No. T-2030-13

FEDERAL COURT

BETWEEN:

NEIL ALLARD
TANYA BEEMISH
DAVID HEBERT
SHAWN DAVEY

PLAINTIFFS

AND:

HER MAJESTY THE QUEEN IN THE RIGHT OF CANADA

DEFENDANT

PLAINTIFFS' MEMORANDUM OF ARGUMENT

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OVERVIEW

1. Plaintiffs[1] consume cannabis for medical purposes per the approval of their medical practitioner under the provisions of either the *Narcotic Control Regulations (NCR)* or the *Medical Marihuana Access Regulations (MMAR)* or the *Marihuana for Medical Purposes Regulations (MMPR)* pursuant to the *Controlled Drugs and Substances Act (CDSA)*.

2. All are, therefore, partially exempt from the general criminal prohibition in the *CDSA* and are or were entitled to lawfully possess (under the *MMAR)* a 30 day supply and to produce and store cannabis for themselves[2],at any approved location and indoors or outdooors.

3. When able to produce cannabis, Plaintiffs have access to a safe, effective supply of medicine that is sufficient to meet their medical needs as determined by their physician. Plaintiffs consume their medical cannabis in a variety of ways, including by smoking, vaporization and by making it into derivative products such as tea, cookies or balms/lotions. They produce, possess and consume cannabis for medical purposes without harm to their own health and safety and without harm or appreciable risk thereof to public health and safety.

4. Defendant removed from the Plaintiffs the lawful ability to produce cannabis in the *MMPR*. It also maintained the prohibition on producing and possessing forms of medical cannabis other than "dried marihuana" and imposed a maximum possession limit of 150 grams, irrespective of patient need. The effect of this withdrawal of rights was to deny the Plaintiffs reasonable access to a continuous safe supply of their medicine, in a manner to which they had become accustomed over numerous years, causing Ms. Beemish (and others) very significant negative effects on health and well-being. But for an injunction issued by this Court, all Plaintiffs would have suffered similar irreparable harms.[3].

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[1] References to "Plaintiffs" should also be read to include those persons similarly situated to Plaintiffs.
[2] References to producers under the *MMAR* should be read to include both personal and designated caregiver production.
[3] Order of Manson J., 2014 FC 280, and affirmed by the Federal Court of Appeal, 2014 FCA 298, and subsequent order of Manson J., 2014 FC 1260.

5. The issue before the Court is whether the Defendant's regulatory scheme (comprised of the *CDSA* as modified by the *MMPR*) violates s. 7 of the *Canadian Charter of Rights and Freedoms* because certain restrictions contained in that scheme infringe the Plaintiffs' liberty and security of the person interests in a manner that does not comport with the principles of fundamental justice and is not saved by section 1

6. The impugned restrictions infringe the liberty and security of the person interests by: (a) criminalizing Plaintiffs' conduct; (b) intruding upon decisions of fundamental personal importance; (c) creating significant and insurmountable state-imposed barriers to accessing a safe, effective and adequate supply of their approved medicine.

7. The evidence at trial further demonstrated that these infringements do not accord with the principles of fundamental justice because they are arbitrary, overbroad and produce effects that are grossly disproportionate to any intended benefits.

8. Finally, Defendant's evidence at trial failed to establish that the s. 7 infringements are reasonable and demonstrably justified pursuant to s. 1 of the *Charter* because: (a) Defendant does not have a pressing and substantial interest in curtailing access to medical cannabis by medically-approved patients and, (b) the impugned restrictions are not rationally connected to any legitimate state objective, do not minimally impair the rights at issue and produce deleterious effects that are disproportionate to any salutary effects.

9. Plaintiffs seek declarations, pursuant to *sections 7, 24(1) and 52(1)* of the *Charter*, Part 1 of the *Constitution Act*, 1982:

> 1. That in order for the *CDSA* to be valid and enforceable legislation, s. 7 requires the state to provide a "constitutionally viable exemption" from the provisions of the *CDSA* to enable the medical use of cannabis in any of its effective forms, including the right of the patient (or a person designated as responsible for the patient) to not only possess in a reasonable amount and use cannabis in any of its forms, but to also cultivate or produce, indoors or outdoors, and possess cannabis in any form that is effective for the treatment of the patient's medical condition;
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> 2. That the *MMPR (*which came into force on June 19, 2013) violate s. 7 of the Charter by, in combination with the *CDSA*, prohibiting personal production of medicinal cannabis by the patient or a designated caregiver of the patient in a manner that cannot be saved by s. 1;
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> 3. That the restriction to "dried marihuana" only contained in the *MMAR* and *MMPR* violates s. 7 in a manner that cannot be saved by s. 1.

4. That the *MMPR* restriction relating to possession and storage by patients to "30 x the daily quantity authorized or 150 grams maximum, whichever is the lesser" violates s. 7 in a manner that is not saved by s. 1.

10. In addition, Plaintiffs seek an Order under s. 24(1) of the *Canadian Charter of Rights and Freedoms* as the appropriate and just final remedy, declaring that the full ambit and scope of the medically approved patients' s. 7 constitutional rights includes the right to produce, possess and store their medicine without any unreasonable and unnecessary restrictions.

11. In the alternative, Plaintiffs seek a permanent constitutional exemption from ss. 4, 5 and 7 of the *CDSA* for all persons holding an authorization to possess pursuant to s. 53 of the *NCR* or an authorization to possess (ATP) pursuant to the *MMAR* and a personal production licence as well as all persons holding an authorization to possess and who have a person designated to produce for them under the *MMAR*, including the designated producer.

12. In the further alternative, Plaintiffs seek an order in the nature of a permanent injunction preserving the provisions of the *MMAR* relating to personal production, possession, production location and storage by a patient or designated caregiver and related ancillary provisions, and if necessary, limiting the applicability of certain provisions of the *MMPR* to such patients or designated caregivers, until such time as Defendant makes appropriate amendments to the *MMPR* to comply with any decision of this Court.

FACTS

Overview of the evidence of the patient-plaintiffs

13. Plaintiffs produce their medicine indoors and outdoors, in residential settings and in outbuildings in agricultural settings. Some Plaintiffs use "dried marihuana" in various forms, including by way of smoking or vaporizing and some use other forms of cannabis other than dried marihuana that are effective for the particular individual. Some of them find that raw cannabis that has not been dried or had heat applied to it (eg raw marihuana juice extracted by a juicer machine) to be a more effective, and non-psychoactive, treatment for their particular ailment. Other effective forms of treatment derived from raw cannabis include the use of extracts or derivative products

such as edibles (cookies and the like) and topical oils, salves and creams. Individual patients have developed these treatment techniques after much trial and error, and as a result have determined that the use of cannabis in various forms is more effective for the treatment of the patients' particular illness.

14. Some Plaintiffs have been producing their own medicine under the *MMAR* for a considerable period of time, and as such have invested in and constructed appropriate facilities and equipment to do so, including equipment to limit the impact of such production on others and for security purposes, and have gone to considerable lengths to ensure a safe, uncontaminated, production site sensitive to the need to avoid a negative impact on their weakened immune systems cause by their various illnesses. They have not had any fires, nor suffered from any toxic mold, nor been subjected to any attempted thefts, nor engaged in diversion to the black market.

15. Most Plaintiffs found that they could not afford to purchase a safe, continuous and consistent quality supply of medical cannabis from the black or illicit market, including compassion clubs and dispensaries, nor could they acquire what they needed through a cost-subsidized government supply provided by Prairie Plant Systems. Plaintiffs learned how to produce their own and took substantial steps to control their production of marihuana to ensure the affordability, safety, quality and regularity of the medicine produced in a safe and healthy manner and location.

16. Defendant admitted at trial that it has no evidence that any named Plaintiff produced their medicine in a manner that was unsafe and/or intruded upon the rights of others. Defendant also admitted that none of the named Plaintiffs are engaged in diversion to the black market. In other words, the evidence at trial confirmed that these Plaintiffs' conduct does not fall into the various categories of harms that Defendant seeks to prevent by its regulatory choices.[4]

Plaintiff's fact evidence

Plaintiff Neil Allard

17. Plaintiff Neil Allard is 60 years old and lives alone in a detached residential

[4] Plaintiffs confine this paragraph to the named Plaintiffs but submit that based on the evidence at trial there is little evidence that any *MMAR* patients engaged in conduct causing or posing unreasonable risk of harm to health and safety.

dwelling in Nanaimo, B.C [5] He suffers from a disease called "*Myalgic Encephalomyelitis*", a serious neuro-immune disorder similar to multiple sclerosis which affects every system in his body. He also suffers from clinical depression. He was declared permanently medically retired in 1999.[6]

18. Mr. Allard's symptoms include total body pain (aching and sharp), encompassing his entire trunk, anterior and posterior, and his head; muscle and joint pain; abdominal and gastrointestinal issues including nausea and cramping, extreme cold; weakness; numbness; difficulty sitting due to back pain; headaches; depression; debilitating fatigue and extremely low energy levels; sensitivity to noise; cognitive and memory problems; tinnitus; sleep difficulties; nausea; and poor appetite.[7]

19. Mr. Allard's doctors prescribed numerous conventional medications to treat his symptoms many of which were ineffective and caused intolerable side effects that worsened his overall state. Mr. Allard has a profound sensitivity and intolerance to most chemicals and pharmaceutical medications.[8]

20. Mr. Allard's doctors first recommended he try cannabis as a medical treatment for his symptoms in 1998, and continue to recommend its use. The results have been very positive. It helps alleviate his muscle and joint pain, and it helps with his headaches, sleep, relaxation, appetite, ringing in his ears, depression, and energy levels. It helps with side effects from his pharmaceutical drugs. His quality of life has improved. Cannabis is the only medication that has been effective for him.[9]

21. Mr. Allard's current prescribed dosage is 20 grams of cannabis per day.[10] At the time of trial he consumed about 15 to 20 grams per day by vaporizing, plus an additional amount for juicing, edibles, and oils, which amount meets his current medical needs. He finds that consuming cannabis juice, which is non-psychoactive,

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[5] Allard Affidavit ("Aff.") No. 1., para. 2, 15, 27 (Exhibit Books ("EB"), p. 219, 222, 226)
[6] Allard Aff. No. 1, para. 4, Exhibit ("Exh.") C, M (EB p. 220, 235, 245)
[7] Allard Aff. No. 1, Exh. M, N, Q (EB p. 245, 246-248, 264-266); Transcripts, Vol. 3, p. 274, l. 20 to p. 275, l. 18
[8] Allard Affidavit No. 1, para. 6, exh. L, N; Affidavit No. 2, exh. B; Transcripts, p. 363, l. 25 to p. 364, l. 7
[9] Allard Aff. No. 1, para. 6, 23, 28, Exh. L, M, N (EB p. 220-221, 226-227, 244-248); Transcripts, Vol. 3, p. 302, l. 2 to p. 303, l. 9
[10] Allard Affidavit No. 2, para. 3

relieves his nausea, cramping and other gastro-intestinal symptoms, and improves his energy and cognitive abilities.[11]

22. Mr. Allard primarily consumes cannabis by way of vaporizing, but he also smokes it sometimes. He also consumes cannabis orally by way of baked goods made with dried cannabis or cannabis butter or oil, tea, as well as placing oil under his tongue. He uses cannabis oil topically to treat skin, back, and other body pain, and itchiness. When he has fresh cannabis he makes cannabis juice and stores any remainder by freezing it.[12]

23. Mr. Allard reduced the number of pharmaceutical drugs he uses because of cannabis. For example, when his doctors increased his dosage from 10 to 20 grams per day he was able to stop using three pharmaceutical medications, Baclofen, Clonidine, and Renadine.[13]

24. Mr. Allard initially obtained his medical marihuana through the BC Compassion Club Society in Vancouver, but found that he could not afford the costs of approximately $500 per month, and he was not satisfied with the quality and types of marihuana that were available. He realized that to obtain the types of marihuana he needed to treat his illness, and at a cost he could afford, he would have to produce for himself. He did his own research on cultivation of cannabis and obtained the appropriate licences.[14]

25. Mr. Allard's indoor site was built by professional certified tradespeople, in the basement of his home, to ensure safety and building standards were met. An electrical inspection was conducted by BC Hydro. He ensures all precautions are taken, to avoid any contaminations such as mold. He has installed significant security features.[15]

26. Mr. Allard grows and uses about a dozen different strains; the number and type changes over time due to him developing tolerance. He determined through trial and

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[11] Allard Aff. No. 1, para. 21, Aff. No. 2, para. 4(g), Aff. No. 3, para. 5-7 (EB p. 181-182, 186, 225); Transcripts, Vol. 3, p. 285, l. 18 to p. 293, l. 9; p. 360, l. 24-27

[12] Allard Affidavit no. 1, para. 20, 28 (EB p. 181-183); Transcripts, Vol. 3, p. 293, l. 13 to p. 296, l. 10

[13] Transcripts, p. 292, l. 24-27

[14] Allard Aff. No. 1, para. 19-20 (EB p. 224-225); Transcripts, Vol. 3, p. 298, l. 16 to p. 300, l. 1

[15] Allard Aff. No. 1, para. 15, 16, 17 (EB p. 222-224)

error which strains, and which hybrids of strains, are most effective to treat his various symptoms.[16]

27. Mr. Allard must only consume organically grown cannabis because of his intolerance to chemicals. Growing his own cannabis allows him to ensure the cannabis is organic and high quality, that he has access to fresh plant material, and that he has sufficient quantities of and access to the particular strains that are most therapeutically effective for him. Knowing he has a continuous safe supply of the medical cannabis he needs reduces his stress and anxiety levels. And he derives therapeutic benefit from cultivating his medical cannabis plants, including reduction of stress, gentle exercise, and a spiritual meditative benefit.[17]

28. Mr. Allard's organic method of cultivating cannabis yields approximately (and sometimes less than) one ounce (28 grams) per plant. He is currently growing 23 plants, at different stages of growth, and he has had up to 75 at one time of which 20-30 were clones. He produces all the cannabis he needs (about 600 grams per month).[18]

29. Mr. Allard's monthly after tax income is approximately $2,700 per month and his monthly expenses are approximately $2,300 per month, leaving about $400 per month left over, which he puts in savings. When Mr. Allard turns 65 his income will decrease to $24,000 per year, or $2,000 per month. His monthly expenses to cultivate his monthly medical cannabis needs (approximately 600 grams per month) total approximately $230 per month.[19] This amounts to a monthly cost of $0.38 per gram.

30. Mr. Allard spent approximately $14,365 on structural type improvements to set up his basement for safe and effect growing of medical cannabis, and approximately $6,766 on various equipment, for a total of approximately $21,131.[20]

31. Based on illicit market and estimated licenced producer prices, which range from $5-$12 per gram, and assuming these costs apply to organically grown strains that Mr. Allard requires, his costs would increase to between $100 and $240 per day,

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[16] Allard Aff. No. 1, para. 19-20 (EB p. 224-225); Transcripts, Vol. 3, p. 298, l. 16 to p. 300, l. 1

[17] Allard Aff. No. 1, para. 22-23, Aff No. 2, para. 6, 9, 10 (EB p. 187-190, 225-226); Transcripts, Vol. 3, p. 305, l. 23 to p. 306, l. 24; p. 331, l. 7-11

[18] Allard Aff. No. 1, para. 3, 18, Affidavit No. 2, para. 30 (EB p. 199-201, 220, 224); Transcripts, Vol. 3, p. 337, l. 19-28, p. 352, l. 8-26

[19] Allard Aff. No. 1, para. 3, 18, Affidavit No. 2, para. 30 (EB p. 199-201, 220, 224); Transcripts, Vol. 3, p. 337 to p. 338, l. 20; p. 341, l. 46; p. 352, l. 8-26

[20] Allard Aff. No. 2, para. 32, 33 (EB p. 202-204)

or $3,000 to $7,200 per month. Even at $5 per gram the cost of Mr. Allard's medicine would exceed his current total after tax pension income.[21]

32. Mr. Allard fears that he will be charged criminally and possibly imprisoned if he continues to produce marihuana if his permit expires, which causes him significant stress and anxiety about his future. He will also no longer be able to use raw marihuana treatments like juicing, and extracts and edibles, which have proved effective for his illness, and he fears that his health will suffer.[22]

Tanya Beemish and David Hebert

33. Plaintiff, Tanya Beemish is 27 years old and her common law spouse is Plaintiff, David Hebert, age 32. Mr. Hebert is an agricultural technician, biologist, and environmental professional currently employed as an inspector of hazardous waste by the B.C. Provincial Government. Ms. Beemish was formerly employed as a barista at Starbucks. Until recently they lived together in Surrey, B.C.[23]

34. Ms. Beemish suffers from Type I Diabetes and a related complication of gastroparesis, which causes her to suffer from extreme nausea, continuous vomiting, pain, lack of appetite and sleeplessness. She often requires a GJ tube which by-passes her stomach. Ms. Beemish is on many pharmaceutical medications for her condition that have limited effectiveness and cause significant negative side effects.[24]

35. Cannabis is an effective treatment for Ms. Beemish for her nausea and discomfort, stimulates her appetite, helps with her anxiety and depression, and helps reduce the unpleasant negative effects of her other medications. She consumes medical cannabis primarily by smoking and vaporizing, in part because eating is difficult for her. She also drank a lot of cannabis juice (mixed with other vegetables), which she found pleasant and helped her symptoms and which research suggests may regenerate damages nerves in her stomach and help with her diabetes.[25]

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[21] Allard Aff. No. 1, para. 21; Aff. No. 2, para. 22 (EB, p. 195, 225)
[22] Allard Aff. No. 1, para. 27, 30, Aff. No. 2, para. 22 (EB p. 195-196, 226-228)
[23] Hebert Aff. No. 1, para. 1, 2; Beemish Aff. No. 1, para. 2, 3 (EB p. 126, 168-169)
[24] Beemish Aff. No. 1, para. 4, 8; Aff. No. 2, para. 2, 12; Aff. No. 3, para. 3 (EB p. 145, 148, 151, 169-170)
[25] Beemish Aff. No. 1, para. 4, 5, 8, 9; Aff. No. 2, para. 2, 9, 12, 25; Aff. No. 3, para. 3 (EB p. 145, 148, 151, 169-170); Transcripts, vol. 2, p. 233, l. 2-7

36. The cannabis strain "Whiteberry" is the most effective at treating Ms. Beemish's nausea and discomfort, another called "Blueberry" is also effective. She determined this through trial and error. Whiteberry is a difficult strain to purchase on the black market and is the most expensive.[26]

37. Ms. Beemish was authorized to use up to 5 grams per day. Prior to November 2013, when Ms. Beemish had access to affordable home-produced cannabis, she used 2 to 10 g of medical cannabis per day to treat her symptoms, depending on their severity. When she has been home in recent months she uses around 10-12 grams per day and up to 15 grams.[27]

38. Ms. Beemish was authorized to possess 150 g on her person and to store 1125 g at her production site. Her designated producer was Mr. Hebert, who was authorized to grow 25 plants. They usually stored 300 to 500 grams after a harvest.[28]

39. Ms. Beemish receives a disability pension of $619 per month because she is unable to work due to her condition, and Mr. Hebert's take home pay after all taxes and deductions is $3,078, for a total monthly combined monthly income of $3,697.[29] Mr. Hebert and Ms. Beemish's monthly expenses when they had the cannabis garden totaled about $4,750, exceeding their monthly income, due in large part to monthly interest payments of $2,375 per month.[30]

40. Mr. Hebert produced on average about 130 grams per month of organically grown cannabis buds (not including fresh leaves) at a monthly cost of $110, which amounts to $0.85 per gram. He never grew more than 14 plants. The setup costs for his grow tent and growing equipment was $4,225.97.[31]

41. Mr. Hebert took the necessary steps to ensure that the cannabis production was safe and secure, clean and healthy (suitable for organic growing), and would not impact on their neighbours by smell or otherwise. They never had any complaints or

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[26] Beemish Aff. No. 2, para. 17, 20, 21 (115, 117-118) ; Transcripts, Vol. 2, p. 256, l. 9 to 15, p. 257, l. 3 to 12, p. 260, l. 17-22

[27] Beemish Aff. No. 1, para. 5, 8, 9 (EB p. 169-170) ; Transcripts, Vol. 2, p. 203, 22-26, p. 233, l. 20-24

[28] Hebert Aff. No. 1, para. 2; Beemish Aff. No. 1, para. 7, 13. (EB p. 126-127, 169, 171).

[29] Transcripts, Vol. 2, p. 223, l. 26 to p. 225, l. 4; Beemish Aff. No. 2, para. 27 (EB p. 155)

[30] Hebert Aff. No. 2, para. 3-5, Exh. D, E (EB p. 111-112, 138-139); Transcripts, Vol. 2, p. 200, l. 15 to p. 201, l. 9

[31] Hebert Aff. No. 1, para. 12-13; Aff. No. 2, para. 27 (EB p. 119-120, 130); Transcripts, Vol. 2, p. 188, l. 13 to p. 189, l. 3. Hebert produced approximately 1,180 grams in 9 months.

problems. A certified electrician installed and inspected the electrical components to ensure safety.[32]

42. Mr. Hebert primarily grew two specific types of organic cannabis, Whiteberry and Blueberry and he does not trust others including the LPs to provide his wife with a safe continuous organic supply of the particular medical cannabis she needs, even if they could afford it, which they cannot.[33]

43. When Ms. Beemish had an adequate supply of affordable organic whiteberry cannabis her symptoms were not as severe as they have been since losing the production licence in October 2013. That loss removed from her a safe, continuous, affordable supply of medicine.[34]

44. Since November 2013, Ms. Beemish has spent most of her time hospitalized and in misery, suffering greatly from gastro-intestinal pain and extreme nausea. She is not permitted to use medical cannabis in the hospital, which aggravates her suffering.[35]

45. If the injunction had covered Ms. Beemish and Mr. Hebert, they would have moved to a residence where Mr. Hebert would have continued to grow medical cannabis for his wife using the equipment from their previous residence. However, since the injunction did not cover Mr. Hebert, if he had decided to continue producing cannabis for his wife after November 2013 without a permit, he would have risked criminal charges, losing his job, and possible incarceration of at least 6 months.[36]

46. In October 2013, Ms. Beemish and Mr. Hebert had to move to another location due to the previous residence being unaffordable. While they notified Health Canada prior to September 30, 2013 of their need to relocate, by the time they found a new location the September 30, 2013 deadline had passed and they were unable to move their production to a new site.[37]

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[32] Hebert Aff. No. 1., paras. 8, 9; Aff. No. 2, paras. 18, 20, 21, 27, 28, 29, 30, 41, 47 (EB p. 116-121, 123, 125, 128-129); Transcripts, p. 195, l. 24-28

[33] Hebert Aff. No.1, paras. 4-5, 9, 16; Aff. No. 3, paras. 6-7 (EB p. 107-108, 127, 129, 131)

[34] Transcripts, Vol. 2, p. 233, l. 25 to p. 234, l. 26

[35] Beemish Aff. Aff. No. 2, para. 25; Aff. No. 3, para 3 (EB p. 145, 154); Transcripts, Vol. 2, p. 234, l. 10-26

[36] Hebert Aff. No. 1, para. 11 (EB p. 129); Transcripts, Vol. 2, p. 173, l. 13-16

[37] Hebert Aff. No. 1, para. 15 (EB p. 131)

47. Since about November 2013, Mr. Hebert has been buying for his wife organically grown Whiteberry cannabis from an illegal grower at a discounted compassionate rate of about $4-5 per gram, risking his liberty for his wife's health and spending about $300 per month for about 60 grams (or somewhat more), which is an adequate amount only because Ms. Beemish now spends most of her time in hospital.[38]

48. The best LP price Mr. Hebert could find for what Ms. Beemish needs was $9 per gram, although those LPs were sold out or not accepting patients, and even then fresh marihuana for juicing is not available. Mr. Hebert also has serious concerns about giving LPs private medical or financial information.[39]

49. If Ms. Beemish is required to buy from LPs rather than have Mr. Hebert grow for her, they would have to choose between buying Ms. Beemish her medical cannabis and between other necessities of life.[40]

Shawn Davey and his caregiver Brian Alexander

50. Plaintiff Shawn Davey is a 38-year-old man who until June 2000 worked 70 hours a week building custom vehicles. On June 16, 2000, he was involved in a serious motor vehicle accident that resulted in a permanent severe brain injury, which reduced his cognitive abilities and causes him to experience constant major pain, numbness for half his body, as well as memory and balance problems.[41]

51. For the first 6 years after his motor vehicle accident Mr. Davey was on prescription medication that cost him approximately $3000 per month, was of unsatisfactory efficacy, and which caused significant unpleasant side effects.[42]

52. Mr. Davey receives $4,500 per month as a result of the motor vehicle accident settlement, together with another $619 per month from a Canada Pension Plan disability pension, for a monthly income of approximately $5,100 month. His monthly expenses including cannabis growing expenses total about $3,747. He has a

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[38] Hebert Aff. No. 3, para. 6 (EB p. 127-128); Transcripts, Vol. 2, p. 201, l. 16 to p. 203, l. 5; p. 207, l. 7-17
[39] Hebert Aff. No. 3, para. 6 (EB p. 127-128); Transcripts, Vol. 2, p. 215, l. 2-22
[40] Transcripts, Vol. 2, p. 235, l. 2 to 13
[41] Transcripts, Vo. 2., p. 31, l. 26 to p. 33, l. 26, p. 93, l. 12-25
[42] Davey Aff. No. 1, para. 12 (EB p. 35)

teenaged son from a previous marriage and continues to voluntarily pay some support for him to his former spouse.[43]

53. Mr. Davey was introduced to medical cannabis in 2002 through a friend when he was in the GF Strong Rehabilitation Center. Cannabis relieves his pain without the negative side effects of the prescription drugs. He also tried the "THC pill" (likely Nabilone or Sativex) and did not like it or find it effective. Thereafter, his doctor prescribed him cannabis that he bought from friends until 2010 when he received an ATP. He tried various designated producers as well as producing for himself but was unhappy with the quality and quantity of the cannabis produced both by the other producers and by himself alone; he was forced to buy from the black market to meet his medical needs at unaffordable cost.[44]

54. Mr. Davey's ATP prescription dosage started at 10 g per day in mid-2010, increased to 12 g per day in 2011, then 14 g per day in 2012, and then to 25 g per day in September 2013. He uses on average all 25 grams per day. Under his last PUPL Mr. Davey was authorized to cultivate 122 plants indoors and store 5290 g. Under his last ATP for a dosage of 25 grams per day he was entitled to possess up to 750 g on his person at any time, a 30 day supply, but the *MMPR* now limits him to 150 g or a 6 day supply.[45]

55. In or about 2012 Mr. Davey met his neighbor Brian Alexander, also an *MMAR* patient, and they leased a five-acre property in the agricultural land reserve that contains a residence, a barn/outbuilding, and distant neighbors, for the purpose of cultivating medical cannabis. Mr. Davey moved into the residence. Mr. Alexander visits the property regularly and has become Mr. Davey's caregiver in other aspects of his life.[46]

56. Mr. Alexander is 44 years old, married, with three children, and works as a self-employed framer and construction contractor. He is prescribed cannabis to treat chronic pain caused by traumatic injuries to his joints, fractures to his ankles and hands, and by osteoarthritis and sciatica. Mr. Alexander had an ATP for 900 grams on

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[43] Davey Aff. No. 1, para. 2-6 (EB p. 32-33); Transcripts, Vol. 1, p. 30, l. 23-28, p. 85-86
[44] Affidavit Davey No. 1, para. 6-7; Aff. No. 2, paras. 8, 9, 19 (EB p. 8, 12, 33); Transcripts, Vol. 1, p. 30, p. 34, l. 22-28, p. 36-37, 47, 52-53, 64, 67-68, 101-102
[45] Davey Aff. No. 1, para. 7-9 (EB p. 33-34); Transcripts, Vol. 1, p. 35-38
[46] Davey Aff. No. 1, para. 11 (EB p. 34); Transcripts, Vol. 1, p. 51, l. 3-28

is person, based on a prescription for 30 grams per day, and he is authorized to grow 146 plants.[47]

57. Mr. Alexander renovated the outbuilding to turn it into a safe and secure medical cannabis production site. Mr. Alexander hired a certified electrician to ensure the electrical system was safe. He installed a "Heat Kill" unit to as added fire protection. He installed a highly sophisticated security and alarm system.[48] Mr. Davey started growing with Mr. Alexander about a year later to save cost and time. Mr. Davey and Mr. Alexander have never had any fire, mold or public safety issues, nor any injuries, and they have never had any complaints of any kind from any neighbours.[49]

58. Mr. Davey and Mr. Alexander have a mutually beneficial collaborative arrangement for cost sharing and division of labour. Mr. Alexander instructs Mr. Davey on cultivation tasks that Mr. Davey can handle, and Mr. Alexander does the more complex work. Mr. Davey enjoys doing these tasks and derives therapeutic benefit from being involved in the production of his medicine and controlling and determining what goes into it, as well as avoiding anxiety about not knowing what is going into his own body. Mr. Alexander also enjoys growing and considers it a hobby. They both spend about 20-25 hours per month tending to their cannabis plants.[50]

59. Mr. Alexander and Mr. Davey estimate that their production costs amount to between $1 and $2 per gram. The monthly expenses total approximately $1,290 per month for the two of them. The initial total setup cost was $27,040. Mr. Davey spends between $750 and $1500 per month on his medical cannabis compared to the $3000 he used to spend on pharmaceuticals.[51]

60. Mr. Davey consumes cannabis by way of regular vaporizing and smoking for rapid onset pain relief, by way of eating edibles such as cookies to relieve pain for a longer period of time and to allow him to sleep through the night. He estimates that

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[47] Alexander Aff. No. 1, para. 2, Exh. A, B; Alexander Aff. No. 2, Exh. B (EB p. 94-95, 98-99, 104)
[48] Alexander Aff. No. 1, para. 4-5; Davey Aff. No. 2, para. 43 (EB p. 22, 95-96); Transcripts, Vol. 1, p. 121, l. 23 to p. 123, l. 8, pp. 126-127
[49] Transcripts, Vol. 1, p. 131, l. 4-7; Davey Aff. No. 1, para. 11, 12; Aff. No. 2, paras. 45, 52, 53, 54, 59, 66, 68, 72 (EB p. 34-35, 24, 26-31)
[50] Davey Aff. No. 1, para. 11-14 (EB p. 34-36); Transcripts, Vol. 1, p. 132, l. 19 to p. 134, l. 15
[51] Transcripts, Vol. 1, p. 69, l. 19-28, p. 71, l. 19-28. At 55g per day, the total grams per month amounts to 1,650, which amounts to less $1 per day.

he uses his vaporizer or smokes approximately every half hour throughout the day. Mr. Davey estimates that 90% of his cannabis intake is through edibles, including in particular, a cookie containing the equivalent of 14 g composed of dried cannabis bud extracted into grapeseed oil or butter which is then used to bake the cookies. He uses the cookies to enable him to sleep. He makes batches of about 50-60 of these cookies at a time and freezes them. He also uses the cannabis oil for topical applications for body pain, and consumes cannabis in tea from time to time.[52]

61. Mr. Davey has used a variety of different strains, determining their efficacy by trial and error, and at the time of trial he only used "Bubba Kush" because of its particular effectiveness.[53] He is very happy with his current situation.[54] His dosage is high on the recommendation of his doctor because he needs large quantities of cannabis buds to make cannabis butter for his edibles, which he finds to be the most effective treatment for his body pain. He used to use many prescription drugs but now because of medical cannabis he no longer uses any prescription drugs and feels "110% better".[55]

62. To purchase from a licenced producer at $5 a gram would cost him $3,750 a month and a high-quality strain at $10 a gram would cost him $7,500 a month. Not only can he not afford those prices on a regular basis, given his income and expenses, but he is also distrusting of any other growers (except Mr. Alexander) being able to produce the quality medicine he requires, because of his previous experiences.[56]

63. Mr. Davey is concerned about his own personal autonomy and bodily integrity in relation to the medicine he intends to use for his condition; in his words: "This is my body, and I don't want anybody else dealing with it, I want to deal with it", and, "I want what I want for my body. I want to know exactly what goes into it, and I want to know exactly what I am getting out of it. That's it." [57]

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[52] Davey Aff. No. 2, para. 12, 23, 24, 25, 26 (EB p. 10, 13-15); Transcripts, Vol. 1, p. 38, l. 26-28, p. 39, l. 13-22, p. 42, l. 16-26, p. 78, l. 26 to p. 80, l. 8, p. 99, l. 2 to p. 100, l. 14

[53] Transcripts, p. 44, l. 1 to p. 45, l. 24

[54] Transcripts, p. 58, l. 7 – 13: "I am happy as heck. I do not have a single problem with it. Everything is 110 percent awesome."

[55] Transcripts, Vol. 1, page 33, 39-42, 48, 58 and 99-100

[56] Transcripts, Vol. 1, pp. 87-88, 101-103

[57] Transcripts, Vol. 1, pp. 87-88, 101-103

64. Mr. Davey fears having to return to pharmaceuticals or to purchasing cannabis on the illicit market. Mr. Davey is concerned about affordability and fears being charged criminally and taken to court to face a minimum of 6 months in prison if his ability to legally produce for himself is taken away, but he will continue growing despite those risks if his licence is taken away. Mr. Alexander shares Mr. Davey's fear that he will face incarceration if he continues growing or if he buys from the black market which he may have to do in order to find cannabis he can afford.[58]

Plaintiff's Expert Evidence

Dr. Zachary Walsh

65. Dr. Zachary Walsh, PhD., R. Psych. ("Dr. Walsh"), is an Assistant Professor at the Department of Psychology of the University of British Columbia.

66. In 2011-2012, Dr. Walsh headed a team of researchers conducting a study called the "Cannabis Access for Medical Purposes Survey" study (the "CAMPS Study") that involved drafting a detailed survey and collecting the detailed survey results from 628 medical cannabis patients. Dr. Walsh thereafter co-authored as lead author two articles published in the blind peer-reviewed *International Journal of Drug Policy*, entitled "Cannabis for Therapeutic Purposes: Patient Characteristics, Access, and Reasons for Use" (the "Therapeutic Purposes Article") and "Barriers to Access for Canadians who use Cannabis for Therapeutic Purposes" (the "Barriers to Access Article"), which analyzed the data gathered in the CAMPS Study and provided conclusions.[59]

67. Defendant did not challenge Dr. Walsh's expert qualifications. Defendant challenged the methodology and analysis employed in the Therapeutic Purposes Article and the Barriers to Access Article and the conclusions derived therefrom, without success.[60] To the contrary, Dr. Walsh's answers under cross-examination and in re-direct further clarified the high level of methodological rigour employed, as well as the strength of the analyses and conclusions, by for example explaining the blind peer-review process, explaining how the sampling strengths outweighed the

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[58] Davey Aff. No. 1, para. 10-14 (EB p. 34-36) ; Transcripts, Vol. 1, p. 88, l. 4 to p. 91, l. 5
[59] Walsh Aff. No. 1, para. 2-5, Exh. B, C (EB p. 307-308, 337-360)
[60] Transcripts, Vol. 1, p. 384 to 419, especially p. 412-419

limitations, the role of averaging to compensate for malingering and outliers and why the CAMPS study is representative of the larger medical marihuana user population in Canada. Furthermore, Dr. Walsh explained under cross and re-direct that patient's reporting of a drugs' effectiveness at providing relief from that patient's particular symptoms is considered a "gold standard" for determining efficacy in the eyes of medical community. In re-direct Dr. Walsh highlighted the quality of the articles in the eyes of his scientific and academic peers when he noted that the Therapeutic Purposes Article was declared "article of the month" by the *International Journal of Drug Policy* for its rigour and impact.[61]

68. In summary form, Dr. Walsh's expert evidence in chief, cross and re-direct provides the following factual conclusions.

Affordability is a Barrier to Access of Cannabis for Patients

69. Affordability was assessed according to two categories:

a. Patient ability to purchase or acquire sufficient cannabis to treat the patient's particular medical condition; and
b. Whether patients who have the ability to pay for sufficient cannabis are forced to choose between purchasing cannabis and purchasing other necessities of life due to insufficient funds to pay for both.[62]

70. The actual cost of cannabis was the major barrier to access for patients in terms of affordability. The median reported cost to patients was $200/month. 54% of *all* respondents said there were sometimes or never able to afford to buy sufficient quantity of cannabis to relieve their symptoms, and 33% reported often or always having to choose between cannabis and other necessities such as food, rent and/or other medicines due to lack of money.[63]

71. Of respondents who fell in the lower income group, 72% said they were sometimes or never able to afford sufficient quantities of cannabis, compared to 30% of the higher income group.[64]

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[61] Transcripts, Vol. 1, p. 416-419; p. 420, l. 22 to p. 421, l. 10; p. 444, l. 12 to p. 445, l. 12; 446, l. 2-11; p. 447, l. 3 to p. 448, l. 12
[62] Transcripts, Vol. 1, p. 422, l. 3-26
[63] Walsh Aff. No. 1, paras. 13-14, Exhibit C, p. 696 (EB p. 310-311, 342)
[64] Walsh Aff. No. 1, paras. 13-14, Exhibit C, p. 696 (EB p. 310-311, 342)

72. Of respondents in the *fair to poor health* category, 66% were sometimes or never able to afford sufficient cannabis, compared to 50% of those in better health. Those with poorer health were nearly twice as likely to report choosing between cannabis and other necessities. Approximately 50% of respondents in the lowest income group reported having to choose between cannabis and other necessities.[65]

73. Dr. Walsh concludes that there is a significant problem for medical cannabis users across all income groups, but in particular for the lowest income groups, in that they cannot afford to purchase the amount of cannabis they need to treat their illnesses, either because they simply do not have enough money or are forced to spend their limited funds on other necessities of life.[66]

74. Dr. Walsh concludes that the financial strain across all income groups, and in particular the poor and the most sick, demonstrated the need to integrate cannabis therapy within a subsidized medicine framework.[67]

75. Dr. Walsh further concludes that the affordability issues under the *MMAR* scheme will likely be worse under the *MMPR* scheme due to the increase in cost to patients resulting from the banning of personal production citing Defendant's Del-sys report as evidence that the *MMPR* regime will result in higher costs that are borne entirely by patients.[68]

Access to cannabis by patients

76. The CAMPS Study and in particular the Barriers to Access Article also looked at the question of "availability" and determined that almost one third of the respondents were self-producing and that the most important reason for doing so was quality (39%), followed by price (36%), avoiding the black market (29%), selection of a specific strain of cannabis (24%), and safety (12%). The major reasons for not producing for oneself were lack of space, expense, or legal concerns.[69]

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[65] Walsh Aff. No. 1, paras. 13-14, Exhibit C, p. 696 (EB p. 310-311, 342)
[66] Walsh Aff. No. 1, paras. 6, 13, 14 (EB p. 308, 310-311); Transcripts, Vol. 3, p. 380, l. 24 to p. 381, l. 11
[67] Walsh Aff. No. 1, paras. 14-15 (EB p. 311-312)
[68] Walsh Aff. No. 1, para. 15, Exhibit C, p. 694, Exhibit E, pp. 12, 141. The conclusion at p. 141-145 makes clear that the cost to current MMAR patients of the ban on self-production will be in the range $1 billion dollars, and that the sole monetary beneficiaries of the MMPR are business and the government. (EB p. 312, 340, 373, 502-505)
[69] Walsh Aff. No. 1, para. 12, Exhibit C, p. 694 (EB p. 310, 340)

77. Most medical marihuana users (86%) continue to obtain their marihuana from illicit sources including friends, unlicenced home growing, medical dispensaries, and the black market.[70]

Dosages and access to variety of strains

78. Patients' self-reporting of therapeutic effectiveness with respect to dosage and strains of cannabis for their particular ailments is the best evidence currently available, because clinical studies of the therapeutic efficacy of different dosages and strains of cannabis in relation to particular ailments are limited or do not exist. Further, patient reports of therapeutic effectiveness, essentially whether the patient feels better, is considered to be a "gold standard" within the medical community for determining whether a drug is an effective treatment for a particular patient's symptoms.[71]

79. 40% of patient respondents reported using more than 14 grams of cannabis per week as therapeutic treatment for their ailments. Of that 40%, the median usage was 28 grams per week.[72]

80. 93% of patient respondents identified access to a specific strain or variety of strains, or to alternative options such as baked goods and extracts, as important options.[73]

Remo Colasanti

81. Remo Colasanti is an expert in cannabis cultivation. His credentials and expertise were not challenged.

82. Mr. Colasanti has produced medical cannabis under the *MMAR* since 2001. He is and has been authorized to grow 98 plants.[74] A fair summary is that Mr. Colasanti has done extensive research into cannabis cultivation.[75]

83. Mr. Colasanti opined on how to produce cannabis indoors in various ways and in a residential area without interfering with neighbours rights in relation to odor,

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[70] Walsh Aff. No. 1, paras. 9-10 (EB p. 309-310)
[71] Transcripts, Vol. 1, p. 410, l. 6 to p. 411, l. 23; p. 413, l. 21 to p. 414, l. 12; p. 438, l. 15 to p. 440, l. 2
[72] Affidavit Walsh No. 1, Exhibit B, p. 4 (EB p. 341)
[73] Affidavit Walsh No. 1, Exhibit C, p. 694 (EB p. 340)
[74] Affidavit Colasanti No. 1, para. 2 (EB p. 552)
[75] Affidavit Colasanti No. 1, para. 3 (EB p. 552); Transcripts, Vol. 4, p. 521, l. 2-10

public safety, fire and electrical safety, and mold, and without such risks to the producer and his/her family.[76]

84. Cannabis needs light, water and nutrients to survive and grow. It can be grown outdoors or indoors. Lighting and physical space are the primary determinants for overall yield in indoor cannabis production, not the number of plants. Small amounts of cannabis can be produced in small spaces such as closets, grow tents, and growth chambers.[77]

85. There are two primary stages in the plant's life cycle: vegetative growth and flowering, characterized by differing amount of light in each stage. The sun provides the light needed to grow outdoor and in greenhouses. For indoor production, different types of lights are used including a) fluorescent, b) LED, and c) high intensity lights designed for indoor plant cultivation.[78]

86. All plants, including cannabis, require nutrients, and there are 14 essential plant nutrients. Producers can use soil which contains all the nutrients required or other methods that require addition of nutrients (either typical garden nutrients available at nurseries, nutrients formulated in optimum ratios for cannabis or nutrients created from mineral salts) to either soil or soilless growth mediums.[79]

87. The Bloom Box is an example of a self-contained hydroponic grow box that can be used to safely and inexpensively grow cannabis without odour and it uses less power than a clothes dryer. It costs $3,300.00 plus tax.[80]

88. Mr. Colasanti opines that it is possible to produce medical cannabis indoors (solo or in collective gardens) in residential and non-residential settings safely and economically in a manner that completely eliminates or substantially reduces the risks of fire, mold, odor, and security to the point that medical cannabis production is no less safe than many other common household activities or uses. Mr. Colasanti has visited countless medical cannabis production sites that posed little or no risk of fire,

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[76] Affidavit Colasanti No. 1, Exhibit B, para (a) (EB p. 565)
[77] Affidavit Colasanti No. 1, para. 5-6, 10 (EB p. 553-554)
[78] Affidavit Colasanti No. 1, paras. 8-9, 11-16 (EB p. 553-555)
[79] Affidavit Colasanti No. 1, paras. 18-28 (EB p. 555-556)
[80] Transcripts, Vol. 4, p. 462, l. 9 to p. 467, l. 14; p. 492, l. 21 to p. 494, l. 19; p. 496, l. 26

had no excess moisture and had no increased risk of mold, emitted no odors, and had not been the target of theft.[81]

89. Mr. Colasanti testified that *MMAR* licence holders must give up their licences if they want to buy from LPs. He is also aware that LPs have sold out right away which means patients have no access to their medicine. Finally he was aware that LPs have sold cannabis with mold to patients.[82]

Dr. Thomas Bauman

90. Dr. Thomas Bauman ("Dr. Bauman") is a horticulturist and Professor of Agriculture at the University of the Fraser Valley.[83] Dr. Bauman was not cross-examined and therefore his credentials and expert opinion are unchallenged.

91. Dr. Bauman provided an expert opinion with respect to general or specific issues or concerns involved in the production or cultivation of plants for food, for enjoyment, or for health purposes, both indoors and outdoors, for personal use or the use of one's family, as well as any limitations thereon. Dr. Bauman was also asked to compare personal production of such plants with production for commercial sale to the public.[84]

92. Dr. Bauman's unchallenged expert opinion is that any person can grow plants such as vegetables, fruits and herbs for their own consumption as food or for health purposes unless that plant is a controlled substance under the *Controlled Drugs and Substances Act*.[85]

93. The *Richter's 2014 Herb and Vegetable Catalogue* ("Richter's Catalogue"), attached to Dr. Bauman's affidavit, sets out the wide variety of plants, herbs and flowers that can be grown by Canadians for their own consumption or enjoyment subject only to local bylaws and regulations. The Richters Catalogue uses various symbols to indicate different purposes or attributes a plant may have, including the

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[81] Affidavit Colasanti No. 1, paras. 45-46, 49, 50-51 (EB p. 561-562); Transcripts, Vol. 4, p. 471, l. 16 to p. 478, l. 11
[82] Transcripts, Vol. 4, p. 486, l.10-18, p. 569, l. 7 to p. 570, l. 9
[83] Baumann Aff. No. 1, Exh. A (EB p. 633-639)
[84] Baumann Aff. No. 1, Exh. C (EB p. 736)
[85] Baumann Aff. No. 1, Exh. C (EB p. 738)

"red cross"' for plants that have medicinal uses, and the "skull and cross bones" for plants that are poisonous to humans.[86]

94. There are examples of herbs and plants throughout the catalogue that are listed as having medicinal benefits, such as Aconite at p. 6, Ashwagandha and Bacopa at p. 7, Belladonna at p. 11 and Foxglove at p. 26. Aconite, Ashwagandha, Belladone and Foxglove are poisonous. Bacopa is a nerve and cardiac tonic with a tranquilizing action similar to reperine. Another plant listed in the catalogue at pp. 63-64 is Tobacco, a plant containing the drug nicotine, which can be used as an insecticide.[87] All these plants can be grown lawfully without any restrictions by individuals at or inside their homes and gardens for their own personal consumption.[88]

95. The limitations to the legal growing plants arise only if the plants are grown for sale to the public or are prohibited substances under the *Controlled Drugs and Substances Act*:

> 1. If the production of a plant is for a large scale commercial sale to the public then the Federal *Food and Drugs Act* and regulations apply, and are subject to inspection by the Canadian Food Inspection Agency.
> 2. If a plant is listed under any of the Schedules to the *CDSA* then the growing or possession of those plants is prohibited even if for personal use.
> 3. A plant that is not prohibited by the *CDSA* and that is held out to have medicinal purposes is subject to the *Natural Health Products Regulations* (regulations pursuant to the *FDA*) if those plants are being offered for sale to the public, but not if one is growing such medicinal plants for one's own personal use.[89]

96. The technology and equipment exists today to enable a person to grow any plant either outside in soil or in greenhouses, or indoors, safely with respect to themselves and others, and without damage to the building or structure in which production takes place. Use of proper electrical hookups, proper water management,

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[86] Baumann Aff. No. 1, Exh. B, C (EB p. 641-735, 739-740)

[87] The use of tobacco is considered a cause of numerous debiliating and fatal diseases, and national public health problem of substantial and pressing concern, under s. 4 of the *Tobacco Act*, S.C. 1997, c. 13. Tobacco is also contained in schedule 2 of the National Health Products Regulations and it is therefore excluded from those regulations, but is regulated both federally by Part 3 of the *Excise Act* S.C.2002.c.22 and the *Tobacco Act* and the *Non-Smokers Health Act* as well as various Tobacco Control Acts Provincially (e.g. R.S.B.C. 1996 Ch.451). Section 25(3) of the *Excise Act* in s.25 permits growing for personal use on land on which the individual resides, limited to 15kg for each family member.

[88] Baumann Aff. No 1., Exh. C (EB p. 740-741)

[89] Baumann Aff. No 1., Exh. C (EB p. 738)

proper environmental controls such as humidity and temperature, and compliance with all laws and regulations, is required no matter the kind of plant being produced.[90]

Eric Nash

97. Eric Nash is both a fact witness and a rebuttal expert witness for Plainitffs. He was cross-examined with respect to his expert witness report but not as a fact witness and therefore his factual evidence below is unchallenged.

98. As designated producers under the *MMAR*, Mr. Nash (along with his spouse) has cultivated, distributed and sold certified organic cannabis to patients since 2002 under the company name of Island Harvest. Mr. Nash has significant experience in medical cannabis research. In 2004, 2010, 2011 and 2012 Mr. Nash attended at meetings with Health Canada officials to provide input and recommendation regarding policy reform and possible changes to the *MMAR*.[91]

99. Island Harvest has applied to become an LP under the *MMPR*. Mr. Nash has ensured compliance with all applicable bylaws and regulations and has political support from all levels of government. Despite this, Mr. Nash's experiences with the LP licensing process were problematic at best. The application policies changed mid-stream and his experience has been one of frustration, delay and government inability to timely process his materials.[92]

Jamie Shaw

100. Ms. Shaw is the President& CEO of the Canadian Association of Medical Cannabis Dispensaries ("CAMCD"), a non-profit society registered in Ontario, and the Communications Coordinator for the BC Compassion Club Society ("BCCCS"), a non-profit society in BC. She was not cross-examined. She provided a history of dispensaries and indicated that there were about 103 such organizations currently operating in Canada.[93]

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[90] Baumann Aff. No 1., Exh. C (EB p. 738)
[91] Nash Affidavit No. 1, paras. 5-17 (EB p. 6253-6255)
[92] Nash Affidavit No. 1, paras. 18-108, Exhibits A,B, C, D, E, F, G, H, I, J, K, L, M (EB p. 6255-6270, 6272-6310)
[93] Shaw Affidavit No. 1 (EB 768-848)

Mike King

101. Mr. King was not cross-examined. He provided information related to the pricing and availability of cannabis from LPs. A fair summary of his findings is that availability of medicine from LPs is sporadic, with many either out of stock or not accepting new customers. He also found that while some offered discounted pricing, the availability of such pricing varied widely and was limited by various criteria.[94]

Jason Wilcox

102. Mr. Wilcox provided an affidavit and was not cross-examined. His affidavit attaches a substantial number of victim impact statements setting out various issues that patients have encountered as a result of the repeal of the *MMAR* provisions.

103. The harms patients are experiencing can be usefully categorized as related to (a) inability to move production site with the need to move arising due to the Health Canada privacy breach and resulting stigmatization or matters beyond their control both pre and post-injunction; (b) negative impact of the 150-gram limitation on mobility and quality of life; (c) loss of designated-producer and inability to appoint a new one or become a personal producer; and, (d) significant problems obtaining access to medicine through LPs.[95]

Danielle Lukiv

104. Ms. Lukiv provided an affidavit setting out and attaching various correspondence received from patients. She was not cross-examined. The harms recounted to Ms. Lukiv can usefully be categorized as related to: (a) significant problems accessing medicine through LPs, including a concomitant need to resort to the black market to obtain medicine; (b) inability to move production site with the need to move sometimes arising due to Health Canada privacy breach and resulting stigmatization or other factors; (c) negative impact of the 150-gram limitation on

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[94] King Affidavit (EB Tab 20); Attached as Appendices A, B and C are charts derived from the evidence of Plaintiffs and Mr. King. These charts set out the evidence of costs and availability of medicine from LPs at various dosages and pricing.

[95] Wilcox Affidavit (EB Tab 23)

mobility and quality of life; and (d) loss of designated producer and therefore access to medicine.[96]

Dr. David Pate

105. Dr. Pate has a Ph.D. in pharmaceutical chemistry and specializes in medicinal use of cannabis. Dr. Pate provided expert evidence with respect to the chemical properties, botany, different strains, resin and extracts, methods of ingestion, and medical uses of cannabis.

106. The *Cannabis* plant is harvested for the medicinal resin compounds found inside the glandular trichomes of the plant. There is no medical utility to the dried plant matter. In essence, the plant is no more than a carrier for the glandular trichomes.[97]

107. The two primary therapeutically active compounds found in the resin are tetrahydrocannabinol (THC) and cannabidiol (CBD), plus associated minor cannabinoids and terpenes. Medical effects of cannabinoid have been well documented and there is no reasonable dispute that these compounds are therapeutically active in humans. Terpenes may augment these effects.[98]

108. There exists no scientific basis, either botanical or pharmaceutical, to differentiate between the whole dried plants and the glandular trichomes or resin in a manner that permits patient access to the whole dried plant, but not the glandular trichomes or resin harvested from that plant. Cannabis plant matter can contain a variety of harmful or unwanted compounds, such as heavy metals, fertilizer residue, pesticides, molds, and insect remnants. The glandular trichomes containing the therapeutically active chemical compounds can be isolated from the plant matter in different ways thus eliminating most of the plant matter in the final product, resulting in resin ("hash" or "kif" or "pollen") or extracts (oil, butter).[99]

109. Restricting patients to consumption of dried marihuana only and prohibiting the production of cannabis resin, or cannabis-based medicine, serves no valid medical

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[96] Lukiv Affidavit (EB Tab 21)
[97] Pate Expert Report, para. 9(b-d) (EB p. 586-587)
[98] Pate Expert Report, Exh. B, para. 10,14 (EB p. 602-603)
[99] Pate Expert Report, para. 9(j), Exh. B, para. 19-22, 24, 25-28 (EB p. 587, 604-606)

purpose. Patients benefit medically from having lawful access to a wide range of methods of ingestion. There are multiple ways to ingest the active compounds of cannabis, which have different risks and benefits: inhalation (rapid onset short-term relief), oral ingestion (gradual onset, longer term relief), topical (skin conditions, joint pain, no psychoactive effects), and trans-mucosal (rapid onset short-term relief without smoking). Ingesting the resin compounds in the form of baked goods is, for some conditions, significantly more effective than other routes of administration.[100]

110. Cannabis has a number of phenotypes (strains) that are created by breeding different varieties of the plant with each other. Different strains produce differing effects and levels of efficacy on the patient, depending on the individual and the medical condition, which is probably caused by varying amounts, ratios and synergistic effects of the therapeutically active compounds.[101]

111. There is no realistic possibility of overdose death from cannabis consumption by humans, whether the consumption is oral, inhaled, or topical.[102]

Defendant's fact evidence

Jeanine Ritchot

112. Ms. Ritchot was Director of the Bureau of Medical Cannabis from March 2010-2011[103] and then Director of Medical Marihuana Regulatory Reform (transition from *MMAR* to *MMPR*) from July 2011-2013 at Health Canada. She is now with the Office of Controlled Substances and Tobacco Directorate of Health Canada (HC).[104]

113. Ms. Ritchot explained that cannabis is not an "Approved Therapeutic Product" under the *Food and Drug Act* because its efficacy and safety has not been sufficiently demonstrated to HC under the procedures available to have a "drug" approved under the *FDA*. HC did not review the history of the use of cannabis, the various Royal commissions studying the issue nor any other evidence of safety and efficacy. Instead,

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[100] Pate Expert Report, para. 9(a), Exh. B, para. 29, 30, 31-36 (EB p. 586, 606-609)
[101] Pate Expert Report, para. 15-18 (EB p. 603-604)
[102] Pate Expert Report, para. 9(i) (EB p.587)
[103] Volume 14, p.730- l. 23 to 731, l. 4-12
[104] Transcripts, Vol. 7, p. 732. Ms Ritchot did not know that a person could grow and keep up to 15 kilograms of tobacco on their property if they grow it for themselves and persons over the age of 18 years.

it simply took the position that nobody has applied to have it approved pursuant to the *FDA* and therefore no evidence demonstrates its safety and efficacy.[105]

114. She did not know that cannabis has no lethal dose ratio (LD50) as set out in HC's Information for Health Care Practitioners publication.[106]

115. While she was at HC and over the 13-14 years of the program, she never had a report of anybody dying from the use of cannabis whether produced by themselves or anybody else nor of anybody ever getting sick from consuming cannabis. There were some adverse events reported but she could not confirm the details and nothing stuck in her mind. She generally understood that people could overdose and die from other prescribed drugs. [107]

116. The *MMAR* program went from a small number in 2001 to 38,000 patients being authorized to possess by 2014. The program grew more quickly than HC expected. While this meant that doctors were approving access in much greater numbers, HC did not infer greater safety and efficacy from that demand or from the fact that HC was predicting that by 2025 there would be an estimated 400,000 patients using cannabis with medical approval.[108]

117. Ms. Ritchot provided statistics as to the operation of the *MMAR* and the *MMPR* programs. The average daily dose in Canada was 18.22 grams a day as of December 31, 2013. Some 896 patients are indebted to HC for cannabis produced by Prairie Plant Systems and are subject to collection action by HC. The total arrears owing by these patients is $1,448,209.67.[109]

118. Affordability of medication including insurance coverage was a concern expressed by physicians, Provinces/Territories, LPs and patients throughout the policy development process. Some physicians expressed a concern about their patient's ability to afford medicine under the new regime.[110]

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[105] Transcripts, Vol. 7, p. 807-808
[106] Transcripts, Vol. 7, 809; Ritchot Aff. No.1, tab 28G (EB p. 2665) Under the heading "8" overdose toxicity.
[107] Transcripts, Vol. 7, p. 811
[108] Transcripts, Vol. 7, p. 812 - 813
[109] Transcripts, Vol. 7, p. 812 – 813, p. 831
[110] Transcripts, Vol. 7, p. 775-778, p. 889, l. 6-10

119. Commencing in 2003, HC sold cannabis produced by PPS directly to patients at a flat rate of $5 a gram with no shipping costs. The government subsidized this cannabis by approximately $5 a gram for a total cost of medicine of about $11 to $12 a gram.[111]

120. As to extracts, Ms. Ritchot was unable to provide details of any specific problems that arose during the course of the program with respect to the use of forms other than dried marihuana.[112]

121. Comments from stakeholders with respect to permitting production of resin or cannabis based medicine and extracts consisted of out of 1,663 total comments received, 139 referred to products in general and 73 referred to oils, lotions, edibles and a preference for Health Canada to make access to those available.[113]

122. Some of the potential Licenced Producers asked for this as well and Health Canada's position was anything other than dried marihuana would have to go through the new drug approval process under the *Food and Drug Act*. Ms. Ritchot was not familiar with a similar procedure for extracts arising under the *Natural Health Products Regulation*.[114]

123. As to the 150-gram possession limit, Ms. Ritchot did not have any data or information on how many, if any, patients were victims of theft or attempted theft of medicine from their person throughout the history of the program.[115]

124. She conceded that the 150-gram cap could pose some difficulties in terms of getting amounts from production site to storage site.[116]

125. Ms. Ritchot testified that public safety was one of the considerations in establishing the 150-gram limit but conceded there was no such limit in regulations for prescription drugs such as OxyContin and that patients could take a 30 day supply of that medicine on vacation, for example, but that a medical cannabis consumer could not do so if that supply exceeded 150 grams.[117]

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[111] Transcripts, Vol. 7, p. 779-781, p. 825, l. 10-12; p. 889; Ritchot Aff, para. 43 (EB p. 1533)
[112] Transcripts, Vol. 7, p. 741-742
[113] Transcripts, Vol. 7, p. 774-775
[114] Transcripts, Vol. 7, p. 777
[115] Transcripts, Vol. 7, p. 743, 746
[116] Transcripts, Vol. 7, p.749, ll. 1-14
[117] Transcripts, Vol. 7, p. 744, ll. 14-26

126. Ms. Ritchot initially took the position that a Licenced Producer could ship to a person on vacation but later conceded that the location would have to be to the patient's address registered with the Licenced Producer and that this was not a restriction that would occur with OxyContin or other prescribed drugs.[118] They certainly could not ship outside the country.

127. As to smell/odor, Ms. Ritchot asserted that HC received complaints about odor from licenced production. HC would respond by writing a letter to the producer asking for discretion but admitted that issues about smells are outside the federal government's jurisdiction. HC could have but did not create any advisory committee or otherwise provide any information to assist patients/producers with proper production site design including equipment to ameliorate odor issues as they did for doctors in relation to their role.[119]

128. As to diversion, Ms. Ritchot was unable to provide any details with respect to diversion by *MMAR* licence holders. Specifics in terms of convictions for the period 2001 to 2013 were sought and the information is not available from either the PPSC or RCMP.[120]

129. As to fires, Ms. Ritchot was unable to provide details of how many, if any, incidents of fires in *MMAR* licenced production facilities were reported during the period 2001 through 2013. Health Canada does not keep nor have records of any such incidents.[121]

130. As to theft, Ms. Ritchot admitted that HC does not keep records of incidents of theft from licenced gardens and therefore has no information on thefts although such thefts are required to be reported to HC by the *MMAR*.[122]

131. On the topic of general data and HC knowledge, Ms. Ritchot conceded that:

a. Although Health Canada has tables for how many kilograms a day are produced by *MMAR* licencees it had no data with respect to public safety issues including fires, thefts, harms arising from fertilizers or

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[118] Transcripts, Vol. 7, p. 745
[119] Transcripts, Vol. 7, p. 759-762, 787, 855-856
[120] Transcripts, Vol. 7, p. 762-763
[121] Transcripts, Vol. 7, p. 765
[122] Transcripts, Vol. 7, p. 768

other chemicals used in gardens and that no effort was made to collect such data.[123]

b. Health Canada has no statistics of people who were producing their own cannabis getting sick from it. [124]
c. The government was the major beneficiary of the move from the *MMAR* to the *MMPR* in terms of cost saving and the persons most impacted were the patients because of the increase in price.[125]
d. Health Canada has no information that Mr. Allard, Ms. Beemish and/or Mr. Davey ever over-produced their licences, diverted medicine to the black market, produced unsafely, caused smells, had any fires or produced any unsafe cannabis or moldy cannabis or suffered any negative health consequences from consuming their medicine.[126]

Todd Cain

132. Mr. Cain was Executive Director, Market Development for Healthy Environments and Consumer Safety Branch and presided over the *MMAR* to *MMPR* transition until 2014. He says he has informed himself as to what has happened in the last six months despite his absence.[127]

133. Mr. Cain said that there was overall sufficient supply to meet current demand (meaning total supply available from all LPs, not in relation to particular strains nor in relation to any individual LP ability to supply their client) but that it was difficult to predict given ongoing market uncertainty. He admitted that there were at least 300 recent situations where the LPs were not able to fulfill their patient's requirements and that, generally, about 4% of orders by patients can not be filled by the LP.[128]

134. Mr. Cain admitted that persons unable to obtain medicine from their LP would need to re-attend their physician to obtain a new medical document in order to register with a different LP. He acknowledged that another option would be to go to the black market for medicine.[129]

135. Mr. Cain conceded that in May 2014 Peace Naturals had to recall of a batch of marihuana for testing positive for bacteria. He's aware of 4 recalls total. 55 patients

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[123] Transcripts, Vol. 7, p. 768-769, 771
[124] Transcripts, Vol. 7, p. 759
[125] Transcripts, Vol. 7, p. 824
[126] Transcripts, Vol. 7, p. 903-904
[127] Transcripts, Vol. 7, p. 906-909
[128] Transcripts, Vol. 7, p. p. 906-909, 916, l.6-19; Cain Aff., para. 30 (EB p. 4057)
[129] Transcripts, Vol. 7, p. 918

were affected by the Peace Naturals recall and they were told to discontinue the batch.[130]

136. Mr. Cain acknowledged that on August 15, 2015 Whistler Medical had a batch of 'white widow' recalled due to mold. There were other recalls due to pesticides and that he was aware of two pesticide related issues found on inspection in the last year.[131]

137. Mr. Cain admitted that in November, 2014 he heard about three recalls for failing to meet the *MMPR* sanitation requirement including problems with unsanitary conditions and dirty equipment.[132]

138. Mr. Cain had no personal knowledge of how the *MMPR* has affected any of the individual Plaintiffs except from reading their affidavits. He agreed that the LP reporting requirements and guidance documents are about producing dried marihuana for sale to the public and not production for oneself.[133]

139. Mr. Cain acknowledged that affordability was one of the significant concerns of patients and was aware that some LPs had expressed concerns about patients' ability to afford their product. He also became aware of concerns on the part of Provinces and Territories that they may be pressured to have to subsidize patients. He conceded that Health Canada knew that there were going to be people who couldn't afford the LP pricing. He also conceded that the main mechanism to address this is the voluntary compassionate pricing programs left up to individual Licenced Producers.[134]

140. Mr. Cain agreed that there are no *MMPR* requirements designed to ensure that all medically approved patients have reasonable access including those that could not afford the LPs and there are no specific provisions around price affordability.[135]

141. Mr. Cain conceded that the only two options for a patient who cannot afford LP prices and is not eligible for compassionate pricing (or who cannot get the strain the patient needs from the LP) must either grow for themselves illegally or go to the

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[130] Transcripts, Vol. 7, p. 919-920
[131] Transcripts, Vol. 7, p. 920, l. 11-28
[132] Transcripts, Vol. 7, p. 947, l. 4-13
[133] Transcripts, Vol. 7, p. 921-922
[134] Transcripts, Vol. 7, p. 947- 949
[135] Transcripts, Vol. 7, p .949, l. 8-14

illicit market to buy it and therefore risk their liberty or go without and risk their health.[136]

142. Mr. Cain reviewed his knowledge of certain compassion pricing programs and acknowledged that Mr. Davey and Mr. Alexander were unlikely to qualify for any. He advised that Ms. Beemish could likely qualify.[137]

Jocelyn Kula

143. Ms. Kula, an HC employee, was offered as a fact witness. Her evidence consisted of describing Canada's international treaty obligations (that she conceded Canada was not meeting with either the *MMAR* or *MMPR* and that contain exceptions for domestic constitutional requirements) and the drug approval process in Canada (that she conceded was unavailable to individual patients and was designed to apply to commercial activity). [138]

144. Ms. Kula conceded that but for its inclusion in the *CDSA,* cannabis and cannabis-derived medicines would be considered natural health products and would therefore be subject, in the case of commercial activity, to significant *NHPR* controls over manufacture and sale but would not be subject to regulatory control when produced and consumed by individual patients. She also acknowledged that the regulatory schemes for drugs essentially did not regulate compliance with electrical codes, fire and safety bylaws and the like because such matters were generally outside the federal government's jurisdiction. [139]

Eric Ormsby

145. Mr. Ormbsy, an HC employee, was offered as a fact witness. His evidence consisted of describing Canada's drug approval process (that he conceded was unavailable to individual patients and was designed to apply to commercial activity) including the *FDA* (that he conceded had never been used for herbal medicine) and the *NHPR* (that he agreed was applicable to medicinal plants, including medicinal plants that pose very significant dangers to human health including the possibility of

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[136] Transcripts, Vol. 7, p. 947- 951
[137] Transcripts, Vol. 11, p. 1607, 1628, 1661-1663
[138] Kula Affidavit (EB Tab 26); Transcripts, Vol. 6, p. 668-700
[139] Transcripts, Vol. 6, p. 668-700

death). He also testified about methods by which access to non-dried-marihuana forms of cannabis medicine could be achieved (but conceded that these were either wholly or largely unavailable to individual patients are that were not designed to provide mechanisms by which individual patients could seek approval on their own). [140]

146. Mr. Ormsby conceded that despite the highly regulated environment for drug approval and the goal of protecting public health and safety, some drugs have been approved for commercial sale in Canada that have caused very significant and unanticipated harms, including death. [141]

Defendant's expert evidence

Corporal Shane Holmquist, Fire Chief Len Garis, Dr. Paul Daeninck, Dr. John David Miller, Dr. Harold Kalant, Dr. Mahmoud ElSohly

147A. The evidence of these witnesses is properly situated in the s. 1 analysis and will be summarized and addressed in that section, below.

Dr. Yehuda Baruch

147. Dr. Yehuda Baruch testified as to Israel's medical cannabis program, that is fully supported by government, and dosages of cannabis in that program. In Israel patients currently pay a maximum of $100 per month for cannabis in whatever dosages are permitted by their physician. The usual dose based on patient feedback is 1 to 3 g per day. Larger dosages have to be approved by a committee. The medicine is produced by 8 primary producers and dispensed in a dispensary type system. The prior system allowed for personal, collective and caregiver production but it is being phased out by attrition. He adopted the video "Prescribed Grass" as accurately setting out the situation in Israel at the time subject to a small reservation.[142]

148. Dr. Baruch agreed that the increased demand for cannabis as medicine in Israel (from 64 in 2003 to 28,000 patients in 2015) suggests it is an effective alternative to other medications, mostly pain medications. He confirms that there is no lethal dose

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[140] Transcripts, Vol. 6, p. 701-725
[141] Transcripts, Vol. 6, p. 701-725
[142] Transcripts, Vol. 11, p. 1607, 1628, 1661-1663

although he asserted that some deaths are attributed to heart attacks from cannabis use when the patients suffered from mainly cardiovascular problems. Dr. Baruch testified that side effects from cannabis are minor including vertigo, dizziness and red eye and they pass soon after one stops using and can be treated. The major side effects are mostly psychiatric, triggering psychosis, and possibly the risk of cardiac arrest. The cannabinoid receptors are involved in pain management, inflammatory processes and immune reactions. [143]

Professor Robert Mikos

149. Professor Mikos was tendered as an expert witness on US state law on behalf of Defendant. His evidence was that as of October 2014, 35 states have legalized medical use of marihuana, 24 states allow use of marihuana containing THC and 11 states allow use of marihuana containing CBD but not THC. Various systems/combinations of supply exist in the various states.

150. Professor Mikos acknowledged that a majority of states authorize non-profit licenced producers and that no state that permits patients to cultivate their own medical marihuana has ever taken legislative action to eliminate this legal right. [144]

Dr. Paul Grootendorst

151. Dr. Grootendorst was tendered as a Crown expert witness on health economics. His report, Exhibit 54, addresses three issues, namely firstly, market trends indicating that price will decline over time, secondly the impact of continued personal production on the LP market and thirdly the calculation of an individual's per gram cost of production. With respect to market trends he says the market appears to a competitive one where others will enter the market if there are excess profits so as to maintain a stable fair price and there are few entry barriers posed by Health Canada. Also the average cost of production and distribution will decline over time because of people learning how to produce more efficiently. With respect to the second point he opined

[143] Transcripts, Vol. 11, p. 1644, 1646
[144] P. 1583, ll. 1-17

that it will simply depend on the share of the total unit volume of medical marihuana consumed. With respect to the third issue, calculating a per gram cost must include private costs, money and opportunity costs and external costs (the costs the grower imposes on others that are not necessarily faced by the grower).[145]

152. In cross examination with respect to market size, share and the competitiveness of the market, he referred to Health Canada's prediction that there will be 400,000 to 500,000 medical marihuana users in the future and that he was unaware of the differences in the shares of the market between LPs and personal producers and possibly others, such as dispensaries. He was unaware of the existence of large grow operations currently nor the difficulties faced by LPs in the approval process from Health Canada. The volume of the market will increase if the costs are covered by federal or provincial governments or insurance companies and the lack of such coverage results in lower demand due to no third party payments.[146]

153. With respect to the effect of the *MMAR* on the LP market he was unaware of the distribution of market share between LPs and personal producers and did not analyse their share and could not agree with the data presented by Professor Walsh because he did not know what the percentage of personal growers was. [147]

154. With respect to opportunity costs and external costs for home growers, he said the opportunity cost depends upon what else the patient producer would be otherwise doing and external costs are based on factors such as a presumed higher fire risk, based on media articles but agreed if there are no such risks then it should be rated as zero. He agreed that there would be no external cost to a producer from police and criminals diverting to an illicit market. His opinion about higher costs for illegal producers because of the threat of prosecution and having to avoid detection is somewhat moot given the existence of the public but illegal dispensaries. He also presumed that there would be no household insurance available and was unaware of any cost difficulties of becoming a Licenced Producer.[148]

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[145] Transcripts, Vol. 12, p. 1826-1828

[146] Transcripts, Vol. 12, p. 1851; p. 1862, l.23-24; p.1874; p. 1893, l.20-22; p. 1903, l.26-27; p. 1981, ll.7-19

[147] Transcripts, Vol. 12, p. 1858, l. 11-12; p. 1860, l.4-28; p.1894, l. 6-15

[148] Transcripts, Vol. 12, p.1871, l.3-10; p.1879-1880; p. 1881, l. 11-19; p.1888-1889; p.1903, l.1-9; p. 1910, l. 23-28; p.1916, l.2-6

155. With respect to affordability he did not conduct any financial analysis on how much income somebody would need in order to be able to pay Licenced Producer prices and he presumed in his conclusions that everyone was in the market place regardless of their ability to pay. He was aware that some people are unable to afford necessities of life and was unaware of any federal or provincial tax relief for medical marihuana patients currently. He also agreed that the cost for a 20 gram daily authorization at only $4 a gram amounts to a yearly cost of $28,000 per patient.[149]

Catherine Sandvos

156. Catherine Sandvos is legal counsel and the Deputy Manager of the Netherlands Department of Health, division called Cluster Farma and the Bureau of Medicinal (BMC) Cannabis is part of Cluster Farma. She has been in that role since May 2007. The Netherlands first developed a policy on medical cannabis in 1998 with the objective of cultivating cannabis to meet pharmaceutical quality standards and make it available for research and product development as a medical product. [150]

157. The BMC was established in 2001. Due to the Netherlands non-enforcement policy related to cannabis generally, some cannabis products were being marketing through pharmacies as early as 1995 but they were of unknown quality and not standardized. An estimated 14,000 patients were accessing cannabis through this system. Consequently the government decided to implement a legal system. The government estimated there would be 10,000 to 15,000 patients in that model but only 600 patients initially registered and now 12 years later they only have 1,200 patients registered.[151] It is suspected that most went back to the coffeeshops that have existed since the mid-1970s as a result of the Dutch non-enforcement policy and it is estimated there are at least 700 such shops in the Netherlands currently. A comparison between the product from the coffeeshops and through the pharmacy process found some mold and fungus in the coffeeshop product but the results were limited with no major

[149] Transcripts, Vol. 12, p.1838, l.6-12; p.1890, l.2 to p. 1891, l.3; p.1892, l.14-23; p. 1894, l.20-26; p.1896, l.17 to p. 1897, l.2
[150] Transcripts, Vol. 12, p.1713-1714; p. 1730
[151] Transcripts, Vol. 12, p. 1752

differences in the samples found. The analysis concluded that patients had decided to make their choice between the two options as consumers.[152]

158. The non-enforcement policy also applies to the production of up to 5 plants so long as there is no evidence of a commercial purpose. If the police find a person doing this they will confiscate the plants but there will be no charges. Enforcement apparently varies from area to area throughout the Netherlands. [153]

159. People can grow their own food in the Netherlands and do not have to submit it to laboratory tests as long as they are producing for themselves and not selling to the public. Sales have to be quality controlled. There are no statistics indicating any health issues or problems from people growing their own food or cannabis for themselves in the Netherlands over the last 30 plus years.[154]

160. Under the new system Bedrocan is the only supplier, having been the only applicant and only company to qualify under the European tender process.[155] They produce the product and provide it to the BMC and the BMC arranges for packaging, labeling and the liek and has it subjected to gamma irradiation as an extra precaution (this also occurs with food that is for sale to the public). Patients go to the pharmacies to get their medicine. There is little or no evidence of diversion of this product. The Bedrocan product is covered by some insurance companies but generally it is not covered because it is not a registered medicine. The usual form is "dried influoresents" (ie, flowers or buds) and they are working on allowing cannabis oil. Patients are not restricted in any way from making extracts from the product if they want to ingest it in a different way as long as it is for themselves and not others. There is no limitation with respect to medical conditions or dosage, both of which are left up to the doctor and the patient. There are no maximums or minimums, though statistics are not available. The cost for patients is $5 Euro per gram plus 6% tax and pharmacy costs which converts to approximately $10-$12 CDN per gram.[156]

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[152] Transcripts, Vol. 12, p. 1716-1720; p. 1761-1762; p. 1767-1769; p.1721-1722; p. 1725-1727; p. 1761-1762; p. 1767-1769

[153] Transcripts, Vol. 12, p. 1780

[154] Transcripts, Vol. 12, p.1727-1728; p. 1743-1744; p. 1767

[155] Transcripts, Vol. 12, p. 1795-1796

[156] Transcripts, Vol. 12, p.1742-1743

161. Some patients have been prosecuted for growing their own and although convicted, the court declined to impose any punishment (eg. Moorlag) and other patients, on social assistance, who have found the Bedrocan product to be ineffective for them have managed to secure funding through the City of Amsterdam to enable them to produce for themselves although doing so remains illegal (eg. Woerlee and Hillebrand).

162. Ms. Sandvos agreed that the patients in the Netherlands have a nice position because they have the coffeeshop and the pharmacy options or they can produce up to 5 plants for themselves under the non-enforcement policy.[157]

Plaintiff's Rebuttal evidence

Eric Nash in Rebuttal

163. In rebuttal, Mr. Nash was called upon to provide opinions with respect to the reports tendered by the Defendant from Cpl. Holmquist, Chief Garis, Larry Miller, and Paul Dybvig.

164. Mr. Nash has been a designated producer under the *MMAR* program since 2002, and a certified organic grower for 5 years. Since 2002 he has communicated with over 400 *MMAR* growers and has personally visited 17 or 18 *MMAR* grow sites, all of which had professionally installed ventilation and electrical equipment, were clean and well maintained, and had been inspected by municipal bylaw officers. None of those sites had any issues with mould, fire, security or otherwise. In Mr. Nash's expert opinion, with professional advice, proper ventilation, installation and monitoring, indoor cannabis production can and does take place safely and securely in residential homes and properties under the *MMAR*.[158]

165. Mr. Nash has been an expert witness in many criminal cases for the purpose of providing expert opinion evidence on the growing of cannabis, crop yields, and value thereof. As a result he has seen many photographs of illegal grow operations and the difference between those and the *MMAR* facilities he has visited is "black and

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[157] Transcripts, Vol. 12, p.1783-1785

[158] Nash Aff. No. 1, para. 9, 34, 36, 39, 40 (EB p. 6234, 6238-6240); Transcripts, Vol. 13, p. 1930-1931, 1954-56

white"; there is no comparison. The comparisons between illegal and legal grow sites in the expert reports of Garis, Holmquist, Miller and Dybvig are therefore inapt.[159]

166. Setting up a small, efficient, safe cannabis garden of up to 90 plants in one's home, in compliance with all applicable bylaws and regulations, and that produces between 1 and 1 ½ pounds every 3 months, is very affordable, and can be done for between $1000 and $2000. A very small bloom box can be made for about $300, which can produce about 8 ounces of organic marihuana every 3 months. Contaminants can be eliminated by use of OMRI certified products. Certified organic marihuana can be produce for $1.29 per gram, and less than $1.00 per gram if not certified.[160]

167. Inspections by Health Canada would not be necessary except in rare cases where there are complaints if growers were required to submit documentary proof that their gardens had been inspected by certified tradespeople and local government bylaw officials. This would obviate issues of non-compliance, security, structural damage, mould, and fire safety.[161]

Professor Susan Boyd, Jason Schut, Scott Wilkins, Tim Moen, Robert Boileau, Robert Clarke, Dr. Caroline Ferris

168A. The evidence of these witnesses will be more comprehensively summarized and addressed below in the s.1 analysis, and as applicable.

Paul Armentano

171. Paul Armentano is the Deputy Director of the US organization called National Organization for the Reform of Marijuana Law ("NORML"). He has submitted a rebuttal report to the opinions tendered by Ms Mehler and Professor Robert Mikos regarding medical cannabis laws in the United States of America. Mr. Armentano has previously testified at state legislatures and before federal agencies regarding use and distribution of cannabis for medical purposes. Mr. Armentano was not cross-examined on his opinions. In his opinion, several US states have adopted legislation

[159] Nash Aff. No. 1, para. 35, Exh. A (EB p. 6239, 6247-6248); Transcripts, Vol. 13, P. 1942
[160] Nash Aff. No. 1, para. 55 (EB p. 6243); Transcripts, Vol. 13, p. 1934, 1976, 1983
[161] Transcripts, Vol. 13, p. 1972, 1975-1976

intending to facilitate state-sponsored production or distribution of medical cannabis, however, in practice patients in many of these jurisdictions lack adequate and/or safe access to the products because the proposed programs are either non-operational and/or fail to provide a feasible mechanism to allow the state licenced manufacture and dispensing of either cannabis or cannabis-derived products. Relatedly, commercial cultivation schemes have resulted in more expensive cannabis product for patients as they must bear the onerous costs levied from those who engage in commercial cultivation. Significantly, however, no state that has permitted patients to cultivate their own cannabis has ever taken action to eliminate that right.[162]

ARGUMENT

Legislative and judicial history of medical cannabis access: Overview

168. As a result of the decision of the Ontario Court of Appeal in *R. v. Parker*[163] the Government of Canada was required, in order to ensure that the *CDSA* was in compliance with the Canadian Constitution and in particular s. 7 of the *Charter*, to put in place a "constitutionally viable medical exemption" to the prohibition against the possession and cultivation of cannabis for medically approved patients. The *Parker* Court determined that failure on the part of the government to provide "reasonable access for medical purposes" as an exemption to the general prohibition violates s. 7 of the *Charter*. The *Parker* court found that patients were being forced to choose between their liberty and their health. This decision ultimately led to medical cannabis exemptions pursuant to s. 56 of the *CDSA* and then to the promulgation of the *MMAR* pursuant to section 55 of the *CDSA*.

169. After the *MMAR* came into effect, various successful s. 7 challenges took place with respect to certain restrictions contained in the *MMAR*. These cases involved restrictions limiting the number of patients a designated producer could produce for, limiting how many production licenses could exist at any one location, and limiting possession to "dried marihuana".

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[162] Armentano Expert Report, p. 1-5 (EB Tab 65)

[163] *R. v. Parker* (2000) 49 O.R. (3d) 481 (Ont.C.A.) leave to appeal to the Supreme Court of Canada dismissed) recently reaffirmed by that Court in *Her Majesty the Queen and Matthew Mernagh* (2013) Ont.C.A 67 (February 1, 2013) (leave to appeal to the Supreme Court of Canada dismissed July 25, 2013), and recently referred to with approval by the Supreme Court of Canada in *Carter v. Canada (Atty. Gen.)*, 2015 SCC 5 at paragraph [67],

170. The ambit and scope of a patient's constitutional right to safe, continuous, reasonable access to cannabis as medicine, including personal production or production by a designated caregiver, was continued during this period, notwithstanding the advent of a government contractor (PPS) selling directly to patients as another supply option.

171. The ambit and scope of the *MMAR* was considered by this Federal Court Trial Division and the Federal Court of Appeal in striking down a provision of the *MMAR* as a negative restriction on the s. 7 liberty and the security of the person rights.[164]

Detailed history of medical cannabis access: a litany of litigation

172. On July 31, 2000, the Ontario Court of Appeal confirmed the existence of a constitutional right to consume cannabis as medicine. The government chose not to appeal this decision and the *Parker* case became the seminal case on the constitutional requirement that the government provide a means by which medical cannabis users can be exempted from the operation of the criminal law.

173. The *Parker* court found that the choice of medication to alleviate effects of serious illness is a decision of fundamental personal importance and intruding into that decision-making by way of threat of criminal sanction is a severe deprivation of liberty.

174. The *Parker* court also determined that the use of the criminal law power to prevent production and possession of cannabis for medical purposes violated the security of the person interest by interfering with Mr. Parker's physical and psychological integrity.[165]

175. In July, 2001, twelve months less a day after the Ontario Court of Appeal decision in *Parker* the government promulgated the *MMAR*.[166]

176. The *MMAR* established a framework or scheme where an individual could apply to Health Canada with the support of their medical practitioner for an

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[164] *Sfetkopoulos v. AG Canada*, 2008 FC 33 (FCTD) and 2008 FCA 328 (FCA); See also *Wakeford v. Canada*, [1998] O.J. 3522; [2000] O.J.1479; [2002] O.J. No. 85, (Ont. C.A.); *R. v. Krieger*, 2000 ABQB 1012, 2003 ABCA 85, 2008 ABCA 394; *Hitzig v. Canada* (2003), 177 OAC 321 ; and *R v. Smith*, 2012 BCSC 544, affirmed in 2014 BCCA 322 except as to remedy, with the appeal to the Supreme Court of Canada as of right having been heard on Friday, March 20, 2015 and judgment reserved, and the decision in *R. v. Beren and Swallow* 2009 BCSC 429.)

[165] *R. v. Parker* (2000), 188 D.L.R. (4th) 385 (Ont. C.A.) (emphasis supplied)

[166] *Marihuana Medical Access Regulations*, SOR/2001-227

"Authorization to Possess" (ATP) "dried marihuana" in accordance with an authorization for medical purposes. The Regulations set out various categories relating to symptoms of various medical conditions with two categories requiring the involvement of one or two specialists. The ATP was subject to annual renewal.

177. Despite there being no lawful supply of seeds or starter plants, the *MMAR* provided for the individual to obtain a Personal Use Production Licence (PUPL) or to designate someone to obtain a Designated-person Production Licence (DPPL) to produce an amount of cannabis and to store and possess certain amounts depending upon a calculation derived from the medical practitioner's authorization of grams per day for the particular ailment.

178. There is no prohibition against production at one's ordinary place of residence or in any dwelling place but if the production site is not owned by the producer and is not the applicant's ordinary place of residence then the written consent of the owner is required.

179. Initially, the *MMAR* provided that a designated producer could only produce for one patient holding an ATP and there could only be three production licences in one place. Furthermore the *MMAR* were limited to the production and supply of "dried marihuana" and no other form of the medicine (eg, edible and/or topical products).

180. Shortly after the *MMAR* were promulgated, the regulations became the subject of litigation launched by a group of medical cannabis consumers. The *MMAR* were found to be constitutionally defective in *Hitzig v. Canada* because they "fail[ed] to provide individuals who have a serious medical need to use marihuana with a legal source and safe supply of their medicine."[167]

181. Health Canada on July 8th, 2003 announced an "Interim Policy" whereby marihuana seeds and dried marihuana grown by PPS, a private company producing for research purposes under contract with Her Majesty, would now be available for sale to individuals having an exemption under the *MMAR* or under s. 56 of the *CDSA*.

182. A unanimous Ontario Court of Appeal then upheld *Hitzig I* and declared invalid specific provisions of the *MMAR*. In addition to striking the restriction on compensating DPPLs, the Court struck a rule that the holder of a DPPL provide

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[167] *Hitzig v. Canada*[167], (2003), 171 C.C.C. (3d) 18 (Hitzig I), para.8

marihuana to only one ATP holder (the 1:1 Ratio Restriction) and another that prevented more than three production licences from being aggregated at any one physical location (the "3-Max Restriction"). No suspension of the declaration was granted. The Court determined that this remedy would immediately render "the *MMAR* as modified a constitutionally sound medical exemption."[168]

183. Subsequent to the decision in *Hitzig II*, the Government re-enacted, verbatim, 2 of the sections of the *MMAR* that had been stricken. One of these two re-enacted restrictions was the 1:1 Ratio. Another was the 3-Max Restriction.[169]

184. On June 29th, 2005 the Government made further amendments to the *MMAR* re-defining the types of applicants by merging categories 1 and 2 into category 1, requiring the declaration of only one physician, and merging category 3 into 2 and eliminating the requirement of a declaration from a specialist but still requiring a consultation with one.

185. On October 3rd, 2007 further amendments were made to the *MMAR* but still leaving the DPPL only able to produce for one patient.

186. These invalid restrictions on supply were again made the subject of *Charter* litigation and were, again, found to violate the *Charter*.

187. In 2008 this Court declared the re-enacted 1:1 Ratio Restriction to be invalid as an arbitrary restriction on s. 7 rights.[170] Strayer J. accepted the *Parker* and *Hitzig* decisions of the Ontario Court of Appeal with respect to the violation of s. 7. In his view, it was "**not tenable for the government, consistently with the right established in other courts for qualified medical users to have reasonable access to marihuana to force them either to buy from a government contractor, grow their own or be limited to the unnecessarily restrictive system of designated producers.**" He found the s. 7 violations could not be overcome by a forced monopoly for PPS product for those who cannot grow for themselves or find an available designated producer[171] The Federal Court Of Appeal (Evans, Sharlow and Ryer J.A.s) agreed with Strayer J, finding no error and declined to suspend the declaration of

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[168] *Hitzig et al v. Canada* (2003) 177 CCC (3d) 449 (*Hitzig II*), paras 111, 161, 165, 166, 175
[169] *Regulations Amending the Marihuana Medical Access Regulations*, SOR/2003-387.
[170] *Sfetkopoulos et.al. v. Attorney General of Canada*, 2008 FC 33, *affirmed* in *Canada (Attorney General) v. Sfetkopoulos*, 2008 FCA 328, leave to appeal to Supreme Court of Canada denied
[171] Strayer J. at [19] – [23]

invalidity due to the long history in the courts of the issues raised in the litigation and the time the government had available to it since his decision[172] .

188. Subsequently, the British Columbia Supreme Court found the 1:1 Ratio Restriction and the 3-Max Restriction violated s. 7 and suspended its declaration of invalidity for one year to allow the government time to respond.[173]

189. As it did in response to *Hitzig II*, the federal government amended the *MMAR* subsequent to the decisions in *Sfetkopolous* and *Beren.*

190. This time, instead of re-enacting the unconstitutional restrictions verbatim as it had post-*Hitzig*, the government elected to incrementally change the scheme.

191. First, in response to *Sfetkopolous* (a civil case brought by 17 patients and one prospective producer) the government implemented a 1:2 Ratio Restriction (one producer could now provide cannabis to a maximum of 2 patients instead of one).[174] Second, in response to *Beren* (a criminal case involving a producer for some 400 patients) the government amended the 3-Max Restriction to allow one additional licence to be placed at any physical location (making it a 4-Max Restriction).[175]

192. The restriction to "dried marihuana" only in the *MMARs* was then challenged on *Charter* grounds. In *R v. Smith*, the application judge found that the restriction violated s. 7, deleted "dried" from the regulations and amended the definition of "marihuana" to include all Schedule II substances. He suspended his declaration of invalidity for one year as it applied to non-patients (ie, designated producers) but made it immediately effective as to patients. At the expiry of the year the government sought more time and the application judge refused that request. Accordingly, as of April 2012 non-dried forms of cannabis medicine were lawful for all *MMAR* patient-participants in British Columbia and as of April 2013 all *MMAR* participants in British Columbia.

193. The court of appeal majority in *Smith* upheld the s. 7 finding of unconstitutionality but determined that the application judge's remedy was inappropriate, modified it to be simply a declaration of invalidity and then suspended

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[172] FCA per Evans J.A. at [3] –[7] (emphasis added)

[173] *R v. Beren*, 2009 BCSC 429, leave to appeal to Supreme Court of Canada denied at paras. 127, 134 and 135

[174] *Regulations Amending the Marihuana Medical Access Regulation*, SOR 2009/S37, Admission CITE para 28.

[175] *Regulations Amending the Marihuana Medical Access Regulation*, SOR/2010-63

the declaration for a year. *Smith* was heard on March 20, 2015 in the Supreme Court of Canada and decision was reserved.

194. Meanwhile, Defendant promulgated the *MMPR*, purported to replace the *MMAR* as the constitutionally viable exemption from the *CDSA*.

195. The *MMPR* continue to limit possession by a patient to dried marihuana only and the patient cannot possess any more than 30 times the daily quantity authorized or 150 grams whichever is the lesser amount. The LPs are not permitted to conduct any activity at a dwelling place and production and related activities can only take place indoors and not outdoors.

196. In the Regulatory Impact Analysis Statement (a statutory requirement when regulations are promulgated) accompanying the *MMPR*, the Government of Canada indicated that the main economic cost associated with the proposed *MMPR* would arise from the loss to consumers who may have to pay a higher price for dried marihuana estimated to be $1.80 per gram to $5.00 per gram in the *MMAR* status quo rising to about $7.60 per gram in 2014 and rising to $8.80 per gram thereafter.[176]

197. The government's history of responding to declarations of invalidity in this area of law has been wholly inadequate to meet the dictates of the *Charter* and the decisions of the various courts that have ruled on the issue. This state of affairs has persisted for almost 15 years, with the courts on one hand making *Charter* rulings and the government on the other hand responding to those decisions in such minimal fashion as to ensure further litigation and further declarations of invalidity. All the while patients are suffering. The latest regulatory change knowingly and intentionally continues this pattern of attempting to restrict as much as possible lawful access to a safe, effective supply of cannabis for medical purposes.

THE SECTION 7 VIOLATIONS

[176] Canada Gazette, Volume 146, #50, published December 15th, 2012

Introduction

198. Plaintiffs submit that the *CDSA,* as modified by the provisions of the *MMPR*, to the extent specifically challenged, violates section 7 of the *Charter* and is not saved under s. 1 of the *Charter*.

199. Plaintiffs submit further that as a result of the decision in *Parker* recently re-affirmed *Her Majesty the Queen and Mathew Mernagh)* and recently commented upon with approval in the Supreme Court of Canada in *Carter*, Defendant is required to provide a "constitutionally viable medical exemption" to the prohibition against the possession and production of cannabis in order to avoid violating the s. 7 *Charter* rights of medically approved patients.

200. Defendant's response after the initial use of s. 56 of the *CDSA* was the promulgation pursuant to s. 55 of the *CDSA* of the *MMAR.* Various successful s. 7 challenges to the *MMAR* were taken as described above.

201. On June 19, 2013 the Federal Government promulgated the *MMPR* to run concurrently with the *MMAR* until March 31, 2014 at which time the *MMAR* was repealed (s. 209 (3) of the *MMPR*).

202. The *MMPR* makes no provision whatsoever for a patient to be able to produce medical cannabis. The sole source of supply under the *MMPR* is through an LP. All other production is absolutely prohibited by the *CDSA.*

203. Section 5 of the *MMPR* limits the patient to possessing a quantity of dried marihuana that is 30 times the daily authorized quantity or 150 grams, whichever is lower, regardless of the nature of their illness or individual circumstances. The *MMAR* did not contain the 150-gram maximum limitation, instead permitting possession of a 30-day supply. Possessing greater than 150 grams is, therefore, criminal conduct irrespective of patient needs or physician-approved dosages.

204. Further, the combination of the *CDSA* and *MMPR* prohibits both highly-regulated LPs from making cannabis derivative medicines and prohibits patients from rendering their lawfully-possessed dried marihuana into those medicines.

205. Defendant purports to have the *MMPR* be the viable constitutional exemption to the *CDSA* that provides reasonable access by patients to this medication. However, the *MMPR* takes away the ability of the patient to produce cannabis for themselves

and therefore compels patients to purchase from an LP whether they want to or not, whether the LP has adequate supply or not, whether the LP has the strains required or not and whether the patient can afford it or not, thereby placing patients once again in a position of having to choose between their liberty and their health in order to have access to an adequate supply of medicine.

206. Plaintiffs submit that a viable constitutional exemption from the *CDSA* should have the effect of removing cannabis from Schedule II of the *CDSA* and Schedule 2 of the *NHPR*, thereby making activities related to medical cannabis no longer criminal in nature and, instead, subject to the *NHPR*. The practical effect of this would enable the consumers of such products to produce them for themselves but would strictly regulate the commercial manufacture and sale of such products to the public.

207. Put another way, Plaintiffs submit that s. 7 permits the government to regulate commercial behaviour in this area but does not permit the government to criminalize individual non-commercial patient conduct such as producing one's own medicine and cannabis-based products.

Defendant's justifications for the impugned restrictions are considered in the section 1 analysis, not in section 7

208. Defendant took the position at trial that it had various legitimate reasons for criminally prohibiting patient production and for the various other impugned restrictions. Plaintiffs submit that it is crucial to a proper analysis of the *Charter* issues to situate those reasons, and the evidence purported to support those reasons, firmly in the s. 1 analysis.

209. The Supreme Court of Canada recently re-confirmed that the s. 7 analysis looks to the objective of the impugned restriction but that the effects of that restriction and evidence related to whether or not the restrictions actually achieve any public good are to be considered in the section 1 analysis where the burden falls on Defendant to demonstrably justify the limitation in a free and democratic society.

210. In *R. v. Malmo Levine (supra)* the Supreme Court made clear that s. 7 should not involve a "free-standing inquiry" in which individual and societal interests are balanced because doing so collapses the s. 1 inquiry into s. 7. Societal interests are to

be dealt with in s. 1.[177]

211. The decision of the Supreme Court in *Carter* is also instructive on this point:

> [79] Before turning to the principles of fundamental justice at play, a general comment is in order. In determining whether the deprivation of life, liberty and security of the person is in accordance with the principles of fundamental justice under s. 7, courts are not concerned with competing social interests or public benefits conferred by the impugned law. **These competing moral claims and broad societal benefits are more appropriately considered at the stage of justification under s. 1 of the *Charter*** (*Bedford*, at paras. 123 and 125).
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> [80] In *Bedford*, the Court noted that requiring s. 7 claimants "to establish the efficacy of the law versus its deleterious consequences on members of society as a whole, would impose the government's s. 1 burden on claimants under s. 7 " (para. 127; see also *Charkaoui v. Canada (Citizenship and Immigration)*, 2007 SCC 9, [2007] 1 S.C.R. 350, at paras. 21-22). A claimant under s. 7 must show that the state has deprived them of their life, liberty or security of the person and that the deprivation is not in accordance with the principles of fundamental justice. They should not be tasked with also showing that these principles are "not overridden by a valid state or communal interest in these circumstances": T.J. Singleton, "The Principles of Fundamental Justice, Societal Interests and Section 1 of the Charter" (1995), 74 *Can. Bar Rev.* 446, at p. 449. As this Court stated in *R. v. Swain*, [1991] 1 S.C.R. 933, at p. 977 "It is not appropriate for the state to thwart the exercise of the accused's right by attempting to bring societal interests into the principles of fundamental justice and to thereby limit the accused's s. 7 rights. Societal interests are to be dealt with under s. 1 of the *Charter*."

212. Accordingly, Plaintiffs submit that the host of justifications offered by Defendant for restricting their s. 7 rights are only relevant to the s. 1 inquiry and are not to be considered in determining whether s. 7 is breached. With that in mind, Plaintiffs turn to the s. 7 breaches arising in this case.

Liberty and Security of the Person are Infringed

213. The Supreme Court of Canada recently explained that while liberty and security of the person are distinct interests, both rest on a foundation of protecting individual autonomy and dignity:

> Underlying both of these rights is a concern for the protection of individual autonomy and dignity. Liberty protects "the right to make fundamental personal choices free from state interference": *Blencoe v. British Columbia (Human*

[177] *R. v. Malmo Levine (supra)* at paragraphs 96-99, *cited with approval in Charkaoui v. Canada (Citizenship and Immigration)* [2007] 1 SCR 350 at page 371.

> *Rights Commission)*, [2000] 2 S.C.R. 307, at para. 54. Security of the person encompasses "a notion of personal autonomy involving . . . control over one's bodily integrity free from state interference" (*Rodriguez*, at pp. 587-88 per Sopinka J., referring to *R. v. Morgentaler*, [1988] 1 S.C.R. 30) and it is engaged by state interference with an individual's physical or psychological integrity, including any state action that causes physical or serious psychological suffering (*New Brunswick (Minister of Health and Community Services) v. G. (J.)*, [1999] 3 S.C.R. 46, at para. 58; Blencoe, at paras. 55-57; *Chaoulli*, at para. 43, per Deschamps J.; para. 119, per McLachlin C.J. and Major J.; and paras. 191 and 200, per Binnie and LeBel JJ.). While liberty and security of the person are distinct interests, for the purpose of this appeal they may be considered together.[178]

214. In addition to protecting autonomy and individual dignity, the liberty interest protects against deprivation of freedom by the threat of criminal prosecution and incarceration.

215. Plaintiffs submit that criminalizing personal production of medical cannabis is a severe infringement on autonomy that deprives them of control over their bodily integrity "free from" state interference. Further, the removal of personal production as a supply option will inevitably (and knowingly) leave patients unable to afford sufficient quantities of medicine, constituting "state action that causes physical and psychological suffering" and may, for some patients, either hasten or lead to their death. These are serious infringements of s. 7.

216. Patient autonomy in medical decision-making is a central tenet of both s. 7 and the common law right to informed consent, as the Supreme Court also recently explained:

> The law has long protected patient autonomy in medical decision-making. In *A.C. v. Manitoba (Director of Child and Family Services)*, [2009] 2 S.C.R. 181, a majority of this Court, per Abella J. (the dissent not disagreeing on this point), endorsed the "tenacious relevance in our legal system of the principle that competent individuals are — and should be — free to make decisions about their bodily integrity" (para. 39). This right to "decide one's own fate" *entitles adults to direct the course of their own medical care* (para. 40): it is this principle that underlies the concept of "informed consent" and is protected by s. 7's guarantee of liberty and security of the person (para. 100; see also *R. v. Parker* (2000), 49 O.R. (3d) 481 (C.A.)). As noted in *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.), the right of medical self-determination is not vitiated by the fact that serious risks or consequences, including death, may flow from the

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[178] *Carter v. Canada (Attorney General)*, 2015 SCC 5 at para.64

> patient's decision. It is this same principle that is at work in the cases dealing with the right to refuse consent to medical treatment, or to demand that treatment be withdrawn or discontinued: *see, e.g., Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119; *Malette v. Shulman* (1990), 72 O.R. (2d) 417 (C.A.); and *Nancy B. v. Hôtel-Dieu de Québec* (1992), 86 D.L.R. (4th) 385 (Que. Sup. Ct.).[179]

217. In *Carter*, the Court determined that protecting choice in individual responses to grievous and irremediable medical conditions is critical to individual dignity.[180] The law, post-*Carter*, allows persons to "request palliative sedation, refuse artificial nutrition and hydration, or request the removal of life-sustaining medical equipment" and to engage in physician-assisted dying even where other treatments may be available. Section 7, thus, confers very broad decision-making authority on patients and protects a wide range of conduct, even where that conduct runs contrary to the life interest also protected by s. 7.

218. The common thread running through the Supreme Court's jurisprudence in this area is that patients' choices are to be respected. In the specific context of cannabis, the Supreme Court has suggested that consumption of cannabis for medical purposes would impact the s. 7 security of the person right because imposing criminal consequences on medical consumers is the imposition of serious state-induced psychological stress.[181]

219. Plaintiffs submit that the "constitutionally viable exemption to provide reasonable access to medically approved patients" was determined to include the right to produce for oneself and this led to the *MMAR* enabling personal production in order to achieve that reasonable access.

220. This did not change when Defendant introduced a government supply option through PPS in 2003. In fact, the government discovered that it was subsidizing patients under that program, because the cost of production was approximately $10-12 per gram and HC was selling it to patients for $5 a gram. Some patients could not even afford

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[179] *Carter, supra,* para.67 (emphasis added)

[180] This Court also made clear that patients would not be forced to first undertake treatments that the patient found unacceptable: "'Irremediable', it should be added, does not require the patient to undertake treatments that are not acceptable to the individual." *Carter (supra)* para 127

[181] *R v. Malmo-Levine; R v. Caine,* [2003] 3 S.C.R. 571 at para.88

that price and were subject to having their access terminated and became the subject of collection proceedings by Defendant.

221. Some 14 years post-*Parker*, Defendant has supplanted the *MMAR* with new regulations that have led to a number of private companies like PPS being licenced to sell "dried marihuana" to patients. In doing so Defendant deprived the individual patient of the ability, by way of personal production, of ensuring for themselves a supply under their control, in terms of cost and quality, and not intended for distribution or sale to others.

222. Defendant, by the *MMPR*, has subjected patients to the vagaries of the free market, with all of the limitations inherent in large-scale production and with no regulations requiring that market to ensure that all patients have access to medicine as a matter of law.

223. In fact, Defendant enacted the *MMPR knowing* that a primary impact of the *MMPR* would be a significant increase in the price of medicine to patients and knew that this price increase would impair or impede access. In other words, Defendant knowingly and intentionally created a state-imposed barrier to patient access to an adequate supply of medicine by removing from patients an option that had, for many years, provided that access. This, Plaintiffs submit, is a severe infringement of s. 7.

224. Indeed, the *CDSA* itself, as modified by either the *MMAR* or *MMPR* is an infringement of s. 7. As the Court of Appeal put it in *Hitzig II*, the effect of a general prohibition with a restrictive regulatory exemption regime is to create a threshold infringement of the s. 7 rights of patients, irrespective of the actual impact of the restrictions. This is because a regulatory scheme that requires patients to jump through state-imposed hoops in order to avoid criminalization intrinsically violates s. 7.[182]

225. Plaintiffs submit that the personal production of medical cannabis involves individual autonomy and dignity and the right to make fundamental personal choices free from state interference and thereby impacts or engages liberty. Similarly, security of the person is engaged because it encompasses personal autonomy involving control over one's bodily integrity, free from state interference, such as interference with an individual's physical or psychological integrity, causing physical or serious

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[182] In this regard, Plaintiffs adopt the reasoning at paragraphs 90 – 105 of *Hitzig II, supra.*

psychological suffering. The liberty interest also protects against deprivation of freedom by the threat of criminal prosecution and incarceration to which a medically approved patient will be subject under the *CDSA*, including potential mandatory minimum periods of imprisonment, and potential civil forfeiture of their property, if they continue to produce medical cannabis.

226. Plaintiffs submit further that, on the evidence, both the liberty and the security of the person interests of medically approved patients are engaged by the policy choice of Defendant to take away completely their ability to produce their own medical cannabis. Plaintiffs have been able to produce their medicine for approximately 14 years and, to varying extents, have invested in equipment and knowledge to be able to do so and to be able to produce particular effective strains under their control with respect to what goes into the making of the medicine and the cost of so doing. Removing this ability under threat of criminal sanction infringes s. 7.

227. Having established that the impact of the *CDSA/MMPR* scheme is to infringe s. 7, Plaintiffs turn to the violation of the principles of fundamental justice.

The applicable principles of fundamental justice are violated

228. The infringements of the liberty and security of the person rights are not in accordance with the principles of fundamental justice

229. Three central principles are identified as fundamental in recent s. 7 jurisprudence: arbitrariness, overbreadth and gross disproportionality in effects.[183]

230. All three can be seen as what Professor Hamish Stewart has described as "failures of instrumental rationality" in the sense that the means chosen by government to achieve its objectives are intrinsically mismatched with that objective.[184]

231. The first step in the fundamental justice analysis is to identify the object of the impugned restriction.

The legislative objective

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[183] *Carter, supra,* para.72

[184] Stewart, Hamish. *Fundamental Justice: Section 7 of the Canadian Charter of Rights and Freedoms.* Toronto: Irwin Law 2012.

232. Plaintiffs submit that the object of the restriction must be defined precisely and go no further than the restriction at issue. They submit that the objective is the protection of the health and safety of patients who are medically qualified to consume cannabis for medical purposes. In other words to provide a viable constitutional exemption to the *CDSA* for those patients.

233. The Supreme Court has cautioned that stating an objective too broadly may "short-circuit the analysis" and effectively "immunize the law from challenge under the *Charter*." Stating the objective broadly in this case could create this very ill, making it "difficult to say that the means used to further it are overbroad or grossly disproportionate" and creating a situation where the "outcome is to this extent foreordained."[185]

234. The objective must, therefore, be "defined precisely" and should not go beyond the "ambit of the provision itself." Recently, the Supreme Court has rejected Canada's attempts to state overbroad objectives in *Carter* (prohibition on physician-assisted death suggested as preserving life whatever the circumstances)[186] and in *Bedford* (goal of bawdy-house provisions suggested as deterring prostitution generally). CITE

235. Under either a broad or specific statement of the objective, however, the evidence at trial demonstrated that the impugned restrictions fail to comply with the principles of fundamental justice because they are arbitrary, overbroad and produce effects that are grossly disproportionate to the objectives.

Violations of the Principles of Fundamental Justice

236. The impugned restrictions compel patients, under threat of criminal sanction, to (a) purchase from LPs irrespective of their individual ability to afford to do so; (b) possess artificially limited quantities of medicine thus denying them the ability to travel for work or pleasure, or requiring them to make multiple orders per month from LPs; and (c) ingest the medicinal compounds in unnecessarily restrictive, less effective and more harmful ways.

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[185] *Carter, supra,* para.77 citing *RJR-MacDonald Inc. v. Canada (Attorney General),* [1995] 3 S.C.R. 199 at para.144. *RJR-MacDonald* is an apt comparison because there the impugned measures were "but one facet of a complex legislative and policy scheme to protect Canadians from the health risks of tobacco use."

[186] *Carter, supra,* para.78.

237. The impugned restrictions, then, impede or prevent access to cannabis by medically qualified patients with concomitant negative impacts on their health and safety.

238. Plaintiffs therefore submit that once patients established that they are medically approved, the principles underlying *Parker* and *Mernagh* apply and they are entitled to a constitutionally viable exemption from the *CDSA* that provides them with reasonable and continuous access to an adequate supply of their medicine. Under the existing case law involving the ambit and scope of s. 7 in this context a right to produce for oneself was included. The Government proposes to take that away completely.

239. Plaintiffs submit that is at least arbitrary as contrary to the purposes of the *CDSA*, overbroad in going beyond what is necessary according to the purposes of the CDSA and will result in grossly disproportionate effects at least upon those who will no longer be able to afford a reasonable effective continuous supply, violating some s. 7 patients' rights.

The restrictions are arbitrary because they will cause, not prevent, harm to health and safety

240. A law is arbitrary when there is no rational connection between the effect and the object of the law.[187]

241. One method of demonstrating this lack of connection is to show that the law's effects are inconsistent with the law's objective:[188]

> [83] The principle of fundamental justice that forbids arbitrariness targets the situation where there is no rational connection between the object of the law and the limit it imposes on life, liberty or security of the person: *Bedford*, at para. 111. An arbitrary law is one that is not capable of fulfilling its objectives. It exacts a constitutional price in terms of rights, without furthering the public good that is said to be the object of the law.

242. Recent decisions of the Supreme Court make clear that restrictions that cause harm to health and safety when they are designed to prevent harm to health and safety are arbitrary.

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[187] *Carter, supra,* para.83

[188] *See,e.g., Morgentaler, supra, Chaoulli, supra, Canada (Attorney General) v. PHS Community Services Society,* [2011] 3 S.C.R. 134

243. In *Chaoulli*, Quebec argued that allowing private health insurance would threaten the objective of providing a public health care system. But the evidence demonstrated that concern was unfounded, and that denying patients the choice of private care harmed their health. Therefore the evidence demonstrated no "real connection in fact" between the restriction and the objective, making it arbitrary.[189]

244. In *PHS*, the Minister's decision not to extend the *CDSA* exemption granted to inSite was arbitrary because the evidence demonstrated that granting the exemption furthered the *CDSA* goals of protecting health and safety while failing to grant the exemption actually caused harm.[190]

245. As in *Chaoulli* and *PHS*, the evidence at trial demonstrates that the impugned restrictions cause harm rather than preventing it. Put another way, there is no "real connection in fact" between the restrictions and the objective and, therefore, they are arbitrary.

246. The evidence at trial failed to show that public safety will be advanced in any significant way by the removal of the ability to lawfully and safely continue to produce medical cannabis. Further, the evidence demonstrated that in so doing, Defendant will put the health and safety of some patients at risk because the exemption proposed by the *MMPR* will not allow Plaintiffs access to adequate supplies of medicine.

247. Patient health and safety (and public health and safety) will be harmed because (a) patients will either go without sufficient medicine or be impoverished or break the law and produce it; (b) patients, fearful of criminal charges, will no longer have their production sites inspected for safety and will go back underground as they did in the period before being able to obtain licensing thus causing risks of harm to public health and safety; (c) patients are forced under threat of criminal sanction to consume medicine in less effective and more harmful ways; (d) patients are criminalized for possessing reasonable quantities of medical cannabis and must either go without or continually order/replenish their supply, leading to gaps in supply.

248. All of these effects are inconsistent with and contrary to the purposes of the *CDSA/MMPR* scheme.

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[189] *Chaoulli, supra,* para.139.
[190] *PHS, supra,* para.131

The restrictions are overbroad

249. If the impugned restrictions are not arbitrary, however, because of some minimal connection between the law's effects and objectives, they are overbroad because in the case of any particular individual patient the restrictions cause harm rather than preventing it. They go too far.

250. The Supreme Court recently confirmed that the focus of the overbreadth analysis is on the individual:

> The overbreadth inquiry asks whether a law that takes away rights in a way that generally supports the object of the law, goes too far by **denying the rights of some individuals in a way that bears no relation to the object**: *Bedford*, at paras. 101 and 112-13. Like the other principles of fundamental justice under s. 7, overbreadth is not concerned with competing social interests or ancillary benefits to the general population. **A law that is drawn broadly to target conduct that bears no relation to its purpose "in order to make enforcement more practical" may therefore be overbroad** (see *Bedford*, at para. 113). The question is not whether Parliament has chosen the least restrictive means, but whether the chosen means infringe life, liberty or security of the person in a way that has no connection with the mischief contemplated by the legislature. The focus is not on broad social impacts, but on the impact of the measure on the individuals whose life, liberty or security of the person is trammeled.[191]

251. This understanding of overbreadth confirms that Defendant's justifications for the restrictions that are related to enforcement practicality (eg, prevention of diversion) actually *support* a finding of overbreadth.

252. In the case at bar, as in *Carter*, Defendant essentially conceded at trial that the impugned restrictions apply to persons whose conduct did not implicate the objectives of protecting health and safety.

253. None of the patient witnesses engage in diversion and there was no evidence that any had suffered any harm to either their health or safety or caused any harm to public health or safety as a result of their production of cannabis and cannabis-based medicines for their individual consumption. Indeed Health Canada was unable to

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[191] *Carter, supra,* para.85 (emphasis added)

produce any significant records of any such problems generally throughout the history of the *MMAR*.

254. Put another way, even if the scanty evidence of possible harms associated with personal production of cannabis and cannabis-based medicines is accepted, the blanket prohibition catches people outside of the class of persons who are suffering and/or causing such harms and is, therefore, overbroad. At least in some cases, the blanket prohibition on production, possessing more than 150 grams and consuming forms other than dried marihuana is simply not connected to the objective of protecting health and safety.

255. In *Carter*, the Court determined that the total ban on assisted dying was overbroad, despite the importance of the objectives in issue:

> [86] Applying this approach, we conclude that the prohibition on assisted dying is overbroad. The object of the law, as discussed, is to protect vulnerable persons from being induced to commit suicide at a moment of weakness. Canada conceded at trial that the law catches people outside this class: "It is recognized that not every person who wishes to commit suicide is vulnerable, and that there may be people with disabilities who have a considered, rational and persistent wish to end their own lives" (trial reasons, at para. 1136). The trial judge accepted that Ms. Taylor was such a person — competent, fully-informed, and free from coercion or duress (para. 16). It follows that the limitation on their rights is in at least some cases not connected to the objective of protecting *vulnerable* persons. The blanket prohibition sweeps conduct into its ambit that is unrelated to the law's objective. [87] Canada argues that it is difficult to conclusively identify the "vulnerable", and that therefore it cannot be said that the prohibition is overbroad. Indeed, Canada asserts, "every person is *potentially* vulnerable" from a legislative perspective (R.F., at para. 115 (emphasis in original)).
>
> [88] We do not agree. The situation is analogous to that in *Bedford*, where this Court concluded that the prohibition on living on the avails of prostitution in s. 212(1)(*j*) of the *Criminal Code* was overbroad. The law in that case punished everyone who earned a living through a relationship with a prostitute, without distinguishing between those who would assist and protect them and those who would be at least potentially exploitive of them. Canada there as here argued that the line between exploitative and non-exploitative relationships was blurry, and that, as a result, the provision had to be drawn broadly to capture its targets. The Court concluded that that argument is more appropriately addressed under s. 1 (paras. 143-44).

256. Similarly, Plaintiffs submit that the *MMPR* goes too far by denying the rights of some medically approved patients in a way that bears no relation to the dual objects of the CDSA.

257. The evidence establishes that the great majority of patients were able to produce their own cannabis as medicine without any threat to their own or public health and safety and in fact, in support of at least the public health component or purpose. As the *Carter* court held "The focus is not on broad social impacts, but on the impact of the measure on the individuals whose life, liberty or security of the person is trammeled " and "the law catches people outside this class".

258. It follows that the limitation on their rights is in at least some cases not connected to the objective of protecting public safety and public health. The blanket prohibition sweeps conduct into its ambit that is "unrelated to the law's objective." The law punishes everyone who produces cannabis as medicine for themselves, possesses more than 150 grams or posseses/produces cannabis-based medicines without distinguishing between those who do so safely and securely without any risk to public safety and consistently with the promotion of public health. It is, therefore, overbroad and the rights infringement is contrary to the principles of fundamental justice.

The law creates grossly disproportionate effects

259. Laws that cause effects that are grossly disproportionate to the objectives violate the principles of fundamental justice.

260. Plaintiffs submit that the state does not have a legitimate interest in prohibiting medicinal cannabis patients from producing medicine for their own personal consumption, from possessing more than 150 grams and from choosing modes of ingestion other than smoking the dried flowers.

261. Even if those interests are legitimate, the criminalization of the conduct is a far too extreme response. Echoing the dissent in *Malmo-Levine*, the harms of using the criminal law to punish the production, possession and consumption of cannabis by medical patients far outweighs any benefits that prohibition can bring.[192]

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[192] *Malmo-Levine* at para.301, per Deschamps J., at para.280, per LeBel J.

262. Similarly, in *PHS*, the Supreme Court found that denying the exemption to inSite caused grossly disproportionate effects on persons suffering the medical condition of addiction; effects that outweighed the general interest in maintaining prohibition.[193]

263. The Supreme Court in *Bedford* made clear that gross disproportionality does not consider the purported social benefits of the restriction and reinforced in *Carter* that public good was a topic for s. 1, not s. 7. Therefore, Defendant's claims about preventing diversion, protecting public safety and the like are matters for the s. 1 analysis, not the s. 7 overbreadth analysis.[194] [195]

264. Instead, in this aspect of s. 7, the court is concerned with the negative effect on the individual balanced against the purpose of the restriction. A grossly disproportionate effect on one patient alone is sufficient to violate this norm.[196]

265. Here, the purpose of the law is to protect the health and safety of medical cannabis consumers (or the public, on a broader conception of the objective). The negative effect of the law on patients is the imposition of criminality; the attendant negatives that flow from criminalizing; the stripping away of autonomy and choice in medical decision-making; denial of an adequate supply of medicine or institutionalized poverty; the forced ingestion of cannabis medicine by smoking or vaporization with the attendant harms; and the removal of the benefits of oral and topical modes of ingestion.

266. Plaintiffs submit that the restrictions negative impact on liberty and security of the person is very high; the law imposes unnecessary suffering on some patients, deprives them of self-determination in respect of what to do with their own bodies and confines their choice in how to ingest cannabis to options that are more harmful, less effective and often impractical or impossible. Against this is an objective that, in the context of this case and on the evidence presented at trial, is of minimal importance – the protection of patients from the exceedingly minimal risks posed by their choice of personally producing and consuming cannabis for medical purposes.

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[193] *PHS, supra,* at para.136.
[194] *Bedford, supra,* para.121
[195] *Carter, supra,* at para.95
[196] *Bedford, supra,* paras.121, 122.

267. Further, Plaintiffs submit that at least those who are unable to afford the LP prices will continue to be placed in a position where they have to choose between their liberty and their health. Their liberty will be impacted if they choose to continue to produce cannabis as medicine for themselves unlawfully and risk the threat of prosecution, imprisonment and criminal or civil forfeiture of their property.

268. Patient health will be negatively impacted if they are unable to access sufficient amounts of the medicine approved for their illness. The continuing example of such a patient is Plaintiff Tanya Beemish and her caregiver spouse David Hebert. It is submitted that she is suffering grossly disproportionate consequences having to go without her medicine to the point of lengthy hospitalization and they both are at risk of grossly disproportionate consequences if he decides to continue to produce for her notwithstanding the lack of authority to do so in the *MMPR*.

269. For all of these reasons, the restrictions are grossly disproportionate and therefore not in accordance with the principles of fundamental justice.

SECTION 1 DOES NOT SAVE THE IMPUGNED RESTRICTIONS

The Law Relating to Section 1 of the *Charter*

270. The recent decision of the Supreme Court of Canada in *Carter* provides both a comprehensive and succinct discussion and application of section 1 by that court:

> [94] In order to justify the infringement of the appellants' s. 7 rights under s. 1 of the *Charter* , Canada must show that the law has a pressing and substantial object and that the means chosen are proportional to that object. A law is proportionate if (1) the means adopted are rationally connected to that objective; (2) it is minimally impairing of the right in question; and (3) there is proportionality between the deleterious and salutary effects of the law: *R. v. Oakes*, [1986] 1 S.C.R. 103.

271. It is difficult for the state to justify a s. 7 violation because those rights are fundamental. *Carter* para 95.

272. A law that violates s. 7 of the Charter because it is arbitrary, overbroad and grossly disproportionate will rarely, if ever, be able to be justified by s. 1. This is because restrictions that are not in accordance with the principles of fundamental justice are demonstrably "inherently flawed" and because fundamental rights are not easily overridden by competing social interests. *Carter* para 95.

273. In *Carter*, the issue was whether the government could demonstrate that the prohibition was proportionate (appellant conceded that the objective was pressing and substantial; plaintiffs herein do not). The Court determined that the prohibition was not. Plaintiffs say that that is also the case within this matter before the Court.

Facts and Argument in Relation to Section 1 and Issues of Public Health and Safety

281. In response to the Plaintiff's case the Defendant is seeking to justify any s. 7 breaches caused by the *MMPR* scheme through the provision of evidence suggesting that Health Canada's *MMPR* implementation has furthered public health and safety by countering the following harms:

A. Cannabis gardens (especially those indoors) are inherently dangerous due to:
   (i) Increased risk of public harm due to fire hazards and the likelihood of related criminal involvement;
   (ii) Increased risk of the presence of mould in buildings containing cannabis gardens, endangering health and causing a reduction in property values;
B. Cannabis is a medicine and therefore needs to be subject to quality controls that apply to pharmaceutical drugs in order to prevent harm to patients caused by bad medicine;
C. Since cannabis has not been subject to any FDA drug approval processes its efficacy and safety as medicine are unknown and therefore extracts are potentially dangerous as are high doses of cannabis.

Fire and Criminality: Threats to public safety

282. The onus on the Defendant to demonstrate that its breaches of the Plaintiffs' s. 7 rights can be saved by s. 1 of the *Charter* as being in furtherance of a greater public good.

283. Plaintiffs submit that with respect to the issue of threats to public safety Defendant has not only failed to meet its positive evidentiary onus at all, but in actuality have provided no evidence whatsoever to support the claims that legal cannabis gardens constitute any kind of risk to public safety. Furthermore, Plaintiffs state that what amounts to "non-evidence" provided by Defendant, and in particular the opinions of RCMP Corporal Shane Holmquist and Fire Chief Len Garis, amply demonstrate that their supposed expertise respecting the dangers of medical cannabis growing is not based on any tested research or social and physical science, but actually based almost entirely on prejudice and the conjecture that obviates it.

Corporal Shane Holmquist and Fire Chief Len Garis

284. Cpl. Holmquist presented an expert report wherein he was requested to attest to, among other things, criminal abuses under the *MMAR* and other public safety risks that the system presented. Under various headings of criminal abuses and public safety risks, including risks of fire, criminality, organized crime, and diversion of excess product, Cpl. Holmquist then provided various examples of same, concluding that that there were such abuses and risks and that overall, public safety was under threat from the *MMAR*.[197]

285. Under cross-examination Cpl. Holmquist admitted that he had not engaged in any proper research with respect to the conclusions he reached, but had merely found examples of abuse. In his report he did indicate that he was aware there were anywhere between 13,000 and 15,000 personal or designated grow licences in British Columbia and possibly as many as 28,000 across Canada.[198] He indicated he had no training in research methodology[199], and, in that vein, reached all his conclusions regarding public safety risks and *MMAR* sites solely on the basis of examples of abuses that he found in police files or in his own investigations, and without conducting random sample or comparative analysis of the *MMAR* growing population as a whole.[200] This was notwithstanding his acknowledgment that abuses are inherent in any regulated

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[197] Holmquist Aff. # 2, EB Tab 30
[198] Holmquist Aff. # 2, EB Tab 30, para. 50; Trial transcripts pp. 990 - 991
[199] Trial transcripts p. 1091
[200] Trial transcripts pps. 1001-1005

environment even with laws and regulations, but at the same time a few abusers among thousands would not necessarily demonstrate widespread abuse.[201]

286. Ultimately, Cpl. Holmquist attempted to evade his research and evidentiary gaps by variously claiming that his mandate was only to find examples of abuse and that he did not have "access" to the *MMAR* growing population as a whole to conduct research; yet he also admitted that he just never tried.[202] When faced with an example of an *MMAR* grower who appeared to not be abusing, namely Plaintiff Neil Allard, Cpl. Holmquist admitted that such compliance could be the norm, but he did not know either way.[203]

287. The reality is that Cpl. Holmquist did no methodological research among the 15-28,000 *MMAR* production licences in Canada other than provide a few examples showing various kinds of abuse (less than ten examples under almost all of the headings). His conclusions cannot, therefore, even remotely be trusted. While examples are simply too numerous as to how his lack of research made his conclusions untenable, three demonstrate the failures of the whole. One relates to conclusions regarding fire safety hazards. Cpl. Holmquist attested to such hazards from *MMAR* sites and provided some examples. However, he agreed that most people exercising common sense would not want to be burned to death and that he did not juxtapose an example of a properly wired *MMAR* site with an unsafe one.[204] Similarly, he did not conduct research regarding fire safety at *MMAR* sites as a whole, all the while further acknowledging that there are, and could be, many personal growers who set up their gardens with certified electricians (such as the Plaintiff Neil Allard).[205]

288. Another particularly egregious display of non-research-based conclusions relates to that regarding the potential for abuse by physicians. Cpl. Holmquist referred to *one* example of a rogue physician abusing the *MMAR* and essentially used it to suggest that an entire heavily-regulated, ethically-bound profession may abuse the system.[206] And finally, Cpl. Holmquist drew conclusions about dangers of toxic mould, but admitted

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[201] Trial transcripts pps. 992-995
[202] Trial transcripts, p. 1090
[203] Trial transcripts, pp. 1028 - 1033
[204] Trial transcripts, pps. 1038 and 1089
[205] Trial transcripts, pps. 1028 - 1033
[206] Trial transcripts, pps. 1098 - 1102

he had not done a random analysis of *MMAR* gardens to determine the actual prevalence of mould, nor had he compared standard non-garden buildings to determine the prevalence of mould more generally.[207]

289. Indeed, even where Cpl. Holmquist attempted to make inferential conclusions, his lack of research showed such conclusions to be improperly founded. And even where evidentiary examples were provided, either from the literature at hand or from his own experience, they were often misleading or unverifiable. On one occasion, Cpl. Holmquist makes the inference that the only reason one would grow a large or "monster" plant would be to illegally divert excess product, but upon being confronted with the reality that individuals could in fact grow a single large plant and therefore far under-produce as per their allowance, he admitted that his inference was based on no evidence whatsoever and was pure conjecture.[208]

290. Cpl. Holmquist also stated that there was difficulty in having the manpower or numbers of inspectors available to check *MMAR* sites, but when confronted with the reality of spot audits in other regulated fields that would allow reasonable inspection of thousands of sites, he asserted that there were problems gaining access to "private property" for such inspections. However, when once again confronted with the reality that limitations were placed on inspecting dwelling homes (the same limitation on which would not prevent obtaining search warrants), he admitted he did not have the numbers relating to gardens in dwelling homes and therefore could not say if there were any impediments with spot inspections.[209] At the same time, Cpl. Holmquist assserted that more generally, there were problems in investigating *MMAR* sites for police, but on further examination agreed that there were no greater problems investigating *MMAR* sites than there would be for illegal grows or any other criminal activity for that matter.[210]

291. Finally, misleading examples were given with respect to organized crime and criminality linked to *MMAR* sites. First, Cpl. Holmquist referred to annex NN of his report, which provides a police report that he claimed provided examples of criminal

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[207] Trial transcripts, pps. 1007-1008
[208] Trial transcripts, pps. 1009-1013, particularly 1013
[209] Trial transcripts, pps. 996-1001
[210] Trial transcripts, pps. 1042 - 1052

links to *MMAR* growing. Upon further examination, however, it was shown that not all the information necessary to conclude that there were criminal links to *MMAR* sites was available and that the examples provided could have been subject to further testing which would fail to demonstrate the presence of criminality.[211] Cpl. Holmquist also referred to one of his own investigations in which a photo of a "Hell's Angels" patch was produced, but admitted that it was only the size of a keychain and there were no large patches or other insignia of organized crime present at the site. Indeed, it was put to Cpl. Holmquist that when he referred to "organized crime" he was actually referring to the more inflammatory rhetoric of gangs. Cpl. Holmquist denied this and stated he merely referred to the *Criminal Code* definition, which involved three or more people working together.[212] Whatever the use, however, Plaintiffs submit that the connotation created is meant to be a reference to gang criminality, when in fact the reality could be three terminally ill individuals simply growing without a licence. It is suggested that labelling this as "organized crime", while possibly technically correct, is very misleading.

292. Professor Susan Boyd provided an expert rebuttal report to the opinion given by Cpl. Holmquist. Plaintiffs discuss Professor Boyd's report in more detail below, at present one factor addressed by her should be cited: the discussion of the problem of "truth claims". Professor Boyd refers to truth claims as coming out of imagery which masquerades as facts that "speak for themselves" another form of confirmation bias in which a truth is held out and an example provided detailing its veracity, without any rigorous research or testing.[213] Truth claims were the claims made by Cpl. Holmquist, and it was this same spurious methodology which was employed by Fire Chief Len Garis.

293. Facially and on cross-examination, the report of Mr. Garis was revealed to be a highly misleading compilation of truth claims which could mislead the reader of the report into believing that medical cannabis growers are a serious public danger to the public when in fact there was no evidence to support such claims. During cross-examination it became apparent that Chief Garis had no qualifications to present an

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[211] Trial transcripts, pps. 1057-1058
[212] Trial transcript, pps. 1067-1068 and 1058- 1061
[213] Boyd aff. # 2, exhibit "C", *Killer Weed*, p. 14

expert research report to the Court and that he is a vocal, public advocate for the abolition of cannabis growing and for the imposition of serious criminal sanctions of marihuana growing or use generally. Chief Garis admitted that he had no expert knowledge at all on the issues of mould, dangers of "chemicals" other than with respect to fire safety, and had no expertise on the growing of cannabis, the chemical properties of cannabis, on which he had written extensively in his report. On the issue of Chief Garis identifying himself as a "professor" at the University of the Fraser Valley (a former community college renamed in 2008), on cross examination it became clear that he has no qualification, training or expertise whatsoever as a scholar and in particular with respect to research methodology and statistics, that he has only taught a few classes on fire safety, and that the research centre he belongs to at the university is headed by a RCMP research chair and is partners with a plethora of law enforcement groups across Canada.[214]

294. Chief Garis' report relies on "literature" that consists primarily of other articles written by himself and persons associated with the research centre (principally Darryl Plecas) that are not peer reviewed but rather are self-publications simply published on the research centre website. These publications express strong anti-marihuana political views, are self-referential, and strongly favour severe sanctions against marihuana growers, including mandatory minimum prison incarceration and civil forfeiture of the homes of growers, without exception. Under cross examination Chief Garis confirmed his support of such views.[215]

295. Chief Garis further admitted during cross-examination that his opinion report began with the assumption that growing cannabis indoors is dangerous and that he then

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[214] Transcripts, Vol. 9, p. 1190-1322. Chief Garis admitted that he hired others whom he believed had expertise in the areas of mould, chemicals, construction defects, etc. to review photographs taken at residences of persons growing cannabis (taken without their consent pursuant to an unconstitutional bylaw scheme) to provide opinions as to those issues, at least one of whom Darrell Waddell has made his living the last 15 years by way of reporting, investigating, and providing expert opinions with respect to illegal marijuana grow operations.

[215] Chief Garis also admitted that he has provided at least five expert opinion reports in civil forfeiture cases on topics entirely outside his areas of expertise, such as cannabis cultivation and the value of cannabis on the black market, in support of the provincial government forfeiting the homes of growers without even asking about the circumstances of the persons subject to the forefeiture action, which may include disabled people who grow cannabis for medicinal purpose but without a licence. Transcripts, Vol. 9, p. 1232-1238

selected evidence to prove the assumed fact that growing marihuana indoors is inherently dangerous. On this basis alone Chief Garis' report is inherently and entirely biased toward the conclusion he assumed to be true, and which conclusion is the position of the Defendant in this case.[216]

296. With respect to the content of the his report, Chief Garis conceded under cross-examination that the vast bulk of his opinion only addressed *illegal* marihuana grow operations. Plainitffs submit that all such sections of the report should be excised or given no weight by this Honourable Court. To the limited extent that Chief Garis did address medical cannabis sites in his report, his statistics and analysis should be afforded no weight in light of his complete lack of credentials in statistical analysis and research methodology, the inherent research bias of his report's approach, and his actual bias as an ouspoken public advocate for the Defendant's position in this lawsuit, that all cannabis self-production by patients should be banned.

297. This brings us to the work completed by Professor Susan Boyd. Professor Boyd holds the title of Distinguished Professor (a special rank afforded to only select full Professors) at the University of Victoria, where she teaches and conducts research within the Faculty of Human and Social Development. Importantly, she is a co-author of the book *Killer Weed: Marijuana Grow Ops, Media and Justice*, in which she systematically studies and compares media and justice portrayals of cannabis use and production in Canada. Her essential thesis, based on extensive research, is that the production and consumption of cannabis, and the individuals who engage in it, is a far more diverse spectrum of action and ideas than the justice industry would have the public believe, with law enforcement and a combination of it and the media being marked by a presumptive bias against marihuana in all its forms. In this vein, as Professor Boyd has analyzed, "research" from that sector often is not research at all, failing to follow generally accepted research standards and thus presenting a misleading picture of whatever data does or, more importantly, does *not*, exist.

298. In *Killer Weed*, seemingly scientific pronouncements by law enforcement and its affiliates, media or otherwise, have to be viewed and assessed critically.[217] This is the

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[216] Transcripts, Vol. 9, 1241 and following

[217] *Killer Weed* is before the Court as part of Professor Boyd's expert rebuttal to Cpl. Holmquist and Chief Garis, attached as exhibit "C" to Boyd aff. #2, tab 67. Its analysis can be

form of analysis employed by Professor Boyd in critically rebutting the expert evidence supplied by Cpl. Holmquist and Chief Garis. The cross-examinations of both Cpl. Holmquist and Chief Garis only further illuminated Professor Boyd's prior exposition as to how the tendered experts' evidence was in fact entitled to no weight as it followed no proper research methodology and made misleading statements that had no basis in evidence. In her report, Professor Boyd comprehensively details what proper research should entail, the initial obvious point being that there should be research questions and that answers to such questions should be based on actual evidence. Research should also include the use of representative and random sampling, and with respect to publications, there must be peer review. Examples of flawed methodology in Cpl. Holmquist's report are simply too numerous to mention, but on review of the report as a whole, Professor Boyd found non-methodology as follows:

> The affidavit, supporting Annex(s), and transcripts arising from Cpl. Holmquist examination fail to provide a comprehensive analysis of *MMAR* sites and solutions to perceived problems related to abusers of the program. The material is anecdotal only and lacks scholarly rigor. No attempt was made to study law-abiding *MMAR* sites or to interview a large sample of law-abiding *MMAR* patients and growers. Nor did the witness look outside of RCMP and law enforcement material to come to his conclusions. The RCMP reports included are also limited due to their flawed methodology, including a lack of references.[218]

299. Further, as Professor Boyd states, there are various statements made by Holmquist that simply have no basis in evidence, such as his statement that *MMAR* growers have four crops a year when there is simply no evidence for same and was "pure conjecture".[219] Overall, with respect to Cpl. Holmquist's affidavit as a whole, Boyd concludes that

> ...it is difficult to understand how Holmquist can offer information about medical marihuana and growing or give recommendations for legislative changes when he has limited knowledge on the subject and has not made any attempt to gain more knowledge or evidence about the issue outside of policing data of abuses in the system. He has only familiarized himself with "abuses" of the system and even then he provides no evidence to support alleged abuse, or

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applied to an assessment of the Defendant' evidence as a whole. See pps. 23-37 of *Killer Weed*.

[218] Boyd aff. #2, tab 67, para. 25

[219] Boyd aff. #2, tab 67, para. 32

> potential abuse, nor does he provide what percentage of all *MMAR* grow sites engage in illegal practices.[220]

300. In Boyd's analysis, Chief Garis' research or lack thereof is similarly flawed, best summed up in the following example studied in the report:

> The photos included in Garis' study work in a similar way as news photos. Through visual repetition of harms assumed to be associated with grow ops and captions that make clear the particular "problem" of grow operations the reader comes to understand that Garis proposes that marihuana grow ops are "threats to public safety." This is a theme he has been asserting since early 2000. The text or captions in Garis's study are necessary though because often times it is completely unclear what a photo is suppose to reveal. For example, Sections 74-88 discuss mould found in grow sites and photos are included (yet no photos of *MMAR* mold). As noted in Boyd and Carter (2014), mould is an issue for all residences in the lower mainland because it is a temperate rain area; mould is not limited to grow operation sites. However, little effort is made (similar to EFSI efforts) by the City of Surrey to identify and eliminate mold in basement suites, low income rentals and homes, nor is there a similar effort by the City of Surrey for electrical violations in residential homes and rentals. The mould depicted in the photos in the report may or may not be harmful. The mould photos may or may not be associated with growing marihuana. There is no evidence provided in the study to confirm this. Even so, if the results of the mould analysis in the report is taken at face value, only 24 percent of all the illegal grows in the study were said to have visible mold (Section 78). "Suspected cases" are included in the summary of mould existence from the photographs; however, suspected is just that, it is not evidence and it should be discounted. Later on in the report it is reported that 25 percent of legal *MMAR* sites contained mould. If taken at face value, or in agreement with the photo analysis employed in the report, a one percent difference is reported; yet, the *MMAR* sample is not representative of all *MMAR* sites.[221]

301. In sum, the rebuttal evidence of Professor Boyd confirm what was illuminated on cross-examination; that the expert evidence tendered by Cpl. Holmquist and Chief Garis had no basis in research or evidence and was thus not expert evidence at all or even evidence, period. Most importantly, in her analysis of Cpl. Holmquist and Garis, Professor Boyd essentially finds that the non-researched biases which have underpinned much of the history of the understanding surrounding cannabis as an illegal product have simply been translated or transported into the analysis by the

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[220] Boyd aff. #2,tab 67, para. 49
[221] Boyd aff. #2, tab 67, para. 84

Defendant's experts towards medical and legal cannabis. The opinions are founded on prejudice and bias and do not have a foundation in actual research or evidence.

302. While it is submitted that the expert evidence on public safety risk tendered by Defendant has thus been conclusively shown to have no weight and does not assist Defendant in meeting the evidentiary onus required by s. 1 of the Charter, a wider point actually emerges from the analysis. While Boyd's report and *Killer Weed* comprehensively discuss how much information regarding cannabis from the justice industry has flawed methodology and is misleading, it very presciently links the non-research imperative to the early history of drug regulation in Canada, which was similarly based on little or no research but on inflammatory rhetoric that had as its purpose the unequal targeting of people deemed undesirable by others. Early drug laws were based on a "drug scare" about the "yellow peril" of Chinese who were spreading drugs and vice among the moral, white, majority. Racist as the idea was, the view espoused was of course not based in research and presumably all that would be needed would be single examples, or alleged and misleading examples, that the "yellow peril" was real. And drug laws were passed that resulted in the heavy incarceration and often deportation of Chinese Canadian males. The reality is that they were not a threat to public safety but non-researched inflammatory rhetoric caused them to be perceived as such.[222]

303. In consideration of this history and its link to the present non-researched public safety threat expressed, it becomes apparent that Defendant's evidence on that point is not only a failure to provide evidence but actually positive evidence on the side of Plaintiffs that suggests that any breaches of section 7 are not to be saved under section 1. Not only is there no evidence regarding public safety risk, but that same non-evidence suggests the *MMAR* system is *in line* with public safety, the contrary suggestion being based on inflammatory rhetoric designed to suggest public safety risk in its actual absence, and prejudiced against the identifiable group of marihuana users generally, translated into prejudice and targeting of medical cannabis users and producers more particularly. This also suggests the confluence of evidence respecting both the s. 1 and s. 7 *Charter* rights of Plaintiffs. The evidence becomes demonstrative

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[222] Boyd aff. # 2, tab 67, exhibit "C", pps. 38-43

of a lack of public safety risk and in that vein suggests that restrictions relating to cannabis use that are based on public safety risk are in actuality arbitrary, having as their effect the potential loss of life, liberty, and security of the person.

304. It was put to both Cpl. Holmquist and Chief Garis that they were advocates instead of experts and that their reports were an exercise in simple confirmation bias. They denied this was the case, but the rebuttal report of Professor Boyd and the cross-examinations of both witnesses demonstrates otherwise. Their opinions, based on bias and rhetoric, would be dangerous if adopted as part of public policy. This Honourable Court should not give any weight to the opinions of Cpl. Holmquist and Chief Garis, and indeed should view such non-evidence as positive evidence for the Plaintiffs with respect to both the s. 1 and s. 7 *Charter* issues.

Plaintiff's further rebuttal to Fire Chief Garis and Fire Safety Issues under s. 1

305. In the area of his actual expertise, that of fire safety, Chief Garis admitted that the Fire Commissioner Office fire statistics did not include a single fire at *legal* medical cannabis production site between 2001 and 2012.[223] Further, Chief Garis agreed with the Plaintiff's further rebuttal experts, Tim Moen and Robert Boileau, that residences with cannabis growing facilities and electrical equipment installed by licenced electricians and which meet the applicable safety regulations and bylaws would not pose an increased fire risk to the public.

306. Mr. Moen is of the view that Chief Garis ignored alternative evidence or explanations for the cause of fires at illegal grow operations. The number of fires at all grow sites, which includes illegal sites, has stayed the same or gone down since the number of *MMAR* licenced growers has increased exponentially, showing there is no causal relationship between licenced growers and fires. Even according to Chief Garis' own fire statistics, there is no difference between the estimated fire risk of houses that have a licenced grow site and other houses in B.C. Mr. Moen's expert opinion, agreed with by Chief Garis, is that properly constructed medical cannabis facilities, in

[223]Transcripts, Vol. 9, p. 1209;

accordance with all laws, do not pose an increased risk of fire to residential buildings.[224]

307. Mr. Boileau's expert opinion is that electrical contractors are able to and do perform electrical installations at indoor marihuana grow facilities under permit for holders of *MMAR* licences, and those installations are inspected in compliance with the *Safety Standards Act*. This process ensures that the installations are done safely. Safety Officers can require an annual operating permit for an installation which requires that the named Field Safety Representative be responsible for the ongoing safety of the installation and that there be annual inspections. Accordingly, electrical installations at legal indoor marihuana grow facilities by *MMAR* licence holders are just as safe as any other electrical installation at any other type of facility.[225]

308. A further rebuttal expert for Plaintiffs is Scott Wilkins, an insurance broker who has arranged for building insurance for approximately 300 *MMAR* cannabis growers who grow inside their residences, in outbuildings, and at commercial properties.[226] He provided expert evidence on the issues of insurability of legal *MMAR* sites, including risks of fire and theft at *MMAR* grow sites. Mr. Wilkins states that the cannabis garden facilities he insures are properly and safely installed according to applicable bylaws and codes. *MMAR* cannabis growers are required to demonstrate the safety of their installation, including having electrical work inspected, confirming structural work is to code, and providing photographs of the building and installations.[227] There has not been a single insurance claim for damage resulting from the growing of cannabis for any of the over 300 *MMAR* cannabis growers he has insured during the 5 years he has been providing them insurance. [228] Most *MMAR* growers already had their cannabis gardens set up prior to seeking insurance with Mr. Wilkins. Out of the more than 300 insured growers, only about 12 did not have an electrical permit.[229]

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[224] Moen Expert Report, paras. 10-43 (EB Tab 32, p. 5546-5556)
[225] Boileau Expert Report (EB Tab 66, p. 7053-7063)
[226] Wilkins Expert Report, p. 1-4; (EB Tab 35, p. 5852-5899); Transcripts, Vol. 10, p. 1392, l. 11-23
[227] Wilkins Expert Report, p. 1-4; (EB Tab 35, p. 5852-5899); Transcripts, vol. 10, p. 1405, l. 2 to p. 1409, l. 2, p. 1416, l.11-21, p. 1412, l. 6-13, 1419-1420
[228] Wilkins Expert Report, p. 1-4 (EB Tab 35, p. 5852-5899); Transcripts, vol. 10, p. 1396, l. 16 to p. 1397, l. 12
[229] Transcripts, Vol. 10, p. 1396, l. 5-11, p. 1403, l. 22-26, p. 1405, l. 26 to p. 1406, l. 5

309. Mr. Wilkins is further of the view that there is no comparison between illegal grow operations and legal cannabis gardens. The main risk elements for illegal grow operations –fire, mould, chemicals, theft, structural problems— are reduced to zero for legal cannabis gardens because of the requirement that all work done and equipment be installed by licenced contractors, inspected, and certified as meeting all applicable safety codes and laws.[230] Indeed, the Plaintiffs themselves provided detailed evidence with respect to their own particular grow sites that amply demonstrated that their growing facilities were properly installed, inspected by certified professionals, had fire prevention systems in place, were properly ventilated and de-humidied, had no problems with mold, had adequate security systems and had never experience any issues with theft or criminal activity.[231]

310. The expert evidence of Mr. Eric Nash and Mr. Colasanti, experts on the safe and effective growing of marijuana, further confirmed that cannabis can be grown indoors (or outdoors) safely, with risks from fire, mould and theft minimized either to zero or to the maximum extent possible for any residence in Canada.[232]

Conclusions Regarding Fire, theft, and the risks posed by legal cannabis grow sites to public safety

311. The Plaintiffs submit that the Defendant has failed to provide any evidence to support the allegation that growing cannabis legally in residences or elsewhere constitute threats to public safety, and has therefore failed to meet the burden of proof upon it. Further, the Plaintiffs have provided overwhelming evidence demonstrating that in fact growing cannabis in buildings with properly installed electrical equipment and fire prevention systems has the same or lower fire risk than other buildings not used to grow cannabis.[233] The evidence with respect to danger from chemicals to children or first responders is entirely deficient, and has been rebutted by Mr. Moen.[234]

Mould and Damage to Residences: Dr. John David Miller and Larry Dybvig

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[230] Wilkins Expert Report, Schedule 4, pp. 44-46 (EB Tab 35, p. 5852-5899)
[231] See Facts sections on Plaintiffs Allard, Herbert, Beemish, and Davey, supra.
[232] See Facts sections on Nash and Colasanti, supra.
[233] See Facts section on Colasanti, supra
[234] Moen Expert Report, para. 30 (EB Tab 32, p. 5546-5556)

312. The Defendant has alleged that growing cannabis indoors inherently creates risk of mould -a threat to the health of inhabitants and visitors- and can cause serious structural damage.

313. In this respect, the Defendant provided the evidence of Dr. John David Miller, an expert in fungal physiology. On the issue of damage to buildings, the Defendant provided the expert evidence of Larry Dybvig, a real estate appraiser. The Plaintiffs do not take issue with Dr. Miller's credentials, and do not submit that he provides entirely unreliable expert evidence to this Court. However, the Plaintiffs do submit that Dr. Miller does not provide any evidence that any indoor medical cannabis grow sites in fact suffer from moisture problems or mould as a result of growing cannabis indoors. His evidence is limited to opinions on the possibility of moisture problems and mould in residences that have inadequate ventilation systems, particularly those with indoor gardens. To the extent that Dr. Miller's report contains irrelevant comments on illegal grow operations, the Plaintiffs submit those should be excised or given no consideration.[235]

314. Dr. Miller opines that mould damage in houses can cause negative health impacts, and that plants, including cannabis plants, are one possible source of moisture in a home, along with showers, cooking, etc. On the issue of potential mould growth, Dr. Miller states that "unless the ventilation capacity of the building is capable of removing [...] water from the air, the building materials and house dust take up the water which then becomes available for mould growth."[236] Dr. Miller further states that moisture problems can be addressed by "adding point source ventilation to remove excess moisture from growing plants" and by an "engineered solution". Dr. Miller also opines that mould can grow on the cannabis plant matter itself, saying that like all plants, cannabis plants have fungi growing on them, and that improperly dried cannabis plant matter can cause the growth of particular fungi that can cause allergic reactions, and is dangerous for people with cystic fibrosis.[237]

315. The Plaintiffs agree that growing cannabis in improperly ventilated buildings can cause mould, and do not take issue with his opinion that, like all plants, improper drying

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[235] Miller Expert Report, p. 5 (EB Tab 63)
[236] Miller Expert Report, p. 7, 8, 9 (EB Tab 63)
[237] Miller Expert Report, p. 11-15 (EB Tab 63)

of cannabis can result in particularly undesirable mould growing on it. However, the Plaintiff also submits that this does not lead to the conclusion that growing cannabis indoors necessarily causes mould, or that legal cannabis growers improperly dry their medical cannabis or store or consume mouldy cannabis.

316. Larry Dybvig was requested by the Defendant to provide an expert opinion on the impact of "marijuana grow operations" on residential property values. As a result, Mr. Dybvig's entire report exclusively considers the impact of *illegal* grow operations to the value of residential properties.[238] The Plaintiffs therefore submit that Mr. Dybvig's entire report and the conclusions expressed therein are entirely irrelevant to the Defendant's allegation that *MMAR* legal cannabis gardens cause mould and necessarily result in damage to residences.

317. In response to Dr. Miller and Larry Dybvig, the Plaintiffs have provided the expert evidence of Jason Schut, an expert in mould prevention techniques and technologies, and remediation of mould infested buildings. In Mr. Schut's view there is no difference between growing 20 marijuana plants and growing 20 tomato plants in an indoor garden. A properly built indoor garden will address the humidity and ventilation issues that exist in a facility and in particular in the room in which the production occurs. Contrary to the findings of Mr. Dybvig, such improvements can improve upon the condition of building/residence by fixing any prior existing ventilation problems that might result in mould damage.[239]

318. Mr. Schut's opinion is that prevention, detection and elimination of excess moisture, the cause of mould, can be easily accomplished at legal cannabis production sites by use of relatively inexpensive modern equipment, including fans, dehumidifiers and dehumidistats, and by proper local government regulation.[240] Further, and as already stated, the Plaintiffs themselves provided overwhelming evidence that they employed proper mould prevention technologies, did not suffer issues with mould, and did not cause harm to themselves or damage to their residences.[241] In addition, the

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[238] Dybvig Report, p. 9, 13, 20-21 (EB Tab 59)
[239] Schut Expert Report (EB, Tab 70)
[240] Schut Expert Report (EB, Tab 70)
[241] See Facts sections of the Plaintiffs Allard, Hebert, Beemish, and Davey, supra

evidence of Mr. Nash and Mr. Colasanti further confirmed that cannabis can be grown indoors safely, without issues of mould, by use of simple and inexpensive equipment available at garden stores and Canadian Tire.[242]

Conclusion regarding Dangers from Mould

319. The Plaintiff's submit that the Defendant has not met the evidentiary burden upon it with respect to its allegation that indoor cannabis growing causes mould and is therefore a threat to public health and safety (or to residential property values). Mr. Schut provides full answer to the evidence of Dr. Miller in that respect, as does Mr. Colasanti, Mr. Nash, and the plaintiffs themselves. With respect to mould existing on cannabis plants and dried cannabis, this is true of all plants, and is true of cannabis grown and dried by LPs, and can be addressed with drying equipment as per Mr. Schut's evidence and Dr. Miller's own evidence. This latter issue is further addressed under safety of medicine heading

Cannabis is a medicine and therefore needs to be subject to quality controls

320. Defendant alleges that self-production of cannabis is potentially dangerous to patients because it may be infested with mould, contain other contaminants such as heavy metals, and may be of inconsistent or inadequate quality and quantity. To avoid these alleged threats to patient health Defendant says all medicinal cannabis should be manufactured by commercial producers, and self-production by patients should be absolutely criminally prohibited.

Mouldy Cannabis

321. As noted above Dr. Miller suggests that improper drying of cannabis can cause a potentially unhealthy type of mould to grow on the cannabis plant matter. Dr. Miller

[242] See Facts sections of Nash as Expert and Colasanti, supra

admits that this can be addressed by proper drying techniques and use of proper drying equipment. Further, use of concentrates such as hashish, and extracts such cannabis butter or oil, entirely eliminates the issue. Defendant provides no evidence that any patient has had problems with mouldy cannabis or has ever become ill due to mould on their personally-produced cannabis. Plaintiffs have, by contrast, provided evidence that they have not had any mould issues of any kind and have not gotten sick from consuming their own cannabis and even if there was mould (which is visible to the naked eye) they simply would discard the cannabis as they would discard moldy food products.

Manufacturing of Cannabis: Dr. ElSohly

322. Defendant expert Dr. ElSohly, a Professor of Pharmaceutics, School of Pharmacy, provided a report on procedures for manufacturing medical cannabis.

323. Dr. ElSohly's opinion is that under United States law cannabis is a "botanical drug" and therefore the same regulations and guidelines for the manufacture of other "botanical drugs" should be applied for the manufacture of medicinal cannabis.[243]

324. Plaintiffs do not take issue with Dr. ElSohly's opinion as to the growing of cannabis for commercial sale and consumption by the public, and do not dispute his opinion that such manufacturing guidelines and practices are appropriate for LPs in Canada who grow cannabis on a commercial scale for sale to patients.

325. However, it is clear from Dr. ElSohly's expert report that "botanical drugs" are drug products that contain natural plant material and are sold in a processed form. He lists examples of prescription "botanical drugs" at p. 9 as "antibiotics, blood pressure medicine, diabetes medication, anti-inflammatories, etc." and then states that all of these drugs products are manufactured under GMP procedures and the public are not allowed and cannot engage in manufacture of these products. He is not opining on the use of cannabis in its raw form as a herbal plant, rather he is talking about the manufacture of drug products for sale in pharmacies in pill or other form, and in particular for sale to the public, not self-production for personal consumption.[244]

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[243] ElSohly Expert Report, p. 2 (EB, Tab 60, p. 6725-6733)
[244] ElSohly Expert Report, p. 7 (EB Tab 60, p. 6730)

326. In Canada the law is different and the *NHPR* apply to herbal plants used medicinally and grown by person for their own consumption. For the types of "botanical drugs" Dr. ElSohly describes the *FDA* would apply, not the *NHPR*, as he describes the "manufacture" of drugs for sale in pharmacies. Dr. ElSohly's evidence therefore has little or no application with respect to patients growing cannabis for their own use and consumption as a raw plant material, or as simple concentrates or extracts.

327. With respect to extracts, Dr. ElSohly describes two forms of extraction that are not extraction procedures used by Plaintiffs, one involving extraction by way of flammable hydrocarbons (organic solvent extraction) and the other by way highly pressurized liquid carbon dioxide.[245] Plaintiffs do not take issue with these extraction processes being dangerous and requiring the safety procedure described by Dr. ElSohly. However, Dr. ElSohly's opinion does not apply beyond these two procedures and does not apply to the safe extraction procedures used by Plaintiffs such as manual manipulation to create concentrated hashish or extraction of cannabinoids from cannabis buds into vegetable oil or butter.

Robert Clarke, Rebuttal Expert to Dr. ElSohly

328. Robert Clarke, a cannabis researcher and author on cannabis botany and history of medical use,[246] provided expert evidence for Plaintiffs in rebuttal to Dr. ElSohly. He was not cross-examined and therefore his qualifications and evidence is unchallenged.

329. Robert Clarke says in response to Dr. ElSohly that the American Herbal Pharmacopoeia[247] and the American Herbal Products Association include cannabis as

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[245] ElSohly Expert Report, p. 7-8 (EB Tab 60, p. 6730-6731)
[246] Clarke Expert Report, Schedule A (EB Tab 68, p. 7333)
[247] The United State Pharmacopeia establishes written and physical reference standards for medicines, food ingredients, dietary supplement products, and ingredients. These standards are used by regulatory agencies and manufacturers to help to ensure that these products are of the appropriate identity, as well as strength, quality, purity, and consistency. Prescription and over-the-counter medicines available in the United States must, by federal law, meet USP-NF public standards, where such standards exist.

a medicinal plant and set the standards for quality and for growing safely both outdoors and indoors in the United States.[248]

330. In response to the need for certificates of analysis, Mr. Clarke states that the levels of cannabinoids and terpenoid for particular strains of cannabis are publicly available and responsible medical cannabis dispensaries often provide this data to patients so they can make informed decisions concerning their choice of medical cannabis.[249] Mr. Clarke also points out in his report that the biochemical variation of cannabinoids and terpenoids of cannabis can only be slightly altered by growing conditions, and that the chemical profile is genetically, not environmentally, determined.[250]

331. With respect to contaminants such as heavy metals or pesticides, Defendant has not provided any evidence that this was an issue for self-producers, and Plaintiffs have entirely rebutted that argument by way of their evidence that they grow their cannabis in safe, clean environments, and that Mr. Allard and Mr. Beemish grow organically, meaning no chemical fertilizers or pesticides are used at all. Mr. Nash grows certified organic cannabis. Mr. Colasanti provided evidence that heavy metal issues are avoided by using the correct type of chemical fertilizers for growing cannabis, which he himself sells commercially. Further, the evidence with respect to LPs is that there have been product recalls due to pesticide use and mould, and there is no evidence that LPs use growing practices that are chemical free and organic. Plaintiffs' evidence is that the LPs use of chemicals, radiation, and non-organic growing techniques is a serious concern for them because they want to ensure that what goes into their bodies as medicine is not contaminated by toxic chemicals or radiation.

332. With respect to quality control in the sense of ensuring effective medicine, there is no evidence to support Defendant's allegation that patient self-producers produce low quality cannabis that is ineffective for treating their various symptoms. To the contrary, the evidence is that one of the main reasons Plaintiffs wish to continue self-producing is to ensure that they have affordable access to the sufficient quantities of the highest quality medicine for their illnesses, in particular by way of being able to

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[248] Clarke Expert Report, p. 11 (EB Tab 68, p. 7330)
[249] Clarke Expert Report, p. 11 (EB Tab 68, p. 7330)
[250] Clarke Expert Report, p. p. 2 (EB Tab 68, p. 7321)

grow the particular strain of cannabis that is most effective to them and that may not be provided by the LPs, and/or at a cost they can afford. Another major concern expressed by Plaintiffs and other plaintiff witnesses is that LPs are not taking new patients and sell out quickly, especially of particular strains. Plaintiffs' evidence on the issue of quantity and crop failure is that the growing cannabis is no different than growing other plants, that Plaintiffs successfully grow cannabis at low cost, in sufficient quantity and at high quality, and without crop failure or significant pest problems, such that their medical needs are entirely met by their self-produced medical cannabis.[251]

Conclusion regarding danger to patients

333. The evidence presented by Defendant on these topics does not meet the evidentiary burden upon Defendant and is entirely rebutted by the Plaintiffs' evidence.

Cannabis has not been subject to any FDA drug approval policies

334. Defendant relies on the lack of *FDA* approval for use of cannabis as medicine as justifying the 150-gram possession limit (dosage) and the limitation to dried cannabis (dosage and form of drug). Defendant also takes the position that high dosages are a problem generally and in particular with self-production of large numbers of plants, because Defendant takes the position that dosages of over 5 grams are not medically necessary but rather indicate abuse for recreational purpose, profiteering by doctors, or criminal resale on the black market.

335. Defendant's evidence with respect to dosage comes from the expert opinions of Dr. Paul Daeninck and Dr. Kalant. The evidence of these experts was challenged by Plaintiffs by way of rebuttal expert reports.

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[251] The only evidence of crop failure comes from Mr. Davey prior to him meeting Mr. Alexander when he tried to grow on his own unassisted. It should be noted that Mr. Davey suffers from a serious brain injury that causes him cognitive and memory disabilities such that his failure to grow on his own unassisted cannot be extrapolated beyond himself and other patients who suffer from similar serious brain injuries.

Dr. Kalant

336. Dr. Kalant confirms that cannabis is a proven therapeutic treatment for many diseases and that the main pharmacologically active ingredients are THC and cannabidiol (CBC). He classifies the groups of illnesses according to those for which there is strong scientific evidence that cannabis is effective, promising evidence, little evidence, and those for which cannabis has been rejected as effective. The therapeutic uses that have good scientific support include chronic musculoskeletal and neuropathic pain, nausea and vomiting, and stimulation of appetite. Promising uses include seizure control, sedation and anti-anxiety, relief of spasticity, anti-inflammatory action, and neuroprotective action. At very high doses cannabis has been shown to inhibit the growth of cancer cells.[252]

337. Dr. Kalant confirms that there are different ways to ingest cannabis and that these manners of ingestion have different therapeutic effects. Smoking cannabis cigarettes is effective but causes harm to the lungs similar to smoking tobacco. Oral ingestion by way of baked goods and oils is common, has a slower onset and prolonged effect, requires less frequent doses, and produces less psychoactivity for a given degree of therapeutic effect. [253]

338. Dr. Kalant points out that cannabis plant material and "crude extracts" prepared therefrom are not approved by Health Canada as drugs in Canada. While Dr. Kalant says that "marijuana has not met any of the requirements" of the drug approval process, the evidence of Ms. Ritchot is that cannabis has never been submitted, by any party, to the Health Canada drug approval process.[254]

339. Dr. Kalant opines that the therapeutic effects are achieved at lower doses and that high doses are either inefficient use of the drug or use for non-medical purposes, but admits that there is "insufficient evidence on which to base scientifically reasoned dosage ranges for different medical uses" and acknowledges that patients can develop significant levels of tolerance of the effects.[255]

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[252] Kalant Expert Report, p. 4, 8-15 (EB Tab 61)
[253] Kalant Expert Report, p. 5, 15-17 (EB Tab 61)
[254] Kalant Expert Report t, p. 6-7 (EB Tab 61)
[255] Kalant Expert Report, p. 17-18, 26. (EB Tab 61)

340. With respect to strains, Dr. Kalant agrees that different strains may have different chemical compositions but is of the view that there is a lack of scientific research as to whether different strains have different effects for particular patients and illnesses.[256]

341. Dr. Kalant opines on adverse effects such as intoxication which in particular is a concern with respect to driving vehicles (he also notes intoxication can have a positive effect of reducing a patient's anxiety or fear), short term mood disturbances (usually for inexperienced subjects), faintness, respiratory harm from smoking, possible adverse effects for brain development if used by children, and addiction by chronic non-medical users. Medicinal use of cannabis is contraindicated for pregnant women, children and adolescents, people with a family history of schizophrenia, and persons with other addictions.[257]

342. Dr. Kalant's comments at p. 27 to 28 suggests his views are somewhat biased in that he suggests young male patients are lying to their doctors about symptoms as a pretext for non-medical use and cites the risk of "diversion" of cannabis to non-medical users. Plaintiffs therefore submit that Dr. Kalant's opinions over-emphasizes potential harms of cannabis use, particularly with respect to dosage. However, even so, Dr. Kalant acknowledges cannabis has many therapeutic uses for several types of symptoms and that different forms of ingestion have different positive and negative utility.

Rebuttal of Dr. Kalant by Mr. Clarke

343. Robert Clarke provides expert opinion evidence and commentary on Dr. Kalant's reports with respect to clarification, contradiction or amplification of Dr. Kalant's evidence regarding scientific knowledge of the therapeutic use of cannabis. In Mr. Clarke's view Dr. Kalant's knowledge of medical cannabis is in many respects not current and Dr. Kalant focuses on limitations and cautions of cannabis use.[258]

344. Mr. Clarke comments that high potency of cannabis in the medical context means that a patient needs to consume less to achieve medical efficacy and lowers the

[256] Kalant Expert Report, p. 18-19 (EB Tab 61)
[257] Kalant Expert Report, p. 20-25 (EB Tab 61)
[258] Clarke Expert Report, p. 1 (EB Tab 68)

chances of adverse side effects.[259] He further comments that medical cannabis users consume only enough of their cannabis medicine to achieve the desired therapeutic effects as they do not want to experience unpleasant side effects.

345. Mr. Clarke disagrees that cannabis is not the drug of first choice for any conditions and in particular for pain and nausea.[260] Further, Mr. Clarke cites a number of studies that indicate that cannabis has beneficial effects far greater than Dr. Kalant portrays in his report, in particular for spasticity, rheumatoid arthritis, Parkinson's disease, Tourette syndrome, movement disorders, cancer, glaucoma, psychosis, and depression.[261] Mr. Clarke comments that the studies he cites indicate that the adverse effects on children are unsubstantiated, that Dr. Kalant's list of contraindications are not absolute (noting that cannabis is a treatment for hyperemesis gravidarum for pregnant women), and that treatment for cancer in particular requires high doses of cannabis. He confirms and clarifies that tolerance develops over time with respect to the THC-related side effects such as intoxication.[262]

Dr. Daeninck

346. Defendant provides the expert evidence of Dr. Paul Daeninck on the challenges faced by doctors with respect to prescribing medical cannabis and on the issue of dosage.

347. On the issue of challenges faced by doctors, Dr. Daeninck describes various beneficial and adverse effects of cannabis in different patient situations for different conditions, and opines that "marijuana, like any therapeutic intervention, should result in better symptom control, improved quality of life or an improvement in function for the patient."[263] Dr. Daeninck further comments that in his experience most patients who use medical cannabis do so to treat symptoms that affect their quality of life, that these patients use only enough cannabis to permit them to function and achieve some element of normality, such as minimizing pain or preventing crippling nausea.[264]

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[259] Clarke Expert Report, p. 1 (EB Tab 68); this opinion is shared by Dr. Pate, see Facts section on Dr. Pate, supra.
[260] Clarke Expert Report, p. 2-3 (EB Tab 68)
[261] Clarke Expert Report, p. 3-6 (EB Tab 68)
[262] Clarke Expert Report, p. 3-6 (EB Tab 68)
[263] Daeninck Expert Report, p. 8, para. 25 (EB Tab 58)
[264] Daeninck Expert Report, p. 8, para. 28 (EB Tab 58)

348. Dr. Daeninck thereafter states that he is of the opinion that there are no medical indications for the use of more than 5 grams of cannabis per day, that the mean daily amount of cannabis prescribed in a multinational review was 3 grams per day, and "thus, the request for doses larger than 5 grams per day is not support by the available research". However, Dr. Daeninck then, contradictorily, states that use of edibles requires 3-5 times more cannabis than for smoking but does not change his view on the 5 gram maximum. He then further opines that use of 5 grams per day could cause "toxicity" and incapacitation, and comments that he sees no way a patient could physically use more than 15 grams per day.

349. In reviewing a chart that details patients' dosage for cannabis, Dr. Daeninck acknowledged that the vast majority of patients have been approved for more than 5 grams per day and a majority of 56% approved for use of 10 gram per day or more.[265]

350. Dr. Daeninck opines there is no medical reason for dosages of more than 10 grams per day, and speculates that this amount may reflect heavy recreational use, opportunity for monetary gain by physicians, involvement of criminal abusing the system, and tampering or lying by the patient applicants. He cites RCMP reports about organized crime and then he speculates that doctors have been visited by organized crime members who force them to give a large prescription, and that crime groups coerce or recruit people to pretend to be patients to get high dose prescriptions. He further speculates that doctors routinely abuse the system for financial gain, and cites media reports of accusations against an unknown number of doctors to this effect. He suggests that patients might change a dosage for 3 grams to 30 grams "or even 300" and cites examples of tampering with opioid prescriptions by drug addicts and criminals.[266]

351. Dr. Daeninck's inflammatory and unsupported speculations of the reason for dosages being above 5 grams suggest his opinions in favour of a maximum dosage of 5 grams per day, the number chosen by Health Canada to justify the 150 g possession limit, are based on and informed by his strong prejudices against patients who use and

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[265] Daeninck Expert Report, p.P. 12, Para. 38, Annex D (EB Tab 58)
[266] Daeninck Expert Report, p. 12-13 (EB Tab 58)

doctors who prescribe more than 5 grams per day (in Canada, the vast majority), rather than a objective and informed scientific opinion.

Rebuttal of Dr. Daeninck by Doctor Caroline Ferris

352. Doctor Ferris is a family physician who also has a position at UBC in a clinical capacity who has recognized and prescribed cannabis as a herbal remedy since the *MMAR* program began in 2001. She has substantial practice experience prescribing cannabis for patients for therapeutic purposes.[267] Doctor Ferris was asked to respond to Dr. Daeninck's expert report as a rebuttal expert witness Plaintiffs. She was not cross examined, and on any issues she covers not covered in the report of Dr. Daeninck, her opinions are unchallenged.

353. Dr. Ferris is of the view that Dr. Daeninck's opinion and experience is limited with respect to use of herbal cannabis as his practice appears to be primarily limited to the prescription of pharmaceutical cannabinoids and for cancer patients.[268] Dr. Ferris disagrees with Dr. Daeninck's views about dosage, in particular given the low to virtually nonexistent lethal does for cannabis.[269]

354. Doctor Ferris takes direct issue with Dr. Daeninck's unscientific opinions with respect to dosage, which she describes as paying homage to "political rhetoric" that cannabis is a "dangerous drug", and says that the unsupported statements by doctors like Dr. Daeninck are regularly challenged by doctors doing clinical trials of medical cannabis.[270] Dr. Ferris further states that some medical cannabis guidelines are more political than scientific in nature.[271]

355. In Dr. Ferris' experience patients and their family request cannabis to assist with diagnosed illnesses specifically because they do not want to use prescription medication that are addictive and/or have serious side effects.[272]

356. With respect to suspicions of substance abuse, Dr. Ferris would recommend a urine test to eliminate any assumptions.[273]

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[267] Ferris Expert Report, p. 1-2 (EB Tab 69)
[268] Ferris Expert Report, p. 5 (EB Tab 69)
[269] Ferris Expert Report, p. 2 (EB Tab 69)
[270] Ferris Expert Report, p. 5 (EB Tab 69)
[271] Ferris Expert Report, p. 7 (EB Tab 69)
[272] Ferris Expert Report, p. 3 (EB Tab 69)
[273] Ferris Expert Report, p. 3 (EB Tab 69)

357. On the issue of dosage, Dr. Ferris generally agrees that doses of 3-5 grams of cannabis per day are adequate for most patients. However, the does for oral consumption is 2.5 times the smoked dose, thus the prescribed range for patients using edibles can easily be 10 to 12.5 grams per day. Tolerance and genetics, and access to low or high-potency strains, also needs to be considered to determine dosage.[274]

358. Concentrates such as hash, oil and tincture are appropriate from a harm reduction perspective because they eliminate or reduce harms caused by smoking.[275]

359. Dr. Ferris is concerned about removal of access to cannabis due to unaffordability if home growing of cannabis is banned.[276]

360. Cannabis has no or a very low lethal dose ratio so she is less concerned about dosage than for other drugs such as OxyContin which can kill by overdose or ibuprofen that can cause gastro-intestinal bleeding and death.[277] Dosage is determined through doctor patient interactions and dialogue that results in a dosage that works for the particular patient's medical issues.[278]

361. Doctor Ferris is suspicious of doses of 20 grams per day or higher because of the possibility of resale by a small minority of patients, and she will not prescribe high doses if she has this suspicion.[279] Dr. Ferris agrees that some poor patients may have been selling some of their medicine to pay for bills, but she disagrees that diversion is the only reason for the lower dosages under the *MMPR*. She notes that most patients new to cannabis start low and then increase dosage, especially if they start using edibles, and the patients under the *MMPR* are mostly new patients.

362. Dr. Ferris notes that Dr. Daeninck only treats cancer patients with Nabilone. By far the majority of bona fide medical cannabis patients are suffering from severe arthritis, MS, or HIV related illnesses and most of them are using herbal cannabis in one form or another.

<u>Conclusion regarding FDA approval, edibles, and dosage</u>

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[274] Ferris Expert Report, p. 3 (EB Tab 69)
[275] Ferris Expert Report, p. 4 (EB Tab 69)
[276] Ferris Expert Report, p. 4 (EB Tab 69)
[277] Ferris Expert Report, p. 4, 8 (EB Tab 69)
[278] Ferris Expert Report, p. 8-9 (EB Tab 69)
[279] Ferris Expert Report, p. 4 (EB Tab 69)

363. Defendant has failed to prove that a 150 gram possession limit, based on a 30 day prescription for 5 grams per day, serves any public safety purpose or has any rational connection to a public safety purpose. Plaintiffs evidence proves the contrary; that they legitimately require dosages of at least 5 (Beemish), 20 (Allard), and 25 (Davey) grams per day to effectively treat their symptoms.

364. Similarly, Defendant has failed to prove that limiting ingestion of medical cannabis to dried forms, which limits legal ingestion primarily to smoking or vapourizing, which are more harmful ways to ingest due to lung damage, serves a public safety purpose or has any rational connection to any legitimate government objective. To the contrary, the evidence of all the experts, including Defendant's medical experts, and Plaintiffs themselves, proves that use of edibles has positive therapeutic benefits and that smoking or vapourizing is potentially harmful, meaning that limiting ingestion to dried marihuana is harmful to patients.

365. Lastly, Defendant's reliance on the fact that cannabis has not received *FDA* approval to say that cannabis is therefore of unknown safety and unproven efficacy is undermined by the evidence of Defendant's own experts Dr. Kalant and Dr. Daeninck (in addition to Plaintiff's experts) who acknowledge that cannabis is therapeutically effective for numerous medical conditions. Further, the entire idea that herbal cannabis requires *FDA* approval to be considered safe and effective medical treatment (and otherwise it should be illegal) entirely misconceives cannabis as an untested pharmaceutical drug rather than what it is: a herbal plant medicine that has been used therapeutically by humans to treat various symptoms and illnesses for thousands of years without serious adverse consequences or deaths.

366. With respect to scientific or medical conceptions of the safety of cannabis, the evidence of Plaintiff witnesses Dr. Walsh, Dr. Pate and Dr. Ferris overwhelmingly proves that cannabis as medicine is considered medically safe due to its very low or non-existent lethal dosage. Furthermore, the evidence of Plaintiffs Allard, Davey and Beemish is that they have never become ill from the use of cannabis even at high dosages; to the contrary, it has been highly beneficial to them and has improved their lives significantly.

The state does not have a pressing and substantial interest in criminalizing the conduct of medical cannabis consumers

367. As in the s. 7 inquiry, it is critical to appropriately delineate the state objective served by the impugned restrictions. Plaintiffs submit that it is insufficient to rely on a broad statement of the objective because they concede that, as to non-medical consumers, the prohibition is appropriate. It is only the application of the criminal law to the conduct of medical consumers that is at issue here.

368. Plaintiffs submit that Defendant has failed to prove that it has a pressing and substantial interest in criminalizing personal medical cannabis gardens, the consumption of derivative cannabis medicines and patient possession of more than 150 grams of medicine.

The restrictions are not rationally connected to the objective

369. Restrictions that are not in accordance with the principles of fundamental justice have already failed to demonstrate "instrumental rationality" when, in s. 7, the burden rested on the rights claimant, and therefore are very difficult to justify in the s. 1 proportionality analysis.

370. This is not the rare case in which such laws are nevertheless able to be saved by s. 1.

371. The objective of the *CDSA* is protection of public health and safety. The *CDSA, MMAR* or *MMPR* objective, narrowly drawn, is the protection of the health and safety of medical cannabis consumers. Defendant asserted several public health and safety goals that it intended the restrictions to achieve including (a) preventing diversion to the black market; (b) preventing buildup of harmful mould on medicine or in properties; (c) preventing risk of fire and theft at production locations; and (d) preventing access to medicine that is unsafe.

372. Moreover, as Defendant's witnesses admitted, many of the goals are simply not within the jurisdiction of the federal government and, therefore, are inappropriate targets of the criminal law power.

373. The evidence, when tested at trial, did not demonstrate a rational connection between the restrictions and the Defendant's goals. The impugned restrictions are not, therefore, saved by s. 1.

The restrictions do not minimally impair the rights

374. The Court heard evidence of the various regulatory schemes used by Defendant in the area of access to medicine, either pharmaceutical products or natural health products.

375. It also heard evidence that cannabis was generally as safe or safer than many other regulated substances, including both pharmaceutical and natural health products. It heard evidence that natural health products are lawful to produce and possess for personal use in virtually unlimited quantities and that the focus of the government's regulations in the area of medicinal plants is commercial activity, not personal conduct.

376. The court heard, further, that these plants could be grown for one self in the identical manner as medicinal cannabis, using the same equipment, nutrients and other inputs, without any regulatory oversight.

377. Finally, the court heard that many of the issues purportedly supporting the government's restrictions were actually areas of Provincial or local governments such as municipal, not federal, jurisdiction.

378. Against this backdrop, Defendant has failed to prove that an absolute prohibition on the personal production of medicinal cannabis minimally impairs the rights of patients. The evidence demonstrates that other non-criminal options exist to eliminate or reduce concerns without absolutely criminally prohibiting patients from producing for oneself, indoors or outdoors, and possessing a reasonable amount of medicine in any form. The restrictios are therefore not saved by s. 1.

The restrictions create significant deleterious effects with little to no salutary effects

379. Patients who can no longer produce lawfully are no longer able to control the quality and cost of their medicine to ensure the continuous safe supply and are forced to rely on the vagaries of the marketplace and large-scale commercial licenced producers, that many patients simply cannot afford. Plaintiffs are deeply concerned that

they will be unable to produce effective medicine for them on a continuous basis and will therefore suffer physically, psychologically, emotionally and in terms of their liberty interest.

380. Moreover, patients are limited to only "dried marihuana" that is normally smoked and can be harmful to one's health in some respects and are precluded from using forms that may be more effective for that particular illness.

381. Many are limited in their ability to leave their site for anything more than a few days due to the 150 g possession limit, for purposes of work, travel, holidays or other reasons.

382. These, in addition to the liberty and security of the person infringements set out above, constitute very substantial deleterious effects. By contrast, Defendant was unable to produce any significant evidence that the impugned restrictions have or will cause any salutary effects. Accordingly the restrictions are not saved by s. 1.

REMEDY

383. Plaintiffs have set out the specific remedies sought by way of declarations with respect to the unconstitutionality of the *CDSA* and *MMPR*. Canada has failed to demonstrably justify the prohibition on personal/caregiver production and failed to justify the specific limitations in the *CDSA/MMPR* with respect to "dried marihuana only" and the 150-gram possession limitation.

384. Plaintiffs submit that it is a fundamental principle of constitutional law that no one shall be convicted under an unconstitutional law and therefore it is submitted that an unconstitutional law should not be permitted to remain on the statute books if it creates a situation where a person may be charged with a criminal offense.[280]

385. For most of the long history of judicial review under the Constitution, on both federalism and Charter grounds, declarations of invalidity have been given immediate effect. It was not until 1985 that the Supreme Court of Canada first suspended a declaration of invalidity in the *Manitoba Language Reference* case, where the court held that all of the laws of Manitoba (that had been published in English but not in French) were unconstitutional and declared the laws invalid, but suspended the

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[280] *R v. Big M Drug Mart* [1985]1 S.C.R.295 at 313

declaration because the Constitution and rule of law would suffer if the province had no laws.

386. The first declaration of invalidity in a Charter case was in *R v. Swain* [1991] 1 S.C.R. 933 where the statutory scheme that provided for the automatic and indefinite detention of individuals found not guilty by reason of a mental disorder violated s. 7 of the *Charter*. The Court suspended the declaration for 6 months to avoid the immediate release into the community of all those found not guilty by reason of a mental disorder, including those who might pose a danger to the public. In other words, public safety was at stake and the circumstances were exceptional. The Court did not suspend the declarations of invalidity in *Morgentaler* with respect to the criminal code provisions regarding abortion nor in the *Vaillancourt* and *Martineau* cases in relation to the constructive murder provisions Criminal Code.

387. In *Schacter v. Canada*, the Court analyzed in detail the remedy of suspended declarations pointing out that it allows a "state of affairs in which has been found to violate standards embodied in the Charter to persist for a time despite the violation" and held that such declarations should generally be limited to 3 categories of cases: (i) where an immediate declaration would "pose a danger to the public" (*Swain*); (ii) where an immediate declaration would "threaten the rule of law" (e.g. *Manitoba Language Reference*); and (iii) where an immediate declaration would result in the deprivation of benefits from deserving persons without benefiting the individual whose rights have been violated, which would occur in the case of the benefits conferring regime found to be unconstitutional because it is underinclusive (*Schacter*).

388. Consequently, it is respectfully submitted that if a suspended declaration is ultimately granted, any potential harm caused to patients in the interim must be ameliorated by exempting them from the unconstitutional law during the period of suspension, in accordance with a modified version of the introductory injunction granted by Manson J, on March 21, 2014.

389. The proposed modifications would be with respect to:

(i) including all previous *MMAR* patients or at least those with valid ATPs on September 30, 2013, the *MMPR* transitional date, and any others who have obtained "Medical Approval" pursuant to s. 53 of the Narcotic Control

Regulations and requiring that the Office of Medical Cannabis at Health Canada be required to maintain and update its database upon notification of such approvals from a physician or patient accordingly, until further order of this court and the end date of any suspension of any declaration of invalidity;

(ii) that all patients falling under (i) above, who held a valid personal production licence or had a valid designated production licence on September 30, 2013, continue to be exempt in accordance with the provisions of their prior licences, except expiry dates, until further order of the court or the end date of the suspension of any declaration of invalidity;

(iii) that the Office of Medical Cannabis at Health Canada be required to maintain its database by keeping a record of notices of change in production sites to existing licences in order that the police might be notified of the validity of a site accordingly and provide limited ancillary assistance to approved patients or their caregivers, or physicians, such as providing copies of lost licences, and other matters, pending the decision of this court and the end date of the suspension of any declaration of invalidity, if granted;

(iv) providing that any circumstances of alleged injustice to any medically approved patient arising pending the decision of the court or the end date of the suspended declaration of constitutional invalidity, if granted, if unable to be resolved through the Office of Medical Cannabis at Health Canada, may be brought to the attention of an officer of the Federal Court Trial Division for a summary resolution and disposition in writing.

CONCLUSION

390. The Plaintiffs submit that their claims should be accepted and the declarations sought pursuant to s. 52 of the *Charter* should be made, with a limited period being provided to the Defendants to ensure the creation of a viable constitutional exemption for medically approved patients. The declarations sought pursuant to s. 52 of the *Charter* should further be made in accordance with the decision of this court while the personal remedy sought pursuant to s. 24(1) should be granted immediately pending this court's decision and pending the conclusion of any period of time set by the Court

to enable the Defendant to make its scheme compliant with the Constitution of Canada, with costs to the Plaintiffs throughout.

All of which is respectfully submitted.

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