

**THE QUEEN'S BENCH**  
Winnipeg Centre

APPLICATION UNDER: *The Constitutional Questions Act, C.C.S.M., c. 180*

AND UNDER: The Court of Queen's Bench Rules, M.R. 553/88

IN THE MATTER OF: *The Public Health Act, C.C.S.M. c. P210*

BETWEEN:

**GATEWAY BIBLE BAPTIST CHURCH, PEMBINA VALLEY BAPTIST CHURCH,  
REDEEMING GRACE BIBLE CHURCH, THOMAS REMPEL, GRACE COVENANT  
CHURCH, SLAVIC BAPTIST CHURCH, CHRISTIAN CHURCH OF MORDEN, BIBLE  
BAPTIST CHURCH, TOBIAS TISSEN, ROSS MACKAY**

Applicants,

– and –

**HER MAJESTY THE QUEEN IN RIGHT OF THE PROVINCE OF MANITOBA,  
DR. BRENT ROUSSIN in his capacity as CHIEF PUBLIC HEALTH OFFICER OF  
MANITOBA, and DR. JAZZ ATWAL in his capacity as ACTING DEPUTY CHIEF  
OFFICER OF HEALTH OF MANITOBA**

Respondents.

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**CROSS EXAM SUMMARIES OF APPLICANTS' WITNESSES**

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**CROSS EXAM SUMMARIES OF APPLICANTS' WITNESSES**

**Dr. Warren**

- He works in a lab that does PCR tests for Covid-19
- His study at footnote 10 on presymptomatic spread – Long term care home is like a household, people live there and there is close contact among residents in the facility
- Qiu study – the authors indicated that it was a challenge to differentiate transmission in presymptomatic versus symptomatic period
  - The majority of secondary cases identified were from the same household
  - They did not test contacts outside of the household
  - The certainty of the evidence in the asymptomatic period is stronger
- Asymptomatic transmission is less than symptomatic transmission

- When SARS CoV-2 enters the body, it replicates in a portion of the population, but not in every person
- It is possible that the SARS CoV-2 virus can enter the nose and not actually infect one's cells due to prior-existing immunity or because it was a small amount that entered the nose.
  - It is possible that under that scenario, the virus could be picked up on a PCR test (when the person wasn't actually infected with SARS CoV2)

### **Dr. Kettner**

- CPHO for H1N1 pandemic
- In the ICU during H1N1, he wanted to know what other health conditions the patients had, i.e. chronic diseases – there are complex reasons why someone becomes ill and passes away
- Without a well detailed surveillance system, one can be misled with insufficient data
- We didn't test for influenza when he was the CPHO, it was never part of disease management to test and count every case
- He is having a hard time figuring out to what degree or in what circumstances SARS CoV2 causes serious illness and death

### **Dr. Bhattacharya**

#### RELEVANT QUALIFICATIONS

- Has a PhD in economics, and an MD
- He teaches medical students and is a Professor of Medicine at Stanford University
- He has written many papers with a focus on the intersection of health outcomes and economics, and many other medical papers which he complained he was not asked to speak about.
- He has studied infectious disease epidemiology for 20 years including HIV, H1N1, H5N1, antibiotic resistance, etc.
- When it was suggested to him that he is not doing primary research on viruses, he said not true, he does primary research on viruses that is published in peer reviewed journals on viruses.

- He confirmed that he did study SARS CoV2 in a lab with his seroprevalence studies in Santa Clara and Los Angeles counties both of which required a lab analysis of antibodies to the virus.
- He studies infectious disease and has published many articles on infectious diseases in peer-reviewed journals over the course of 20 years.
- He has done an enormous amount of research in infectious disease and infectious disease epidemiology.
- He has published in psychiatry in peer-reviewed journals.
- He has spent his entire career building models and working on them.

#### RISK FACTORS FOR SERIOUS OUTCOMES OF COVID-19

- In the US in 2020, more children died from the flu than died from Covid – Covid is substantially less dangerous than the flu for children.
- For Covid-19 mortality, the single biggest risk factor is age. If there is a group of young people getting Covid in crowded conditions, it's very unlikely that there will be many deaths or hospitalizations in that group.
- Diabetes, obesity, and to a lesser extent hypertension are risk factors.
- There is a very steep age gradient for Covid-19, much steeper than for the flu.
- The infection mortality rate data (from Covid-19) suggests that a 52-year-old has a survival rate of 99.8%, and in the US the hospitalization rate would be 4-5%.
- The infection fatality rate provides a much better estimate of how deadly the disease is than the case fatality rate in the newspapers.

#### SANTA CLARA SEROPREVALENCE STUDY - INVESTIGATION

- For the Santa Clara seroprevalence study, the test he used was FDA approved because of its high quality. He undertook an enormous number of investigations to check to see the quality of the test kit he used.
- Stanford lawyers concluded that there was no problem with the conduct of the Santa Clara study.
- Stanford lawyers investigated whether the owner of JetBlue airlines influenced the study's design and outcomes, and the answer was that he did not.
- Stanford lawyers found that there was no conflict of interest.

- He never said that the study was FDA approved in his Facebook ad to recruit volunteers, and the lawyers found nothing was wrong in the way that he recruited volunteers.

## NEW CLASSIFICATION OF DEATHS RE: COVID-19 – COMPARISON TO INFLUENZA AND OVERESTIMATION OF DEATH DUE TO COVID-19

- Statistics Canada guidance on classifying Covid-19 deaths is different than the standard guidance. He says physicians wouldn't normally be told to count any condition as related to Covid unless the physician thought it was related. This is different than the normal counting of deaths.
- As a result, the direct compatibility with the flu statistics is difficult to make.
- WHO Certifying Guidelines for Certifying Covid as a cause of death – the instructions to report Covid on all death certificates where the disease caused or contributed to the cause of death is different than a normal death certificate. If it just contributes, it normally would be listed as a secondary cause of death or not at all. It is a judgment of the doctor that's filling out the death certificate to decide. The new guidance says, if you think it contributed at all, you should count it.
- The key words are “assume to have caused or contributed to death.” The “assume to have caused” means a doctor doesn't need a test to verify that the patient actually had Covid-19, he can mark it down as such. Or if he thinks it contributed in any way, he can put it down as a Covid death.
- The reason that the WHO and Stats Can give this guidance is because it is different than the norms they are used to for this kind of reporting. That is why the document was put together. They have a specific purpose in mind. They want to be very expansive so that they catch things where it really is truly in the chain of the underlying cause of death, which can include situations where it's questionable.
- In response to the assertion that the WHO had to put out new guidelines on Covid because the usual document didn't have any Covid listings, he said that it had other respiratory viral infection listings. Assigning cause of death for respiratory viral infections is not novel and has been done for a very long time. This is new guidance put forward because they wanted doctors to change how they thought about where a respiratory infection goes in the chain/cause of death/underlying cause of death.
- If the purpose of the statistic is to get an upper bound on the number of people for whom it's plausible that Covid figured in the chain of events leading to death, then it's good advice. Whether that number is accurate is a different question. There is great uncertainty around that number.
- Statistics Canada's procedure will lead you to an overestimate of the total number of people for whom Covid really played a role in the underlying cause of death.

- What is unique is the guidance about the threshold for deciding that the disease belongs in the chain of death. The recommended threshold is different for Covid than it is for other respiratory diseases.
- Mortality is the most important factor in understanding the consequences of Covid-19.

## PRE-SYMPTOMATIC v. ASYMPTOMATIC v. SYMPTOMATIC TRANSMISSION

- Presymptomatic transmission – *JAMA* paper (Madewell) is great because it focused on a specific setting, the household. The paper found that if you are asymptomatic or pre-symptomatic, you spread the disease 0.7% of the time.
- He has read that 70% of transmissions take place within a household setting. Households are interesting for asymptomatic and symptomatic spread because it's a place where people don't social distance or wear a mask, and they don't take the precautions they take outside. When a study says that finds that there is 0.7% spread when those precautions aren't taken, it is an upper bound on the likelihood of asymptomatic spread in other settings where some people do take more of those precautions.
- Asymptomatic spread is very, very rare.
- The peak of infectivity corresponds with symptom onset. When people start getting symptoms, it is when they are most likely to be infectious.
- ***He addressed presymptomatic transmission in his second expert report.***
- Presymptomatic spread is very rare in settings where there are no controls.
- Asymptomatic spread – Buitrago Garcia study (China study) – 300 asymptomatic people out of 10 million did not pass Covid-19 on to anyone.
- *JAMA* study is the best study as it reflects what is in the literature. Presymptomatic spread is very rare.
- When challenged on whether the *Qiu* study changes his opinion on the findings in the *Madewell/JAMA* study, he said:
  - *Qiu* says that pre-symptomatic spread is about the same as symptomatic spread.
  - But presymptomatic spread happens for a very short period of time, a couple of days before symptom onset.
  - You need to look at the total risk from it.
  - ***You need to account for the short period of time that pre-symptomatic spread actually happens, and it's rare.***

- The Buitrago Garcia (China study) (300 people) is not pre-symptomatic. It is purely asymptomatic. So that 0.7% has to be coming from mainly pre-symptomatic.
- 0.7% is an upward bound on the risk of presymptomatic spread.
- Problem with the Qiu study is that they didn't just look at household spread. The Madewell/JAMA study is so good because by looking at a homogeneous setting, you control for a lot of exogenous factors that could lead you to an incorrect conclusion. By focusing on a homogenous study, you avoid that problem.
- Qiu study – it uses many studies that wouldn't belong in the Madewell study by nature of the fact that some focus on non-household settings.
- Madewell's study says that the presymptomatic are about as equally likely to spread as symptomatic. BUT if you account for how long they are presymptomatic, which is a very short time, you want to take the average not just of the people, but the time spent producing the risk. They are only presymptomatic for a short time. That is why you get 0.7%.
- Pre-symptomatic and asymptomatic spread are much less important than symptomatic spread.
- In terms of study size, 151 well-chosen individuals will give a very good answer to the question posed in this study.
- ***It makes common sense that asymptomatic spread is less likely. If you are sneezing, coughing, you will spread the virus more than if you are not.***
- What matters with the 151 individuals is that the focus is on household spread. They didn't want to mix in lots of other studies that are in different settings because you have different probabilities of transmission. Most of the spread is symptomatic.

## MODELLING

- He has spent his entire career building models and working on them.
- The question is whether they are populated with enough accurate info so that you can actually come to forecast the path of the epidemic, forecast the number of deaths, and ask whether certain policies are wise or not wise.
- Models can be used to try to get some sense of what the benefits are, but you can also use them to get a sense of the costs of locking down a country as that has enormous costs.
- Models in the literature about the use of forecasting have been very poor.

- He looked at Dr. Loeppky's affidavit and exhibits and didn't see much in the way of details about the assumptions in there that she had made.
- When asked the question about how good or poor Manitoba's model is, he said:
  - The evaluation of Dr. Loeppky's work is that it failed to predict very well about the search and basically a very large number of increases in cases that didn't actually materialize.
  - The transmission models don't account for the fact that asymptomatic transmission is actually quite rare.
  - There are lots of problems with these models – the underlying parameters don't lend competence to results.
  - Manitoba populates its models projecting what the case rise is going to be, and it doesn't account for the CT values. Manitoba's models are going to have a lot of non-infectious people parameterize among people that are deemed infectious inside the context of those compartment walls. There have been estimates on which to base Manitoba's decisions regarding lifting or imposing lockdowns as well. There are all kinds of implications of this kind of error. There are enormous costs of those actions, so Manitoba should want a realistic appraisal of the risk as well as the realistic appraisal of benefits. If you ignore the CT value parameters, you will end up making poor decisions not justified by the data.

#### EFFICACY OF LOCKDOWNS / GREAT BARRINGTON DECLARATION APPROACH

- When asked if there was a randomized study of the Great Barrington approach, he responded that unlike the lockdowns, it's not an experiment it is standard public health.
- He says the best study that is published on lockdown efficacy was ***his own study*** published in the *European Journal of Clinical Investigation*. It compared places that had very severe lockdowns to those that did not have mandatory stay-at-home orders or business closures. It found that there was no difference in the growth of cases in the places with severe lockdown versus the places that avoided the lockdown.
- The growing consensus in the literature is that lockdowns are not particularly effective over a long period of time.
- There are 30 papers he could have cited for this consensus.
- The *Nature* (Savaris) study is excellent (in Scientific Reports) on lockdown efficacy, but he thinks his own study is better. These studies are better because they are using real comparators, not models.



- ***The editors of the Savaris paper (Scientific Reports/Nature) are not telling the public not to rely on the paper, they are telling the public that there are criticisms of the paper and they are letting the authors respond. The paper is controversial because it is of interest both within the scientific community and outside of the scientific community – its results call into question government decisions. That makes it controversial.***
- Sweden for example did not lock down and it had the same results as countries that did lock down.
- Florida age adjusted death rate is now lower than California by quite a bit. Florida has the lowest age adjusted Covid death rate in the country.
- Florida and California are similarly dense, have similar climates, yet they have very different policies. He says what can be learned from Florida and California is that lockdowns are not the final driver of these outcomes otherwise Florida would have ended up much worse.
- The Governor of Florida has adopted the principles of the Great Barrington Declaration. Many jurisdictions have adopted the principle in terms of how vaccines were rolled out. The idea of Focused Protection is much more widely accepted now than in October 2020.
- There are some people who are vulnerable to Covid-19 and some who are not. Governments cannot treat everyone as if they are all the same risk when it is possible to focus attention on the population most at risk.
- Due to vaccinations, in Sweden, US and Israel, when cases go up, deaths don't follow. When appropriate Focused Protection plans are followed, death rates don't follow increases in cases. Sweden had an enormous rise in cases since February, but deaths haven't followed because of the vaccinations.
- Tens of thousands of epidemiologists, scientists, doctors have signed the Great Barrington Declaration. There is less support for "community suppression" in Canada than the government may think there is. A lot of Canadian health professionals are uncomfortable with the suppression strategies.
- North Dakota followed the lockdowns. South Dakota did not. If you compare the two, they have very similar results.

## LOCKDOWN HARMS / LACK OF COST/BENEFIT ANALYSIS

- Plummeting vaccination rates can be due to the fact that people were afraid to go to the hospital or clinic. The government sets the tone for the policy. If the government sets the tone for panic, then people will not bring their kids in to be vaccinated.

- People are not getting routine checkups because they are scared to go to the doctor. When there are public announcements that the hospital systems are overrun, people stay home even with very severe illness.
- The anxiety caused by the Covid response and the lockdown has affected everyone. Some people are coping, and some are not. Lockdowns have caused enormous mental stress on the population. Alcoholism is sharply up in Canada.
- Lockdowns cause increased anxiety, increased alcoholism, increased opioid use. A substantial portion of people are suffering mental anguish caused by lockdowns.
- One in four young adults in the US has seriously considered suicide last June.
- When asked about a negative outcome of Covid-19 which is like PTSD, he said: That negative outcome doesn't necessarily have to do with getting Covid-19. People who never had Covid-19 have similar kinds of psychiatric outcomes. The issue is the panic around Covid more than getting it.
- When the demand for fentanyl goes up because of psychological distress caused by the lockdown or the 2008 recession, unfortunate things happen. They are entirely predictable.
- Lifting the lockdown would reduce the demand for these drugs.
- Drug users weren't getting the services they needed because the clinics were short staffed due to the lockdowns. Governments can't use the risk of staff getting Covid as an excuse not to provide services to patients who are dying. The result is the increase in opioid deaths in the community.
- It is the Canadian health system's job to provide the care for these patients so that they don't die at higher rates than they have. They should protect the vulnerable staff who are at high risk from Covid, but not in a way that compromises the care to which the profession is committed to give.
- As a result of their not coming up with creative solutions to provide care to patients with drug addictions, there is increased death in the Canadian population.
- The fact that drug users are using drugs at such high rates and dying from it is an inevitable outcome of the lockdown policy.
- Isolation itself in the elderly population, especially in the population with dementia, leads to increased medical care needs and mortality. The isolation caused by the lockdowns, especially the extended isolations for many families from their parents living in long term care home facilities could very easily be an important cause of the rise in deaths.
- Isolation is a cause of death.

- In the US there was an enormous increase in suicide ideation. All cause excess deaths went up in the younger population in the US. It's not Covid because Covid doesn't have that high mortality rate in the younger age group. The primary causes are related to lockdown.
- When asked about how a lockdown in Manitoba can have any effect on world poverty and economic collapse in the third world as a result of the lockdown, he answered: ...the reasoning is the same as with CO2 and global warming. One jurisdiction doesn't have an effect on the overall large scheme, but if those connections are ignored, the third world suffers much more than the first world.
- Sweden had its schools open for the whole epidemic. Teachers had lower Covid rates than the average of other essential workers. Children were at a very low, almost zero risk of dying. Schools can stay open safely and they should because schools are vitally important for children.
- Children are a much less risk of spreading disease than adults, and the harm to children from closing schools is so high.
- When asked about children getting hyperinflammatory antibody response from Covid-19, his response was: ...with any viral infection, this is not unique. Influenza also causes some extra respiratory consequences. Mono has longer term fatiguing effects. This is not distinct from other viruses in that sense.
- Part of the responsibility of public health is to help people manage the uncertainty of how Covid-19 will affect them if they get it. Study after study shows that people overestimate the harm, the likelihood of severe outcomes from Covid. That is an indicator of failed public health messaging. The Canadian Mental Health Association document (TAB 109) shows that there is a lot of worry about being separated from family and friends in Manitoba and elsewhere. The lockdowns themselves create this kind of anxiety.
- The tool for managing the uncertainty is the cost/benefit analysis. He is surprised in this case and in other cases he has testified in that there has been a lot of effort to understand the uncertainty around Covid risk but almost nothing in parallel to understand lockdown harms, to do a cost/benefit analysis.
- For an extraordinary measure like a lockdown it would be appropriate for governments to consider both the harms and benefits together in making these decisions. Each restriction should have that similar kind of analysis done where the harms and the benefits are both considered.
- When asked to agree that in the circumstances of a pandemic, decisions have to be made on a fairly quick basis, he responded: I would have expected more of an analysis of the harms of lockdowns after a year of the pandemic to help inform government decisions.
- Putting in mental health supports after the fact is a good step, but governments should also consider the mental health effects when imposing the lockdowns. A

vital part of public health is to consider harms – costs and benefits - before enacting extraordinary measures. That is what is missing.

## WHO / CDC GUIDANCE FOR RELIGIOUS COMMUNITIES DURING THE PANDEMIC

- WHO Guidance from April 2020 provides guidance on how religious gatherings can happen safely. The guidelines say, if you are going to have a religious gathering, here is how to do it safely. Religious services should remain a vital part of national life even during a lockdown.
- CDC Guidance on religious services gives tools to be used by faith communities so that they can continue to practice their faith in the middle of a pandemic. The document states an important principle which is that “No faith community should be asked to adopt any mitigation strategies that are more stringent than mitigation strategies that are asked of similarly situated entities or activities.” Governments should not discriminate against religious activities.
- The fact that this court is hearing this case is that there has been a failure of public health – it has lost a connection with the community it is supposed to serve.
- There should be guidance for religious communities, but in many places in the US the religious communities cooperate with it because they have been accommodated. Where they haven’t been accommodated, court cases such as this one arise.

## HERD IMMUNITY

- He studied immunology in medical school, and he knows how to read the medical literature because he has been doing that for a long time.
- The evidence about immunity after infection is overwhelming. The John Snow Memorandum makes an enormous mistake on that point. It says that there is some doubt about whether immunity occurs after a natural infection, which is false. There is no doubt. Immunity can last a very long time.
- There is a range of responses to vaccines as well as to natural infection.

## PCR TEST

- The PCR test can turn positive when only viral fragments are present.
- It finds fragments of sequence and you infer whether it’s infectious or not. Like any medical test, there are false positives and false negatives.

- CT value is a proxy for infectiousness, but it's only a good proxy if you account for how many cycles it took to get to the point of being able to detect it. If you say that you will declare a positive at the 40<sup>th</sup> replication point, that is a poor proxy.
- A test is often called positive as if it was positive for infectiousness when all it is positive for is the presence of a viral fragment.
- A positive test does not mean infectiousness. The fragment was present in some quantity, no matter how small, and whether it was infectious or not.
- Cell culture is a proxy for infectiousness. Growth of cell culture doesn't mean that the patient was infectious, but it is a much better proxy than the high CT PCR test.
- "False positive" other authors have used in the scientific literature. It is used all of the time. He introduced "functional false positive".
- In footnote 150, the study authors found that in the settings with high cycle times, there is a very high inability to grow the virus.
- Manitoba populates its models projecting what the case rise is going to be, and it doesn't account for the CT values. Manitoba's models are going to have a lot of non-infectious people parameterize among people that are deemed infectious inside the context of those compartment walls. There have been estimates on which to base Manitoba's decisions regarding lifting or imposing lockdowns as well. There are all kinds of implications of this kind of error. There are enormous costs of those actions, so Manitoba should want a realistic appraisal of the risk as well as the realistic appraisal of benefits. If you ignore the CT value parameters, you will end up making poor decisions not justified by the data.

## CONTACT TRACING

- He doesn't believe that anyone thinks contact tracing works very well.
- UK concluded that contact tracing was very ineffective in accomplishing much. When the cases are high contact tracers get overwhelmed.
- The time delay between the identification of the case and the contacts is long, and that basically undermines its efficacy altogether. If you find someone who was sick three weeks ago, it is unlikely they are still sick. It can create incentives in the population to underreport.

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