 diabetes.

[320] Dr. Kindrachuk noted that in Alberta, the total number of Covid-19 cases were the highest in individuals under the age of 19, with nearly 54,000 cases having been reported. This was followed by the 30-39, 20-29 and

40-49 age groups, while hospitalizations were highest in the group over 50 years old, with ICU admissions being the highest in the 60-69 year age group. As Dr. Kindrachuk explained, this means that younger age groups are susceptible to moderate or severe illness and risk of hospitalization or admission to intensive care. Covid-19 is not simply a disease affecting the elderly.

[321] Dr. Kindrachuk reports that Covid-19 can present with no symptoms (asymptomatic infections) to severe and fatal illness. The way symptoms present is variable. Covid-19 often presents with a broad spectrum of mild symptoms like cough, fever, myalgia (muscle aches and pains) and headache. One third of individuals did not experience fever or cough as their symptoms, and nearly half of infected people continued to work while experiencing some symptoms, some for several days. The signs, symptoms and severity of the disease in adults over the age of 65 and those with health conditions may also be "atypical or subtle". As the way that Covid-19 symptoms present is wide ranging and variable in both type and severity, in Dr. Kindrachuk's opinion, screening alone as a measure of case identification would likely lead to many missed cases of infection.

[322] While over the last 20 years, three coronaviruses have emerged with significant public health consequences, what makes SAR-CoV-2 distinct is its high degree of community transmission. Because of the amount of community transmission, it has been important to establish the "infectious period" of those infected with the virus. This investigation has been driven by the viral load (amount of virus) present within a person's respiratory tract. Dr. Kindrachuk testified that understanding the presence of viral load and the duration (kinetics) of the virus within the respiratory tract are key in determining infectiousness and thus transmission in both the pre-and-post symptomatic periods.

[323] Viral loads vary between severe and non-severe infections, but they do not appear to be altered by age or sex as children have displayed similar viral loads at symptoms onset as their adult counterparts. There is also a growing appreciation that children can be infected and transmit SARS-CoV-2.

[324] Dr. Kindrachuk's report indicates that there has been considerable scientific study into the role of pre-symptomatic and asymptomatic transmission of Covid-19. Prior assessments of respiratory tract viral loads suggested that peak viral loads occur either just prior to symptoms or coincident with symptom onset. However, a 2021review, which considered data from nearly 80 studies, found that, the accumulated data across all studies suggests the highest risk of transmission falls from a few days prior to symptom onset to five days post-onset. Thus, people may be highly infectious for up to three days before they display symptoms and before they may have any reason to realize they are infected and know to limit their contacts with others.

[325] Dr. Kindrachuk also reviewed the growing number of investigations focussed on separating asymptomatic and pre-symptomatic infection in order to facilitate increased understanding of transmission risks throughout the infectious period. He noted that a 2020 comprehensive systematic review that focused on asymptomatic and pre-symptomatic infections determined that 20% of infections resulted from asymptomatic individuals, with the remaining 80% being infected by pre-symptomatic individuals. Thus, 1 of 5 infected individuals will remain truly asymptomatic throughout their Covid-19 infection. Another systematic review showed asymptomatic infections ranged between 4-41%. The authors of both reviews stated that a combination of nonpharmaceutical interventions will continue to be needed to curb transmission.

[326] It is Dr. Kindrachuk's opinion, assessing the evidence to date, that while true asymptomatic transmission may occur less frequently than symptomatic transmission, there is a greater likelihood of transmission before symptom onset than post- symptom onset. This means that both asymptomatic and pre-symptomatic transmission present a significant risk because people who have SARS-CoV-2 but are not displaying any symptoms can and do transmit the disease and infect others. Thus, relying on symptom checks alone would not be an effective way to control the spread of Covid-19 in group settings.

[327] Dr. Kindrachuk concludes that:

> Taken together, there is strong scientific evidence for SARS-CoV-2 transmission to primarily occur from a few days prior to symptom onset up to 5 days post-onset. Direct assessments of viral loads and the kinetics of viral shedding, when the virus is released from infected cells in the respiratory tract, are in agreement with this and contact tracing studies in household cohort

> studies provide direct evidence for asymptomatic and pre symptomatic transmission of SARS-CoV-2. Further additional epidemiological studies of SARS-CoV-2 suggest that similar patterns of asymptomatic and pre symptomatic transmission likely occur with children as well as with adults.

[328] Dr. Kindrachuk reported that there is scientific evidence that shows the spread of Covid-19 in religious settings, even when physical distancing is in effect. In reaching this conclusion, Dr. Kindrachuk relied on a number of "superspreader" events, including a single symptomatic individual who infected 53 of 61 (and killed 2) attendees during one 2.5 hour choir practice. The addition of a face mask during loud singing reduced particle emission rates to those of a normal "talking level" but Dr. Kindrachuk is of the opinion that emission of SARS-CoV-2 from infected individuals. Infection is positively correlated with vocal activities, with the risk of spread increasing based on the volume and exaggeration of vocalizations.

[329] Dr. Kindrachuk referred to a 2021 study that provided epidemiological evidence for airborne transmission among attendees at a religious service in the absence of close contact. In this study, 12 "secondary case-patients" were identified from among 508 attendees across 4 religious services where an infectious individual (the index patient) sang for 1 hour from a choir 3.5 meters above the congregation. Dr. Kindrachuk explained:

> The authors [of the study] concluded that singing likely resulted in more dissemination of droplets and aerosols than talking, that limitations to ventilation may have allowed for the concentration of infectious virus in shared air and lastly that the index patient was likely near the peak of infectiousness with symptom onset occurring around the exposure date. The index patient performed during his infectious period starting from 48 hours prior to symptoms onset (initially malaise and headache).

[330] Dr. Kindrachuk also reviewed a number of studies considering the efficacy of non-pharmaceutical interventions (NPIs), which Dr. Bhattacharya claims have no causal relationship to case growth and mortality. In his opinion, without medications and vaccines, NPIs are steps that communities and people can take to slow the spread of illness, including handwashing, good hygiene, face masks or other personal protective equipment, social distancing, restricting gatherings, and even stay-at-home orders or lockdowns. Dr. Kindrachuk reviewed the results of a number of studies that show face masks are associated with a significant reduction in transmission risk per contact and reduced infections. Dr. Kindrachuk's opinion was that NPIs are "extremely effective in reducing the spread of SARS-CoV-2 in a population, especially when used in combination, and are indeed necessary to limit exponential spread". However, he also testified it is important to consider the adherence and adoption of voluntary public health measures, rather than relying just on mandatory measures.

[331] During cross-examination, Dr. Kindrachuk did not agree that cloth masks provided little or no protection from Covid-19, noting that they provide some protection, additive on top of other behaviours, When asked about reports that suggest the opposite, Dr. Kindrachuk noted the sheer quantity of new information constantly being produced; 6,000 papers each month on Covid-19, which equates to 200 papers a day for 27 months. He stated that he looked at the available evidence and what the "overarching opinion was of multiple publications" that were considered to be of high quality.

[332] With respect to variants of concern, Dr. Kindrachuk noted that there is evidence to suggest that variants of concern may have emerged in chronically infected Covid-19 patients. He stated that there is strong evidence to suggest that prolonged infections or infections in those with compromised immune systems likely exert "selective pressures on SARS-CoV-2 resulting in a more extensive genetic change than found during typical infections". As a result, Dr. Kindrachuk concluded that reducing community transmission (effectively reducing the number of infections in people who have compromised immune systems or will experience prolonged infections) reduces the potential for additional variants of concern to emerge that may better escape immune detection and notes that such variants could have detrimental impacts on global vaccination programs. Dr. Kindrachuk reviewed how variants of concern pushed the healthcare systems across many regions to the brink of hospital and ICU capacity, and sometimes beyond during the third wave of the pandemic.

[333] Dr. Kindrachuk explained that:

> In Canada variants of concern had deleterious effects on health and healthcare systems across many regions during the third wave of Covid-19 in early 2021. While the high mortality associated with individuals in long term care facilities and personal care homes were drastically reduced during the third wave, hospitalizations and ICU admissions pushed healthcare systems beyond their capacity in numerous jurisdictions.

[334] Dr. Kindrachuk also explained by why natural herd immunity is a seriously concerning and ultimately not effective strategy to combat Covid-19, with reference to country examples.

[335] In Dr. Kindrachuk's opinion:

> .... reaching herd immunity without vaccines would require somewhere here between 50-90% of the population to get infected. At Alberta's population of 4.4 million, this would equate to roughly 2.2 [to] 4 million people infected. Using a conservative death rate of 1%, this would equate to 22,000-40,0000 deaths.

[336] The up to 40,000 deaths Dr. Kindrachuk described did not include the number of people who would likely die as patients would be unable to access the overwhelmed healthcare system.

[337] Dr. Kindrachuk noted there are a number of ongoing and future research topics that must continue to be investigated, notably research to further understand the factors underlying transmission, including the minimum infectious dose, virus concentrations and viability in indoor and outdoor settings. He also discussed other areas of ongoing study, including long term complications relating to extended fatigue, shortness of breath and the like after a Covid-19 infection, along with reproductive health concerns as some recent data has suggested severe Covid-19 can damage reproductive tissue in men, and other evidence showing that infection late in pregnancy is associated with adverse birth outcomes.

[338] Dr. Kindrachuk was cross-examined with respect to Dr. Bhattacharya's response to his surrebuttal report.

[339] Dr. Kindrachuk testified that he was of the opinion that Dr. Bhattacharya underestimated the role of asymptomatic transmission in disease spread, particularly with respect to new variants of Covid and their increased transmissibility.

[340] With respect to Dr. Bhattacharya's criticism that Dr. Kindrachuk's opinion did not provide any evidence that Alberta had conducted any validation exercises that would suggest that the models on which it relied to infer the efficiency NPIs actually matched real-world evidence from scientific literature, Dr. Kindrachuk responded as follows:

> So I guess I'm interested in this idea of validation. So validation of the models through what mechanism, through randomized controlled trials of masking during a pandemic where nearly 6 million people have been recorded to die or have been recorded to have died already? I would argue that there is an ethical and moral consideration as to whether or not trials or validation models can be run in real time...

[341] With respect to Dr. Bhattacharya's criticism of modelling, Dr. Kindrachuk pointed out that Dr. Bhattacharya himself used forecasting in his prior assessments of pandemic flu and seasonal flu. He noted again:

> ... in the middle of a pandemic, and appreciating the breadth of this pandemic because I think this is something that we continue to see minimized, although it has had drastic health and economic effects, there is a question of do you lead with the public health approaches that have been employed in the past through decades of time to reduce infectious disease spread during pandemics and epidemics or do you have the time to go through and validate your procedures without putting undue stress on your health care system and costing lives and livelihoods".

[342] With respect to Dr. Bhattacharya's criticism that Mr. Kindrachuk provided a misleading analysis of the role that herd immunity plays in the control of the epidemic, Dr. Kindrachuk disagreed and provided a vigorous analysis of what he meant by "herd immunity".

[343] He noted that, when talking about herd immunity, "when we look at the overall [indication of how many people an infected person can potentially infect] of this virus" and its variants, "the likelihood for you to be able to reach herd immunity is.. very low, it's infinitely small."

[344] Dr. Kindrachuk testified that he believed Dr. Bhattacharya's recommendations "that he has continued to make... certainly fly in the face of many of the concerns that were seen with Covid-19... and would likely have disproportionate effects on... communities that are likely most vulnerable to this disease" and that these recommendations do not adapt to continued emergence of new variants.

[345] He noted as follows:

> I'll pull up right now looking at excess deaths in unvaccinated populations in the US from May 30th to December 4, 2021. When we look at age groups that are impacted, all age groups from 18 plus were impacted in terms of excess deaths. So there is a higher risk for people, again, that are higher age groups, so those above the age of 65, and those with underlying comorbidities, and those that ...have a mixture of those, ... what we have to appreciate is that the disproportionate effects of Covid-19 have also exposed other disparities in our population and that includes racialized communities and the communities with low socioeconomics status. So when we talk about this idea of who is most vulnerable, it is not as simple as being able to say, well, it's only these people that are above this specific age or have this particular comorbidity. In fact if we look at the litany of comorbidities now that are linked to higher risks of Covid-19, it is a broad set of comorbidities, so that now makes it difficult.

[346] He noted that, despite all of the medical advancements that have been made over the last 100 years, Covid-19 claimed 5.89 to 6 million dead.

[347] He agreed that incidence of death for people under 30 were low in Alberta, but when talking about the impact of Covid-19:

> ... If we don't talk about morbidity, again, we are missing the point. There are numerous disease that have a very, very low mortality rate but have a high morbidity rate in our communities. We know that those put tolls on our health care systems, and we know they have impacts, long-term impacts, on health across individuals and across populations.
>
> So, yes, there is a lower mortality risk certainly that aligns with age, we've seen that. When we talk about morbidity and we talk about hospitalization, we talk about ICU admissions and, certainly, we get in the guise of long Covid which we're still trying to understand at this point in time, we need to be appreciative of those points as well.

[348] Ms. Ingram submits that Dr. Kindrachuk offered expert opinion outside the scope of his expertise, in particular arguing that he has no formal training in virology. However, Dr. Kindrachuk's experience working as a virologist for at least the last 13 years qualifies him to give opinion evidence as an expert in the area of virology. Ms. Ingram gave no examples of specific evidence outside Dr. Kindrachuk's scope of expertise. If there were any opinions that strayed from Dr. Kindrachuk's scope of expertise, they were elicited through cross-examination.

[349] Ms. Ingram also submits that Dr. Kindrachuk failed to fulfill his obligations to provide the "full story" to the Court, citing an answer during cross examination that may seem flippant when viewed without the context of proceeding questions and answers. In response to the following questions from Ms. Ingram's counsel that it was Dr. Kindrachuk's position that as an expert, he would provide a one-sided report, Dr. Kindrachuk's answer was as follows:

> No. In fact, I've talked about the considerable scientific investigations that have gone on, as well as the conclusions that have been drawn and some of the inferences that can or cannot be made.

> As well, if you were to look back at my publications, I'm sure you would see as well that I adopt both sides of the evidence...
>
> I'm providing what I feel is the best evidence in support of masking and what is the highest quality evidence that's available at the time of this report.

[350] Other than this exchange in the context of confrontational cross-examination, Dr. Kindrachuk did not take an adversarial position in his evidence nor act as an advocate for the Respondents. He did vigorously defend his opinions, which does not detract from his credibility. Cross-examination did not impeach his credibility nor cast doubt on his opinions.

[351] While counsel for Ms. Ingram objects to the term "tropes", it was used by Dr. Kindrachuk to describe what he considered a continued theme or theory that he described as being without scientific linkage. Dr. Kindrachuk was not excessively or inappropriately argumentative in his evidence.

Dr. Nathan Zelyas

[352] Dr. Zelyas is a medical microbiologist, a speciality within medicine that focuses on the laboratory diagnoses of infectious disease. He has been one of the medical lab leads for Covid-19 diagnostics at the Alberta Public Health Laboratory. He was qualified as an expert to give opinion evidence as a medical microbiologist regarding Covid-19, including an analysis of polymerase chain reaction (PCR) diagnostic tests of Covid 19, to determine cases of Covid-19 including their accuracy/inaccuracy, their use to determine cases of Covid-19 and whether people who test positive on a PCR test are infected/contagious with Covid-19.

[353] Dr. Zelyas filed an expert report on July 9, 2021 in response to the opinion of Dr. Bhattacharya.

[354] Dr. Zelyas explained that the primary samples used to diagnose Covid-19 are from nasopharyngeal swabs, which are inserted deep into a patient's nose to reach the nasopharyngeal area. Once a swab is collected, it is typically placed in a tube that contains a transport medium, which preserves the virus and inhibits the growth of bacteria and fungi. When the swab is inserted into the transport medium, the human material and virus collected on the swab disperses into the transport medium. The tube, including swab and transport medium, are then transported to a laboratory for processing where the paperwork is checked to ensure that the sample matches the patient information. The transport medium, which contains human material and virus, is subjected to "nucleic acid extraction to break open the cells and virus to release and purify the nucleic acid encoding the SARS-CoV-2 genome". The process frees the nucleic acid of the SARS-CoV-2 virus so it is available for detection using advanced laboratory techniques.

[355] Dr. Zelyas noted that scientists were able to design specific tests to detect SARS-Cov-2 through the use of a method referred to as PCR. PCR takes advantage of the ability of DNA to be replicated numerous times in an exponential fashion based on a specific DNA sequence. Because SARS-CoV-2 has an RNA genome (as opposed to a DNA template), an additional enzyme called "reverse transcriptase" is added to the reaction, which replicates the targeted region of the SARS-CoV-2 into the DNA template needed for PCR.

[356] This alternative form of PCR is referred to as reverse transcriptase- PCR or RT-PCR. Real-time-RT-PCR (RT-PCR) has become the accepted method for clinical diagnostic purposes, as it allows the amplification of the SARS-CoV-2 targeted DNA to be visualized on a computer.

[357] During the RT-PCR process, if the SARS-CoV-2 DNA is present, it approximately doubles in amount with each cycle. The number of cycles that is required to reach the threshold to determine whether a sample is positive or negative is known as the "cycle threshold" or CT value. Generally, the higher the CT value, the lower the amount of the SARS-CoV-2 virus present in a sample, and the lower the CT value, the higher amount of the SARS-CoV-2 virus present in a sample, however, Dr. Zelyas pointed out that there are no Health Canada approved quantitative real-time PCR tests for Covid-19, meaning all approved tests only provide a positive or negative test result.

[358] Dr. Zelyas noted that broad sweeping generalizations that claim that CT values above a certain number are effectively false positives is a "common fallacy". CT values are inherently variable based on a number of factors, including stage of infection, type of sample collected, quality of sample, PCR test used, duration of

PCR positivity following an infection, and the potential impact of emerging variants. CT values from the same sample have been found to vary by up to 14 CT values in different lab tests.

[359] This lack of consistency indicates that CT values are not generalizable between different tests, and using a CT value-cut-off to define infectiousness would risk misclassifying a large number of people as non-infectious, therefore contributing to the spread of Covid-19.

[360] In Dr. Zelyas' opinion, viral cultures are "untenable for use in a diagnostic laboratory". This is because viral cultures, as a diagnostic modality, are relatively slow. Most nucleic acid testing (like PCR testing) takes between one and six hours to perform, whereas a culture may take three or more days to observe signs of viral infection. Cultures are also non-specific- the viral effects observed could be from the SARS-CoV-2 virus or from a different respiratory virus, which means that a further test would need to be done to identify the specific virus. The likely test to confirm or identify the virus would be an RT-PCR test.

[361] Dr. Zelyas explained that virus cultures also require specialized technical expertise that is not widely available, as viral cultures have fallen out of favor within the diagnostic community due to their lower sensitivity and lengthy turnaround time. Viral cultures are also not necessarily an adequate proxy of infectiousness because the cells used in viral cultures are not the same type of cells in which SARS-CoV-2 would typically reproduce. In his opinion, "it would be an impossible kind of attempt if you tried to [use it] for a routine Covid-19 diagnosis in Alberta."

[362] Dr. Zelyas was asked on cross-examination if the RT-PCR test would "often" generate a positive result even if an individual is not infectious. He agreed that, since the test detects the genetic material of the virus, its RNS, that RNA could be present when the virus is no longer actively infectious but had infected the individual at an earlier time point.

[363] He also agreed that viral culture was probably a better indication of transmissibility or active infectiousness of a patient infected with SARS-CoV-2. He conceded that there could be a positive PCR test for a number of days after individuals were infected with Covid-19, and that it had been documented that this could be up to 100 days but he stated that a more typical timeline is probably a few weeks.

[364] However, Dr. Zelyas noted that case counts are important "not just for you know, saying whether someone is infectious at that date in time but also to do contact tracing, to look back and to limit further spread by going back to their contacts". Case counts are also important for planning purpose, to know the number of cases that are occurring or that have occurred, whether or not they are infectious at the given time that they're sampled and tested. He stated that "if you are using those case counts for things other than defining whether someone's infectious at the point of time of collections, then it's a different matter".

[365] In further response to questions about viral testing, Dr. Zelyas testified as follows:

> So I would agree that PCR, if that test is being used to interpret someone as actively infectious at that moment that they're sampled, that could lead to misinterpretation of that result as we know that the virus could be picked up or the RNA could be picked up by the test after someone's acutely ill and infectious time point. That being said, even though culture is a better or more accurate way of depicting someone's infectivity, culture just is not a very tenable method ... to be used for routine clinical diagnostics anymore. It's just – there's numerous issues with it. It requires a special laboratory, a containment level 3 laboratory, which there are very few in the province that actually exist. So, if you were to try to do culture to diagnose someone with SARS-CoV-2, then you wouldn't be able to actually keep up. It's not a scalable procedure or technique. So, while culture is I would say superior to PCR in determining whether someone is harbouring live virus, it's just not a method that can be used in current routine diagnostics.

[366] Dr. Zelyas was a candid, knowledgeable and credible witness.

Dr. Thambirajah Balachandra

[367] Dr. Balachandra is the Chief Medical Examiner in Alberta. He provided an expert report filed July 9, 2021 in response to a report prepared by Dr. Martin Koebel. Dr. Balachandra explained that "[c]ause of death is a medical opinion determined by a medical doctor based on medical findings or reasons for the death".

[368] As Dr. Balachandra explained, there are two parts to a death certificate: immediate cause of death and contributing cause. An example of an immediate cause of death is a ruptured heart caused by a heart attack. Contributing causes of death are any other disease that contributed to the death but are not causally related to the disease that caused the death.

[369] With respect to Covid-19, if a test confirms that an individual has Covid-19 and his symptoms worsen, he would be admitted to the hospital. Despite all the tests and supportive treatments, that person may die. If so, there would be no doubt that this person died due to, or as a complication and consequence of, Covid-19.

[370] The clinician may also list the cause of death as acute respiratory distress syndrome due to Covid-19 pneumonia due to Covid-19 or Covid-19 pneumonia. If this patient were to die before a diagnosis of Covid-19 was made, the clinician would report the case to the Medical Examiner and would not give the cause of death. The Medical Examiner would bring in the body, review the clinical notes and request all results of tests ordered. If the test for Covid-19 was positive, and if there were no other concerns, the Medical Examiner would list the cause of death as pneumonia due to Covid-19. An autopsy would only be necessary in suspicious and unconfirmed cases.

[371] Dr. Balachandra was not cross-examined at the hearing. The Respondents did not refer to the evidence of Dr. Koebel in their pre-trial and closing arguments.

Scott Long

[372] Mr. Long was called as both a fact witness and an expert witness. He was the Executive Director of Operations of the Alberta Emergency Management Agency (AEMA) in the spring of 2020 and the Acting Managing Director from October 2020 until May 2021. The Respondents sought to qualify Mr. Long to give opinion evidence as an expert in emergency management in rebuttal to the evidence of Mr. Redman.

[373] With respect to his qualifications, Mr. Long testified that he had a bachelor's degree in military arts and applied sciences and, a master's degree in defence studies. In terms of emergency management, he is a qualified business continuity planner and has taken the ICS 100 through 400 incident command system training. Like Mr. Redman, Mr. Long has had significant military experience, including internationally. He was Chief of Operations for the Canadian Support Group that is responsible for high-level logistics planning and co-ordination for the Western part of Canada. After his retirement from the military in 2014, he joined the AEMA. He was with the AEMA until August of 2021, and is now Executive Director for Rural Economic Development in Alberta.

[374] It was Mr. Long's evidence that AEMA was the supporting agency throughout the Covid-19 pandemic. He explained that AHS was primarily responsible for the Covid-19 pandemic. He noted that any emergency response plan must serve as a starting point to understand response activities, roles, and responsibilities during an emergency. Mr. Long's evidence is that Alberta Health and AEMA consulted widely with other Canadians provinces to identify the best response options in the face of the Covid-19 pandemic.

[375] Mr. Long testified that, as part of Alberta's emergency response to Covid-19, the *Emergency Management Act*, was revised twice to ensure it meets the needs of Alberta to manage the secondary impacts of the pandemic. The Alberta Health Emergency Operation Centre (AHEOC) was accurate to the lead the Covid-19 response. The AHEOC was enhanced by loaning staff well-versed in emergency management roles from AEMA and other ministry staff, due to the overlap between Covid-19 and the annual hazard season. Additionally, AEMA and the Ministry of Municipal Affairs created the Pandemic Response Planning Team, to look at the whole-of-society issues like business and economic impacts, and the PPE Task Force to supply non-healthcare sectors with masks, gloves, hand sanitizer, and face shields, to assist Alberta Health in managing the Covid-19 pandemic.

[376] Mr. Long stated in his report that Alberta's approach favoured moderate restrictions to individuals while instituting a number of supports to minimize economic disruptions and ensure the healthcare system could continue to operate. His opinion was that more stringent measures, while being more effective, would not have been feasible in Alberta.

[377] Ms. Ingram objected to the tendering of Mr. Long as an expert witness on the grounds of lack of independence.

[378] Ms. Ingram submits the following:

a) Mr. Long's expert evidence should be given no weight, except for the admission that no cost-benefit analysis of the impact of the restrictions of *Charter* rights was done;

b) Mr. Long, as a full-time employee of the Alberta government, does not have requisite independence to be an expert witness on emergency management;

c) Mr. Long assumed the effectiveness of the implemented NPIs without pointing to evidence. Ms. Ingram accuses Mr. Long of "championing the prompt implementation of NPIs without evidential basis"; and

d) Mr. Long opined on things he had no authority to speak on.

[379] I found Mr. Long to be qualified to give opinion evidence as an expert on emergency management. I noted that a mere employment relationship with the party calling the evidence was not a matter for disqualification in and of itself, citing ***White Burgess Langille Inman v Abbott and Haliburton Co.*** 2015 SCC 23 (CanLII), [2015] 2 SCR 182.

[380] I also noted that I had read Mr. Long's report and could not find that it was tainted by bias or partiality so as to render it inadmissible. I noted that the Applicants were free to argue that Mr. Long's evidence should be given little weight if there were concerns about his independence after he was cross-examined.

[381] Ms. Ingram submits that Mr. Long's made a "frank admission that no cost-benefits analysis was done with regard to the imposition of civil rights restrictions on the citizens of the Province of Alberta". This is a mischaracterization of Mr. Long's evidence. Mr. Long testified that, although cost benefits analysis were not done by the AEMA since Alberta Health was the lead for the pandemic, he thought that reports of cost-benefit analysis had been done and he saw some later on in the pandemic. Later in cross-examination, Mr. Long said that he was not seen cost-benefit analysis for anything prior to the NPIs that were brought in for wave 1.

[382] It is correct that Mr. Long at one point during cross-examination indicated that there was a current plan in government designed for the pandemic, which he later identified as the 2014 influenza plan, that guided the initial actions of government for wave one... "[b]ut there was no cost-benefit analysis and I'm not quite sure... can you give one example of what you mean by a cost-benefit analysis".

[383] However, this comment must be viewed in the context of his cross-examination evidence as a whole, particularly his evidence that it was not the AEMA that was making the decisions to issue the restrictions.

[384] Ms. Ingram also submits that Mr. Long made assumptions about the effectiveness of NPIs without any basis and suggests that his "championing" of the prompt implementation of NPIs was an indication of his lack of independence. This is again a mischaracterization of the evidence. Mr. Long did offer the opinion that the decision to put NPIs in place early was reasonable, after making the point that there were a lot of unknown factors at that point in time. Ms. Ingram submits that Mr. Long "opined on things he had no authority to speak on", again referring to his opinion that the NPIs out of place early in the pandemic were reasonable. As stated in his report, his opinions with respect to the effectiveness of NPIs (qualified to be with respect to wave 1, when he was actively involved) were informed by his personal knowledge and the other sources identified within his report. Mr. Long was not cross-examined on the basis for this opinion.

[385] During cross-examination, in response to the question of why Alberta decided to "lock down the healthy and people who were not as vulnerable to the virus", he responded:

> Again, we were not sure the details of the virus, in terms of transmissibility, asymptomatic, what have you, so the decision was made by... the recommendations went up, the decisions were made by the political leaders of the Province, that we would take a cautious approach initially with regards to lockdowns. Not only that, transmissibility, people were going around, you could be totally asymptomatic and you could be spreading it to those vulnerable populations. So, some of those NPIs about restricting social gatherings, social distancing, certainly I think made sense, were reasonable and probably saved lives in the earliest parts. And again, the mitigation strategies were put in place as quickly as possible to limit the impacts on society and on people.

[386] He admitted that he was not an epidemiologist but referred to the results of those early NPIs on the ICU rates, the hospitalization and the "R" factor.

[387] On cross-examination, Mr. Long was referred to an article by an economist released in April, 2021 that criticized early cost-benefit studies, suggesting that research conducted during the last six months had indicated that lockdowns had a marginal effect on the number of Covid-19 deaths, which the author attributed to the inability of lockdown jurisdictions to prevent non-compliance. He was asked whether this changed his opinion, and he responded that it did not, noting the economist's opinion was given in hindsight, a year after the lockdowns in question, and that he had read other opinion that contradicted it.

[388] It is evident, then, that while Mr. Long may have given opinions outside his scope of expertise, they were given in response to cross-examination. These opinions were not relied upon in terms of the ***Oakes*** analysis.

Dr. Natalie Exner Dean

[389] Dr. Dean, PhD and MA in Biostatistics from Harvard University is a biostatistician and Assistant Professor with the Department of Biostatistics and Bioinformatics in the Rollins School of Public Health at Emory University. She was the supervisor and co-author of the Madewell Study. Her research interests include public health surveillance, infectious disease epidemiology, emerging pathogens, and vaccine evaluation. Her evidence was provided to the Court as she was the supervising author of the Madewell Study.

[390] Dr. Dean explained that while the Madewell Study's meta-analysis did use 54 studies to assess transmission of the SARS-CoV-2 virus using only household settings, the sub-analysis that actually studied the transmissibility of asymptomatic SARS-CoV-2 cases contained much less data. The Madewell Study's sub-analysis separated out symptomatic cases (27 studies) from those cases that were either asymptomatic or pre symptomatic (4 studies), but the Madewell Study was not able to separate out in the 4 studies those that fully involved asymptomatic cases from those that were pre symptomatic.

[391] Dr. Dean explained that "since the Madewell Study relied on other studies in the literature they were unable to fully separate out asymptomatic index cases from pre- symptomatic index cases".

[392] However, she also confirmed Dr. Kindrachuk's opinion that the Qiu Study does separate out asymptomatic and pre- symptomatic index cases in concluding that secondary attack rates from asymptomatic index cases ranged from 0% to 2.8% (9 studies) and that secondary attack rates from <u>pre- symptomatic index cases ranged from 0.7% to 31.8%</u> (10 studies).

[393] The Qiu Study also found that the highest transmission rates occurred between contacts living in the same household as the index case.

[394] Dr. Kindrachuk's opinion was consistent with that of Dr. Dean who confirmed that while there was a growing body of evidence that asymptomatic individuals are less infectious (than symptomatic and pre-symptomatic) that pre- symptomatic transmission does occur. Further, Dr. Dean explained that even if an asymptomatic person is far less infectious, if a person without symptoms has more contacts than someone who has symptoms then the lower risk of infection from the asymptomatic person may be lost.

[395] Dr. Dean concluded her evidence by explaining that knowledge on the transmission of the SARS-CoV-2 virus has grown and evolved since December 2020 when the Madewell Study noted that some studies report "timing of peak infectiousness at approximately the period of symptoms onset", and that as of the date of her

affidavit in August 2021 there were many peer reviewed articles showing that persons infected with the SARS-CoV-2 virus in the pre- symptomatic period can be highly infectious.

Patricia Wood

[396] Ms. Woods is a Senior Mortality Classification Specialist with Statistics Canada. Her affidavit evidence responded directly to what Alberta submits is factual inaccuracy contained in Dr. Bhattachanya's expert report, Dr. Bhattachanya had asserted that Statistic Canada records Covid-19 deaths and influenzas deaths differently, which he claimed artificially inflated death statistics for Covid-19. As Ms. Wood's affidavit explains, Covid-19 and influenza deaths are coded using the same international coding rules and guidelines.

[397] Ms. Woods was not cross-examined at the hearing.

[398] Alberta also provided affidavits from Chris Shandro (Assistant Deputy Minister, Agency Governance and Program Delivery Ministry of Jobs Economy and Innovation) and Darren Hedley (Sr. Assistant Deputy Minister, Budget Development and Reporting Treasury Board and Finance) with respect to various provincial and federal programs and benefits, including emergency financial relief programs targeted to help those in need of assistance during the pandemic.

iv. Pressing and substantial objective

[399] The next part of the ***Oakes*** analysis is whether the legislative goal is pressing and substantial.

[400] The purpose of infringing measures must be of significant importance and consistent with the principles integral to a free and democratic society: ***Vriend*** at para 108. The objective must be defined carefully and with precision: ***R v KRJ***, [2016] SCR 906 at para 63. Alberta submits that the pressing and substantial objective is clear: to preserve life by stopping the spread of Covid-19. Alberta submits that the preservation of life is one of the most pressing and substantial objectives, and there is significant evidence that not only is Covid-19 a deadly disease that disproportionately affects our vulnerable and elderly populations, but also that, without intervention, Alberta's health care system would have collapsed. Moreover, Alberta submits that there is clear and convincing evidence, including from Dr. Kindrachuk, that Covid-19 is not simply a disease that affects the elderly and infirm.

[401] The Applicants submit that the objective of "the preservation of life" is insufficient, citing the Supreme Court's decision in ***Carter***, where such an objective was rejected and deemed inaccurate.

[402] However, the facts of ***Carter*** are distinguishable, and in any event, Alberta does not 'merely' rely on the preservation of life, but also the preservation of Alberta's healthcare system, in order to ensure care is provided to those in need of medical attention.

[403] Dr. Hinshaw explained that Alberta's objectives have been to prevent and limit the spread of the virus, thus minimizing the number of serious outcomes, in terms of both death and illness.

[404] Ms. Ingram, while recognizing the objectives articulated by Dr. Hinshaw, submits that they are "not sufficiently important objectives that are even capable of being empirically evaluated", and "could be said in the face of every severe cold and flu or pneumonia outbreak".

[405] The evidence, particularly from Dr. Hinshaw and Ms. Gordon, does not support these unsubstantiated opinions.

[406] Contrary to the Appellants' submissions, there is clearly evidence that establishes the risks the pandemic posed to the healthcare system.

[407] As noted in ***Trinity*** at para 132:

> It is difficult to quarrel with the importance of these objectives. It borders on trite to observe that human life is sacred, and that public health and safety is important. Of similar import is the viability of the health care system relied upon by all residents of the province. Not surprisingly, courts across Canada have held that "containing the spread of the virus and the protection of

public health is a legitimate objective that can support limits on Charter rights under s. 1": ***Beaudoin***, at para. 224.

v. Rational Connection

[408] The limit must be rationally connected to the objective. Alberta must demonstrate on a balance of probabilities a causal link between the impugned measures and the pressing and substantial objective. The measure must not be "arbitrary, unfair or based on irrational considerations": ***Sharpe***, at pg. 78.

[409] The causal relationship between the limit and the objective should be proved, where possible, by scientific evidence, showing that, as a matter of repeated observation, one affects the other, although scientific proof is not always necessary: ***Sharpe*** at 81.

[410] As noted in ***Sharpe***, courts should be cautious about demanding an unrealistically high level of proof. It is not necessary to demonstrate that the limit on a right will inevitably achieve the objective. "A reasonable inference that the means adopted by government will help bring about the objective suffices": ***Sharpe*** at pg. 81, citing ***Mounted Police Association of Ontario v Canada (Attorney General)***, 2015 SCC 2 at para 143.

[411] The evidence of Alberta's witnesses, both factual and expert, demonstrate that the limits were rationally connected to the objectives.

[412] Dr. Kindrachuk's evidence explains why the limits were rationally connected to transmission of the virus, including through asymptomatic and pre-symptomatic transmission. Ms. Gordon's evidence explains why the limits were important in helping to prevent ICUs and acute care facilities from being run over capacity. Evidence relating to confirmed cases of Covid-19 transmission outdoors and the spread of the virus through person to person contact supports Alberta's restrictions with respect to outdoor gatherings. Evidence with respect to the spread of virus at indoor gatherings, including evidence of outbreaks at places of worship and related to singing in choirs indicates a rational connection to the indoor gathering restrictions.

[413] The Applicants submit that, given Dr. Zelyas' evidence with respect to the fact that PCR tests may have their limits, the impugned Orders cannot be rationally connected to the Respondents' objectives, since they argue, such Orders "were entirely premised on the number of positive cases as determined by PCR testing".

[414] This submission misses the mark. The evidence establishes a rational link between requiring people with a positive PCR test to quarantine and reducing the spread of the virus. While the PCR tests may not be a perfect tool, the evidence is clear that they are the only feasible tool to measure the risk of infection.

[415] Ms. Ingram submits that there is no proof that NPIs prevent transmission or that fitness facilities have contributed to the spread of Covid-19. Again, this mistakes the rational connection test. Alberta is not obliged to provide an unreasonably high level of proof, only to demonstrate a reasonable inference that the limit will help achieve the objective. Evidence about indoor transmission provides that inference, and also supports the effectiveness of NPIs at reducing the spread of the Covid-19. There was in fact credible evidence that NPIs prevent transmission, including from Dr. Bhattacharya, and evidence of outbreaks arising from fitness facilities in Alberta.

vi. Minimal Impairment

[416] The limit must impair the right or freedom "as little as possible". However, government cannot be held to a standard of perfection: ***R v Edwards Books and Art Ltd***, 1986 CanLII 12 (SCC), [1986] 2 SCR 713. It is sufficient if the means adopted falls within a range of reasonable options to achieve the legislative objective: ***RJR-Macdonald***, at para 160. A government needs not accept options that are less effective at achieving the objective than the one chosen: ***RJR-MacDonald.*** The test is not whether the alternative satisfies the objective to exactly the same extent or degree as the option selected by the government. Rather, the test is whether the government can demonstrate that, among the range of reasonable alternatives available, there is no other less rights-impairing means of achieving the objective in a real and substantial manner: ***Hutterian Brethren*** at para 55; ***Carter*** at para 102, 118; ***R v KRJ*** at para 70; ***Ontario (Attorney General) v G***, 2020 SCC 38 at para 75.

[417] The limit must be careful tailored to its objectives and must impair the right no more than reasonably necessary with regard to the practical difficulties and conflicting tension that must be taken into account: ***R v Chaulk***, 1990 CanLII 34 (SCC), [1990] 3 SCR 1303; ***Trociuk v B.C. (A.G.)***, 2003 SCC 34 (CanLII), [2003] 1 SCR 835; ***RJR-Macdonald***, at para 160.

[418] The Applicants repeatedly assert that Covid-19 is only dangerous "for a small percentage of those already vulnerable", despite ample and credible evidence to the contrary. They admit, however, that age is a definite risk factor but they concentrate on mortality statistics and largely ignore the morbidity effects of the virus.

[419] The Applicants submit that the idea of focussed protection as recommended by Dr. Bhattacharya would have been a less intrusive method of handling Covid-19.

[420] However, as cross-examination of Dr. Bhattacharya established, the focussed protection recommended by the Great Barrington Declaration is fraught with practical difficulties. The idea of isolating everyone older than 60 or 65 fails to take into account the role of people of this age and older in the community- their positions as doctors, nurses, police and their other myriad roles in business and the economy. The theory ignores or minimizes the issues of multi-generational families, the health of caregivers and the expense of providing necessities of the life to those who are isolated in accordance with the theory.

[421] Contrary to the submissions of the Applicants, the Respondents provided a great deal of evidence about why this approach would not work. It is little wonder why the approach has not been adopted or followed by most jurisdictions. The integration of both those over 60 and those with vulnerabilities to the virus for reasons other than age make this theory, as Joyal CJ in ***Gateway*** noted, "insufficiently nuanced and unduly simplistic".

[422] Practicalities aside, the approach recommended by the Great Barrington Declaration also suffers from ethical and moral questions arising from the concept of quarantining an older population for an indeterminate period of time, over-optimistically suggested to be three or four months, in the hope that the virus would play itself out among this group.

[423] It must be recalled that minimal impairment does not mean the least intrusive choice imaginable: ***Trinity*** at para 139, citing ***JTI-Macdonald***. As Pomerance J noted, complex problems may be addressed in a variety of different ways, with no certainty as to which will be the most effective. "The operative question is whether the measures chosen by government fall within the range of reasonable alternatives": ***Trinity*** at para 139.

[424] Alberta is not obliged to "justify its choices on a standard of scientific certainty, nor was it obliged to wait for scientific consensus before acting in a pandemic to prevent illness and death. It has in fact through its evidence established that its choices were within a range of reasonable alternatives, given what was known about Covid-19 at the time the choices had to be made.

[425] In cases involving scientific evidence:

> If the legislature has made a reasonable assessment as to where the line is most properly drawn, especially if that assessment involves weighing conflicting scientific evidence and allocating scarce resources on this basis, it is not for the court to second guess. That would only be to substitute one estimate for another.
>
> This Court will not, in the name of minimal impairment, take a restrictive approach to social science evidence and require legislatures to choose the least ambitious means to protect vulnerable groups. There must nevertheless be a sound evidentiary basis for the government's conclusions.: ***Irwin Toy Ltd v Quebec (Attorney General)***, 1989 CanLII 87 (SCC), [1989] 1 SCR 927 at pg. 990.

[426] Even if some of the choices were imperfect, and I do not find that the Applicants have established that they were, decisions taken on the basis of imperfect information should not be undermined later with the benefit of hindsight": ***Trinity*** at para 143.

[427] I reject the Applicants' criticism of the evidence that Alberta has prevented as having relied upon at the time of impugned Orders were made. I see nothing flawed or deficient about the evidence and accept that it was the best evidence that was available at a time when little was known with certainty about the Covid-19 virus, and there was a vast body of speculative and controversial opinions, both scientific and not, about the disease's effects and transmission. What was known was that the risk of death was real, the possibility of an exponential contagion was real, the pressures on the Alberta health system were real.

[428] To be clear, notwithstanding the testimony of Dr. Bhattacharya and Mr. Redman, I am persuaded by the evidence of Alberta's witness, both factual and expert. I found their evidence credible and the science they referred to, and on which they relied when making their decisions, convincing and reputable.

[429] The Supreme Court has emphasized that the factual and social context of a case plays a key role in analyzing a limitation of a *Charter* right under section 1, and that when a limit arises from complex policy decisions involving the assessment of conflicting science, demands on resources and the protection of vulnerable groups, greater deference is owned to government action: ***Irwin Toy*** at page 993; ***JTI-Macdonald*** at paras 41, 43; ***Carter*** at para 98.

[430] However, given the strength of the evidence in this case, it was not necessary to resort unduly to deference.

vii. Final Balancing

[431] The final stage of ***Oakes*** requires that there must be a proportionality between the deleterious and salutary effects of the law at issue.

[432] This part of the test engages the Court in a balancing exercise, weighing the significance of the infringement of the right in question against the importance of attaining the objective of the legislation: ***Sharpe*** at 83.

[433] As noted by Alberta, the Applicants make three main submissions with respect to proportionality:

a) NPIs do not work and therefore have limited salutary benefits;

b) the negative effects of the impugned Orders were significant; and

c) no formal cost-benefit analysis was performed.

[434] With respect to the first submission, Alberta presented evidence that the data shows that approximately two weeks after restrictions were implemented on May 5, 2021, the number of people in ICU peaked and then began to decrease. Dr. Hinshaw gave credible evidence backed by data that during the second and third waves it was clear that without widespread immunization, restrictions on how people interacted with others outside of their households were effective in reducing cases of Covid-19 by reducing the transmission of SARS-CoV-2.

[435] Both Dr. Hinshaw and Dr. Kindrachuk gave evidence that masks provide at least some protection against transmission.

[436] Dr. Bhattacharya and Dr, Kindrachuk agreed that there are studies supporting both sides of the argument on the effectiveness of masks, and Dr. Bhattacharya agreed that it was an "open question" of whether masks as used in the community actually have any effect.

[437] Dr. Kindrachuk explained that NPIs "that have been employed" for Covid-19 "have been based on prior experience with similar pathogens", and "historically, we can say that there have been benefits". However, as "we are only 27 months" into Covid 19, then more work will need to be done to better understand the effectiveness of all the different NPI measures employed.

[438] Dr. Bhattacharya's view on the efficiency of lockdowns relies primarily on the Savaries study, which was withdrawn from publication, and his own study published in January 2021, which attracted some criticism.

In additions, Dr. Bhattacharya conceded that Alberta did not have a stay-at-home order during the pandemic and that he was not aware of the particulars of the Business Closure Restrictions.

[439] It is clear, even from the evidence of Dr. Bhattacharya, that whether or not NPIs have been effective, to what degree, and with respect to what specific NPI is being analyzed, is a matter of controversy.

[440] I agree with the Court in ***Trinity*** at para 163 that "it may be impossible to draw a perfectly straight causal line" between the limits set out in the impugned Orders and the reduction of Covid-19. As noted by Pomerance J, there are too many factors at play to empirically measure the impact of a single restriction on infection rates. Despite this, Alberta has presented evidence of the benefits of the impugned measures.

[441] With respect to the negative effects of the impugned Orders, it is important to note that Alberta acknowledges that the impugned Orders have caused hardship and inconvenience, including preventing Albertans from practicing their religion in their preferred manner and limiting their in-person interactions. However, there was never an outright prohibition on religious gatherings nor on outdoor gatherings, limits changed and evolved over time, and programs were put in place to help minimize the economic effects of the impugned Orders.

[442] With respect to whether cost-benefit analyses were preformed, the evidence of Dr. Hinshaw, and of Mr. Long, establishes that Alberta did consider and take into account potential harms and balanced them against the benefits of the limits, and the severity of the pandemic.

[443] In their opening statements and closing arguments, the Applicants have sought to minimize the severity of the pandemic. They refer to the impugned Orders as "a sledgehammer, used to swat a fly".

[444] They submit that what has been going on in Alberta has not been a public health crisis, but an emergency management crisis.

[445] Ms. Ingram, through her counsel, suggests that "this so-called novel coronavirus is simply another respiratory illness that strikes out in society from time to time... not particularly or markedly different from a severe flu outbreak or a bad outbreak of a particularly virulent cold strain".

[446] The Applicants submit that the public health measures have caused more harm than good, and that they are more harmful than the virus itself.

[447] The Applicants submit that the government has convinced and continues to attempt convincing the public that we are in the midst of a major health crisis, and has thrust our province into chaos. "Meanwhile, all cause mortality in Canada is in line with trends from the past several years and indicates no such crisis. You have instilled fear in the general public of Covid-19 by publishing egregious data such as daily cases and ICU numbers, without putting those numbers into context".

[448] I cannot accept these attempts at minimization of the Covid-19 pandemic. The evidence before me establishes that the pandemic was a threat of severe health consequences and death for a large swath of the population.

[449] As noted by Dr. Hinshaw, the majority of scientists in the field looking at the risk that Covid-19 poses would agree that Covid-19 poses an extraordinary threat to populations as a whole.

[450] Its effects were not, as the Applicants submit, limited to the elderly and those with comorbidities. Thousands of people died and many thousands more were infected, with symptoms that varied from mild to severe. The health care system was at risk of being over-whelmed: surgeries and treatment of non Covid-19 related afflictions were postponed and health care workers were exhausted and dispirited.

[451] I must conclude that the salutary benefits of the restrictions outweighed the deleterious effects of the limits. If I am incorrect about the validity of the impugned Orders with respect to section 29 of the *Public Health Act*, Alberta has met its burden of establishing that the impugned Orders are reasonable limits, demonstrably justified in a free democratic society.

C. Do the impugned Orders offend the Alberta Bill of Rights?

1. Submissions of Ms. Ingram

[452] Ms. Ingram submits that the impugned Orders are inconsistent with sections 1(a)(c)(e) and (g) of the *Alberta Bill of Rights*, RSA 200 c.A-14 (*ABR*). Ms. Ingram is the only applicant to claim an infringement of her rights under the *ABR*.

[453] With respect to section 1(a) of the *ABR*, Ms. Ingram submits that the impugned Orders offend her right to enjoyment of property and that they amount to the expropriation of her property without compensation and a deprivation of her property rights without due process of law.

[454] Section 1(a) of the *ABR* provides that:

> It is hereby recognized and declared that in Alberta there exist without discrimination by reasons of race, national origin, colour, sexual orientation, sex, gender identity or gender expression, the following human rights and fundamental freedoms, namely:
>
> a) the right of the individual to liberty, security of the person and enjoyment of property, and the right not to be deprived thereof except by due process of law

[455] In her decision at 2021 ABQB 343, Kirker J found that there was no reasonable basis upon which the Court could find that the Applicants were deprived of the due process protection afforded them by section 1(a) of the *ABR* in relation to the impugned Orders. However, she was not satisfied that she could reach the conclusion that the Business Closures Restrictions fell within the delegated order-making authority conferred on medical officers of health by the legislation: "that is, whether the impugned business restrictions are consistent with the purpose of the *Public Health Act*, and the means designated to achieve its purpose". Thus, she did not strike Ms. Ingram's claim that the impugned Orders offended section 1(a) of the *ABR*.

[456] The Court in ***Lavallee v Alberta (Securities Commission)***, 2009 ABQB 17 at para 178, found that the right to enjoyment of property is only protected from infringement in cases where the deprivation is done without due process of law. The issue of whether there was any question of due process of law, other then with respect to the delegated order making authority of the CMOH, has already been decided by Kirker J. Therefore, there would be no breach of section 1(a) of the *ABR* if the impugned Orders were *intra vires* the *Public Health Act*. However, I have found that they are not.

[457] The Court in ***Lavellee*** notes that the expression "enjoyment of property" has been broadly interpreted and includes enjoyment of land and money: para 178. In accordance with such broad interpretation, it must be concluded that the impugned Orders with respect to Business Closures infringed Ms. Ingram's section 1(a) rights under the *ABR*. There is no equivalent *Charter* right relating to enjoyment of property.

[458] It is thus unnecessary to decide whether the Business Closure Restrictions amount to expropriation without compensation.

[459] With respect to section 1(c) of the *ABR*, Ms. Ingram submits that, given the analogous language of section 2(a) of the *Charter* and section 1(c) of the *ABR*, the case law interpreting "freedom of religion" under the *Charter* applies equally to the interpretation of "freedom of religion" in the *ABR*. Therefore, she submits that the Indoor Gathering and the Private Residence restrictions that restrict attendance at worship services and restrict private religious gatherings such as Easter and Christmas are a *prima facie* limit on her freedom of religion as guaranteed by section 1(c) of the *ABR*.

[460] As noted earlier, I have found that the impugned Orders did not constitute a *prima facie* infringement of Ms. Ingram's freedom of religion rights under the *Charter*. Nor for the same reasons, do they infringe her section 1(c) rights under the *ABR*.

[461] Section 1(e) of the *ABR* protects freedom of assembly and association.

[462] Ms. Ingram also submits that the Private Residence, Indoor Gathering and Outdoor Gathering restrictions are inconsistent with and offend her freedom of assembly and association. Again, she submits that

case law interpreting "freedom of peaceful assembly" and the "freedom of association" in sections 2(c) and (d) of the *Charter* should be used to interpret section 1(e) of the *ABR*.

[463] No Crown concessions were made with respect to the *ABR*. However, the Crown acknowledges a *prima facie* infringement of Ms. Ingram's freedom of peaceful assembly and freedom of association under the *Charter* in so far as the impugned Orders prohibited her from hosting Christmas and other holiday events or barred her from celebrating with her mother on her birthday. I find that the concession must of necessity include an infringement of Ms. Ingram's section 1(e) rights under the *ABR*.

[464] As noted by Ms. Ingram, no relevant case law exists with respect to section 1(g) of the *ABR*, the right of parents to make informed decisions respecting the education of their children, and there exists no express analogous *Charter* right. However, Ms. Ingram submits that it is analogous to the protection of life choices guaranteed by section 7 of the *Charter*, citing ***B. (R.) v Children's Aid Society of Metropolitan Toronto*** 1995 CanLII 115 (SCC), [1995] 1 SCR 315. Given the lack of detail with respect to the alleged infringement of this right in Ms. Ingram's affidavit, this is not an appropriate case to decide the scope of this right.

[465] The issue thus becomes whether the *ABR* includes an implicit internal limit similar to section 1 of the *Charter*.

2. Relevant Legislation

[466] The *ABR* was first enacted in 1972. It guarantees a range of civil liberties, the majority of which are also protected by the *Charter*. Provincial bills of rights have lost much of their importance since the enactment of the *Charter*: Hogg at 34-4, but the *ABR* remains part of the legislative landscape.

[467] Section 75 of the *Public Health Act* states that:

> Except for the *Alberta Bill of Rights*, this Act prevails over any enactment that it conflicts or is inconsistent with, including the *Health Information Act*, and a regulation under this Act prevails over any other by law, rule, order or regulation with which it conflicts.

3. Internal Limit to the *Alberta Bill of Rights*

[468] I find that an implicit internal limit to the rights protected by the *ABR* must exist for three reasons:

a) analogous bills of rights, such as the *Canadian Bill of Rights*, have internal limits;

b) the modern approach to statutory interpretation rejects interpretations that lead to absurd consequences or that violate constitutional norms; and

c) duplicative provisions must be subject to a *Charter* analysis.

a. Analogous bills of rights contain internal limits

[469] Analogous bills of rights have been interpreted as having limits, even if the limit is not expressly provided in the text of the bill. Peter Hogg writes that "the courts have not interpreted the guarantees of the *Canadian Bill of Rights* and the *American Bill of Rights* as absolute; they have recognized the necessity to limit them in pursuit of other widely shared values": Peter W Hogg, "A Comparison of the Charter of Rights with the Canadian Bill of Rights" in Gerald Beaudoin & ED Ratushny, eds. The *Canadian Charter of Rights and Freedoms*, 2nd ed (Toronto: Carswell, 1989) at 8. *The Canadian Bill of Rights* has no limiting clause similar to the one in the *Charter*, but "similar limits would be implied by the courts": Hogg, at 20.

[470] Limits on rights and freedoms are set out in our Constitution via the *Charter*. Where the statute is silent on the scope of limitations, *Charter* limits can be implied, given the presumption that statutes accord with the Constitution.

[471] Similar limits have in fact been implied. The following cases are examples:

(i) ***Robertson and Rosetanni v The Queen***, 1963 CanLII 17 (SCC), [1963] SCR 651was concerned with whether the Lord's Day Act, which precluded business activities on Sundays, infringed freedom of religion as guaranteed by the *Canadian Bill of Rights* of those whose

religion did not mandate Sunday as a day of rest. The majority found no infringement of freedom of religion: at 658.

[472] The Court in ***Robertson*** commented at 654 as follows:

> ... the *Canadian Bill of Rights* is not concerned with "human rights and fundamental freedoms" in any abstract sense, but rather with such "rights and freedoms" as they existed in Canada immediately before the statute was enacted. ... It is therefore the "religious freedom" then existing in this country that is safe-guarded by the provisions of section 2.

[473] Both the *ABR* at section 1 and the *Canadian Bill of Rights* at section 2 employ the same language: rights and freedoms are "recognized and declared". Therefore, the *ABR* can also be understood as enshrining freedoms as they existed before the statute was enacted.

[474] The Court elaborated at 655:

> It is to be remembered that the human rights and fundamental freedoms recognized by the Courts of Canada before the enactment of the *Canadian Bill of Rights* and guaranteed by that statute were the rights and freedoms of men living together in an organized society subject to rational, developed and civilized systems of law which imposed limitations on the absolute liberty of the individual.
>
> Thus, the Court in ***Robertson*** was clear that rights in existence prior to the *Canadian Bill of Rights*, and which were enshrined by the *Canadian Bill of Rights*, are subject to limitations.

[475] The Court can make the reasonable assumption that the same would apply to the rights enshrined by the *ABR*.

> (ii) In ***The Queen v Beauregard***, 1986 CanLII 24 (SCC), [1986] 2 SCR 56, Chief Justice Dickson, in considering an alleged infringement of the right to equality under section 1(b) of the *Canadian Bill of Rights*, concluded that as long as the legislation was enacted in pursuit of a valid legislative objective, there was no infringement of the *Act*. He stated at para 70 that:
>
>> ... [O]nce it is accepted that the general substance of the law is consistent with the valid federal objective of providing for renumeration of s. 96 judges and that it is not discriminatory of Parliament to draw some line between present incumbents and future appointees, I do not think the jurisprudence I have summarized above allows the courts to be overly critical in reviewing the precise line drawn by Parliament in *Canadian Bill of Right* cases.

[476] In ***Beauregard*** and the cases cited next, the Supreme Court did not follow a process of finding a violation of the *Canadian Bill of Rights*, and then subsequently upholding the provision given there was a valid legislative objective. Rather the analysis was done concurrently: no violation of the bill of rights in question was found because there was a valid legislative objective to the restriction. In this way, the limitations analysis differs from the clear delineation between rights violation and justification set out by the structure of the *Charter*.

[477] It is incorrect to say, as Ms. Ingram does, that the test of whether legislation was enacted in pursuit of a valid legislative purpose is only applicable with respect to the breaches alleged in specific cases. As noted in ***Beauregard*** at para 67:

> ... a majority of the Court was never prepared to review impugned legislation according to an exacting standard which would demand of Parliament the most carefully tailored, finely crafted legislation. On the contrary, a majority of the Court was consistently prepared to look in a general way to whether the legislation was in pursuit of a valid federal legislative objective. (emphasis added)

[478] (iii) In ***R v Burnshine,*** 1974 CanLII 150 (SCC), [1975] 1 SCR 693, a majority of the Court concluded that, in order to succeed, the respondent needed to demonstrate, at least, that Parliament was not seeking to achieve a "valid federal objective".

[479] (iv) In ***Prata v Minister of Manpower and Immigration***, 1975 CanLII 7 (SCC), [1976] 1 SCR 376, the Court, citing ***Burnshine***, disposed of a section 1(b) claim by stating that the limitation in question sought to achieve a valid federal objective.

[480] (v) In ***Bliss v Attorney General of Canada*** 1978 CanLII 25 (SCC), [1979] 1 SCR 183, the Court, again citing ***Burnshine***, found that the impugned legislation was an integral part of Parliament's unemployment insurance scheme, and therefore was enacted for the purpose of achieving a valid federal objective.

[481] (vi) In ***MacKay v The Queen***, 1980 CanLII 217 (SCC), [1980] 2 SCR 370, a majority of the Court relied on the "valid federal objective" test to deny any conflict between the *National Defence Act* and section 1(b) of the *Canadian Bill of Rights*.

[482] (vii) In ***R v Cornell***, 1988 CanLII 64 (SCC), [1988] 1 SCR 461 at para 16, the Court reached a similar conclusion, noting:

> [T]here must be a federal objective that provides a reasonable justification for the particular inequality in the sense that the inequality is not clearly arbitrary or capricious but finds some legitimate basis in the particular legislative policy.

[483] (viii) In ***The Queen v Drybones***, 1969 CanLII 1 (SCC), [1970] SCR 282, there was a rare finding of a violation of the *Canadian Bill of Rights*. A provision of the *Indian Act* made it an offence for an Indian to be intoxicated outside an Indian reservation. The majority held that the provision was inconsistent with section 1(b) of the *Canadian Bill of Rights*.

[484] In essence, the Court found that there was no valid legislative objective, as other Canadians could do the prohibited act without penalty.

[485] The "valid legislative objective" approach has not been restricted to the interpretation of the *Canadian Bill of Rights*. It was applied to the *ABR* in ***Marr v Alberta (Public Trustee)*** 1989 CanLII 3228 (AB KB), 63 DLR (4th) 500 at para 47. The plaintiff argued that a statute granting partial tort immunity between spouses was inoperative by reason of conflict with section 1(b) of the *ABR*. O'Leary, J concluded that "[i]f the provisions is clearly designed to promote a valid provincial legislative objective, the court cannot question the wisdom of creating inequity in pursuit of that objective": para 50. The Court further asked itself if the legislative policy was arbitrary or capricious and concluded that it was not: para 53.

[486] In summary, the rights in the *ABR* can be limited if the law was enacted pursuant to a valid legislative objective. This analysis occurs concurrently with the analysis of whether the right was infringed, rather than in two-step *Charte*r- like process, although in this case, the limit has been considered separately for reasons of clarity. The right will not be deemed infringed if the legislature had a valid purpose in enacting the law. A valid objective is not arbitrary or capricious.

[487] The restrictions on rights set out in the *ABR* that Ms. Ingram submits were infringed were clearly enacted for a valid legislative purpose, to control the spread of the Covid-19 virus and to protect the healthcare system and vulnerable persons.

[488] As I have found with respect to section 1 (a) of the *Charter*, in this case the impugned Orders, to the extent they are in breach of the *ABR*, were not arbitrary or capricious, but had a legitimate basis in public protection.

b. The modern principle of statutory interpretation supports reading in a limit

(i) Rights are not absolute and this is a constitutional norm

[489] It is not controversial that *Charter* rights are not absolute.

[490] In ***Germany*** (***Federal Republic) v Rauca***, (1983), 1983 CanLII 1774 (ON CA), 4 CCC (3d) 385 at 401, the Court held that "it is recognized that the listed rights and freedoms [in the *Charter*] are never absolute and that there are always qualifications and limitations to allow for the protection of other competing interests in a democratic society".

[491] In ***R v Oakes***, 1986 CanLII 46 (SCC), [1986] 1 SCR 103 at 136, Chief Justice Dickson wrote that "[t]he rights and freedoms guaranteed by the *Charter* are not, however, absolute. It may become necessary to limit rights and freedoms in circumstances where their exercise would be inimical to the realization of collective goals of fundamental importance".

[492] The principle that rights are not absolute was reiterated in an *ABR* case, ***Peter v Public Health Appeal Board of Alberta***, 2019 ABQB 989. The plaintiff alleged that his rights under section 1(a) of the *ABR* had been violated when, following a complaint about the condition of his rental property. Alberta Health Services sought to conduct an inspection of the residence. The plaintiff objected to the inspection and the resulting orders to conduct repairs and vacate the premises, submitting that they violated his section 8 *Charter* rights and his section 1(a) *ABR* right.

[493] Justice Graesser concluded at para 86:

> An individual's rights to liberty, security of the person and enjoyment of property is expressly limited by the Legislator's ability to legislate to the contrary. The rights recognized in the *Bill of Rights* are not absolute. There are limits to freedom and the enjoyment of property. As with the *Charter*, rights are subject to justifiable limitations having regard to the rights and interests of others and the public in general. (emphasis added)

(ii) Interpretation must be harmonious with constitutional norms, as absurd results are unacceptable

[494] The *ABR* must be interpreted in accordance with the modern approach to statutory interpretation.

[495] Professor Ruth Sullivan points out that the consequences of an interpretation are important: Ruth Sullivan, *The Construction of Statutes*, 7th ed (Toronto: LexisNexis, 2022) at s. 10.01;

> Consequences judged to be good are presumed to be intended and generally are regarded as part of the legislator's purpose. Consequences judged to be contrary to accepted norms of justice or reasonableness are labelled absurd and are presumed to have been unintended. If adopting an interpretation would lead to absurdity, the court may reject that interpretation in favour of a plausible alternative that avoids the absurdity. (emphasis added)

[496] In ***Rizzo & Rizzo Shoes Ltd***, [1998] 1 SCR at para 27, Iacobucci, J stated that:

> It is a well established principle of statutory interpretation that the legislature does not intend to produce absurd consequences.

[497] In ***Ontario v Canadian Pacific Ltd***, 1995 CanLII 112 (SCC), [1995] 2 SCR 1031 at para 65, the Supreme Court emphasized that, as among two or more available interpretations, the courts should adopt the interpretation that best advances the legislative purpose and reject the interpretation that would lead to negative unintended consequences.

[498] In the present case, an absurdity would ensue from an interpretation that generates an absolute right unlimited by public interest considerations. Therefore as, between an interpretation of the statute that contains an implicit internal limit and one that does not, the one that finds an internal limit avoids the unreasonableness of protecting absolute freedom of religion and association when no such absolute right is allowed by the Constitution.

[499] As noted in ***R v Stipo***, 2019 ONCA 3 at para 179, "[c]ourts are also required to interpret legislation harmoniously with the constitutional norms enshrined in the *Charter*." *Charter* values play an interpretive role when there is genuine ambiguity in the legislation, meaning there are two different but equally plausible

interpretations, each of which is equally consistent with the apparent purpose of the statute: ***R v Rodgers***, 2006 SCC 15 at para 18.

[500] In ***Reference re Secession of Quebec***, 1998 CanLII 793 (SCC), [1998] 2 SCR 217 at para 25, the Court wrote that "[o]ur law's claim to legitimacy also rests on an appeal to moral values, many of which are imbedded in our constitutional structure. It would be a grave mistake to equate legitimacy with the 'sovereign will' or majority rule alone, to the exclusion of other constitutional values". The *Charter* is a clear expression of the democratic choice to embed the moral value that no right is without limits, thus balancing democratic rule with individual rights.

[501] With respect to both the avoidance of absurdity consideration and accordance with constitutional norms, an implied internal limit to the rights in the *ABR* is the appropriate interpretation.

(iii) Duplicative provisions must be subject to the *Charter* analysis

[502] Peter Hogg, writing specifically about the *Canadian Bill of Rights*, argues that "[d]uplicative provisions are not expressly preserved by section 26 of the *Charter* because section 26 preserves "other rights and freedoms": Hogg, *Charter* at 3. However, "duplicative provisions of the *Bill* will not be overridden by the *Charter* unless they can be said to be "inconsistent" with the provisions of the *Charter*": at 3.

[503] Alberta notes that Professor Hogg opined at one point that "there seems to be no point at all in the same civil liberty being guaranteed by two instruments" and expressed the view that those provisions of the *Canadian Bill of Rights* that purport to guarantee rights of freedoms that will be guaranteed by the new *Charter* are rendered "of no force and effect" by the enactment of the new *Charter*". Thus, Alberta submits that section 1(a) of the *ABR* (the right not to be deprived of property except by due process of law), and perhaps section 1(g) have been entirely subsumed by the *Charter* freedoms.

[504] However, this view was contradicted by the Supreme Court in ***Singh v Minister of Employment of Immigration*** 1985 CanLII 65 (SCC), [1985] 1 SCR 177 at para 85 where the Court noted that the *Canadian Bill of Rights* "retains all its force and effect, together with the various provincial Charter of Rights", and the suggestion to the contrary in Professor Hogg's book was removed from subsequent editions.

[505] Beetz, J noted that, by operation of section 26 of the *Charter*, the *Charter* cannot be construed to deny the existence of any other rights and freedoms that exist in Canada. Bills of rights are "susceptible of producing cumulative effects for the better protection of rights and freedoms": ***Singh*** at para 85.

[506] ***Singh*** specifically pointed out the importance of retaining the provisions of bills of rights that do not exist in the *Charter*: para 85. However, most of the provisions of the *ABR* at issue in this case are also in the *Charter*: they are not at risk of being abandoned and they are duplicative. ***Singh*** does not stand for the principle that an aspect of the "better protection of rights" in a bill of rights is the protection of an absolute right. The case simply emphasizes that there are rights in certain bills of rights that do not receive protection in the *Charter*. However, as noted previously, bills of rights have always been subject to limitations.

[507] The Supreme Court has found that duplicative provisions should be interpreted to offer protection equivalent to the *Charter* guarantee. In ***Mouvement laïque québécois v Saguenay (City),*** 2015 SCC 16 at para 68, the Court acknowledged that there was no relevant difference in the meaning of the freedom of religion guarantees in the *Charter* and the Quebec *Charter of Human Rights and Freedoms*, CQLR c C-12.

[508] The Court decided that case under the Quebec *Charter*. While there is a section 1 equivalent to the *Charter* in the Quebec *Charter*, and thus the Court did not need to deal with the issue of whether equivalent limits should be implied, the case implies that duplicate provisions should be read as including equivalent limits.

[509] The adoption of the *Charter* transformed our system of government into one of constitutional supremacy: ***Secession Reference*** at para 72. A legislated override of a constitutional provision (s 1) and a constitutional norm (rights are not absolute) is anathema to our Constitution.

4. Conclusion

[510] I find that a limit to the rights provided by the *ABR* must be implied, and that, as with the *Charter*, the breach of any *ABR* right is subject to a limitation based on a valid legislative objective. In this case, the impugned Orders, to the extent they are in breach of the *ABR*, are not arbitrary or capricious. Alberta has demonstrated through the evidence presented at the hearing that, at all times when the impugned Orders were in force, there existed a pressing and substantial legislative objective. If, as Grasser J suggests, the rights are subject to the same balancing act that would be conducted pursuant to the ***Oakes*** test, the restrictions would be found to be justifiable.

D. Other Issues

1. Bias

[511] Ms. Ingram, through her counsel, submits that the Court of King's Bench of Alberta's response to Covid-19 has created a reasonable apprehension of bias with respect to the matters at issue.

[512] She suggests that, because after the Respondents lifted or rescinded many of the CMOH Orders at issues, the Court of King's Bench of Alberta continued with its own NPIs, which included mandatory masking, she is concerned that she has not and will not be afforded a fair and impartial hearing.

[513] Ms. Ingram submits that "the hearing Justice routinely appeared in Court wearing a cloth mask". In fact, I wore a mask while travelling between my chambers and the courtroom, in accordance with the Court's guidelines, and removed the mask while in the courtroom.

[514] Ms. Ingram goes further. She suggests that, "in order to avoid a mistrial with respect to this issue", she urges me to find in her favour with respect to either the section 29 issue or the *ABR* issue. She states that:

> Any ruling as to the effect that the CMOH Orders were "reasonable" enough to afford them section 1 protection is irredeemably tainted with reasonable apprehension of bias.

[515] They can be no reasonable apprehension of bias from the Court implementing its own rules with respect to protection of judges, staff and the public during the pandemic. This submission assumes that the answer to these complex questions of public health law and constitutionality would be decided, not with reference to legal analysis and precedent, but by a judge's personal views and beliefs. This is a deeply flawed understanding of the rule of law.

2. The Undemocratic Argument

[516] Prior to their change if direction on the issue of whether the impugned Orders were ultra vires the *Public Health Act*, the Applicants other than Ms. Ingram submitted that because the CMOH, an unelected official, issued the Orders she had made "undemocratic laws".

[517] This argument was essentially rejected by the Case Management Judge, and in any event, is inconsistent with the facts.

3. The John Hopkins Meta-Analysis

[518] During the hearing, I made a ruling about the admissibility of the John Hopkins Meta- Analysis. Ms. Ingram disputes this ruling and submits that it calls for a mistrial. In closing submissions, her counsel repeated arguments that he had made at the time of the objection.

[519] The ruling was made, and whether or not it was correct is an issue for appeal, not reconsideration.

Conclusion

[520] In summary, I find that the impugned Orders are *ultra vires* section 29 of the *Public Health Act* in that the final decision makers were the cabinet and committees of cabinet, rather than the CMOH or one of her statutorily authorized delegates.

[521] I have found that, in addition to the concessions made by Alberta with respect to the *Charter* rights, the impugned Orders infringed Ms. Tanner's section 2(a) *Charter* rights. There was no infringement of any of the Applicant's section 7 rights as they were enacted pursuant to a valid legislative purpose.

[522] However, if I am incorrect with respect to whether the impugned Orders are *ultra virus* the *Public Health Act*, these infringements were amply justified as reasonable limits in a free and democratic society pursuant to section 1 of the *Charter*.

Dated at the City of Calgary, Alberta this 31st day of July, 2023.

B.E. Romaine
J.C.K.B.A.

Appearances:

Jeffrey Rath & Katherine Newton
for the Applicant, Rebecca Marie Ingram

Leighton Grey, KC, Natalie L.A. Johnson & Tamer Obeidat
for the Applicants, Heights Baptist Church, Northside Baptist Church, Erin Blacklaws and Torry Tanner

Nicholas Parker, Nicholas Trofimuk, Brooklyn Leclair & David Kamal
for the Respondents

Appendix A

Affidavit Evidence of the Applicants

Rebecca Marie Ingram

[523] Ms. Ingram owns a gym and personal fitness studio in Calgary. She is a single mother of five children, four of whom lived with her during the pandemic.

[524] Ms. Ingram notes that her three school-aged children have been prevented from attending school while her older children are legally allowed to attend bars, strip clubs and casinos. She is concerned about the psychological harm done to her children by preventing them from attending school and requiring them and their fellow students to wear masks and not engage in normal socialization. She is concerned about being prohibited from having her extended family, who used to see each other frequently, visit her home. Ms. Ingram mentions her mother's birthday specifically.

[525] She notes that she was unable to run the Calgary Healing Hands organization, during the pandemic, which she started as a charity to feed homeless Calgarians every two weeks. She has "had to cease" attending her church.

[526] Ms. Ingram says that restrictions on weddings and funerals, "two of the most important sacrament milestones in Christianity", have "irreparably harmed... [o]ur society and religious life". However, Ms. Ingram no longer asserts that the CMOH orders limiting attendance at weddings and funerals offend section 15 of the *Charter*.

[527] Ms. Ingram says that she was denied fully celebrating Easter in 2020, and, as of the date of her affidavit sworn on December 8, 2020, she was concerned that restrictions would prohibit her from attending Christmas services as well.

[528] Ms. Ingram says that she is unable to wear a mask due to anxiety and panic attacks. While she concedes that exemptions from mandatory mask wearing are available, she asserts that the masking provisions created "an atmosphere of fear of being accosted by police or irate busybodies for those of us who have bona-fide concerns about our breathing being restricted by wearing a mask."

[529] Ms. Ingram worked part-time with the Canadian Corps of Commissionaires, primarily at the front desk of police stations. As of November 2020, due to the proclamation of CMOH Order 38-2020, she was unable to work as a commissionaire as there were no more expressed medical exemptions to mandatory masking requirements in public indoor places and the police service and others did not recognize the new voluntary nature of the mask exemption.

[530] Ms. Ingram notes that on March 18, 2020, her gym was shut down for three months, yet her corporation was still responsible for a portion of the rent, whereas the government rent subsidy and landlord had to pay the remainder of rent. The gym was still responsible for all utility bills. She says that as a result of the mandatory shut-down the gym experienced no revenue during this time and incurred considerable debt: $10,000 in unpaid rent and $12, 000 to Enmax for utilities. As well, other companies still billed her each month that the gym was forced to remain closed, such as insurance, phone etc., for a total of approximately $25,000.

[531] She notes the gym had no reported cases of Covid 19. She says that it received "numerous harassing messages and complaints", daily membership cancellations and holds. She says that the restriction on attendance at her gym led to the loss of a considerable number of members. Ms. Ingram says that, while the gym could easily accommodate 100 people and still comply with social distancing guidelines, on average, there were only 30 members using the gym.

[532] Ms. Ingram complains that the CMOH unfairly favoured malls, large "box" stores and international stores over small Alberta businesses.

[533] In a supplemental affidavit dated January 22, 2021, Ms. Ingram repeated that the public health orders issued by the CMOH "have devastated my business and the value of the shares I own in that business" and have detrimentally affected her personal life and finances. She referred specifically to CMOH Order 02-2020, which shut-down fitness facilities between March 17, 2020 and June 15, 2020, and CMOH 42-2020, which shut down fitness facilities as of December 11, 2020.

[534] Ms. Ingram notes specifically that:

- in January 2021, the gym lost payments from special offers and new year resolution sign-ups;
- the gym's financial stability and future are uncertain;
- the gym has been unable to realize its investment in renovations pre pandemic; and
- there have been an unprecedented number of memberships resignations, and corresponding loss of sales of other items.

[535] Ms. Ingram sets out details of the government relief she received against her lost revenue in this affidavit.

[536] The Oral Hearing Order provides that the affidavits of Abdullah Al-Shara, Shawn McCaffery and Kyle Pawelko shall not be considered unless Ms. Ingram demonstrates an infringement of at least one right guaranteed by the Charter, and at any rate, shall only be considered in the final stage of the ***Oakes*** analysis.

Abdullah Al-Shara

[537] Mr. Al-Shara is 24 years old. He says that six years ago he led a unhealthy lifestyle and was addicted to cocaine and at times fought recklessly. He was mentally unstable, had no hope for the future and was unaware of the damage he was causing to himself and his family and friends.

[538] Two years ago, he was introduced to Ms. Ingram's gym, and, since then, has never stopped going. His commitment to physical fitness opened many opportunities for him.

[539] He says that the gym saved him in many ways and helped his mental health.

[540] Mr. Al-Shara says that he has made tremendous progress and changes in his life in comparison to 10 years ago. He has turned his life around, left the "ghetto", cut out his old friends with a poor mentality and left his previous bad environment.

[541] Mr. Al-Shara made new friends at the gym and cultivated healthy relationships. His friends today make good and healthy choices in life because that is all there is at the gym. They support one another. Within the first three months, he became a person with personality and character and now has hope.

[542] Mr. Al-Shara says that the first lock-down at the beginning of 2020 affected his mental health severely. He became suicidal, was not able to interact with people the way he used to. He needed the day-to-day in-person interactions. He went back to his old habits after having been clean for a year, and he was mentally deteriorating.

[543] He lost himself and it was hard to get back after the first opening.

[544] The shut-down in December 2020 was worse. He has sought help with his mental health issues but for him, his heart and soul is being in the gym.

[545] Mr. Al-Shara says he has become an adult who understands the value of life because of the gym. He knows of other ex-addicts who feel the same.

[546] Mr. Al-Shara says the gym is always clean, safe, and continuously monitored for social distancing. It is run by someone who respects the risks and strives to ensure the well-being of its members.

[547] Mr. Al-Shara says he does not want to change for the worse and asks the Court to save him and the city from "criminal activity just because we are locked at home and bored."

[548] Mr. Al-Shara believes that by reopening gyms and giving people like him an opportunity to workout, relieve their stress and focus on themselves both physically and mentally, providing them with a purpose and context to life, many lives, including his, will be saved.

Shawn Valerie McCaffery

[549] Mr. McCaffery, a resident of Leduc, Alberta, is the sole shareholder and director of Wee Leprechauns Pot of Gold Inc., operating as Leduc Lanes. Leduc Lanes is a bowling alley. Mr. McCaffery contends that the restrictions and public health orders issued by the CMOH for Alberta have devastated the value of his business and had a detrimental affect on his personal life and finances.

[550] Mr. McCaffery used his residence as security for loans to construct Leduc Lanes in 2012. As a result of Covid-19, he had to cancel his private home insurance, business insurance, and life insurance and had no protection "if disaster strikes."

[551] The monthly revenue for Leduc Lanes is attached to his affidavit. Every month Leduc Lanes pays $6552.00 in rent, approximately $1000.00 for a line-of-credit, $1,500.00 for internet, telephone, and an alarm system (total = $9052.00).

[552] Mr. McCaffery had to sell numerous personal possessions to pay for rent and other expenses, including his vehicle in January 2021.

[553] CMOH Order 02-2020 closed Leduc Lanes, and the business was forbidden from operating between March 17-June 15, 2020. CMOH Order 037-2020 prohibited all team sports from congregating and shut down all bowling leagues as of November 12, 2020. CMOH Order 42-2020 shut down Leduc Lanes and fully

prohibited it from operating indefinitely as of December 11, 2020. Mr. McCaffery contends that the CMOH orders have rendered his business financially unfeasible.

[554] Mr. McCaffery concludes by emphasising there has not been a single COVID-19 transmission in Leduc Lanes and states that Brad Rutherford, MLA for Leduc-Beaumont, informed him that there had not been a single Covid-19 transmission associated with any bowling alley in all of Alberta.

Kyle Pawelko

[555] Mr. Pawelko, a resident of Calgary, Alberta, detailed the negative impact the restrictions and public health orders issued by the CMOH have had on him, focussing on his inability to attend Ms. Ingram's gym.

[556] Mr. Pawelko emphasizes the positive impact physical activity has on his life, such as helping him battle addiction and suicidal thoughts — "it helps me with stress, depression and anxiety and is the outlet that I need to keep on the right path" — "I have found myself in my bathtub feeling like not living another day, with a knife to my wrists because I found it hard to handle the overwhelming stresses, challenges and trepidations of life. After a good hour of contemplation, I go to the gym and grind it out... its not even about progressing on a life it's about grinding my thoughts out and making sure that my mom gets to see her son another day".

[557] Mr. Pawelko states that he attended an addiction center in April of 2020, after the first lockdown closed the most important tool he had for dealing with his addiction, depression, and anxiety. He also notes that the lockdowns made struggling with addiction and depression difficult and led to a suicide attempt in 2020. He again attempted suicide on Tuesday, January 19th, 2021, and was admitted to Rocky View Hospital that day.

[558] Mr. Pawelko concludes by begging the Alberta government to allow fitness facilities to open.

Erin Blacklaws

[559] Mr. Blacklaws is a resident of Sherwood Park, Alberta. His affidavit summarizes interactions he had with medical staff in November 2020, after his 88-year-old father was admitted to the Grey Nuns (and subsequently University) Hospital.

[560] Mr. Blacklaws father was admitted to the Grey Nuns Hospital around noon on November 22, 2020 and subsequently transferred to the University Hospital later that day. He required surgery for a brain bleed caused by a fall but was told he had to wait 3-5 days for the surgery.

[561] Mr. Blacklaws went to see his father at the University Hospital around 9:45AM on November 23. Although Mr. Blacklaws was told that his father had not yet been tested for Covid-19, his father had been placed in an isolation room for precautionary reasons. Mr. Blacklaws stayed at the hospital until 2:00PM when his brother, Marc Blacklaws, arrived to be with their father. His brother stayed until 7:00PM on November 23.

[562] At 6:57AM on November 24, Mr. Blacklaws received a voicemail from a nurse on his father's unit informing him that his father had tested positive for Covid-19 and was moved to the Covid-19 ward. Mr. Blacklaws asked how it was possible for his father to test positive when he had not been tested — neither Mr. Blacklaws nor his brother saw their father tested while they visited him on November 23. The nurse informed Mr. Blacklaws that his father's chart showed he was tested at the Grey Nuns around noon during his stay and that the test returned a positive result. The nurse also informed him that there was a Covid outbreak at the retirement residence where his father lived.

[563] Mr. Blacklaws called the retirement residence that morning and was advised that there was no outbreak and that all the residents had been tested a few days before. The residence. informed Mr. Blacklaws that his father's results from that test were negative.

[564] Next, Mr. Blacklaws called Grey Nuns Emergency at 8:12AM on November 24, and was advised that no Covid-19 test had been completed on his father there.

[565] Mr. Blacklaws called the University Hospital at 8:30AM on November 24, and informed the nurse of his conversations with the retirement residence and the Grey Nuns. Mr. Blacklaws was told by the intake nurse at the Grey Nuns that all patients coming in from seniors' homes were marked Covid-19 positive whether they had been tested or not as a precautionary measure. Mr. Blacklaws told the nurse that the Grey Nuns had

automatically marked his father as Covid-19 positive because he had arrived from a seniors' residence, and demanded to know why he was told his dad was Covid-19 positive if he had not been tested. The nurse told him someone would call him back.

[566] At 10:22AM, a woman who was in charge of the Covid-19 ward at the University Hospital called Mr. Blacklaws back. She informed Mr. Blacklaws that a Covid-19 test had been completed at both the Grey Nuns and the University Hospital and both results were positive. Mr. Blacklaws did not believe his father had actually been tested as he had gone over his father's chart with the head nurse at 1:30PM on November 23, and as of that time it did not show he had been tested at the University Hospital. Mr. Blacklaws pressed the nurse to show him the order for the Covid-19 swab, but the nurse had only heard that a Covid-19 test had been done.

[567] At 5:28PM on November 24, Mr. Blacklaws received a call from a doctor, who advised him that two Covid-19 tests had been completed on his father at the University Hospital, but the results had not come back yet. He was also informed that his father had had x-rays and his lungs were good, and he was not presenting as Covid-19 positive.

[568] At 9:16PM, the doctor informed Mr. Blacklaws that one of the Covid-19 tests had come back positive, but he did not know the result of the other test. The doctor also informed Mr. Blacklaws that his father was not doing well — he was unresponsive and unable to communicate.

[569] From then onward, Mr. Blacklaws spoke with doctors at the University Hospital every day for the next several days, pleading with them to allow him to visit his father. They refused his request, even when he was informed that it was a matter of hours before his father was going to pass away.

[570] Around 7:00AM on December 3, 2020, Mr. Blacklaws was informed that his father had passed away sometime during the night. Mr. Blacklaws was allowed into the Covid-19 ward to see him after he had passed away.

David Adkins – Northside Baptist Church

[571] Mr. Adkins is the lead pastor of Northside Baptist Church.

[572] The first half of the affidavit outlines the beliefs of the Northside Baptist Church. In essence, the Church believes that the Bible "is the ultimate and final authority over all of the affairs of human life" and physical gathering on Sunday is necessary. Mr. Adkins says that "[s]ocial distancing mandates hinder the spirit of God's church to freely and physically assemble." The Church also believes that people are created in the image of God and therefore "[w]earing face masks practically and symbolically covers up the image of God and hinders our ability to reflect his glory through something as simple as a smile." Therefore, "compliance with the Chief Medical Officer of Health's Orders make it impossible for Northside Baptist to fulfill the mandate outline" and "[t]he Health Orders directly contravene the authority of the local church, and the supreme authority of the Lord Jesus Christ."

[573] The second half of the affidavit outlines the harmful impacts of the impugned Orders on the members of the Northside Baptist Church. Members reported increased depression and loneliness. Mr. Adkins stresses the importance of mental and spiritual health, as opposed to solely focussing on physical health — "[T]he severe restrictions imposed on otherwise healthy persons that prevent them from freely participating in Northside Baptist's worship services do not attempt to balance the minimal risk from COVID with the severe harm to the spiritual and emotional well-being caused by being prohibited from participating in religious practices fundamental to our faith."

[574] Mr. Adkins believes that Dr. Hinshaw or the Alberta government lacked the theological or spiritual authority to mandate how worship would proceed at Northside Baptist. "This authority resides exclusively with the head of the Church, the Lord Jesus Christ."

[575] The affidavit concludes by stating that Northside Baptist does not desire conflict with government and seeks to avoid conflict and live at peace with all people but believes the mandates of Scripture are in direct conflict with the mandates of Dr. Hinshaw and the Alberta government.

[576] The remainder of the affidavit is comprised of exhibits. Exhibit A is a pamphlet from Northside Baptist, detailing what the Church believes. Exhibit B contains Scripture References.

Patrick Schoenberger - Heights Baptist Church

[577] Mr. Schoenberger, a resident of Medicine Hat, is the lead pastor of the Heights Baptist Church.

[578] The first half of Mr. Schoenberger's affidavit details the foundational beliefs and values the Church's members hold. In paraphrase:

1. (a) the Bible is the Word of God and has supreme authority in all matters of faith and conduct and is the final authority for daily living, faith and practice;
2. (b) the Lord Jesus Christ has committed two ordinances to the local church: Baptism and the Lord's Supper;
3. (c) corporate prayer and corporate worship are essential for spiritual growth and for carrying out Height Baptist's mission; and
4. (d) each local church is independent and competent under God and must be free from interference by any religious or state authority.

[579] The Church also believes that Scripture commands that the congregation meet in person on a regular basis, and that wearing face masks practically and symbolically covers up the image of God and hinders the ability to reflect his glory. The remainder of the first half of the affidavit discusses Heights Baptist belief in practicing the Lord's Supper, baptism, laying hands on people during times of prayer and commissioning, the blessing of physical touch, and that homes are to be used to offer hospitality to one another. Heights Baptist contends that the impugned Orders interfere with or purport to prohibit the manifestation and implementation of all the above beliefs.

[580] The second half of Mr. Schoenberger's affidavit describes the harmful impacts the impugned Orders have on members of the Church. Some members "went long periods without being permitted to see their spouses in long term care facilities" and had to wear face masks when they were able to visit them. Other issues include job loss, the inability to visit the sick in hospitals, wedding postponement, and an increase in depression and loneliness.

[581] Two Exhibits are attached at the end of the affidavit. Exhibit A is a copy of a brochure detailing the history, purpose statement, articles of faith and core values of the Church. Exhibit B contains excerpts of scripture texts supporting the Church's beliefs.

Torry Tanner

[582] Ms. Tanner disagrees with CMOH Orders 38 and 41 which deny her the opportunity to gather with her children and extended family in her home to celebrate Christmas. She emphasizes the importance of Christmas and accompanying traditions to her and her family, and their ability to celebrate the birth of Jesus. Ms. Tanner states that she "never would have thought that the Alberta government would issue orders attempting to cancel Christmas."

> "I feel like I am living in a nightmare I cannot wake up from. I feel like I do not recognize anymore the society in which I live. I feel oppressed by the government and as though I can no longer depend on my constitutional rights to protect me from the government."

Appendix B
Business Closure Restrictions

CMOH Order 02-2020, ss. 2-4; CMOH Order 07-2020, ss. 6,12; CMOH Order 18-2020, ss.3-4, 6-7; CMOH Order 19-2020, ss. 11-12, 14-15; CMOH Order 25-2020, s. 3; CMOH Order 34-2020, s.3; CMOH Order 37-2020, ss. 3-4, 8-9, 15-16; CMOH Order 39-2020, ss. 6-13, 17-21, 23-25, 29-30; CMOH Order 42-2020; ss. 25-32, 34-36, 40-42; CMOH Order 43-2020; CMOH Order 44-2020; CMOH Order 01-2021, ss. 25-31; CMOH Order, ss. 02-2021, ss.34-47, 54; CMOH Order 04-2021, ss. 31-46, 51-56; CMOH Order 05-2021, ss. 42-46, 51-56, 69-72, 78-79; CMOH Order 08-2021, ss.34-45, 50-54, 69-73, 85-87; CMOH Order 09-2021; CMOH Order 10-2021, ss.6.7-7.4, 8.5-8.7, 9.2-9.6; CMOH Order 17-2021, ss. 9-17; CMOH Order 14-2021, s. 3; CMOH Order 12-2021, ss. 5.1-5.4, 6.2, 6.5, 6.7-6.12, 8.5-8.7, 9.2-9.5, 10.3; CMOH Order 19-2021, ss. 5.1-5.1.4, 6.3-6.5, 6.1.2, 6.1.5, 6.1.7-6.1.12, 8.3, 8.1.4, 9.3-9.4, 9.1.2-9.1.4, 10.3-10.4, 10.1.3; CMOH Order 20-2021, ss.5.1-5.6, 6.2, 6.5, 6.7-6.12, 6.1.4-6.1.6, 8.2, 8.4, 9.2-9.4, 10.3; CMOH Order 30-2021, ss.4.1-4.4, 5.2, 5.5, 5.7-5.12, 8.3, 8.5; and CMOH Order 31-2021, ss.4.2-4.3, 4.7-4.9, 4.11, 5.3, 6.2-6.6, 7.2, 7.4, 8.2, 8.4, 10.2, 11.2-11.5, 12.2, 12.7-12.10.