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

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

BETWEEN:

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

Plaintiffs

and

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

Defendants

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H E A R I N G
(Excerpt)

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Calgary, Alberta
April 5, 2022

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| J.R.W. Rath (remote appearance) | For R. Ingram |
| L.B.U. Grey, QC (remote appearance) | Heights Baptist Church, Northside Baptist Church, E. Blacklaws and T. Tanner |
| N. Parker (remote appearance) | For Her Majesty the Queen in Right of the Province of Alberta and The Chief Medical Officer of Health |
| B.M. LeClair (remote appearance) | For Her Majesty the Queen in Right of the Province of Alberta and The Chief Medical Officer of Health |
| N. Trofimuk (remote appearance) | For Her Majesty the Queen in Right of the Province of Alberta and The Chief Medical Officer of Health |
| M. Palmer | Court Clerk |

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**Discussion**

THE COURT: Okay, good morning, everyone. It is very unfortunate we have --

MR. PARKER: Morning.

THE COURT: -- had these technical difficulties and I do not know whether the clerk has advised you but there is a possibility that we may further during the course of the morning, but we are doing our best here. So, Dr. Hinshaw, you are online. Mr. Grey, are we ready to proceed?

MR. GREY: Yes, Madam Justice, I just wanted to confirm at the close of yesterday's proceedings you had indicated that there were some documents that the Court and my friend had not yet received. We had forwarded those, I just want to confirm that they had been received, specifically this report that was I was referring to yesterday in cross-examination with Dr. Hinshaw. This is a report Alberta Health Services --

THE COURT: Right.

MR. GREY: -- has that been received now by the Court?

THE COURT: I will tell you. Madam clerk, have you received it?

THE COURT CLERK: I have not, Madam Justice.

THE COURT: Okay, I checked SharePoint, Mr. Grey --

MR. GREY: Okay.

THE COURT: -- this morning and I could not find it. I have sent my assistant to try to do a search to see. You sent it electronically, did you?

MR. GREY: Yes and also, I was -- we had arranged for our hard copy to be brought over as well.

THE COURT: Okay, yes. I am sorry, Mr. Parker, have you --

MR. GREY: Go ahead, what was --

THE COURT: Mr. Parker, have you received it?

MR. PARKER: Yes.

THE COURT: Okay.

MR. PARKER: Yes, we did and there were two emails, and one went to us and your assistant Angela and then when they got the out of office, they sent it to somebody else and so sorry, Mr. Grey, I can’t remember the other person's name --

MR. GREY: Okay.

MR. PARKER: -- you sent it to.

THE COURT: Yes.

MR. PARKER: But yeah --

MR. GREY: Okay.

MR. PARKER: -- we got it, correct.

MR. GREY: So, what I am proposing --

THE COURT: Ms. Traquair I think is now this week is subbing for Ms. Wright. I had sent her an email this morning saying can you find it and when you find it let me know but so far, I have not got it. But we can proceed I think as long as Mr. Parker has it.

MR. GREY: Well, I'm -- I'm -- I'm finished asking questions about it. What I propose to do and I think would be consistent what we -- with what we had been doing is simply have it marked for identification --

THE COURT: Okay.

MR. GREY: -- and then once the Court has it then Mr. Parker or someone from the respondent -- on behalf of the respondent can make submission on whether or not it can be admitted as an exhibit. That seems to be the process we've been following.

THE COURT: Okay.

MR. GREY: -- if Mr. Parker has no objection to that.

MR. PARKER: Yeah, I think in the circumstances where Dr. Hinshaw couldn’t say for certain whether she had read it that that makes sense, so no problem with that --

MR. GREY: Okay.

MR. PARKER: -- Mr. Grey, thank you.

MR. GREY: Thank you.

THE COURT: Okay, thank you. So, madam clerk, do we have any others in the line-up for identification or is this going to be?

THE COURT CLERK: This will be marked for identification as letter 'V' --

THE COURT: Okay.

THE COURT CLERK: -- 'V' as in Victor.

THE COURT: Okay, marked for identification as 'B'.

THE COURT CLERK: Sorry, 'V' for Victor.

THE COURT: Victor --

MR. GREY: 'V'.

THE COURT: -- I am sorry --

MR. PARKER: 'V'.

THE COURT: -- as 'V', okay, thank you.

**EXHIBIT V - FOR IDENTIFICATION - AHS Covid-19 Scientific Advisory Rapid Evidence Report**

THE COURT: Okay, go ahead, Mr. Grey, unless there is anything else.

MR. GREY: No, thank you, Madam Justice.

**DEENA HINSHAW, Previously Sworn, Cross-examined by Mr. Grey**

Q Good morning, Dr. Hinshaw.
A Good morning.

Q So, I'd just like to pick up sort of where we -- we left off. If I could refer you to page 34 of your July 2021 affidavit.
A Yes.

Q I had been some questions about paragraph 111. At the top of page 34 there is a bullet point that reads: (as read)

> The role of conspiracy theories, naysayers, and nonbelievers and the power of social media to propagate misinformation and create a

> groundswell of people who do not believe COVID risk is real and therefore do not change their behaviours.

That's an awfully strong statement of concern about misinformation, would you agree?

A Misinformation is a serious concern, that is true.

Q Okay and this is a concern actually which was something that the -- the government was interested in from the very -- from the very outset, wasn't it? From the very, very beginning when you started to learn of the existence of COVID-19?

A I'm not sure exactly what you're referring to in terms of --

Q Okay.

A -- the actions. I'm -- I'm afraid I don't know exactly what you're referring to.

Q All right, that's fair enough. I have -- we've created a -- a transcriptions of many of your public statements or if you want to call them press conferences. There is one that was made on the 14th of February and I'm just going to ask -- see if my assistant can bring that up for you so you can see it. Here it is. So, can you see that, Dr. Hinshaw?

A Yes, I can.

Q Okay, so this appears to be one of if -- one of if not the first public statements that you made concerning COVID-19 and right in the middle of that you'll see there's a sentence that begins, Another thing. Do you see that?

A Yes.

Q And it says: (as read)

> Another thing you can do is stay vigilant against the risk of misinformation which can spread fear and division.

So, this is from the 14th of February 2020, about a month before the declaration of emergency -- health emergency was made in Alberta. So, coming back to my question, it's very clear that the Government of Alberta was -- was concerned about the control of information about COVID-19 from the very, very beginning.

A I would say that certainly I was concerned with the availability of accurate information with respect to COVID-19. We had seen early in the pandemic some unfortunate incidents of individuals of Asian decent being targeted simply because of what they look like. And so again, it was important to make sure that people understood what we knew about COVID, what we didn't know and -- and what we were doing to find out. And so, throughout the entire pandemic it has been a key concern to be transparent with information, to provide reliable information and to direct people to reliable and

verifiable sources for information.

Q Right and by reliable you -- you meant sources of information that came from Alberta Health or from the Alberta Government?

A That was one source of reliable information, there certainly were other sources of reliable information including again the ability for people to look at peer reviewed published articles, there were lots of preprints that were printed without peer review in an interest of having information made readily available.

And so, making sure that people understood the limitations of that preprint process and able to find information on for example, academic websites, as well as government websites where the vetting process to ensure that that whole picture was being looked at. But it was again Alberta Health Services, Alberta Health were some of the reliable sources, certainly there were others that -- that would have been reliable as well.

Q Okay, I'd like to show you next your statement from the 21st of February 2020, can we bring that up please, that's the -- so here there's a paragraph which begins with, First I encourage you. Do you see that?

A M-hm.

Q So, here again this is a week later and here again you're saying

> First, I encourage you to stick to reliable sources for information about the Corona Virus. Both Alberta Health and Alberta Health Services update their pages daily with information on the virus as well as useful advice to returning travellers, schools, employers, and healthcare workers.

So, again you're referring Albertans to Alberta Health Services information and telling them really to disabuse their minds and to ignore other sources of information which the Government of Alberta regarded as incorrect. That's essentially what's being done here, isn't it? You're controlling the narrative?

A Again, we wanted to make sure that people were aware of some of the challenges with accessing information and -- and just like we would do with any topic for people to be aware of what the source of information was, what some of the challenges could be with that and so two reliable sources at that time and throughout the pandemic -- reliable sources for information have been and -- and at that time were the Alberta Health Services and Alberta Health website. Again, clearly this states these were two reliable sources.

Q So, coming back to what in your affidavit, at the top of page 34 where you refer to

conspiracy theories. To put that into context a conspiracy theory would be for example a conspiracy theory might be that the COVID-19 virus does not pose a serious health risk to Albertans for example. Would that be a conspiracy theory?

A No, that would not be considered a conspiracy theory.

Q Would that be the statement of a naysayer?

A Well, it would depend on the context within which that particular piece of information was shared, it's possible.

Q Okay and what about the term nonbeliever, which seems somewhat incongruous when we're talking about science. Seems to me belief is something more relative to faith and religion than science, but what do you -- what do you mean when you say nonbelievers?

A So, in the -- we know that behaviours, people's -- again choices and behaviours are influenced by their knowledge, by their attitudes, and by their beliefs about the world around them as well as their contexts. And so, it's common in terms of when considering the impacts that -- that those different attributes have on behaviour to consider again people's knowledge, attitudes, and beliefs about the world around them.

And so, this particular term here is -- is I suppose shorthand for those who had adopted beliefs that would align with again a -- behaviours that would potentially again put both that individual and their communities at risk in terms of the fact that, again as we discussed yesterday, while COVID does not carry the same risk of severe outcomes for everyone and most people do not need hospital care, our community is as whole are at significant risk from widespread transmission. And so again, this -- this is referring again to how knowledge, attitude, and beliefs shape individual's choices and behaviour in the context of in which they live.

Q Right and that was the -- that was the goal of government is to shape people's attitudes and behaviour? To -- to --

A So --

Q -- control their behaviour so that they would comply with what -- whatever the government was telling them to do in terms of complying with COVID, that’s -- that’s what you're talking about here. You're trying to get to people and convince people who are not -- who are not "buying into the government narrative" and to win them over so that they would adhere and comply. Isn't -- wasn’t that the point? That’s really what you're talking about here, isn't it?

A So, the goal was to provide accurate information to enhance people's knowledge of the threat that we were facing collectively so that people could make important choices based on again reliable and verified sources of information. And when necessary, as we have spoken about, when the recommendations that were put in place were not

sufficient to protect our healthcare system and minimise the volume of severe outcomes there was a necessity then at a certain point to use mandatory orders to be able to protect the healthcare system and minimise the -- the volume of severe outcomes.

Q Right but it's important to note here that there really is not and there never has been a scientific consensus about the risk of -- of COVID-19. If there is one that -- that -- that is a -- I'll put it to you that's a false consensus. In other words, the government's view, what you're stating now is -- is not a scientific consensus view. There are many eminent scientists, among them Dr. Bhattacharya who disagree with that narrative. So, there never was a consensus in science to support the idea that somebody is a naysayer or a conspiracy theorist, isn't that so?

A I would disagree with that. I -- the important part again when you're looking at the conclusions with respect to the -- the full body of evidence or looking at what the majority of experts in the field in terms of reading the -- the body of evidence, kind of what the majority would conclude.

And it's -- it's very clear that the majority of scientists in the field looking at the risk the COVID poses again to populations as a whole would agree that COVID-19 poses an extraordinary threat to populations as whole. Certainly, within the timeframe that we're talking about, before we had widespread availability, additional protective measures that the fact that a -- a small number of -- of individuals may have had different opinions doesn't change the fact that the majority of scientists would agree that COVID-19 was an extraordinary threat.

Q Right but there wouldn't be the same consensus of opinion, even if there is one, on the efficacy any usefulness of nonpharmaceutical interventions. Clearly, that is not a settled matter in science, there is not a consensus of opinion on that topic, would you agree?

A No, I would disagree with that statement.

Q Okay, so the opinion that you have, the position that the Alberta Government is correct, it's the only opinion that is correct and therefore everybody else who disagrees with that, regardless of whether they're a scientist from Stanford, or Harvard, or Oxford, they are conspiracy theorists, naysayers, and nonbelievers propagating this information. That's essentially what you're saying on page 34, paragraph 11, bullet point number 1, correct?

A I don't agree with that assessment.

Q All right, well here's some -- here's some data. This is from -- comes from the Government of Canada. As of April 1st, Government of Canada statistics are that about three and a half -- there are about 3 and half million and quarter cases of COVID-19 in Canada since the beginning of the pandemic. 3,507,206 for a population slightly over

38 million, that's less than 10 percent, agreed?

A I'm sorry, is that April 1st, 2022?

Q Yes.

A I -- I'm sorry, I thought we were speaking specifically about the time period up until July of 2021.

Q Right, we are but these -- these numbers I put it to you would be accurate for this time period as well. At any given time, less than 10 percent of Canadians or Albertans were infected with COVID-19.

A So, the numbers that are recorded with respect to PCR diagnosis as we spoke about yesterday would only be a small proportion of the number -- the total number that would've been infected. And within different timeframes depending on availability of PCR testing, there would be different proportions of the total number of cases that would have been detected by -- by PCR. So, I would want to be clear that the -- the number of people infected with COVID-19 would be larger than the number diagnoses with COVID-19.

Q Right but we're talking about the number of people actually infected with COVID-19 and according to Government of Canada numbers, less than 10 percent of the population as of April 1st, 2022 had been infected. So, that would include the time period that we're talking about, wouldn't it?

A So, that -- that again would be the -- the percentage of people who had been diagnoses with COVID-19 I believe, I -- I -- I'm not --

Q Okay.

A -- able to see the reference --

Q Okay.

A -- that you're sharing but my --

Q Okay.

A -- assumption would be that it would be the number diagnosed.

Q All right, well the Government of Canada also a number concerning the number of deaths. That's 37,728 COVID related deaths --

THE COURT: I am sorry.

MR. PARKER: We can't hear you --

THE COURT: Mr. Grey, I think it would be useful --

MR. GREY: Yes.

THE COURT: -- if you would provide the witness with the evidence that you are now giving.

MR. GREY: Well, I could -- I could come back to it. I don't have it in a form where I can show it to her, I can come back to this point later --

THE COURT: Okay, thank you.

MR. PARKER: And I was -- sorry, I was going to object. I was letting it go there as Dr. Hinshaw said that she thought we were dealing with the second and third wave, we are. And so, I do and -- and I appreciate that it would be useful to have the document in front of Dr. Hinshaw but again we're talking about numbers that I understand are from April 2022, so less than a few days ago, well outside the time period in question. And so, I raise the issue of relevance as well since we're apparently going back to that.

THE COURT: Well, if we go back to that I will hear your objection, Mr. Parker, but --

MR. PARKER: Sure.

THE COURT: -- I was becoming increasingly concerned with the fact that the witness was being given numbers without any evidence to back them up. Thank you.

MR. PARKER: Thank you.

MR. GREY: All right.

Q MR. GREY: All right, Dr. Hinshaw, if I could refer back to page 34 then of your affidavit. There's bullet point number 3 at the top of that page, begins with, Societal context. Do you see that?

A Yes.

Q (as read)

So, societal context plays a role, a disease -- a disease like COVID

> where people need to change behaviour and can therefore be inconvenienced. May spur deep seated beliefs, cultural viewpoints and values like personal freedom that oppose behaviour change.

This suggests that the loss of personal freedom is merely an inconvenience, is that what you meant to say?

A No, the intent there was to say that behaviour change is inconvenient and that in addition to that there is the knowledge that different people value different -- different people hold different values and would -- and would weigh things differently. And so, it's essentially two parts, one is saying that changing behaviour is inconvenient. The second part saying that those who hold different values may have different perspectives about the -- again kind of the -- the relative impacts of the changes that were necessary to minimise the severe threat to the population from COVID.

Q Right, so what you're saying here though is that people need to change their attitudes and be willing to change their viewpoints for example about the value and importance of personal freedom so that they will change their behaviour and comply with government imposed mandates. Isn't that essentially what you're saying here in this bullet point -- bullet point number 3 on page 34?

A The intention of that bullet point was to indicate again in the context of all of the bullet points that these are the factors that are needing to be taken into account as we consider what potential options there are for managing the risk of COVID. So, the intent is not to change people's values, people have those values and it's not expected that those would change but rather to identify that these are some of the factors that will play into the choices that people make and -- and how ultimately the -- the options that are available for again managing the risk that COVID poses to the general population.

Q This though seems to suggest that in the government's view personal freedom is something less important than compliance with behaviour controls on the population that support the agenda to prevent the -- the spread of COVID-19. There -- there -- I put it to you there's a hierarchy of values expressed in this statement that puts personal freedom below the importance of changing behaviour so that people will comply with nonpharmaceutical interventions. Isn't that what that’s -- that’s saying here?

A So, again as we spoke about yesterday, it's important to look at the whole picture of the response which included the significant importance places on using only least restrictive means and to preserve that ability for people to make their own choices and personal freedoms as a -- a foundational unpinning of the response. And it was only when the threat that COVID posed to the population as a whole was so significant that -- and was not being mitigated by the recommendations that those mandates were put in place.

And so again, this particular statement is indicating that the difference of perspectives, differences of values in the population is one factor to consider. Again, personal freedom is a very important value, it's aligned with that least restrictive means ethical principle that was followed throughout the response.

Q The -- and we talked about this yesterday though and -- and your answers -- what I heard you say is that with many of the health orders that you made, you knew -- the Government of Alberta knew that they were limiting or restricting individual freedoms, even ones that are legally recognised -- constitutionally recognised, that you knew that you were doing that. Isn't that -- isn't that so?

A That was again the last resort was to restrict those freedoms when the ability to mitigate the risk that COVID posed to the population was not possible with the means -- the -- the voluntary means that had previously been employed.

Q So, does that not support my assertion about the hierarchy of values that the Government of Alberta had? That the -- that dealing with COVID as a public health issue was more important that the individual personal freedoms in the context of COVID-19?

A Again, I would say that at the times where the healthcare system was under significant threat of becoming overwhelmed then clearly the decisions that were made were to limit some personal freedoms in order to protect the healthcare system and minimise severe outcomes for the good of the whole population. So, at -- in those specific --

Q Okay.

A -- moments of time where the -- the threat was significant and rising then again, very specific freedoms were limited for that purpose of protecting the population as a whole.

Q And it was your evidence yesterday that the use of these nonpharmaceutical interventions was effective in reducing the spread of COVID-19 and in saving lives in Alberta, that was essentially your evidence yesterday, was it not?

A Yes, that's correct.

Q Okay but there really -- although not withstanding that that is your -- your assertion -- your opinion, there really isn't any data to support that is there?

A I would disagree with that. There is a great deal of data to -- to show the effectiveness of nonpharmaceutical interventions.

Q Okay, well give us an example of a scientific study that -- that was commissioned by the Government of Alberta that’s been produced that shows that any of the lockdown measures, any of the nonpharmaceutical interventions was shown to reduce death in Alberta.

MR. PARKER: I'm going to object, Justice Romaine. This line of questioning was fairly extensive yesterday and in my submission --

MR. GREY: All right.

MR. PARKER: -- has been addressed by Dr. Hinshaw already.

THE COURT: Okay, Mr. Grey?

MR. GREY: What I'm asking Dr. Hinshaw to do is simply -- she's expressed this opinion and all I'm asking her to do is to point us to a scientific study or data that would support the opinion. I don't recall asking that question yesterday, so I'm really just following up on a line of questioning that I had pursued yesterday.

THE COURT: Okay, well Mr. Grey, there are two things. You did extensively cross-examine Dr. Hinshaw about the evidence to backup her opinion that interventions were effective, and she answered those questions. You have now posed a specific question; can you point me to a scientific study commissioned by the Government of Alberta that would indicate that these interventions were effective? That is a limited question, Mr. Parker, I will allow Dr. Hinshaw to answer it.

MR. PARKER: Thank you.

MR. GREY: Thank you.

A Thank you. So, you've asked about data and a study, again the -- there have been many publications in many places around the world that show the impact of nonpharmaceutical interventions. It's important to note that when looking at impacts of nonpharmaceutical interventions, it's important to consider the timing, when they're implemented matters a great deal, the specifics of which interventions are used also matter.

And so, I think I would refer you back to what I said yesterday in terms of what evidence do we have in Alberta that nonpharmaceutical interventions have saved lives and protected the healthcare system and refer you to the -- the data with respect to the first wave and second wave. So, if you look at Exhibit L which has the epidemic curves for the different waves, specifically if you look at figure 6 on page 213, looking at the cases.

And if you look at on page 220, figure 14 and then figure 16 pandemic page 221, you

can see there if you look at the first wave which was in the spring of 2020 and you compare that you to the second wave, which was in the -- the fall/winter of 2020 through to 2021, you can see that the implementation of the nonpharmaceutical interventions early in the first wave, before widespread transmission had taken place, resulted in dramatically lower hospitalisations, ICU utilisation, and deaths than in the second wave where nonpharmaceutical interventions were deployed much later.

And as a result, the -- thankfully they did result in a bending of the curve and a reduction in the overall mortality that could have happened if the nonpharmaceutical interventions had not been put in place. But again, clearly the timing of implementing those interventions resulted in a much greater burden on the hospital system as well as a much more significant death toll than what we had seen in the first wave.

Q MR. GREY: But don't we know that the government's own data concerning ICU numbers is unreliable. I -- I know that you gave us a public statement on January the 10th where you said that according -- in some our historical data patients admitted for COVID treatment were categorised as being in ICU when the unit they were on in fact had been changed back to a non-ICU unit at that time. So, how are we to rely on -- on these numbers when you publicly stated that they were wrong?

A It's really important to again underscore the importance of transparency in the reporting that we do. And so, we do quality control on our data regularly and when that particular classification issue was identified we corrected it and then shared that information with Albertans, again because transparency has always been a core and important foundation of the information that we share.

It's important to note two things about that. One is that those individuals were in hospital for COVID, however given the unprecedented nature of the pressure on the healthcare system at that time there were spaces that were fitted out to potentially be used as ICU beds if needed. But that particular -- you know some of those particular units were shifted back and forth depending on the nature of the pressure in that particular location at that particular time.

And so, the overall burden on the healthcare system was exactly the same. So, the total of ICU and non-ICU did not change for those time periods. What changed was again some of the patients who were in those particular units where the administrative data had not changed that -- that classification. And so, there were a small number of patients again at different points in time.

The -- the second wave was one of the timeframes that was impacted by that particular classification issue and again we corrected that and made sure that our -- our website had the updated information and also made sure that people knew that the data as of

that point in time had -- had been corrected and -- and could be relied upon.

So, ultimately that -- that classification does not change the fact that the magnitude of the pressure on the healthcare system was enormous, and those patients were in hospital to be treated for COVID. Again, simply a small number happened to -- to be on wards that had a different classification at that time.

Q All right but wasn't the original reporting of that data to Albertans clearly an example of misinformation? It was clearly wrong, you had to correct it. So, wasn't the original reporting about ICU numbers when it was originally reported to Albertans, wasn't that misinformation or does that not fit your definition of misinformation?

A My -- how I would define misinformation would be information that people know to be inaccurate that's shared for the purposes of misleading others. In this particular instance, it's important to know that our data teams work with millions of data points every single day and rely on administrative processes to categorise, and then as I mentioned, do ongoing quality control to ensure that they are looking at those processes and updating and correcting any issues.

So, in this particular instance, the teams were following the typical processes and it was -- it was an issue that had happened in the background and then when that was identified, again we corrected it and made sure that we were sharing that information. And so, at no time did we share information that we knew to be incorrect with the purposes of misleading.

Q Right but it was still inaccurate information that was used to fuel the -- the policy of nonpharmaceutical interventions. This idea that hospitals and ICU wards were going to be overwhelmed was a constant song that was being sung by you and other people on behalf of the government and -- and so, that was really based upon inaccurate information. So -- so, you -- you expected the trust of Albertans but then you provided incorrect information that was used to support nonpharmaceutical interventions that seriously infringed upon their constitutionally protected freedoms. Isn't that -- isn't that so?

A I would disagree with that. So, the imposition of nonpharmaceutical interventions for the purposes of protecting the healthcare system and safeguarding the population, those necessary measures were put in place as our numbers were rising and our impact on our hospitals were rising.

If you look at page 49 of the affidavit, there are two graphs there showing actual hospitalisations versus predicted, practical ICU admissions versus predicted and these forecasts were generated on October 26th with the team that was using the historical data to be able to understand that our current trajectory was the mean for what we would

likely see going forward.

You can see the grey line is the actual number of hospitalisations and then the second graph, the actual number of ICU admissions. The blue again, it's important to note the blue line was generated on October 26th and so you can see the actuals that came to pass were tracking almost identically along the lines that had been predicted on the 26th and you can see the -- the slope of those lines was going straight up. The issues that we had with classification in the ICU occurred near the peak of the second wave, much later than this in December.

So, the data that informs the need to utilise nonpharmaceutical interventions to prevent an overwhelming impact on the healthcare system was based on data that was not impacted by that classification issue, was based on a trajectory of the extremely rapid rise in transmission that were seeing and the impact that that would have had on our acute care system if we had not intervened to change the course of that particular wave.

Q Right but coming back to that, I know we disagree about this, but I put it to you that that -- that is a -- that is a subjective analysis that you've made based upon reading graphs that are based on modeling. That really there is no -- there is no empirical way to prove that the -- the imposition of nonpharmaceutical interventions reducing infections or death. That's a -- that's a theory that has not -- that has not been proven to the scientific standard.

A Again, I think --

Q I understand what your justifications are, but I mean that -- that -- there's really no way to prove that (INDISCERNIBLE)

THE COURT: Mr. Grey, you have asked Dr. Hinshaw two questions already and have not given her a chance to answer --

MR. GREY: All right.

THE COURT: -- first question was but is it not so that there is not empirical way to prove that what she is saying is a theory and not proven to a standard of scientific proof. Please allow Dr. Hinshaw to answer that.

A So, again I would disagree with that statement. It's -- it's very clear if you look at comparable jurisdictions where nonpharmaceutical interventions were not utilised that the death toll in those particular jurisdictions per capita has been higher than what we have experienced.

And again, it's -- it's important to recognise that the body of evidence looking at the effectiveness of measures, the predominant conclusion in those papers is that nonpharmaceutical interventions, again depending on the timing of when they're employed and which interventions that are used, are highly effective at preventing transmission, thereby preventing hospitalisations and death.

Q MR. GREY: All right, well I think it's also important to look at the -- the harms that are caused by nonpharmaceutical interventions. And so, I'd like to turn to that now and begin by bringing up I believe it's Exhibit O in the hearing please.

THE COURT: I am sorry, you are referring to Exhibit O of Dr. Hinshaw's --

MR. GREY: Yes --

THE COURT: -- affidavit?

MR. GREY: -- Exhibit O.

THE COURT: Okay.

MR. GREY: No, Exhibit O in the hearing, this would be the report that’s --

THE COURT: Right.

MR. GREY: -- on the screen.

THE COURT: Yes, thank you.

Q MR. GREY: Do, Dr. Hinshaw, this is a report entitled COVID Lockdown the Cost-Benefits, a Critical Assessment of the Literature --

MR. PARKER: Justice Romaine, I am going to object, this report is not produced in the evidence of any of the experts in this proceeding. So, this report is not in evidence.

MR. GREY: All right, may I respond?

THE COURT: Yes, of course.

MR. GREY: It doesn't need to be in evidence, this is cross-examination. I -- I can put -- I can put -- and it's being put to the witnesses for the purpose of -- of impeachment. She has testified about the efficacy of lockdowns. This is being put to her for the purposes of impeachment and the law is very clear on this point, that I can show anything to the witnesses subject only to the bounds of relevancy for the purposes of impeachment.

I realise that -- that the -- that this -- this being adopted as part of our evidence is something differ, but there's no procedural or evidentiary rule that I know of in -- under Alberta law which supports what Mr. Parker is saying. And if he -- if does -- if he has caselaw to support the position he's taking then perhaps we should take a break and he can produce it and I'll be happy to review it.

THE COURT: Okay.

MR. PARKER: May I respond, Justice Romaine.

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

MR. PARKER: Thank you. So, the procedure that's being followed in this Ingram litigation was that Dr. Bhattacharya filed a primary report, Alberta filed its rebuttal evidence on July 12th and the applicants were entitled to file surrebuttal report, which they did through Dr. Bhattacharya at the end of July. Dr. Bhattacharya chose to put in certain studies on NPI effectiveness in his primary and secondary, his surrebuttal report. This paper did not go in there, there is a requirement to seek leave of the Court if further papers are to be put into evidence, or further documents to be put into evidence.

This particular study, the abstract was put to Mr. Long and the whole paper was put to Dr. Bhattacharya in redirect, we objected to it at that point. And so, in the context of the procedure that's being followed in this particular litigation, the submission of the respondents is that it is inappropriate at this point to put a study on NPI effectiveness to -- to Dr. Hinshaw that hasn't been put into the evidence of Dr. Bhattacharya.

So, that's -- that's my submission why I'm saying we should -- we should be cautious about going down the road of putting numerous studies on NPI effectiveness to Dr. Hinshaw, which we seem to be doing, that haven't been put into evidence in the surrebuttal report of Dr. Bhattacharya.

THE COURT: Right. Okay, Mr. Grey, do you agree that the procedural order put in place by Justice Kirker requires you to seek leave to put before into

these proceedings new documentation?

MR. GREY: I'm not -- that is not what I'm doing. As I indicated, I'm putting this document to the witness for the purposes of cross-examination. This is just as what Mr. Parker did when he was questioning Dr. Bhattacharya and he put to Dr. Bhattacharya a case that he had testified to in Tennessee you'll recall, Madam Justice. That case was not in evidence, we did -- and -- and Mr. Parker was able to question Dr. Bhattacharya, that was clearly for the purposes of impeachment.

That's what it was produced for and that was -- that is really the exact same situation that we're dealing with here. I'm not asking to -- to submit -- I'm not trying to submit this report into evidence through Dr. Hinshaw. I'm putting it to her for the purposes of impeachment on the point that I've indicated. She has stated repeatedly that the efficacy in Alberta resulted in this -- the -- the saving of lives --

THE COURT: Yes.

MR. GREY: This -- what I'm putting to her is for the purposes of impeachment, that's what --

THE COURT: Okay.

MR. GREY: -- that's what I'm doing here, and I submit this is proper cross-examination and that -- that cross-examination would be blunt instrument indeed if Mr. Parker's definition of it were accepted by this Court. So, I'm afraid we are going to need a ruling from you on this point --

THE COURT: Okay --

MR. GREY: -- Madam Justice.

THE COURT: Okay, I am happy to give you a ruling, however what I am going to do because time is of the essence here and Dr. Hinshaw's time and also valuable court time and counsel's time, I am going to allow you to ask Dr. Hinshaw questions about this document in a voir dire and I will want written submissions from both sides on this by the end of the week.

So, I will consider whether or not it is admissible evidence in the cross-examination. However, having said that, I do not believe that you have asked Dr. Hinshaw whether she is familiar with this document, and I think it is appropriate that you do so before you continue with your voir dire examination, okay?

MR. GREY: Thank you. All right, if we could please have the document back on the screen? All right.

Q MR. GREY: So, Dr. Hinshaw, are you familiar with this document, have you seen this before?

A Not to my recollection. I typically have relied on again summary literature by (INDISCERNIBLE) paper if -- if you did want me to comment on it, it would be important for me to have a chance to read it first.

Q All right, perhaps that would be -- that would be best if there's no objection --

MR. PARKER: Well, there -- sorry, there is an objection and --

MR. GREY: Okay.

THE COURT: Well, okay. Mr. Parker though, just to facilitate this I am going to ask Mr. Grey to provide copies of this document to everyone so that the cross-examination within the voir dire of relevance can continue, okay?

MR. PARKER: Okay and -- and --

THE COURT: And then so that means that --

MR. PARKER: -- and so --

THE COURT: -- that Dr. Hinshaw has to have a reasonable period of time to read it for sure.

MR. PARKER: Right and I just wanted to put on the record the concern and this certainly was reflected in the *Gateway* proceeding and Chief Justice Joyal indicated to Manitoba's counsel, if you're going to seek to do cross-examination on a document that somebody -- such as this type of document, a study that they hadn't seen before. Then they obviously -- the limit of the cross-examine -- there's going to be limits to the cross-examination. What I hear you saying, Justice Romaine, is that Dr. Hinshaw will be given time and is expected to read -- review this 55-page document for the purposes of answering questions on cross-examination --

THE COURT: Well --

MR. PARKER: -- within the voir dire?

THE COURT: Well, you know if the two of you can provide me with the submissions on whether or not this is a proper question, and I can make a ruling on it before we are faced with a possibility of Dr. Hinshaw being required to answer questions on it, then that is fine. I did not know this was 55 pages, obviously that is going to take Dr. Hinshaw some time to read it and absorb it before she is questioned on it.

So, really the timing on it depends on you, Mr. Parker, and Mr. Grey to provide me with the submissions on relevance and whether it is a proper question for the cross-examination. So, we have to move on obviously from this document, Mr. Grey --

MR. GREY: Okay.

THE COURT: -- until that process is followed.

MR. GREY: That's understood.

THE COURT: Yes.

MR. PARKER: Sorry, Justice Romaine, the submissions were due when?

THE COURT: I said by the end of the week, obviously Dr. Hinshaw is not going to here until the end of the week. So, this may require us to ask her to come back before the hearing is over or not to come back but to be available to answer questions depending on how I rule.

MR. GREY: All right.

MR. PARKER: We're -- we're scheduled to argue Thursday and Friday --

THE COURT: Okay, now if you --

MR. PARKER: -- closing argument.

THE COURT: Yes, now if you would prefer to have the weekend to make your -- you know clearly it is not going to happen before the end of the week and Dr. Hinshaw is not going to continue to be in limbo until I make my ruling. If by rule that she has to answer questions on this then we will make arrangements to ask her to be available to do that. So, what I am saying is I hear you saying --

MR. PARKER: (INDISCERNIBLE)

THE COURT: -- I hear you saying that you are going to busy with respect to all of this by the end of the week. If you want an extension to sometime next week to address this particular problem that is fine too.

MR. RATH: And Madam Justice, this is Mr. Rath.

MR. PARKER: Sorry, if I could just -- Mr. Rath, thank you. I was -- what I was concerned about was we are scheduled to argue the respondents Friday and so we wouldn't know what to argue on this having not received your ruling yet. So, I was just trying to determine are we still on schedule to do closing argument Thursday, Friday or is this issue and the submission taking us off that schedule because that impacts by reaction to this line of questioning and this document.

THE COURT: I understand, Mr. Parker, and you know clearly we have Dr. Hinshaw here for a limited period. Are you saying that you need to have the answer to this objection before she continues?

MR. PARKER: No, I'm not saying that because certainly we could deal with it a voir dire but we would need to know what to argue on Friday with respect to this document and if we did not get your ruling then that might be a problem. The other thing I'm saying is Dr. Hinshaw has already indicated she's not -- she doesn't believe -- sorry, not -- she doesn't -- she's not been able to identify the document for the purpose of making it an exhibit, that gets back to my concern about well the limited use that can be made of cross-examination having chosen to proceed in this fashion.

My -- my -- my submission is that Mr. Grey should go ahead and ask whatever questions he wanted to ask about this document now without asking Dr. Hinshaw to go away and review a 55-page document and then we can argue that the weight that be given to those submissions or those -- those answers when we -- when we're in closing argument.

In other words, we can move forward with these questions on this document now and there should be no need to have Dr. Hinshaw to go away and review a 55 page document. Again, noting that Dr. Bhattacharya declined to do so with the other documents where we suggested that would be appropriate.

So, that's what I'm saying. Two things is we need to know for closing argument what we're argument but also more to the point, she hasn't been able to identify it and so it may be appropriate then just to move forward and get this document out the way so we're delayed

for closing argument and there's no need for written submissions potentially.

MR. RATH: Madam -- Madam Justice --

MR. GREY: Ma'am, may I just -- Mr. Rath, I just want to respond quickly. I think Mr. Parker has a sensible approach because I -- I don't intend to spend a lot of time on this document or to take Dr. Hinshaw through all 55 pages. I really was just going to show her the abstract and ask a couple of follow-up questions concerning it. So, it's not as though I'm going to spend a lot of time here, so actually Mr. Parker's approach makes sense.

THE COURT: Okay.

MR. GREY: Sorry, Mr. Rath, please go ahead.

MR. RATH: Madam Justice, this was an issue that I was going to raise and it's following on the issue raised by my friend Mr. Parker with regard to closing arguments. Given the extensive nature of Dr. Hinshaw's testimony and the fact that it's not clear yet as to whether she's going to be finished tomorrow at 3:00.

Our view is that we could simply put over final argument in any event to give counsel an opportunity to review transcripts from this week and prepare written submissions given the importance of these issues. So, I -- I simply raise that in the context of where we're at and (INDISCERNIBLE) we'll leave that as a housekeeping matter to be discussed.

THE COURT: Okay, thank you all. There are two things that concern me. One is the law is pretty clear that when cross-examining an expert witness, if the expert witness is unable to identify the document that is put to her then that ends the matter. But we are not talking about cross-examination of an expert witness here, we are talking about cross-examination of Dr. Hinshaw and her affidavit, which gives rise to some questions. Dr. Hinshaw has indicated she has not seen the document to her recollection.

And Mr. Grey, you and Mr. Parker appear to have come to a consensus that it is okay for Mr. Grey to continue to ask her questions even though Dr. Hinshaw has not read the article and of course we will take that into account with respect to her answers. So, I think we will continue with that at this point in time.

With respect to final argument, Mr. Rath, you know I would certainly suggest that you talk to counsel and see if all of you are of one mind with respect to that and I will hear submissions for you when we get to that point. Okay --

MR. PARKER: May I?

THE COURT: Who?

MR. PARKER: Thank you, My Lady.

THE COURT: Who is asking me?

MR. PARKER: It's Mr. Parker -- sorry, Mr. Parker, just wanted to --

THE COURT: Sorry.

MR. PARKER: -- make a brief comment and --

THE COURT: Sure.

MR. PARKER: -- recognising what you said, Justice Romaine, that if the expert is unable to identify the document it ends the matter. Dr. Hinshaw is a party, she is not produced as an expert, that said she has given opinions in her affidavit quite appropriately within her area of expertise and if she's now being asked and is being asked her opinion on the effectives of NPIs and so, it's certainly not unlike an expert.

I'm fine to have the questions keep going but my point is as with an expert there will be very limited use that can be made of this cross-examination. That -- that -- I just wanted to be clear on the record on that.

THE COURT: Okay, I understand, Mr. Parker, that you will likely be arguing in your arguments with respect to this voir dire of Dr. Hinshaw's evidence. But anyway, at any rate it looks like we have a consensus. Mr. Grey, go ahead and ask Dr. Hinshaw questions about this article but I still would like --

MR. GREY: Thank you, Madam Justice.

THE COURT: I would still like a copy of the article to be sent to everybody involved here as soon as possible. Thanks.

MR. GREY: I --

MR. PARKER: We --

MR. GREY: I --

MR. PARKER: We already have it, it's an exhibit for identification already --

THE COURT: Do I?

MR. PARKER: -- Justice Romaine.

THE COURT: Okay, do I? Thank you.

MR. GREY: It's Exhibit --

THE COURT: Thank you.

MR. GREY: It’s Exhibit O, Madam Justice.

THE COURT: Okay, thank you. Madam clerk, would you provide me with that exhibit, or do you have it here? Yes, thank you. Go ahead.

Q MR. GREY: Okay, Dr. Hinshaw, the document that’s on the screen, can you see it?
A I can.

Q If you could just pull it up, I'd -- what I'd like you to do is just give you a chance to read the abstract. That’s really the -- the only part of the document I want to ask you questions about. So, just take a minute to -- or two to read that. And we can scroll it up whenever you're ready.
A Yeah, could you scroll it, please?

Q Okay, sure.
A Yeah, I've completed it.

Q Okay, so here the -- what's expressed -- the -- the opinion, of course this -- this is a document that is generated by the Department of Economics for Simon Fraser University but essentially it is -- the opinion expressed is -- is possible that lockdown will go down as one of the greatest peacetime policy failures in Canada's history.

So -- so, the point here is you’ve asserted that the nonpharmaceutical interventions, which are often called lockdown measures, were highly effective in Alberta in reducing infections and saving lives. But here we have a contrary opinion that is based upon the

assertion that cost-benefit analysis clearly shows that the harms imposed on society, on Albertans by lockdowns vastly outweigh the benefits. What do you have to say about that?

A Again, not having read the entire article what I would say is this appears to be the opinion of a single individual. Again, coming from a -- a background that -- that -- again from an epidemiologic perspective, kind of looking at the impacts of a particular intervention, you'd be looking at the -- the epidemiologic science and you'd mentioned that this is someone from the Economics Department.

So, I think the conclusions would depend greatly on the assumptions that were made in the analysis which again, I -- I haven't read the whole paper, so wouldn't be able to comment on -- on -- on those. But ultimately, again I think this would be viewed as the opinion of a single individual and I -- I wouldn't be able to comment on the methods used and whether to not the -- the methods would be appropriate to assess the -- the health outcomes of -- of these particular interventions.

Q Right but you would acknowledge though that there are measurable negative impacts on society of nonpharmaceutical interventions and -- and that -- you -- that you knew that they were going to be when you imposed them?

A Again --

Q These are measurable.

A -- that was really very clear and certainly something that I have said publicly on many occasions, that the reason that they have been utilised sparingly and -- and cautiously has been because they have -- nonpharmaceutical interventions themselves have harms, as does COVID and again, it's all about seeking the balance and ensuring that population protection and -- and protecting the healthcare system for everyone's benefit.

Q Okay but --

MR. GREY: Dustin, you can take down the document now, thank you.

Q MR. GREY: Coming back to our discussion yesterday about you know this ratio with 96 percent versus 4 percent. The nonpharmaceutical interventions affected all Albertans and -- and -- and arguably affected nearly all of them adversely, at least in terms of infringement of their liberty. So, when you do the const-benefit analysis, taking into account that only 4 percent of Albertans were exposed to serious health outcomes versus the impact -- the broad harms caused by lockdowns, wouldn't you agree with me that the cost-benefit analysis really weighs against the imposition of nonpharmaceutical interventions?

A It's important to remember that it's not simply the 4 percent of -- of those diagnosed with COVID who go onto require hospital care. That those are not the only negative impacts of COVID infection and that the negative impacts of lack of access to healthcare for other reasons when the healthcare system is not able to cope with the volumes of COVID patients, as well as the negative implications of Long COVID, the post-COVID syndrome.

All of those are things that would not be factored into that 4 percent and so I -- I think that to do a -- a robust analysis it would be important to factor all of those things in, not simply looking at the -- at the 4 percent who require hospital care.

Q All right. At page 35 of your affidavit, paragraph 114 refers to PCR testing. So, I --
A Yes.

Q -- I realise that you're -- you're not an expert in PCR testing, Dr. Zelyas was a witness in this hearing, and he gave testimony -- expert testimony about this. But he -- he gave very frank testimony about the frailties of this testing, that it is not -- it is not perfectly reliable. In fact, that -- and he was -- what he was put under cross-examination some data from Dr. Bullard suggesting that PCR testing could be wrong as much as 56 percent of the time even under optimal conditions. So --

MR. PARKER: Sorry, I'm going to object that that -- I object that is not the evidence of Dr. Zelyas on the 56 percent. That is putting to this witness evidence that is not the evidence of Dr. Zelyas on this point.

MR. GREY: I'll -- I could go back and refer to the transcript but perhaps I'll just rephrase the question so that it doesn't offend Mr. Parker.

THE COURT: Mr. Grey, you know that comment in inappropriate. We have to make sure that the evidence of Dr. Zelyas is what you are in fact putting to the witness for process fairness. So, go ahead.

MR. GREY: All right.

THE COURT: Go ahead.

Q MR. GREY: All right, so leaving aside Dr. Zelyas, Dr. Hinshaw, are you familiar with Dr. Bullard and what Dr. Bullard has to say about the reliability of PCR testing?
A No, I can't say that I have -- I have read Dr. Bullard's --

Q Okay.
A -- opinions.

Q Okay, he is an expert who was called by the Government of Manitoba in the *Gateway* case that was heard last year. And he -- his -- his opinion, he gave testimony there that PCR testing is -- can often be unreliable, particularly given circumstances where the number of cycles are increased and that it can be incorrect as much as 56 percent of the time. Are you -- are you aware of that or were you aware of that during the time that you were forming these -- the -- the -- the orders that are impugned in this action?
A So, I would need to understand exactly what -- what was meant by the "incorrect". So, if the -- the -- the one way of measuring the effectiveness of PCR testing would be to understand the ability of the test to pick up virus when it's present. And so, that particularly accuracy, picking up the virus when it's present would be one way of testing sensitivity and specificity.

There would be another question which I certainly referenced in my affidavit of the positive result being equated to someone who is actively infectious to others. And so, those two things are different, I'm not sure which Mr. -- or Dr. Bullard was -- was referencing and -- and those are quite important distinctions because it's my understanding that the ability of PCR to detect the virus when it's present is very high, very sensitive, very specific.

When you're looking the equating of the presence of the virus to someone who is actively infectious to others, that is more challenging because someone who has been infected can continue to shed virus and have detectable virus for up a few months after they've recovered from the infection.

So, again I -- I'm certainly aware of that second point and some of the challenges of PCT testing, which is why as I stated in my affidavit, our policy ensures that those who had tested positive and then tested positive again within 90 days were not considered to be a case because we know about that potential for shedding. And so, that -- that evidence certainly was taken into account as we set our policy but I'm again not clear which -- which of those two areas of -- kind of again correct or incorrect Dr. Bullard was speaking out.

Q Okay, so you're referring to I think paragraph 117 and 118 of your affidavit I think and at paragraph 118 it -- you -- you state: (as read)

> It is true the small proportion of people who test positive are not contagious, however the policy change to not require isolation if the individual tests positive again within 3 months or a previous positive

result is a change that mitigates the risk.

Is that what you're referring to?

A Yes, that's correct.

Q Okay and then paragraph 119 which is one page 36, you state, For this reason in the early pandemic all positive results were treated as a positive. Is that -- okay.

A Sorry, yes. So, in -- in --

Q Okay.

A -- for example the first wave at that point in time we were just learning about the virus and so at that point in time, yes we would have considered a positive result to -- to be a positive.

Q So --

A We did however investigate follow-up samples as we were very interested in learning about reinfection and there were -- was a very -- again, I would have to go back and -- and talk to our team. I only recall one or two examples within the first several months of the pandemic. Again, I can't recall exactly the number but suffice it to say that the numbers were exceedingly small and so the vast majority of people who would have had a positive result would only have had one result in that course of the -- the early months of the pandemic.

THE COURT: Before you ask your next question, Mr. Grey, it is now about the appropriate time for a morning break. During this break, can I suggest, Mr. Parker, that given the questions that were asked on the article that was the subject of the voir dire and the answers that were given, whether you continue to object to this evidence going in and I will just leave that with you and perhaps you can let me know after the break and we will go from there. Okay, thank you.

MR. PARKER: I'm sorry, the evidence being -- the evidence being not the document but Dr. Hinshaw's responses, Justice Romaine, you're asking about?

THE COURT: That is right.

MR. PARKER: Thank you.

THE COURT: Okay.

MR. PARKER: Okay, thank you.

THE COURT: Thank you.

(ADJOURNMENT)

THE COURT: Okay thank you. Thank you everyone. I am sorry for the delay, but I have now been able to find the materials, Mr. Grey, that you had delivered. So we can proceed. Okay.

Mr. Parker, you are speaking but I cannot hear you.

MR. PARKER: That will help. To answer your question before the break in respect of the evidence of Dr. Hinshaw and the Allen Study, Exhibit O for ID, I believe, we take no objection with those answers going in.

THE COURT: Okay. Thank you. So the answers that were given in the voir dire will now form part of the trial record. Thank you.

MR. PARKER: Thank you.

MR. GREY: I thank my friend.

(WITNESS RE-TAKES THE STAND)

MR. GREY: May I continue then, Madam Justice?

THE COURT: Yes, yes. Thank you.

MR. GREY: Thank you.

Q MR. GREY: Dr. Hinshaw, could I refer you to paragraph 1 --

THE COURT: Sorry, Mr. Grey, you are frozen, and I do not think any of us heard what you were saying.

MR. GREY: Oh sorry, can you hear me now, Madam Justice?

THE COURT: Yes, yes, I can. Thank you.

Q MR. GREY: Okay. What about -- Dr. Hinshaw can you hear me?

A I can. Thank you.

Q Okay. So I was asking you to please refer to page 41 of your July 2021 affidavit and specifically paragraph 138 of that document.
A M-hm.

Q Do you have that in --
A I do, yes.

Q So here it reads: (as read)

> If Alberta's COVID-19 hospitalization capacity had been significantly exceeded, it could have resulted in a need to ration acute care resources.

And you go on: (as read)

> This could have meant that some patients who were in need of critical care supports may not have received those supports.

And then it goes on: (as read)

> If the requirements for in hospital care had continued to escalate a need for to triage access to care supports, especially supports in intensive care may have been required necessitating doctors and nurses to make decisions between which patients lived and which died.

From those series of sentences which contain a number of predicates like "if", "could", and "may" sort of set up a statement of hypothetical, don't they, would you agree? You're talking about hypothetically about what could have happened, is that fair?
A So the intent is -- the intent was to detail what the impact would have been if the Dr. non-pharmaceutical interventions had not been applied, as we saw happen in some other jurisdictions when they reached the limit and went above the limit of what they could provide within their intensive care unit.

Q Okay. But the wording that you used is not what would've happened, it was what could've happened, do you agree? I don't see the word would in here, I see could several times; do you agree with me about that? You're saying what could've happened hypothetically if certain steps had not been taken, that's how I read those sentences; do you agree?

A So again, I think I think when speaking about counterfactuals, so something that we didn't observe, it's always appropriate as I talked yesterday to have a measure of reasonable caution in the language and so given the modelling that had been done that was proving to be extremely accurate over the course of the month following the -- the running of the model. It's extremely likely that this is the scenario we would've encountered. However, I think it's appropriate to again utilize the language that indicates that we would've expected this to happen given everything that we saw in other jurisdictions, as well as our own forecasting, however, thankfully it did not happen and therefore there is the inclusion of some appropriate level of caveats in the phrasing of that particular paragraph.

Q Right, so -- so the last sentence says that: (as read)

> Fortunately the public health measures in place in December 2020 worked to reduce hospital and ICU admissions before this could occur.

So then what you say is all of these things could've happened, but they didn't because of the measures that we took including non-pharmaceutical intervention, correct?

A Yes.

Q Okay. So this gets back to what you and I had been talking about before where I put it to you that you're stating as an authoritative assertion that these things worked, but actually that that is a subjective analysis and I think that's supported by what's here at paragraph 138, isn't it where you say basically you set up a series of hypotheticals of things that could've happened, if, may, could and then you state at the end, you say, well none of that happened because -- because everything that we did worked, that these non-pharmaceutical interventions worked.

And so what I submitted to you and I submit to you again really what you're talking about here, your last sentence, fortunately these things worked, that's a -- that's a subjective analysis, that's a subjective opinion that you're giving about how what you did worked and it prevented all these theoretical problems from occurring; would you agree?

A That assertion is based on the evidence of -- again I would refer you to page 39, with the facts that are our model, our forecasting accurately predicted a months worth of acute care burden and that the trajectory -- there's no reason to believe that trajectory would've changed substantially, that the models would not have accurately predicted out from that point. And thankfully, if you go to the next page, page 50, you see how when taking into account changes in transmission from reduced interactions of the population, the difference in the -- what again would've been expected to happen based

on our own observed data from prior and forecasting and then the impact that reducing the interactions that the population had.

So again, there is evidence, again mathematical evidence based on our own experience and I would again point to the fact that we know that our first and second wave had dramatically different outcomes, again based on the timing of the implementation of non-pharmaceutical interventions.

Q I'd like to refer you to page 64 of your affidavit and this is at paragraph 216. So, at paragraph 216, do you have that before you, Dr. Hinshaw?
A I do, yes.

Q Okay. Okay. So paragraph 216 reads: (as read)

> The critical stage of the third wave was reached during late April to mid-May, when on April 30th the record daily high of 2408 new cases were identified and on May 3rd when the positivity rate reached a record high of 13.37 percent (daily). By comparison the positively rate during the critical point in the second wave was only 8.43 percent, the week ending December 13th.

And then at paragraph 217 it says: (as read)

> Because cases and positivity continued to climb on May 3rd, measures were expanded to additional areas.

Doesn't this tend to show that the highest spike in cases occurred during the most severe restrictions?
A I'm sorry, can you re-state that?

Q Well, I'm saying based on what's in paragraph 216 and 217, it appears to me that the highest spike in positive -- in positivity rate occurred during the most severe period of restrictions?
A No, so what you're -- so 217, you're saying what is being said there is on May 13 measures were expanded so additional --

Q Right --
A -- measures were put in place, so that the peak of positivity as well as the peak of new daily cases actually happened before the most strict interventions were put in place. It's also really important to remember that there's always a lag effect. So, the state of interactions in the community and the transmissions that's happening, that reality will

show up in cases with a one to two week lag and then that will show up again a couple of weeks later in hospital. So, you would always expect that if your restrictions come into place, that it will take some time for them to have an impact.

So, as you'll see in the previous paragraphs there are certain measures that had been put in place and that transmission continued to happen, cases continued to rise and again, it's important to remember that as -- again we were putting recommendations forward based on the current stays and decisions were being made, we only had the information at that time. We didn't have the benefit of hindsight. So at this point, looking backwards and saying well when did the peak happen, all that we knew at that point in time was that we were continuing to see an accelerating trajectory and we knew that as cases continued to accelerate, we would expect to see subsequent acceleration in acute care impact again with a couple of weeks lag time.

And so again turning the -- the transmission curve, the positivity, the cases always precedes the peak of acute care impact and then that will begin to decline. So, in fact, the peak occurred just before the most strict measures were implemented.

Q So bearing in mind what you just said, it's pretty clear that by the time you got to -- I should say, we got to the beginning of May of 2021, you had learned a lot about COVID-19, about how it behaved as a virus, certainly much more than you knew in March of 2020; is that fair enough?

A We knew a great deal about COVID in general, however, the third wave in that spring of 2021, was driven largely by a new variant which we now know as Alpha.

Q Okay.

A And so again each new variant of concern, it had different characteristics that did take some time to understand, so yes, we knew more about COVID in general and we were still learning about the Alpha variant at that point in time.

Q Okay and one of the things that you had learned is that -- and I think this is part of the reason why you began referring to the COVID outbreaks as waves, is that it tended to move in waves, so you would have a spike in cases and then -- and then over time they would come down and then there would be -- as you just described a new variant and then we have a spike with cases. So a wave, as I understand it, this is fundamentally what it does, it goes up and down, it goes up and then it crashes. So, my question is this, given that and first of all, do you dispute that or do you think that's wrong what I just said --

A (INDISCERNIBLE) --

Q -- is what we know about -- sorry --

A Sorry -- I was just going to say it's very clear that any infectious disease when introduced into a population will again move in a form where it spreads widely and then will peak and will decline. And so the control that we have is over how high that peak is, how steep the rise is and what the subsequent impact on acute care and severe outcomes is. So the wave will go up and down, but we have ability to impact the severity of each wave.

Q So when we look at the -- the graph that you pointed us to on page 49, the graph that is part of paragraph 164, it doesn't show a wave, it only shows a rising -- sort of the rising crest of a wave, it doesn't show them coming down. So, is it the position -- the position of Alberta that but-for these interventions, these non-pharmaceutical interventions that COVID-19 would just -- would've kept on rising exponentially, is that what you're saying?

A No, it's important when you look at, for example, the top graph, you can see the slope and we -- through the fall of 2020 when we were looking ahead we did shorter term forecasts because it was very clear from earlier experience that to try to project out for say six months was very difficult. We weren't going to be able to do that with any certainty, we could forecast out a couple of months in a short term. So, what you're seeing there is the -- again you can see the slope begin to decline towards the later part of that particular graph and so what would've been expected is that we would've seen the peak around the time of sort of early to mid-January and then it would've declined at that point in time. Again, it's very clear from -- from the slopes that we were only on that first half and then it would've started to come down again.

And as I mentioned earlier, what we can control or what we can impact, I should say more accurately, what we can impact is the magnitude, the slope and the overall impact of each wave.

Q Okay.

A And so again what's demonstrated is that with the utilization of non-pharmaceutical interventions, this peak happened earlier and was lower as it pertained to the impact on the acute care system, than would have been expected without those interventions.

Q All right. So implicit in what you just said is that COVID-19 it's likely the infection rates would've likely risen and fallen in a wave independent of anything that Alberta did, but that the goal that you were trying to achieve was to reduce the severity of those rises -- of those rises; is that correct? Is that a fair characterization of what you were trying to do?

A Yes, just to make sure that I'm clear, so yes, again any infectious disease, COVID or anything else would be expected to rise and fall in a population --

Q Okay.
A -- and that the interventions are really intended to lower the height of the wave and shorten the duration of it in order to minimize that overall impact on the acute care system and on the population as a whole.

Q All right. So then looking at the imposition of NPIs that the pattern appears to be pretty clear that restrictions would increase in connection with infection rates increasing and that restrictions would be relaxed when infections started to fall when the wave would sort of crest and fall; isn't that -- isn't that what was happening?
A Yes.

Q Okay. And so on one view of the matter, you're saying that -- that these NPIs were impacting this wave, but it's entirely possible and perhaps even probable that what Alberta was really doing was just following the natural sequala of the disease, that you would impose restrictions as infections were going up and then as you start -- them start to fall you would remove restrictions and that would -- that would create a very convenient argument that you were impacting the pattern of this disease; do you see what I'm saying?
A I understand what you're saying -- I'm sorry go ahead.

MR. PARKER: Sorry, there hasn't been a question, there's been lots of argument so far, but no question.

THE COURT: Okay.

MR. GREY: No I said do you see what I -- I said, do you see what I'm saying, that was my question.

THE COURT: Yes, so the question -- yes.

MR. PARKER: Okay.

A I understand your point and I don't believe the available evidence would support that theory.

Q MR. GREY: Okay. All right. Dr. Hinshaw, if I could refer you to page 42 of your affidavit, please, paragraph 142.
A Yes.

Q So this is under the heading --

THE COURT: I am sorry, I just did not catch, page 142, Mr. Grey, is that what you are referring to?

MR. GREY: Page 42, Madam Justice, paragraph 142.

THE COURT: Page 42, oh, okay.

MR. GREY: Yeah, those are confusing there.

THE COURT: Thank you.

Q MR. GREY: Okay. On the previous page, page 41, there's a boldface heading about, Can Certain Activities Business and Locations Be Open Safely and What are Their Benefits? And then it appears that you go through an explanation of how each one of these different categories are impacted and why non-pharmaceutical interventions were imposed on each; is that -- is that a fair characterization of this section of your affidavit, would you agree with that?

A Yes.

Q So at paragraph 142, it says that: (as read)

> Alberta has acknowledged the importance of allowing faith based activities throughout the pandemic.

That's notwithstanding the fact that at one point, in-person worship was restricted to only 15 percent, right?

A I would have to go through -- certainly -- certainly at one point, that was the restriction.

Q Okay.

A There have been different restrictions at different points in time.

Q Was there ever a time during the course of the pandemic pursuant to one of your orders when in-person worship was -- was totally restricted or prohibited?

A No.

Q However, there have been at certain times church closures and one in particular, you're aware of that?

MR. PARKER: Objection, irrelevant.

THE COURT: Yes, okay there is an objection Mr. Grey on the

basis of relevance.

MR. GREY: The paragraph states that in-person attendance at a place of worship has never been prohibited.

THE COURT: Yes.

MR. GREY: So that's a very broad statement, I just wanted to clarify it.

THE COURT: So you are suggesting that the fact that church closures may have occurred because of non-compliance with orders impeaches that sentence; is that what your suggestion is?

MR. GREY: I just wanted to clarify that there have been church closure, in fact, perhaps ask the witness whether she wanted to modify that statement.

THE COURT: Mr. Parker, I will allow the witness to answer that.

MR. PARKER: Okay.

Q MR. GREY: Okay. So here's what I have in mind, so there's a sentence here, Dr. Hinshaw, that says in-person attendance at a place of worship has never been prohibited, I think it's more accurate to state that in-person attendance at a place of worship has never been prohibited pursuant to any of your Chief Medical Officer of Health orders, the ones that are impugned in this action; do you accept that?
A That was the intent of that particular phrase --

Q Okay.
A -- in the context discussing the orders. So, again, I think that clarifies the intent.

Q Okay. Good.

MR. GREY: That's all -- that's the only question I had on that point.

THE COURT: Okay. Thank you.

Q MR. GREY: Dr. Hinshaw, if I could refer you please to page

43 of your affidavit at the bottom, it's paragraph 149.
A Yes.

Q So, this reads: (as read)

> Younger children do not drive outbreaks, they are less likely to be infected.

That's true based upon your best knowledge of -- of the disease right, or the virus?
A At that particular moment in time with what we knew about the particular -- the original strain, in particular, and the -- what we knew at that point about Alpha, that was correct. It would not be necessarily an accurate statement of the entire pandemic but is reflective of the evidence at that particular moment in time.

Q So, just to clarify that, would that statement be true as of the date that you swore the affidavit, July 12, 2021?
A Yes, that's what I'm saying, yeah.

Q All right. And you also state here: (as read)

> Individuals under 18 are also more likely to have a mild disease or be asymptomatic.

That's true?
A Yes, that's correct, I think we established that yesterday.

Q Yes, okay and, in fact, you -- Alberta knew very early on even before the pandemic was declared in Alberta, that COVID-19 was particularly -- I should -- let me phrase this another way -- it was known that the most vulnerable segment of the population were the elderly who were suffering from pre-existing conditions or comorbidities; that was known very early on about the disease based upon what had happened in other jurisdictions, correct?
A The data from other jurisdictions that experienced the first significant waves of COVID indicated that in those jurisdictions it was those who were elderly and had certain health conditions who were most at-risk of severe outcomes, that's correct.

Q Okay. And so is that what informed your -- your early policy regarding COVID-19, in other words, we had the initial 15 days to flatten the curve, but as you went on it appears as though these NPIs applied to everyone and they don't appear to be particularly targeted at the most vulnerable people in the population; would you agree with that?
A It would depend on the timeframe in which you're talking. So at the very beginning of

our response in March of 2020, we had seen some of that early data from other jurisdictions, there was still a great deal we didn't know about COVID-19 and so as we were watching the evolution of the virus in other jurisdictions and seeing the early arrival in our own Province, we took a precautionary approach at that time, because there was so much that we did not know.

As we learned more throughout the pandemic, throughout the course of that wave and over the summer, we adapted our policies accordingly and so, for example, in the fall of 2020, in early fall in September, we had very minimal mandatory requirements in place. Most of what we required were COVID safety plans in different settings. We did have some mandatory restrictions, for example, in high risk settings like continuing care and places like schools went back in person because of what we had learned over the first wave.

So, I would suggest that again early on there was a precautionary approach given how much we did not know about the virus and that in the ensuring policy there were many adjustments made to focus the highest level of protection on those who were most at-risk until unfortunately the time came where again widespread community transmission was occurring in a way that we were not able to mitigate with targeted measures. And so later in that second wave, it was necessary to implement non-pharmaceutical interventions in order to preserve the health care system and minimize the number of deaths.

Q We're talking specifically about the schools and this is in the context of paragraph 149 where you say, younger children did not drive outbreaks and that they're less like to be infected, when the schools were reopened there were still non-pharmaceutical interventions in the schools though, weren't there? For example, masking and social distancing and -- and other measures were still in place in the schools weren't they when they re-opened?

MR. PARKER: I'm going to -- sorry the objection here is relevant. Mr. Grey's clients are not children and I'm questioning the relevance of this line of questioning to the pleadings as it relates to the clients that Mr. Grey is representing.

MR. GREY: Well -- sorry Madam Justice --

THE COURT: Go ahead.

MR. GREY: -- do you want to hear from me on this?

THE COURT: Of course, yes.

MR. GREY: I'm cross-examining the witness on what is in her affidavit. Of course, I didn't control what goes in the affidavit, but it is a little strange to hear from opposing counsel that something that they put into an affidavit is not relevant and that I can't question the witness on it. I do appreciate my friend's point, but as I said, I don't -- I take everything that's in the affidavit to be evidence in the hearing and therefore subject to cross-examination, so that's the point to that question.

THE COURT: Okay. Mr. Grey, I will allow the question, go ahead.

Q MR. GREY: Dr. Hinshaw, would you like me to repeat it or …?

A Please.

Q Okay. What I was asking about is you were talking previously about reopening schools and I was -- I said to you though that even after you reopened schools and notwithstanding what is said at paragraph 149 about younger children do not drive outbreaks and they are less likely to be infected, when children went back to school they were still subjected to certain non-pharmaceutical interventions, such as, masking and social distancing; that's true isn't it?

A You may recall that the requirements for masking were for older children only, so we did have a grade 4 cut-off and younger children were not required to wear masks in schools because of the fact that at that time the evidence indicated that those very young children did not seem to be likely to be infected or spread. And so we did adjust the requirements based on the age of children, the likelihood that they could potentially spread.

You'll also note in that particular paragraph 149, it talks about the fact that older children do have a higher risk of spreading, partly because of behaviours and partly because the older the child, the more similar the risk would be of them getting COVID and spreading it to others. And so the measures that were implemented were tailored based on the evidence at that time of the risk to different age groups and there certainly were some interventions such as cohorting that were implemented in younger age groups so that if transmission were to occur, even with them being at loser risk that that transmission would be limited and not, for example, spread to multiple classrooms in a lower elementary grade. Because even though that risk is lower, it is still possible for a spread to occur.

Q All right. So at paragraph 152, it's on page 44, it says that: (as read)

> Though outbreaks do occur in school settings multiple studies have shown that transmission in school settings is definitely lower than or at least similar to levels of community transmission when mitigation strategies are in place in schools.

Is that what you're speaking of right now? That's what you were just referring to?

A No, I was -- I was referring to the probably more specifically paragraph 151 in terms of the specific strategies that were employed.

Q All right.

A And although it's not articulated in 151, providing the information about the fact that different age groups of children would have different risks of infection and risks of spreading and therefore there were approaches that were taken that were tailored to specific age groups.

Q Okay.

A So I -- that's what I was referring to.

Q Okay. At paragraph 152 in the second sentence it says: (as read)

> Increases in case incidents among school age children parallels trends observed among adults in the community and do not appear to create increases in community transmissions. Although they have a low mortality rate young adults are susceptible to infection and transmission.

So, notwithstanding their low risk of mortality or serious health outcomes you still thought it necessary to impose these restrictions on school age children, older school age children; is that correct?

A So the point in that particular paragraph 152, is to outline that schools are impacted by community transmission, as community transmission rises there's a higher likelihood of exposure events happening in schools and especially with older -- older children and young adults, their ability to become infected and pass onto others, for example, people who they live with was equivalent to an adult. So again the older the child the more equivalent that was and therefore interventions to mitigate spread in schools were necessary as a part of that overall approach to protecting the community.

Q All right. Doctor, if I could refer you to page 48 of your affidavit and to paragraph 163?

A Yes.

Q So here it's stated: (as read)

> Alberta's objective, in common with all other 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.

But the non-pharmaceutical interventions have caused significant harm to society, haven't they? I mean you do acknowledge that.

A I believe I acknowledged that multiple times in the course of our conversation, as well, as publicly on numerous occasions and again it's clear in that paragraph that the intention is to really outline the balance that's necessary because there are significant harms that COVID poses. And so weighing those two things against each other has been a part of the response to the pandemic throughout the last several years, certainly during the period of time that we're talking about, this was always as part of the recommendations that were provided and considerations in decision-making.

Q Okay. So, but you say here that what was done were the least restrictive measures -- the least restrictive measures possible, is that what you're saying?

A So I think what it says is the least restrictive measures required to prevent or limit the spread of the virus, to minimize the volume of serious outcomes, both deaths and illness. Certainly it's again really important to remember that when the acute care system is overwhelmed, it's not just the direct COVID infection risk that is a harm to all of us as a population, but the inability to access care for other purposes and so there are various significant direct harms that are broader than just infection that need to be rated against what we know are harmful impacts of non-pharmaceutical interventions and that's why that balance is part of those considerations.

Q Okay. Well, let's take a look at these least restrictive measures more specifically. Could I refer you to page 65 of your affidavit, paragraph 218?

A Yes.

Q So here it says: (as rad)

> On the 6th of May, 2021 in order to stem the tide of rising cases and acute care admissions Order 19-2021 was put into effect outlining COVID-19 measures for areas with 50 or more active cases of COVID-19 for 100,000 and 30 or more active cases …

And then there's a colon and then there's a series of bullet points. And so -- and then it

lays out the specifics of the restrictions.

The first bullet point says: (as read)

> Outside gatherings were limited to five people down from ten.

Right?

A Yes, that is correct.

Q Okay. And the second bullet point: (as read)

> All indoor fitness closed including one-on-one training.

Correct?

A Yes.

Q Bullet point 3 is: (as read)

> No more than 10 people could attend funeral services down from 20.

Correct.

A Yes.

Q Next is all --

THE COURT: I am sorry, Mr. Grey --

MR. GREY: Yes --

THE COURT: -- just, are you asking Dr. Hinshaw to identify that this is, in fact, in her affidavit? That all of these things are set out in paragraph 218, is that what you are asking? Maybe we can speed things along a little bit, if you just ask her if that is what is in paragraph 218.

MR. GREY: I could. I think it's important that these be on the record, but I won't quarrel with you on the point, Madam Justice, I'll rephrase the question then.

THE COURT: Okay.

Q MR. GREY: So, Dr. Hinshaw, under paragraph 218 of your affidavit there's a dozen different categories of restrictions that were imposed pursuant to Order 19-2021 that was issued on the 6th of May, 2021, correct?
A Yes, that's correct.

Q And these -- these conditions are actually very restrictive, aren't they? They are significant restrictions upon people's liberty, their ability to move around to do a whole number of things that are listed there in paragraph 218, would you agree?
A Yes, this particular list is a list of significant restrictions.

Q All right. In fact, I dare say there are prison inmates at that time who would not have been subjected to such severe restrictions as are listed here, these are very, very significant restrictions on liberty.

MR. PARKER: Objection.

MR. GREY: I wasn't finished the question.

Q MR. GREY: So how do we put this into context of least restrictive measures given the severity, the obvious severity of these restrictions? So just wait before you answer because Mr. Parker has an objection that he might want to maintain.

MR. PARKER: The objection is argumentative.

THE COURT: Mr. Grey?

MR. GREY: Well, I'm not arguing, I'm cross-examining. I asked the -- the crux of the question I'm asking the witness is she states that -- at paragraph 163 that what the Government did was the least restrictive measures and I'm asking her, how that can be justified given the severity of restrictions that are listed, for example, in paragraph 218. So that's essentially what I'm asking her.

THE COURT: Okay. To start with you started to -- you stated to the witness that, in your opinion, that these restriction -- that prison inmates would have not been subjected to the severity of these restrictions and then you followed with a question of, you know, how can you say that these are least restrictive measures. I am sure that Dr. Hinshaw can respond to that question. I do agree, Mr. Parker, there has been a good deal of editorial comment from Mr. Grey, but the question is specific enough. Okay, Dr. Hinshaw.

MR. PARKER: Thank you.

A So as with the other responses, so as we've talked about in the second wave, the same course of actions were taken in the third wave, which is to say that measures that were less restrictive were employed initially. And when those measures were not effective in changing the course of transmission and trajectory the impact that we were likely to see on the acute care system, that additional measures were employed to protect again the acute care system.

And as I mentioned just a little bit ago, it's really important to remember that at the point in time that decisions were made, we had evidence and data available only until that point. So, it was impossible to know when the peak of a wave had been reached until several weeks after that peak had crested. At the point of making decisions all we are able to base those decisions on is a trajectory that we're seeing and -- and the subsequent impact of high transmission on acute care and what that -- whether or not the previous, lessor restrictive measures have been actually impactful at changing that trajectory.

Q MR. GREY: Dr. Hinshaw, could I refer you to page 56 of your affidavit.

A Yes.

Q At paragraph 186 it reads: (as read)

> Nonetheless the continued rapid growth in cases necessitated a stronger response heading into winter and the significant religious and social holidays, such as Hanukkah and Christmas that traditionally involved many Albertans in indoor social gatherings.

Wasn't that approach fundamentally discriminatory?

A I don't believe so -- can you -- I don't believe so.

Q Well, you -- it says that rapid growth in cases necessitated a stronger response heading into winter and significant religious and social holidays such as Hanukkah and Christmas --

MR. PARKER: I'm going to object. It wasn't clear but the witness is being asked for a legal interpretation it seems related to the *Charter of Rights* or section 15 of the *Charter*, so the objection is on that basis.

THE COURT: Mr. Grey?

MR. GREY: Well, I can rephrase -- rephrase the question. I could try to rephrase it differently, My Lady.

THE COURT: I think you better because I agree with the objection. So go ahead.

MR. GREY: Okay.

Q MR. GREY: This -- this paragraph gives the impression that people who celebrated Hanukkah and Christmas were targeted by these restrictions. That they would be most impacted by them, that's what this appears to say, would you agree?

A No, I wouldn't agree. The intent of that particular paragraph is to outline the -- the fact that there are gatherings of many kinds that happen in the month of December for various reasons and that we know very clearly that having people come together for social interactions indoors. So again the winter is relevant in terms of knowing that indoor interactions are higher risk than outdoor and knowing that a particular season was one that would typically involve indoor social gathering that would happen with people from different regions travelling to spend time together. So it's a simple statement of fact in terms of the typical pattern of interactions which happens in Alberta during that particular time and knowing that the level of transmission that we had at the end of November combined with a significant mixing impact of travel and social interactions would accelerate and spread that transmission to even greater extent.

Q What -- what consideration was given to the social and societal costs of restricting people's ability to engage in Hanukkah and Christmas gathering and celebrations at that time? Or was the only consideration the risk of increased infection? Was it taken into account that restricting people's ability to engage in Hanukkah and Christmas celebrations, how that might impact them in other ways, or were you just looking strictly at the -- at the health concern?

A For every restriction that was put in place, every non-pharmaceutical intervention, there was consideration of the impact that would have more broadly and also of the -- again the impacts of widespread COVID transmission, the impacts on the acute care system and those broader population impacts if people were unable to access care.

So, with every deliberation and specific intervention, there was consideration of other impacts and again a balance was always considered and at this particular time, we were in very significant risk of having our acute care system unable to deliver all the care that Albertans need for all of the -- the health issues that they have.

Q Dr. Hinshaw, if I could refer you to page 58 of your affidavit.
A Yes.

Q So this is -- this is again referring to mask wearing became mandatory effective immediately for at least three weeks for all indoor workplaces in the Calgary and Edmonton areas, except when working alone in an office or safely distanced cubicle where a barrier is in place. Not following the mandatory restrictions could result in fines of $1000 per ticket offence up to $100,000 through the Courts. A $100,000 fine sounds very heavy handed, would you agree?
A The consideration of the penalties was a consideration of the significance of the threat that COVID-19 was posing for our population.

Q But it was aimed at intimidating people into compliance?
A It was aimed at ensuring that the penalties were consistent with the potential harms of the choices to not follow what was a mandatory requirement.

THE COURT: I am --

MR. GREY: Would you like to take a break now?

THE COURT: Yes, yes, I think that this is an appropriate time.

MR. GREY: Okay.

THE COURT: We will take the lunch break to 1:30. Thank you.

MR. PARKER: May I ask a very quick question, Justice Romaine?

THE COURT: Sure.

MR. PARKER: I wondered -- we're halfway through the scheduled time for Dr. Hinshaw's cross-examination, I wondered if Mr. Grey and Mr. Rath could give us an update on how long they expect to take.

THE COURT: Okay.

MR. RATH: Certainly from our perspective, Madam Justice, the time scheduled for Dr. Hinshaw is whatever time is required. I'm -- you know -- I'm letting my friend continue his cross-examination, he has quite a ways to go and that's why I've been clear from the outset that we'll have to revisit where we're at tomorrow afternoon

at 3:00.

THE COURT: Well, we'll see Mr. Rath --

MR. RATH: (INDISCERNIBLE) --

THE COURT: Mr. Rath, Mr. Grey -- Mr. Grey, could you please if you are able to, would you answer Mr. Parker's question.

MR. GREY: I'd like to have a chance to consider that and then perhaps come back after the break if that's okay.

THE COURT: Certainly. Sure.

MR. GREY: By way of follow-up, I also -- I had mentioned at the outset of my cross-examination that I would like to have the opportunity to ask Dr. Hinshaw some questions about her earlier affidavit.

THE COURT: Yes.

MR. GREY: Has that been provided to her now?

MR. PARKER: It has been provided. Dr. Hinshaw if you could -- yes she's nodding, she has that Mr. Grey.

MR. GREY: Okay.

MR. PARKER: And thank you for getting back to us on your timing. I appreciate that. Thank you Justice Romaine.

MR. GREY: Okay. Thank you.

THE COURT: Thank you.

(WITNESS STANDS DOWN)

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PROCEEDINGS ADJOURNED UNTIL 1:30 PM

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**Certificate of Record**

I, Michelle Palmer, certify that the recording herein is the record of oral evidence of proceedings held in the Court of Queen's Bench, held in courtroom 1702, at Calgary, Alberta on the 5th day of April, 2022 and I was the court official in charge of the sound recording machine during these proceedings.

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I, Ethan Zaherie, certify that

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

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

TEZZ TRANSCRIPTION, Transcriber
Order Number: TDS-1004639
Dated: April 6, 2022

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

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| April 5, 2022 | Afternoon Session |
| The Honourable Justice Romaine | Court of Queen's Bench of Alberta |
| J.R.W. Rath (remote appearance) | For R. Ingram |
| L.B.U. Grey, QC (remote appearance) | Heights Baptist Church, Northside Baptist Church, E. Blacklaws and T. Tanner |
| N. Parker (remote appearance) | For Her Majesty the Queen in Right of the Province of Alberta and The Chief Medical Officer of Health |
| B.M. LeClair (remote appearance) | For Her Majesty the Queen in Right of the Province of Alberta and The Chief Medical Officer of Health |
| N. Trofimuk (remote appearance) | For Her Majesty the Queen in Right of the Province of Alberta and The Chief Medical Officer of Health |
| M. Palmer | Court Clerk |

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THE COURT: Okay. Thank you everyone. Mr. Parker you are online. Mr. Grey you were going to attempt to answer Mr. Parker's question, if you could. Have you had any thoughts over the lunch break?

MR. GREY: Yes, as best as I can estimate, I don't think that I would finish with the witness today, but I would probably finish sometime tomorrow morning and that would be -- I'd have to spend some time -- and I would spend some time this evening paring down some of the questions that I have, or at least streamlining for tomorrow. That would be my expectation.

THE COURT: Okay. Thank you. Well, it is clear then that we are going to run into problems meeting the estimate of cross-examination time that the plaintiffs' counsel have given us and we know that Dr. Hinshaw is not available after 3:00 tomorrow. Mr. Parker, are you aware and certainly, Dr. Hinshaw, can answer for herself, would she be able to give us Thursday to try to finish this cross-examination?

MR. PARKER: I have not had those discussions with Dr. Hinshaw. Dr. Hinshaw, are you able to -- are you willing to answer that now or do you want to talk about it and we can get back to Justice Romaine and the counsel?

DR. HINSHAW: I have a full day booked on Thursday, so I would just need to either find coverage or reschedule. So if I could maybe get back first thing tomorrow about that, I would just need to confirm.

THE COURT: Of course. Just let me say that it would certainly be my preference that we finish your cross-examination this week if there is any way possible, but of course that I understand that you have only booked -- well the three days and so we will wait to hear from you.

Before we continue with cross-examination then counsel, that gets us into the issue of whether we will have time this week to do -- to finish argument on this and I do think that I need to hear from you because I would have to make -- my preference would be to continue even into next week if we can with oral argument. That would require me though to get the approval of the Chiefs to interrupt my regular sitting, I am sitting in another area next week. But I do believe that that would be the best thing possible for this hearing.

I just want to make sure with you, I will hear from you, Mr. Parker, Mr. Grey and Mr. Rath, about doing that, but is there any impediment to you continuing with oral argument next week if that is necessary?

MR. RATH: Go ahead, Mr. Grey.

MR. GREY: I have other commitments, but I think I could move things around to accommodate that, Madam Justice.

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

MR. RATH: Unfortunately -- I have a court hearing on Tuesday, so if we didn't go over Monday, I would be fine, Madam Justice.

THE COURT: Okay. So you are saying Wednesday, Thursday, Friday might be -- would be fine with you.

MR. RATH: That's correct.

THE COURT: Mr. Parker?

MR. PARKER: Is Friday --

THE COURT: It is a holiday --

MR. PARKER: Sorry, I'm -- Monday I'm available next week, Mr. Trofimuk is, I will let Ms. LeClair indicate her available, she's nodding, so we're all available next week, Justice Romaine, if necessary.

THE COURT: Okay. Thank you. That will give me some parameters to talk to the trial coordinators about. Okay. Then shall we go on with the cross-examination, Mr. Grey.

MR. GREY: Yes, thank you.

**DEENA HINSHAW, Previously Sworn, Cross-examined by Mr. Grey**

Q Dr. Hinshaw, could I refer you to paragraph 211 of your affidavit, it's on page 63.
A Yes.

Q So here it says: (as read)

> Fortunately, the public health measures implemented in late November and December worked to slow transmission and bend the curve in new cases and hospitalizations.

And so this is consistent with evidence that you had given before. I want to make sure I have this correct, first of all. I understood your earlier evidence was that during the second wave, the Government tried voluntary measures from October through early December 2020, but since those measures were not working to reduce transmission that you had no other course but to implement mandatory restrictions. And then after that you clearly saw a bend in the curve, does that accurately summarize what you said about that?
A Yes.

Q Okay. So, my first question is this, isn't it true that any successful measures would be expected to impact the case curve after a period of time corresponding roughly to the incubation period of the virus?
A It would depend again on the timing (INDISCERNIBLE) that you would expect from impact within approximately two weeks of -- two to three weeks of when measures were implemented you would expect to see a change in the trajectory. Again, the nature of the change, the degree to which the change happened, that would depend on the specific measures that were utilized, but you would expect to see some adjustment of the trajectory, yes, that's correct.

Q Okay.

THE COURT: Can I -- sorry Mr. Grey, before you continue, I am sorry, Dr. Hinshaw, but your -- the sound seems to be going in and out on your answers at least for me. I do not know whether everybody got all of that answer and I am certainly hoping that the court reporters did. But at any rate -- well I do not know what to do, but I may be interrupting from time to time if I do not hear your entire answer. Go ahead.

MR. GREY: Right, Madam Justice --

MR. PARKER: Justice Romaine --

MR. GREY: -- sorry go ahead -- go ahead Mr. Parker.

MR. PARKER: -- we thought it was perhaps the court microphone again, it sounded similar to what was happening in the past.

THE COURT: Oh okay, madam clerk?

MR. RATH: I agree, that is what it sounded like.

THE COURT: She is going to mute me then. Okay.

MR. PARKER: Thank you.

A I could perhaps repeat my answer, just to make sure that Justice Romaine hears, just to say that it would be expected that within two to three weeks after implementing a non-pharmaceutical interventions that you would see some alteration of the trajectory. The degree to which the trajectory would be altered would depend on the nature and intensity of the non-pharmaceutical interventions and the timing when they were implemented with respect to how broadly transmission had already become established in the community.

Q MR. GREY: Right, so just following that through, so if the measures were successful, would we expect to see a decrease in the slope of the case curve, either slowing of the growth of the cases on the upside of the curve, or a speeding up in the decline in the cases on the downside of the curve about 7 to 10 days following the implementation of the measures? Isn't that what you'd expect to see if what you are saying is correct?

A What I had just said was two to three weeks because incubation period is two weeks and if you'll recall, what I had talked about previously was transmission events that

happen in the community typically would be picked up in our case diagnoses, you know, approximately two weeks later and that you'd see their subsequent impacts on hospital admissions and deaths as those lagging indicators several weeks following that.

So, I would not expect to see any change in cases within 7 days of implementation of non-pharmaceutical interventions. Again it would be expected to see that happen within a couple of weeks is when you would -- would see that start to change.

Q Okay. So, looking at the -- at the graph, so I'm speaking specifically about the ones -- the one that you referred to previously, I believe this is on page 49. Yes. If you look at that one though it appears that the rapid growth of cases in the fall of 2020, starts slowing towards the end of November and then the cases peak on December 4th, 2020 and then cases started to decline prior to the implementation of mandatory measures that you're referring to; would you agree with that? That that's what is seems to show?
A Sorry on page 49, is the hospitalizations and ICU --

Q Right, right --
A -- is there a different page that you're referring to?

Q Well, for example, look at -- sorry -- paragraph 211, the one I was referring to earlier.
A M-hm.

Q Here in that paragraph it reads: (as read)

> Fortunately the public health measures implemented in late November and December worked to slow transmissions and bend the curve and new cases and hospitalizations.

And it says: (as read)

> As shown in the graph below, following the implementation of the December 8th measures, daily new cases peaked on December 13th and then began to drop.

But it appears to me and my question is, that the rapid growth of cases in the fall of 2020, it looks as though they started to slow towards the end of November and then they actually peaked on December 4th, 2020 and then cases started to decline prior to the implementation of the measures that you're referring to in mid-December; do you disagree with that?
A So I apologize, I apologize, the piece that says, as shown in the graph below, should read: as shown in the graph above.

Q Okay.
A So if you look under 208 --

Q Okay.
A -- point 208 on page 61 is the graph that shows October through the end of December of 2020 and the graph below 2011 is showing the second part of that with respect to what happened in January through till July.

Q Okay.
A So, I apologize, the reference is actually referring to that graph on page 61 where you can see that we had quite a prolonged peak in terms of the new cases, you can see there that we were seeing a very high level of cases at the end of November that seemed to be sustained till about December 13th or so. So we hit a plateau but didn't really decline until kind of after that mid-December time point.

Q Okay. All right. So my question was, it appeared to me that actually the cases peaked earlier than that on December 4th, 2020 an then started to decline prior to the implementation of the mandatory measures and that they spiked again in December of -- on December 13th and then was followed by two days of much lower cases. That's my point and you disagree with that analysis?
A I do. So if you notice throughout the -- throughout the wave, what's actually more important is sort of your seven day averages which aren't shown on this graph. But in terms of test seeking patterns there's always a drop over the weekend and then a rise throughout the week.

So it would be incorrect to assume that the case numbers that are seen in that week just prior to December 10th, so I suppose that would be the 8th and the 9th, it would be incorrect to assume that those daily numbers are a reflection of overall transmission trends and instead if you look at the -- the again it's not listed on the graph as a seven day average. But you can see that case numbers were quite high at the end of November, beginning of December, and then it roughly plateaued throughout the next several weeks and it only began to decline really moving into that middle part of the month.

So again the -- each daily case count is going to be influenced by many things including tests behaviour patterns which are influenced by the day of the week. So what you're -- what you're seeing on this graph again is a several week plateau and then the decline actually happened in mid to late December.

Q Right, but based upon the incubation period that you just commented on wouldn't that begin to start about seven to ten days after the mandatory measures were put in place?

In other words, you wouldn't really begin to see any impact of mandatory measures until after the incubation period, is that -- isn't that so?

A So what you'd be seeing in that early December time period where you can see we've moved from a growth trajectory to a plateau trajectory, would be the beginnings of the impacts of the measures that we had implemented prior to that. So through mid to late November we did begin to move with mandatory restrictions that again you can see had some impact. The measures that were put in place on -- some on December 8th and some on December 13th, again it's important to remember that decisions were made about the case trajectories that we saw at that time and we had seen a persistent plateauing.

But we hadn't really seen a decline in cases and so those additional measures that were put in place at that period of time, were put in place because at that time, really the information we had was that we were not substantially declining and there was significant concern about the impact to the health care system that would be subsequent to that very high case count. And in fact, you can see that the increase in non-ICU and ICU hospital burden, that those numbers continued to climb for several weeks after the case trajectories began to alter.

So what -- what you can see again is that several weeks after each of the measures were implemented you'd be seeing the impacts of those measures in the case counts which then subsequently would result in decreases in the acute care burdens.

Q All right. Could I refer you to page 67 of your July affidavit please, July 2021 affidavit?

A Yeah.

Q So, paragraph 223 refers to CMOH Order 29-2021 and: (as read)

> This was put into effect on the 27th of May, 2021 to address the escalating frequency of public protests in Alberta while the health care system was still at a critical point due to a spike in cases, particularly driven by the highly contagious variants of concern. Order 29-2021 established specific rules applicable to protest gatherings which had previously been covered by measures applicable to private social gatherings.

So here again the -- Alberta is restricting liberty for the sake of a stated benefit to the health care system, right?

A Interestingly enough this -- this particular Order actually expanded the ability of Albertans to be able to protest. So you'll note there that previously we did not have any parameters around protests. So they would've generally been considered to be covered

by other measures and it was recognized that we needed to have a framework that enabled people to express their perspectives. And so this actually enabled more people to gather together for purposes of protest and so this -- this particular Order in how it was framed actually enabled more -- more freedom to -- to protest, not less.

Q How then was it -- how did it address the escalating frequency of public protests?
A The way that it addressed that was because it had been very challenging to apply the previous measures, which at that point on May 27th we were seeing a decline in cases and it was important again to ensure that people had that ability to protest. So the way that it addressed that was by removing some of the previous restrictions as they had previously been -- again some of the blanket restrictions that were being applied not just to protests, but other things in saying no protests don't have a number, there can be any amount of people there, we're not going to limit that because we recognize as cases come down that that's a particular action that we need to enable. And so again, it expanded people's ability to engage in that behaviour in a way that was appropriate to the conditions at that time.

Q Dr. Hinshaw, I'd like to refer you next to your previous affidavit, this is the one dated December 18th, 2020.
A Yes, I have it, if you could let me know what page.

Q At paragraph 9, you state that there are no drug therapies to cure COVID-19 or prevent the spread of SARS-CoV-2, correct?
A Yes, that's correct.

Q What about things such as Ivermectin and Hydroxychloroquine, are those not therapeutics that can be used or can be effective in relation to COVID-19?
A At the beginning of the pandemic in early 2002, Hydroxychloroquine was a medication that, in some small trials, there had been some findings that indicated that there could be benefits. And so it was used in many different trials we, in fact, had a clinical trial in the Province to analyse the effectiveness of Hydroxychloroquine as a medication. And over time as there were many trials done across -- around the world, the -- unfortunately the results of well done randomized clinical controlled trials showed that Hydroxychloroquine did not, in fact, have benefit for people who had COVID-19 and in fact there were more harms that were caused from side effects than benefits. And so while it was a medication, again at the beginning that there was interest in, those clinical trials -- unfortunately did not bear out that promise.

With Ivermectin, a similar situation took place. So a little later in 2020 there were some claims, some smaller trials that had indicated that Ivermectin could potentially have benefits in treatment. And we have again relied on the clinical expertise and scientific

expertise of our scientific advisory group and again looked at the evidence summaries from different expert advisory bodies on the sum of all of the available evidence with respect to Ivermectin. And there are no large, randomized control trials that shows that Ivermectin caused a benefit in the treatment of COVID-19 and in fact there are significant harms that had been shown with utilization of Ivermectin.

So we have followed the evidence closely and continued to watch the new evidence as it comes out, but the -- again it's really important when looking at the evidence to look at all available data and to be really looking at the methodology that's used in different studies when we're looking at whether or not a therapy is something that's appropriate to use in the general public. Now, again that's not something for clinical treatment the decisions about that would be made by Health Canada with respect to which drugs are authorized for what purposes and which drugs are licensed for use for particular purposes and then the use of medications for specific purposes. There's a College of Physicians and Surgeons Association standard that would oversee if a clinician wished to use a label -- a medication that's off label, so not licensed for that use by Health Canada, there's a framework that physicians would need to follow.

So, again, it's really important to note two things. First of all, there is no robust evidence and in fact the preponderance of evidence does not show benefit with Ivermectin or Hydroxychloroquine and second that therapeutic decisions are not ones that come out of my office and are ones that again have a different regulatory framework that oversee what medications are used for treatment.

Q All right. Thank you. Doctor, at paragraph 14 it states that: (as read)

> Not all people infected with SARS-CoV-2 have developed symptoms, but even without symptoms an infected person can transmit the virus to others. This is called asymptomatic transmission.

This has been the subject of considerable evidence in this hearing, suffice it to say that the risk of asymptomatic transmission is very, very low. One report that Dr. Bhattachrya's original report based upon a Madewell study was that it was as low as .7 percent. Are you aware of this or would you agree that the risk of asymptomatic spread is at least very, very low?

A So I would refer you to appendix T of my affidavit which is the Scientific Advisory Group Rapid Response Report on the possibility of asymptomatic transmission of SARS-CoV-2 where the conclusion is, first of all, that it is difficult to evaluate. As I think we spoke about yesterday, it is difficult to evaluate fully the asymptomatic, pre-symptomatic, mildly symptomatic, sometimes called paucisymptomatic, where someone has symptoms but they're perhaps similar to a chronic condition, they may

have allergies and so they may not necessarily recognize that they're symptoms are actually COVID-19. And so to tease apart all of the different factors, again asymptomatic, pre-symptomatic and paucisymptomatic, is incredibly difficult to do and you'll note that in this particular evidence summary, again they note the significant challenges of assessing this. So making a really definitive statement is very, very difficult.

However, they do indicate that pre-symptomatic transmission is likely higher than asymptomatic, so you'll note on page 277 at point 4, the indicate the best students of asymptomatic proportions suggest a range of 15 to 20 percent of transmission being asymptomatic.

And then there is the indication that younger people may have a higher likelihood of asymptomatic or paucisymptomatic transmission, again more likely to have mild illness, therefore, potentially more likely to transmit while asymptomatic up to, in this particular study, 18.9 percent is the estimate.

So, again, it's really important to recognize that when you're looking at this question, looking at the preponderance of evidence and bringing it together is -- is important. So, again this particular summary indicates that pre-symptomatic transmission is more likely than asymptomatic, but even asymptomatic transmissions at 15 to 20 percent of all transmission is not negligible.

Q All right. But I was asking you about asymptomatic spread, the risk of that is very, very low as low as .7 percent, do you agree with that, or not, that was my question.

A I've just indicated that there's other evidence that would indicate it's as high as 15 to 20 percent. So it is true that someone with symptoms is a higher risk of passing on virus to others, but someone without symptoms can transmit and that that of the proportion of all transmission could be as high as 20 percent, which is a significant consideration.

Q But during the relevant timeframe that we're talking about, in this case, at any given time, the vast majority of Albertans were not -- were not infected with COVID-19, right? So that 15 or 20 percent you're talking about is within that smaller category who people who are -- who actually became infected?

A So, I think again the 15 or 20 percent of all transmission being asymptomatic is -- so it's not -- it's important to think about what the denominator is, so that's the transmission. As transmission rises, as you have more infected people in a population, obviously the contribution of asymptomatic transmission to the trajectory of the spread in the population becomes more and more important and especially as the health care system experiences significant strain, 20 percent, 15 to 20 percent of transmission happening from asymptomatic people is a significant contributor to the epidemic curve.

The problem being again even though the majority of Albertans at any given point in time don't have COVID, because we don't know which individuals could be infectious because people can transmit while asymptomatic. And it's simply not possible especially when transmission is so high, that we don't have the ability to identify and locate ever single chain of transmission and the majority of transmission is happening from unknown sources. That means at any location, at any time, that could have someone who is infectious who doesn't know it present and spreading to others.

Q All right. And paragraph 24 of this affidavit it states that -- you're talking about -- actually I should back up and refer you to paragraph 23, you're talking about Alberta's capacity for hospitalization due to COVID-19, it's dependent on demand for other health issues but I'm advised by AHS and do believe to be true that Alberta's main hospitals are operating at over 90 percent capacity for COVID-19 inpatient care. So that was already true in December of 2020, right?

A Yes.

Q All right. So, are you saying that your evidence is that -- that the stress on the hospitals increased to the point where they became overrun and couldn't handle the number of COVID cases that were -- that were being admitted?

A It is my evidence that there were other health procedures that were being paused, delayed and limited to enable the system to have the capacity to care for COVID-19 patients. So the system throughout the course of the time period that we're talking about thankfully retained the capacity to care for all COVID patients who needed in hospital care, however, the burden was such that it was necessary to delay treatments such as surgeries for other conditions for several months as the waves progressed.

So, again the -- the intent of utilizing non-pharmaceutical interventions was to prevent the health care system from becoming so overwhelmed that not going did they have to defer some of these other treatments, they also would have not been able to care for all patients who required acute care due to COVID and also could potentially have gotten to the point where they may have had to limit access to more urgent services for other health issues.

Q Right, so at paragraph 24 of your affidavit you say, "when this capacity is exceeded", you're talking about the 90 percent capacity: (as read)

> … non-COVID-19 patients will experience cancelled treatments for non-urgent conditions. The cancellation of these non-urgent, but necessary surgeries, can have health impacts such as ongoing pain and mobilities.

Two question about that. First of all, you say when not if, so you assumed that these -- that it would be necessary to cancel all these surgeries. How were you able to know that in December of 2020, because that actually started to occur much later, didn't it?

A At that particular moment in time, so this affidavit was submitted on December 18th and at that particular moment in time, if you will recall when we looked at that curve, we were only beginning to see a few days of lower case numbers, which again we had seen historically that there could be fluctuations day-to-day. So it was too early to know with certainty what the next month would hold. We'd seen in our projections concerning trends that -- that you know if that trend had continued, if we hadn't been able to change the course of transmission that we would have reached a point in time where we would not have been able to maintain the capacity to care for all COVID patients and all urgent care needs for other health issues.

And so at that particular moment in time, in December, it seemed likely at that moment in time that we would be reaching that threshold, again we hoped that we would not which is why we had moved to implement measures to prevent that outcome, but that was the fear at that time.

Q But the calculation that was made there again in terms of rationalization and resources, you put COVID patients ahead of these other people who had non-urgent but necessary surgeries, isn't that the rationalization of how that decision was made, the rationalization of care? COVID-19 patients were given priority over people who were considered to have non-urgent but necessaries surgeries pending. Is that how it was rationalized?

A So the process for triage of patients and the decision-making around which procedures were deferred or cancelled, would be questions that AHS would be more able to answer and we spoke about that yesterday that the planning and response with respect to providing acute care capacity would be work that they would do, potentially in conversation with the Minister. But in terms of making decisions about which patients got care when, that would not be something that I would be -- it wouldn't be a part again of that public health management, that would be part of the acute care system management.

Q So that was -- are you saying that was not a decision that you were a part of? That was all done within Alberta Health Services?

A The decisions about which specific surgeries to defer would have been made by Alberta Health Services.

Q Right, I'm not talking about that decision, I'm talking about the decision to put -- to rationalize care so that COVID-19 patients would be given priority over these other people; that's the decision I'm talking about. Is that a decision that you were part of or

was that strictly Alberta Health Services?

A So, my recollection is that the planning around the allocation of care would utilize things that historically would be utilized in the health system in terms of those require care most urgently typically are given precedence over those whose care is less urgent. So someone who has COVID-19 and has a low oxygen saturation and could potentially have significant if not fatal complications if they didn't get acute care within that timeframe within which they were sick, again typically the system of care is oriented to provide care preferentially to those who are the sickest and have the highest acuity at that moment in time.

So I don't specifically recall being a part of a discussion where it was contemplated not admitting COVID patients or saying no to admitting COVID patients in order to facilitate non-urgent procedures, if that discussion happened I don't recall being a part of it. Again, it would flow from the typical way that care would be allocated which is the sickest people would get the care that they needed in that particular moment and if the capacity is being pressured, those whose care is less urgent would need to wait longer. So again that's -- that's again a fairly foundational element of how decisions are made in general and so that's my understanding is that flowed then into COVID.

And again there may have been decision where it was asked, should we stop admitting COVID patients so we can continue surgeries, but I wasn't a part of those conversations if they happened.

Q But if the -- whether you made the decision of Alberta Health Services, the decision to prioritize COVID-19 patients did result in harm, harm to the people who were not getting their -- their non-urgent surgeries. It certainly was not in their -- it didn't benefit their health to have those surgeries cancelled or postponed, did it?

MR. PARKER: I am going to object. Mr. Grey has put a question to the witness that did not, from what I heard, contain the answer to the question that the witness had just given him.

THE COURT: Mr. Grey?

MR. GREY: Madam Justice, it's not a crucial point, I'll withdraw the question and move on.

THE COURT: Okay. Thank you.

MR. GREY: Thank you.

Q MR. GREY: Dr. Hinshaw, if I could refer you please to paragraph 31 of this December 18th, 2020 affidavit.
A M-hm.

Q So here it's under the bold heading, Alberta's COVID-19 Public Health Measures and it says that: (as read)

> Alberta has attempted to control the spread of the SARS-CoV-2 virus by implementing a number of public health measures.

And those included NPIs, corrects?
A Yes.

Q Okay. And the next sentence reads: (as read)

> Restrictions on how people interact with others outside of their households are necessary to prevent the transmission of SARS-CoV-2 and are effective in reducing cases of COVID-19.

So, here it's stated -- it's a statement of fact that restrictions on how people interact with others outside of their households are necessary to prevent transmission. My question is, was it ever contemplated or considered by Alberta that instead of assuming that these restrictions on people, on how people interact with each other outside of their household were necessary; was it ever considered instead to simply provide Albertans with the relevant health information and recommendations and to trust them to make their own -- their own choices as opposed to removing those choices and restricting their liberty? Was that ever considered at any time by Alberta during this timeframe?
A In fact, that is exactly the approach that was taken through October, in particular, was to provide information, recommendations, data about the impacts that we were seeing to enable people to make the decisions that again would have minimized the spread of the virus in the community. So we did, in fact, attempted to use exactly that approach with respect to non-mandatory, voluntary, geographically targeted measures that were about information and guidelines and that unfortunately was not successful in changing the trajectory of the second wave.

And so at that point in time in December when this affidavit was sworn, the statement the restrictions being necessary, was accurate at that point in time as all of the attempts that we had made to utilize non-mandatory interventions had not been successful. And at that point in time our hospitals were at significant risk of becoming overwhelmed.

Q But doesn't that presume that the cause of the increase in cases is due to people not

complying with the Government's recommendations? Isn't that -- isn't there an assumption in there, isn't that so?

A The cause of increase in transmission is opportunities for the virus to spread from a person who is infectious to someone who is susceptible and the more interactions that people have in the general population with other people, the greater the number of people that the average person spends time with every day, the greater the chance for transmission to happen. And so the voluntary recommendations that were put in place in October, were the same measures that ultimately moved into the realm of mandatory requirements. And when they became mandatory at that point is when we did see that our transmission curve shifted and as we've discussed the trajectory changed and ultimately after several weeks of increases thankfully again the burdens on our hospital system eased subsequent to that shift in the transmission trajectory.

Q But if these NPIs were as effective as you say they are wouldn't -- wouldn't they have eradicated COVID? They don't seem to have had the effect in the long term that you state that they have. We still have COVID in Alberta more than two years on, so it doesn't appear that these NPIs really had the effect that you're -- that you're stating and if they did have an effect, it was at best short -- short lived, right?

A I don't believe that I have at any time indicated that non-pharmaceutical interventions will eliminate COVID. In fact, I believe I've been very clear in public statements that the intent of non-pharmaceutical interventions is to spread out the course of the pandemic so that we don't have a large number of people requiring acute care all at the same time and therefore overwhelming the system. So, the intent of NPIs in Alberta has never been to eliminate the virus. It's always been clear that the virus is something that we would need to respond to, but eliminating it, there's -- again that really was never the intent. So, I'm sorry, I'm not quite sure exactly how you got the impression that that was ever something that I had indicated.

Q All right. Let me put it another way. We know -- we know that there are other jurisdictions, for example, Florida that after the first period of lockdown went in a different direction. They went in a direction that I suggested to you, that is that they stayed really in a situation where they provided relevant health information to the public and really trust the public to make their own decisions without significant restrictions upon liberty.

And the health outcomes for Florida, while not perfect, still seem to be roughly just as -- or comparable if not better than what we've experienced in Alberta. So -- so in that situation, isn't it difficult to show that these lockdown measures, as you state, were necessary? That these restrictions were necessary, when there was another way to go, wasn't there?

MR. PARKER: Objection argumentative.

THE COURT: Mr. Grey? Mr. --

MR. GREY: Well, this is cross-examination Madam Justice (INDISCERNIBLE) --

THE COURT: -- well, Mr. Grey, let me --

MR. GREY: -- I am --

THE COURT: Mr. Grey can I just stop you?

MR. GREY: Okay.

THE COURT: First of all, I heard there was a great deal of editorializing, some statements of opinion, some evidence that you have not put before the witness and then there were a series of questions. I am not sure which one you wanted the witness to answer. So let's back up a little bit and ask the question that you would like the witness to answer and then I will see if Mr. Parker objects to it.

Would you like a break, Mr. Grey?

MR. GREY: Yes, I would be grateful for that.

THE COURT: Okay. Let's take a 10 minute break.

MR. GREY: Thanks.

(WITNESS STANDS DOWN)

(ADJOURNMENT)

THE COURT: Okay. Thank you. Mr. Grey, did you want to repeat your question now so that we can be clear?

MR. GREY: Certainly. (INDISCERNIBLE).

THE COURT: Okay.

(WITNESS RE-TAKES THE STAND)

Q MR. GREY: Dr. Hinshaw, we were -- I was asking questions (INDISCERNIBLE) decision that Alberta made to -- that it was necessary (INDISCERNIBLE) in terms of (INDISCERNIBLE) of Albertans; right? And what I was asking about is that there was -- was there another way to (INDISCERNIBLE) that would involve less restrictive measures and more -- putting more trust in public and that that strategy has been (INDISCERNIBLE) jurisdictions with some degree of success? Do you acknowledge that there was another way (INDISCERNIBLE) --

THE COURT CLERK: My apologies. Just having issues with the recording machine.

THE COURT: So, Mr. Grey, (INDISCERNIBLE) technical issues ongoing. I apologize (INDISCERNIBLE) --

(PORTION OF PROCEEDINGS NOT RECORDED)

THE COURT CLERK: My apologies. I think it should be okay.

THE COURT: Okay. Thank you, Mr. Grey. We can continue. Go ahead.

MR. GREY: All right. Thank you.

Q MR. GREY: So, Dr. Hinshaw, my question is understanding that other jurisdictions took a different approach, to use an example of Florida, they were less restrictive of individual liberty, do you still maintain that the restriction of liberty was absolutely necessary and that there was no other path that Alberta could've taken to deal with the, you know, the risk or the menace that COVID-19 presented to public health?

A With the goal of preventing the healthcare system from becoming overwhelmed and unable to care not only for COVID patients but patients with other health issues that were more urgent than rescheduled surgeries, it's important to remember that when comparing Alberta with US jurisdictions that per capita acute care capacity in the United States is much greater than the per capita acute care capacity in Canadian jurisdictions, particularly if you look at Alberta. And so the ability to care for higher per capita numbers of people in acute care without completely overwhelming the system, again, that's just a different context.

It's also important to look at the death toll in places that didn't utilize restrictive measures. Again, I haven't looked recently at Florida so I can't say currently but it

certainly was 2 to 2.5 times higher with respect to per capita deathrate than Alberta. So the -- I think critical question is if the goal is to prevent the healthcare system from becoming completely overwhelmed, there was no way to accomplish that without using restrictive measures in our province.

Q I previously referred you to a transcription of a statement that you had made, one of your public statements, I'd like to refer you to one from the 6th of March, 2020.

MR. PARKER: Mr. Grey, can I just ask if these documents -- are you planning to mark them as exhibits? The press conference?

MR. GREY: No, I'm not. I just want to ask questions about them.

THE COURT: Ask questions on them? Mr. Grey, we better mark them as exhibits for the record. I am a little confused by that; okay? And is this -- this is in your book of materials that you sent me and Mr. Parker, can you tell me --

MR. GREY: That's correct.

THE COURT: Yes. Can you give me a page reference or give us a page reference?

MR. GREY: I don’t think that the pages are numbered, Madam Justice.

THE COURT: Oh, okay.

MR. GREY: They are all dated.

THE COURT: Okay. Thank you.

MR. PARKER: There's numbers at the bottom of the page, it's actually page 8, Justice Romaine.

THE COURT: Page 8? Oh, okay. Thank you.

MR. GREY: Oh, thank you. Mine are not paginated, I'm sorry.

THE COURT: No problem. Thank you.

Q MR. GREY: All right. So, Dr. Hinshaw, here is a transcription of what you had stated publicly in one of your press conferences and you'll see about midway down the page there's a sentence that begins, "I want to remind Albertans".
A Yes.

Q (as read)

> I want to remind Albertans that despite this case ...

That is this the -- this is -- on this date you were announcing the first probable case of COVID-19 that was detected in Alberta and here you're stating that:

> The risk of catching the virus is still considered low in our province.

Do you see that?
A Yes.

Q What was the -- what was the basis for your statement about that at that time? What was it that made you think that?
A So that particular time we knew that there had been travel-related cases, a small number of travel-related cases in other provinces, we detected the first, as you said, probable case in Alberta that had a clear link to travel so at this point in time we did not have evidence that COVID was circulating within our community. And given that, again, we were still at a time where cases were -- our case and cases in neighbouring provinces were clearly linked to travel, that it had not become established -- we had no evidence that it had become established as a circulating virus in Alberta at that time.

Q All right. The next sentence there says:

> We have been preparing for this since the virus first emerged in January and we have proven processes and well-trained teams to protect Albertans.

So there was evidence -- there is evidence in this hearing from other witnesses about plans that were in place to deal with, and how Alberta planned to deal with COVID-19, so here when you're talking about proven processes and well-trained team, can you detail that? Can you flush that a little bit? What sort of plans or prudent processes did you have in place at that time to deal with COVID-19?
A So what we had been doing since the time in January where this was identified as a novel virus, we had seen challenges emerging in other places, we had activated our pandemic plan. It was written specifically for pandemic influenza but many parts of

that plan were applicable to COVID-19. We were utilizing the lessons that we had learned from the influenza pandemic of 2009, as well as the SARS experience of 2003. We had and have very skilled communicable disease control teams that were able to do contact tracing and so we were preparing all of those -- using those protocols and preparing our teams for what we understood at that time. And, again, we know much more about COVID now and so at that particular moment in time we were, again, going from what we were seeing in other jurisdictions combined with what we had in terms of frameworks in our own province and felt that we were prepared to deal with the threat that COVID-19 was going to pose, again, by utilizing those particular frameworks and foundations.

Q The -- I'd like to refer you next to your statement from March the 9th, in 2020. So here at the top it says: (as read)

> I'm here today to announce that three new cases of COVID-19 have been detected in our province. These are the fifth, sixth, and seventh cases of COVID-19 in Alberta.

And on the following page if we could scroll down, please, there's a paragraph that begins, "What does this mean to Albertans?" It says: (as read)

> What does this mean to Albertans? It means that all of us need to be engaged in this response and we need to start thinking about what our new normal will look like over the coming months.

So here on March the 9th, of 2020, only seven cases diagnosed in Alberta, but you were already talking about a new normal. What did you mean at that time by a new normal?

A So if you go a little up in this particular excerpt, so if you scroll a bit up, you can see that I was referring to what we were seeing unfold around the world. So at that point in time, we were seeing significant outbreaks in places like Italy, in New York, in Spain, where we were seeing the outcomes of widespread community transmission. At that moment in time, again, we had very early information, we were working off that early information that again you can see the -- given that China was the country that had first identified this where we had the most data, their early data indicated that 1 in 5 people had required hospital care, 1 in 5 of those they diagnosed. Of course, at this point in time we know that's likely because there were many others in the community with mild infections who hadn't been diagnosed, but at that time this is what we knew. And so based on the fact that we had seen that COVID-19 was behaving dramatically differently from any respiratory virus that we had dealt with in our lifetimes, we were seeing impacts on analogous jurisdictions like I've mentioned in terms of New York as an example, the new normal over the coming months I think we all remember a time

where going to work with a mild cold was considered not just normal but proof of dedication to work, and so things like making sure that we stayed home even if we were only mildly sick, some of those particular pieces taking care to think about not just ourselves but those around us, not just friends and family, but people that we interacted with that we didn't know because of how quickly an infectious disease and a respiratory infectious disease can spread. So those were some of the things that were being referenced in that particular time. Again, given what we knew, given what we were seeing around the world, that it was becoming clear that the way that we had gotten used to behaving, you know, that simply was not going to give us the best chance of managing with COVID without significant negative impacts.

Q So you were speaking of a form of, and I realize this is in the early stages, you're talking about behaviour modification and actually it says here further down, it says: (as read)

> It is time to start greeting each other with elbow bumps or waves instead of handshakes. This is not a overreaction but, rather, a very practical way of eliminating the spread of germs.

So the new normal, really, this is the beginning of, and I think this is what you just said, of having Albertans modify their behaviour. Their every-day behaviour, even to the extent the way that we greeted each other. Isn't that what you're talking about in the context of the new normal?

A Certainly the ways that we historically would've interacted with each other would be things that would be higher risk of spreading infectious pathogens one person to another. And I don't know if people recall in 2009 when we had the H1 influenza, H1N1 influenza pandemic, for example, there were many public campaigns, media campaigns, to encourage what's called respiratory etiquette. So coughing and sneezing into one's elbow, ensuring that people washed hands frequently. So this, again, is information that was shared with Albertans to say here are ways that we can protect each other, protect ourselves. And given that COVID is an unprecedented threat at that point in time, it was becoming clear that this was unlike anything that any of us had experienced before, it was providing Albertans with that information that are ways that we can protect ourselves and each other.

Q The other interesting thing about this press conference is already -- and this is here in the previous paragraph which says, "What does this mean to Albertans," you're already talking about vaccines. You say: (as read)

> With no vaccine for this virus likely to be available for a year or more, we need to protect each other.

So was there already at that time contemplation of a vaccine or are you just speaking theoretically at that stage?

A Part of the pandemic planning, which again for influenza there is an established process for making influenza vaccines and then one needs to modify the specifics of the particular strain, so part of the plan does involve plans for vaccine rollout. In addition to that, as soon as the generic sequence of the SARS-CoV-2 virus was known, researchers were beginning to work on what vaccines could look like very early in the response to COVID-19. Again, clearly this was an infectious pathogen that was having huge impacts and to be able to have an effective vaccine was a worldwide goal. There are many, many researchers who were embarking on the work to use technologies that, again, different types of technologies were being used. Some protein subunit technologies, some, again, we've seen the earlier ones the viral vectors or the mRNA vaccines, and so this was something that was common knowledge at that point in time that research had begun on what could be effective vaccines. And so the comment here was indicating what the timeline looked like for a coronavirus. Because, again, with influenza we could've had a vaccine, you know, H1N1 we had one within about 6 months, but it would take longer because that's a coronavirus, there would need to be additional research done which is exactly what we saw, that that did take longer.

Q I'd like to refer you next to your press conference from the 11th of March, 2020. So there's a sentence here near the top, Dr. Hinshaw, it says -- it reads: (as read)

> I want to encourage all Albertans to access reliable information about what is happening and do their part to stop the spread of rumours and inaccurate speculation.

What specifically were you referring to there; do you recall?

A It's very difficult for me to remember that specific day two years ago, and specific examples. Throughout the pandemic there have been inaccurate rumours that have spread on social media about the nature of the virus, about the types of treatments that are considered to be effective, and as I mentioned earlier, some of those things are just not based on reliable information. So I'm not able to specify exactly what type of misinformation I was thinking of on March 11th, of 2020, but certainly those are some very common themes that have cropped up and been persistent throughout the course of the pandemic.

Q Referring next to the press conference on the 12th of March, 2020.

MR. PARKER: I'm sorry, could I just interject? I don't have an objection but I just wanted to go back to the question on exhibits. As I understand it, Dr. Hinshaw hasn't been asked if she's been able to identify and confirm the authenticity of the

documents that have been put to her. And considering the amount of documents, there's 767 pages here, you know, the questions are asking specific questions or, rather, Mr. Grey's asking specific questions before even asking if Dr. Hinshaw is able to identify the documents and has seen them before. So I just wanted to get back to questions on exhibits because documents of this size I would've expected to be put in through an affidavit authenticating it in advance, somebody saying this is what we've done, so that we can tell the Court that these are what we say they are. So, sorry, I just wanted to raise that for a process, not to get in the way. Thank you.

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

Mr. Grey?

MR. GREY: I appreciate my -- yes, I appreciate my friend's comments. It isn't my intention to go through all of these, I certainly -- we certainly could have them marked, the ones I referred to, marked for identification. I had made the assumption, and I appreciate my friends pointing this out, that because these were Dr. Hinshaw's own words that she acknowledged them as her own. However, I will ask that -- I will go ahead and ask the question --

THE COURT: Okay. Just --

MR. GREY: -- of whether or now she recognizes.

THE COURT: Yes. Thank you. Thank you, Mr. Grey. I am not clear, does Dr. Hinshaw have a copy of all of these it looks like transcripts of press releases that you are referring to? They are not an official Government of Alberta -- they are not official Government of Alberta releases, what they appear to be is 495/500 pages of something somebody has prepared for this cross-examination. Just for clarity, is that the case?

MR. GREY: That is -- that is correct, Madam Justice. What had been done was these were provided to my friend and to the Court, what I might suggest doing, subject to the Court's approval, if there's no objection from my friend, and I should've thought of this earlier, I regret not doing so, but perhaps what might be best is if I put together a more tight package of the ones that I'm going to refer to and then I could provide them to my friend so that he could provide that package to Dr. Hinshaw and then that would streamline things quite a bit. And then, of course, we could deal with objections from Mr. Parker about whether or not -- how they should be treated as evidence. That's my -- my suggestion here --

THE COURT: Okay.

MR. GREY: -- subject to your approval.

THE COURT: Okay. Mr. Parker, what do you think about that suggestion?

MR. PARKER: I did have -- the first question is how big would the tighter package be, Mr. Grey? This is 767 pages. What are you thinking, sir?

MR. GREY: I would -- I would think that it would be between -- between 40 and 50 at most.

THE COURT: Okay. Mr. Grey --

MR. GREY: And then that would give Dr. Hinshaw the opportunity to read them or peruse them and determine whether or not she recalls or at least refresh her memory. I think it would be more a case of refreshing her memory. Of course it's open to her to dispute what's there and say well, no, I --

MR. PARKER: And so my second, thank you, Mr. Grey, I appreciate -- thank you, sir. I appreciate that. The 40 to 50 pages would be more manageable. I'm not still sure thought that Dr. -- a couple of things, that Dr. Hinshaw can read the 40 and 50 pages and say they're a completely accurate transcription of what was said from whenever those -- the dates of those particular press conferences, although she may well remember certain of the words and believe she used those words. So there is still a concern about authenticity in that case. The second part just goes to the order of Justice Kirker and if we're going to put in documents that she's going to be able to identify so they go in as full exhibits and it's just -- it would require, I believe, it was the leave of the Court to put in those documents as well. So I just wanted to raise that. Thank you.

MR. GREY: I appreciate my friend putting me on notice of his position.

THE COURT: Okay. So you appear to both agree that Mr. Grey should winnow down this to 40 or 50 pages which will be given to Dr. Hinshaw and she can tell us whether she recalls or is able to identify them as actually the words of the press release that were issued. That is going to be a little bit of a time-consuming exercise. Mr. Grey, are you able to do that or have someone in your office do that overnight so that we can --

MR. GREY: I would do it --

THE COURT: Okay. Okay. Let's follow that then and if you want to move on -- I do understand, Mr. Parker, you are talking about 700 pages, I was only talking about the press releases because there are certainly many more pages in tab 1 and in another binder. Are there more press releases in the other binder? I have not had a chance to look.

MR. PARKER: The binder we got -- or the material we got today from Mr. Grey is 767 pages.

THE COURT: Yes. Oh, I see.

MR. PARKER: And that is the press releases. And so thank you for the direction on winnowing it down, or direction to Mr. Grey, can I also make a suggestion that while that would help in terms of the size of the document and would help if we're going to ask Dr. Hinshaw to review these, it would be beneficial if they could provide us with an affidavit indicating -- I mean, I see on the first page it's catalogues of statements, links used. So it looks like somebody has gone to these two lengths and then put these documents together. And so if there was an affidavit accompanying the winnowed down version that indicated what they were, how they were put together, that would be helpful to the process as well, in my submission.

THE COURT: Okay.

MR. GREY: I have no difficulty complying with that, Madam Justice.

THE COURT: Okay. Okay. Let's do that and we will leave any cross-examination on these until we have winnowed them down and then we can deal with how to deal with them as exhibits. Okay. Thank you.

Mr. Grey?

MR. GREY: So, Madam Justice, these documents were going to be the last part of my questioning of this witness so it seems that I'm -- I've hit a wall for now. I don't know whether you'd want to have my friend, Mr. Rath, start now or whether you -- it's just 3:00, do you want to adjourn until tomorrow or I would propose to have Mr. Rath step in and begin. Perhaps I could come back and conclude my questions for Dr. Hinshaw at a later time.

THE COURT: Okay.

MR. GREY: I'm in your hands here.

THE COURT: Yes. I think we should use whatever available time we have. Mr. Rath are you prepared to start your cross-examination and then perhaps defer to Mr. Grey when you are -- well, you can decide what would be the appropriate time. Mr. Rath?

MR. RATH: Madam Justice, I can start with a bit this afternoon but I was obviously planning on proceeding tomorrow so, I mean, I can get started today to use the time -- and use some of the time we have available certainly.

THE COURT: Okay. Thank you. Let's do that. So do you need a bit of a break? It is 3:00, should we take a 15, 20-minute break so you can get started?

MR. RATH: Yeah. Thank you. That would be great. Thank you.

THE COURT: Okay. We will take a 20-minute break.

MR. GREY: All right. Thank you, Dr. Hinshaw.

THE COURT: Yes. Thank you. And just to be clear, we will take a 20-minute break so, Mr. Rath, you can put your thoughts together and then we will proceed to 5:00 today. Thank you.

(WITNESS STANDS DOWN)

(ADJOURNMENT)

(WITNESS RE-TAKES THE STAND)

THE COURT: Okay. Dr. Hinshaw, I see you.

Mr. Rath, are you ready to proceed? Mr. Rath?

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

THE COURT: Okay.

**The Witness Cross-examined by Mr. Rath**

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

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

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

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

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

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

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

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

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

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

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

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

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

Okay. Go ahead, Dr. Hinshaw.

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

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

THE COURT: Okay.

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

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

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

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

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

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

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

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

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

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

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

MR. PARKER: Objection.

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

MR. PARKER: Yes. My apologies.

THE COURT: Okay.

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

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

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

THE COURT: Okay.

Q MR. RATH: Dr. Hinshaw, are you aware that the orders that you've issued under the *Public Health Act* have resulted in numerous business bankruptcies in the Province of Alberta?

A As I spoke to Mr. Grey, the orders that have been (INDISCERNIBLE) to protect the acute care system and minimize the severe outcomes from COVID-19, those orders I am aware have had impacts on Albertans that have been harmful and that is clear. I have acknowledged that throughout. Again, the important question has always been how to protect the healthcare system with the least restrictive means and to balance the harms of COVID with the harms of the public health -- sorry, the non-pharmaceutical interventions.

Q Right. Thank you. And, again, Dr. Hinshaw, specifically with regard to my specific question, are you aware that your orders have resulted in business bankruptcies in the Province of Alberta?

MR. PARKER: I believe she's answered that question. She just answered the question, sir.

MR. RATH: My Lady --

THE COURT: Yes. Mr. -- I am sorry, okay, Mr. Rath, respond to the objection please; okay?

MR. RATH: That's what I was (INDISCERNIBLE).

THE COURT: Okay.

MR. RATH: So, My Lady, with respect to my friend, she hasn't responded to the question. I've asked her a very specific question with regard to business bankruptcies and she's provided another one of her very broad general answers that does not specifically respond to the question. So, my view is that I have asked the question, her answer is non-responsive, and I'd seek a direction from the Court that she be directed to answer the question. Albertans are entitled to know the degree of knowledge that Dr. Hinshaw has with the degree of harm that they have suffered as a result of her orders.

THE COURT: I uphold the objection. I find that Dr. Hinshaw did answer the question. Go ahead, Mr. Rath.

Q MR. RATH: Dr. Hinshaw, at paragraph -- sorry, the tab has just come off my page.

MR. RATH: Just bear with me, My Lady, the tab that I was trying to flip over to just came off my page. I'm looking for the paragraph dealing with suicide in the Province of Alberta.

Q MR. RATH: It's at paragraph 90 at the bottom of page 28. Dr. Hinshaw, you state at paragraph 90 that: (as read)

> As detailed in the table below, Alberta's suicide rate for 2020 was 5 percent lower than the five-year average from 2015 to 2019.

What about the suicide rate for 2021, did you have that data?

A I don't have it in front of me. If that's something that -- I'm not sure what the process typically is but I don't have that at my fingertips.

Q All right. Was the suicide, to your recollection, was the suicide rate higher in 2021 than in 2020?

A I'm sorry, I wouldn't want to speculate. I don't have that data in front of me.

Q All right. And then when you're talking about suicide rates being lower for five -- 5 percent lower from the five-year average from 2015 to 2019, you're not putting that evidence in your affidavit to suggest that your orders did not cause any suicides in the Province of Alberta, are you?

MR. PARKER: Objection.

THE COURT: Okay. Mr. Parker, the reason for your objection?

MR. PARKER: Yes. The question was why did you put certain evidence into your affidavit which I understand is not a question that you're allowed to ask. You're allowed to ask questions eliciting factual response, not to ask questions as to why you chose to put certain evidence in which is a question about legal strategy.

MR. RATH: No. My question was specifically that she wasn't suggesting by putting that table in, suggesting that the suicide rate was lower by 5 percent in 2020 wasn't to -- for that five-year period, wasn't to suggest that no people have committed suicide as a result of her orders.

THE COURT: Okay. No. Okay. I will allow the specific

question which I understand to be did you mean to suggest that there were no suicides that occurred as a result of your orders, that is the question, is it not, Mr. Rath?

MR. RATH: That is, My Lady. Thank you.

THE COURT: Okay. Ms. Hinshaw -- I am sorry, Dr. Hinshaw, please.

A That was not my intent.

Q MR. RATH: All right. Are you aware of any suicides that were caused as a result of your orders?
A I think it's very difficult to understand all of the factors that go into an outcome like suicide. So I -- I think it would be very difficult to know, again, how to differentiate the different causes. So I, again, I just am not able to answer that question.

Q Are you aware of any suicides that were caused -- that were economically driven as a result of your orders?
A I haven't seen an analyst of the underlying reasons for the suicides that were reported in 2020. So, again, I just find it very difficult to -- for me to comment on the reasons for the individual suicides that were documented in that report.

Q Was it something you were concerned about while you were promulgating your orders, Dr. Hinshaw?
A I have always been concerned about all health outcomes for all Albertans and so mental health has always been a serious consideration and a concern for me.

Q So it was within your contemplation then when you were promulgating these orders that these orders could in fact cause an increase in suicides in the Province of Alberta, or specific -- or cause specific suicides within the Province of Alberta; is that fair?
A So in considering the recommendations on policy put forward to elected officials, the impact on things like mental health as well as determinates of health were considered, in addition to the significant impacts of the COVID-19 pandemic as well. So all of those things were considered, yes.

Q All right. And can you elucidate and provide us some further information on specifically how these matters were considered?
A As our team was working on response, so as I mentioned earlier, in the first wave where we had very minimal information about the nature of COVID-19 and took a precautionary approach to implementing measures to prevent the spread, at that particular moment in time, again, given that we had very little information, the

measures that were put in place were broader than at any other time in the course of the pandemic. Following that experience where we gained knowledge and information about COVID-19 and were able to learn from other jurisdictions, the approach that we took was to use a minimally restrictive and minimally mandatory approach. And, again, throughout the second wave, knowing that mandatory requirements would come with some unintended negative consequences, again wanting to limit the use of those, unfortunately the voluntary measures that were employed were insufficient and so at the time that we saw our acute care system under significant stress with the direct death toll of COVID rising substantially in the latter part of 2020, the balance tipped again in seeing the direct harms that COVID-19 was causing and the use -- even recognizing again that there would unfortunately be some harms from non-pharmaceutical interventions, if those had not been used the acute care system would most likely, again, based on all of our evidence and projections, would, I believe, almost certainly have become overwhelmed causing problems not just for those with COVID but those with other health issues as well who would not have been able to seek care. So, again, each of those specific considerations, whether it be mental health or other considerations, were weighed out. And there were supports that were put in place. We worked with my colleagues who work in mental health policy to provide mental health supports to try to mitigate some of the negative consequences of the restrictions.

Q Mitigate some obviously but not all, is that fair, Dr. Hinshaw?
A I don't think it's possible to entirely remove all negative outcomes just with the measures. It was not possible to remove all of the negative direct COVID impacts. All it is, is a balance.

Q Thank you.

MR. RATH: My Lady, we were going to provide this document to the Court this evening but under the circumstances can we just put it up on the screen? It's one page and it's an Alberta Government document.

THE COURT: Okay. Go ahead and do that, Mr. Rath. If Mr. Parker has an objection, we can hear it.

Q MR. RATH: Dr. Hinshaw, can you see that document?
A I can see. I don't know if you can enlarge it a little bit?

Q Now, Dr. Hinshaw, is it your understanding and do you agree that 45 percent of emergency department visits for suicide attempts or self-harm are adults in the 20 to 39-year age bracket? Do you have any reason to quibble with that statistic?
A In general, the information that Alberta Health Services provides, again I'm not sure if

there's a date in this document, that would of course be relevant in terms of the timeframe that it was produced.

Q It says Alberta Health Services 2021 dashboard of suicide related injuries, Alberta injury surveillance dashboard, retrieved August 19th, 2021. Would you have any reason to argue with that or to think that might not be true?
A This would be an accurate reflection of what's in their dashboard. I wouldn't be able to comment on the methodology that they used but, in general, again, I would believe this is an accurate representation of what would be in their dashboard.

Q All right. Fair enough.

MR. PARKER: Could I just -- I don't want to object, but was the date did you say, Mr. Rath, August 2021 on this document?

MR. RATH: Yes.

MR. PARKER: Then the concern, again, is this is outside of the period of the second and third waves, although perhaps it's referring to information from within that time. So I'm not sure -- my apologies, I just wanted to clarify the date on it.

MR. RATH: I would imagine, Mr. Parker, that the -- or, My Lady, I apologize.

THE COURT: That is okay. Mr. Rath, it is okay. I understand what Mr. Parker is saying and I also understand that your position might be the data would be from before that date. Obviously, that would be true. So, continue with your question, Mr. Rath.

MR. RATH: Thank you.

Q MR. RATH: Dr. Hinshaw, with regards to the statistic that 45 percent of emergency department visits for suicide attempts or self-harm are adults in the ages 20 to 39-year bracket, would you agree that that age cohort overlaps an age cohort that's at very extremely low risk of death from COVID-19?
A Yes. That certainly is a low-risk age group.

Q Right. For COVID-19; correct?
A Low risk of severe harms for COVID-19 for those who don't have chronic conditions.

Q Right. But, again, I think Mr. Leighton had taken you through the statistics. For people

under the age of 30, deaths from COVID-19 are virtually non-existent, you agree with that don't you, Dr. Hinshaw?

A Again, you know, when speaking about risk, low risk, high risk, often sort of in the context of comparing it to other things. So this in this particular age group have a much lower risk of severe outcomes including death from COVID-19 than those who are older. That is absolutely true.

Q Thank you. So, with regard to that statistic, is it not possible that your emergency orders, to the extent that they drove any suicides in that age cohort, may have in fact killed more Albertans than COVID-19?

A Again, I think it's difficult to conclude that the single driving factor behind all suicides that happened in that year were the orders. I think that would require a deeper analysis of those specific tragic losses. So I think it's difficult to, again, make that conclusion without further analysis of that information.

Q Right. But, again, Dr. Hinshaw, to the extent that there's virtually no one in that age cohort under the age of 30 that's died from COVID-19, is it fair to say that if there was even two or three suicides in that age cohort that were driven by your CMOH orders, that your CMOH orders killed more people in that age cohort than COVID-19?

MR. PARKER: Objection. She's answered the question.

THE COURT: Okay. Mr. Rath, what is your response to --

MR. RATH: I'm not sure what the nature of the objection was. I just heard my friend say "objection" and then you saying "yes". So I am not sure what the objection is.

THE COURT: Okay. I believe, Mr. Parker, you said your objection was based on the fact that Dr. Hinshaw has answered the question.

MR. PARKER: Correct. Thank you.

THE COURT: Thanks.

MR. PARKER: Yes, Justice Romaine.

THE COURT: Yes. Thank you.

Mr. Rath, your response?

MR. RATH: I hadn't heard her answer to that question, My Lady. If you have, I'll take your ruling on that.

THE COURT: Well, I think you were asking Dr. Hinshaw -- why do you not give us the question again.

Q MR. RATH: Dr. Hinshaw, to the extent that any more than two or three deaths in the under 30 age cohort could be attributed to your CMOH orders, is it not fair to say that your CMOH orders in the under 30 age cohort have killed more people than COVID-19?

THE COURT: Well, okay, I will let Mr. Parker -- my concern with the question is it assumes that there have been suicide deaths caused by the COVID orders which is not in evidence as far as I can tell in this hearing so far. So I am not sure that it is a fair question for the witness.

Q MR. RATH: Dr. Hinshaw, are you aware of any suicides that are directly attributable to your CMOH orders?
A No.

Q And in that regard, Dr. Hinshaw, is that because you haven't been looking for that data or on what basis are you not aware of any such deaths?
A Again, the combination of cause of death is complex and the statistics that we've been watching closely are more of an aggregate nature. So that just isn't data that I have. I would expect that the Officer of the Chief Medical Officer could potentially have that information but I think it would be very difficult to ascertain, again, the single driving factor behind an individual's suicide.

Q Right. And there's been no direction given to the Chief Medical Officer -- or examiner of Alberta to investigate suicides in this province to determine which of these suicides are attributable to your orders; is that fair?
A I have not had that conversation with the Chief Medical Examiner, no. We've talked about, again, watching suicide trends and wanting to make sure that we understand the direction of the trends to determine if there has been an increase or not. But I have not had that conversation with the Chief Medical Examiner.

Q All right. And then are you aware, Dr. Hinshaw, of any members of your Scientific Advisory Group that are either trained psychiatrists or trained psychologists?
A The terms of reference for that group is at tab Q of my evidence. So at that moment in time, that particular membership which again would have been produced in July of 2021, so there was not mental health specialists on the Scientific Advisory Group at

that time.

Q Is there now, Dr. Hinshaw?
A I'm sorry, I don't have a current listing of the Scientific Advisory Group membership at this time.

Q So as of the time this affidavit was being sworn and the information in this affidavit was being compiled, is it your evidence that there were no members of the Scientific Advisory Group that were either trained psychiatrists or trained psychologists?

MR. PARKER: She -- objection. She just answered the question.

THE COURT: Yes. Mr. Rath?

MR. RATH: That's fine. Withdrawn. I think I got the answer, the answer's no.

Q MR. RATH: So, in that regard, Dr. Hinshaw, is it fair to say that with regard to the orders that you were promulgating in terms of the input from the Scientific Advisory Group that you were not receiving any input as to the psychological or psychiatric impact of these orders on the broader Alberta population?
A It's true that that particular group did not have that expertise. I am sorry, I can't recall whether or not they did any evidence reviews that were specific to mental health. I would have to look back at the reviews that they did and the timeframe that they did them to be able to say whether or not they provided a review of evidence related to mental health. It's possible that -- again, I simply don't recall. If they had done a specific review, they could have had an individual come for a specialized area of expertise in that particular topic. So I would have to go back and check the list of evidence reviews to be able to answer that question.

Q All right. Do you recall any evidence reviews with regard to potential psychological harm that occur in grade, you know, in elementary school children that were being forced to wear masks in school with regard to their -- with regard to their social development or their psychological health?
A We did ask the Scientific Advisory Group to review all available evidence with respect to potential harms of masking and so that review was done with all available published evidence at that time and concluded that there -- at that time there was no evidence regarding serious health outcomes or adverse health outcomes from wearing masks. So that -- that review was done to inform the masking policy.

Q Right. But specifically I'm talking about psychological harm and psychiatric harm. Do

you recall any specific information that was -- that was considered in that regard?

A The Scientific Advisory Group would have looked at all published evidence related to harm so that would have included, if there had been publications related to harms and mental health, that would have been included in that review.

Q But, again, on that Scientific Advisory Group you had no psychologists or psychiatrists so you had no specialists in those fields providing you input from that group, that's correct, yes?

A That's correct. And at the same time, that particular group is well versed in the scientific method in reading evidence and their scope of that particular masking harms review was to look at any -- any published literature that documented harms from wearing masks.

Q So with regard to your review of that information, do you recall any specific sections in the report provided to you that spoke to psychiatric or psychological harms provided -- caused to children as a result of wearing masks?

A I would need to go back and read that review again to be able to answer that question. Again, I don't recall what specific sections they divided their report into.

Q Perhaps you could do that this evening, Dr. Hinshaw, if you'd be so kind.

MR. PARKER: Sorry, we're not -- objection. Unless directed by Justice Romaine.

THE COURT: Okay. Mr. Rath, this is not a questioning, this is a cross-examination. On what basis do you wish me to direct Dr. Hinshaw to go back and look at documents?

MR. RATH: Well, that's fair enough, My Lady. Withdrawn.

THE COURT: Okay.

MR. RATH: Her answer is she doesn't remember, we'll just work with that. Thank you.

THE COURT: Well, her answer is her answer, Mr. Rath.

MR. RATH: Thank you.

Q MR. RATH: Now, Dr. Hinshaw, one of the other things that I wanted to dip into this afternoon is I'd like to go back to those graphs that you were

looking at with Mr. Grey this afternoon starting with the one at paragraph 208 on page 261.

A Yes.

Q And with regard to those graphs specifically, can you advise, and I'm looking at the graph under paragraph 208, would you agree with me that you were bringing in public health measures while the line was trending upwards in cases and that the public health measures that you were bringing in did not seem to have any appreciable effect on cases trending upward?

MR. PARKER: Objection. We went through a series of questions this afternoon on this graph, on this topic, with Mr. Grey. I appreciate they have different clients but they have indicated they would do their best not to repeat each other's questions.

MR. RATH: I don’t believe Mr. Grey asked that question, Mr. Parker.

My Lady?

THE COURT: I am sorry, Mr. Rath, I have to agree that I do believe that Mr. Grey went through this topic in some extensive detail with Dr. Hinshaw.

MR. RATH: I don't believe he asked her that question. I'm trying to stay away from questions that Mr. Grey asked.

THE COURT: Well, he may not have asked that specific question but he asked whether -- I am reluctant to, I can go back to my notes, I think the gist of this question has been asked and answered. So, go on.

MR. RATH: All right. I'll move on. Thank you.

Q MR. RATH: Now, Dr. Hinshaw, throughout your testimony you've repeatedly stated that the goal of your Chief Medical Officer of Health orders was to protect hospital capacity; fair enough?

A I would say the goal of the orders was to minimize severe outcomes including making sure that we had sufficient acute care capacity for all Albertans, for all of their health needs. So --

Q Right.

A -- it's a bit broader than what you stated.

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

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

THE COURT: Mr. Rath?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

question as best she can. She said she didn't have the information at her fingertip when asked how many billions of dollars her orders had cost the Province.

THE COURT: Mr. Rath?

MR. RATH: I'll withdraw the question. I'll ask -- I'll ask a different question.

THE COURT: Okay.

Q MR. RATH: Dr. Hinshaw, with regard to the economic information that you've been privy to in the period up to the swearing of your affidavit, what estimates have you heard or have been advised of with regard to the impact of COVID-19 and your orders? So everything combined with regard to the economy of the Province of Alberta?

MR. PARKER: Again, objection. She's been asked and she's answered the question. She doesn't have --

MR. RATH: I haven't asked that question and I don't know that I've heard an answer to it, My Lady.

THE COURT: Well I understand your question to be, as of the date of Dr. Hinshaw's affidavit, does she recall any estimate of the damage done to the economy both as a result of the pandemic and because of the directives. Is that your question?

MR. RATH: That was my question. I hadn't asked that previously.

THE COURT: Okay. I agree that you have not asked that specific question previously so, Dr. Hinshaw, would you please respond to it?

A Again, I don't have that information at my fingertips.

Q MR. RATH: All right. And, again, with regard to -- I'll ask -- now with regard to hospital capacity, do you recall the Premier of Alberta in April of 2020 indicating that there was a path forward to create in excess of 1,800 ICU beds in the Province of Alberta? Do you recall that?

A I know that the estimates in early 2020 about what was possible for acute care capacity were higher than what ended up being possible as the second wave evolved. The details

of exactly how the acute care capacity was estimated in those different timeframes and the reason for the changes, those questions would be best directed to Alberta Health Services and the details of acute care capacity, again, would be -- would be best put to someone from AHS.

Q So is it your evidence then that during the period of March 2020 to the swearing of this affidavit that this wasn't information that you considered or had at your fingertips?
A That's not what I said.

Q Well, did you consider that information prior to promulgating these orders?
A I'm sorry, which information?

Q All the information with regard to the capacity of the Government of Alberta to increase ICU capacity.
A So part of the decision-making process included the acute care capacity and the ability of Alberta Health Services to facilitate enhanced capacity. That was always a part of the decision-making processes.

Q Right. So my next question, Dr. Hinshaw, is rather than promulgating orders that shut down businesses, forced masks onto children, locked people in their homes and caused all of these other harms that you've acknowledged that have happened, why didn't you simply order or recommend that the Government of Alberta put more money into hiring doctors, hiring nurses, increasing doctors' and nurses' salaries, hiring more respiratory therapists, and increasing hospital capacity?
A It was -- so there are a couple things. One is that the impacts of COVID-19 are being felt and were being felt around the world and skills, healthcare professionals, are in short supply. So it's not possible to, over a very short period of time, generate a large volume of net new healthcare professionals in this province. And Alberta Health Services was doing everything it could to enhance the ability of their facilities to care for people with COVID-19 and to expand ICU capacity. The only way it was possible to do that within a short time period was to redeploy staff from areas that typically would be assisting patients who had important but perhaps non-immediately life-threatening issues, to defer care to allow those healthcare workers to be shifted to areas where the capacity for COVID care could be expanded. So I don't believe that an order would have changed the practical realities on the ground of insufficient healthcare staff to simply expand capacity in a way that would -- will facilitate care for COVID patients as well as continue to provide care for all non-COVID related needs. So, it really is an issue of the availability of healthcare workers and all that could be done was being done in terms of bringing back those that had retired, enhancing and speeding the training of, for example, senior nurses in training. Again, the details of all of the work that was done to enhance capacity would be better spoken to by someone from Alberta Health

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

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

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

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

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

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

A It's my evidence --

MR. PARKER: Objection.

A Oh, sorry.

MR. PARKER: Objection.

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

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

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

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

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

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

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

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

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

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

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

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

(WITNESS STANDS DOWN)

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

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

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

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

MR. RATH: That's correct.

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

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

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

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

MR. RATH: Thank you, My Lady.

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

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

THE COURT: I understand.

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

THE COURT: Okay.

MR. RATH: So, I would appreciate that.

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

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

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

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

unfair to require him to proceed unexpectedly and so we will adjourn a little earlier.

Mr. Parker, I would just ask you to let Dr. Hinshaw know that this has been required by the nature of the objection.

MR. PARKER: Certainly. And to tell her, what time do we start tomorrow?

THE COURT: Well, that is a question now. I am quite happy to start again at 9:30.

MR. PARKER: Sure.

THE COURT: Or even 9:00. But both Mr. Rath and Mr. -- well, all of you now have some things to consider arising out of the testimony today. So, still 9:30, not any earlier, is that satisfactory?

MR. RATH: 9:30 is fine.

MR. PARKER: Sure. Thank you.

THE COURT: Okay, 9:30 tomorrow. Thank you.

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PROCEEDINGS ADJOURNED UNTIL 9:30 AM, APRIL 6, 2022

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**Certificate of Record**

I, Michelle Palmer, certify that this recording is the record made of the evidence in the proceedings in the Court of Queen's Bench, held in courtroom 1702, at Calgary, Alberta, on the 5th day of April, 2022, and that I was the court official in charge of the sound-recording machine during the proceedings.

**Certificate of Transcript**

I, Nicole Carpendale, certify that

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

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

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