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

MOTION RECORD

Solicitor for the Applicant:

John W. Conroy, Q.C.
Conroy & Company
Barristers & Solicitors
2459 Pauline Street
Abbotsford, BC V2S 3S1
Telephone: (604) 852-5110
Facsimile: (604) 859-3361

SERVICE OF A TRUE COPY
HEREOF ADMITTED
THIS 11 DAY OF
SEPTEMBER 20 14
William F. Pentney
Solicitor for
A.G.C.

Solicitor for the Respondent:

Mr. Jan Brongers
Senior General Counsel
Attorney General of Canada
900 – 840 Howe Street
Vancouver, BC V6Z 2S9
Telephone: (604) 666-2061
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NOTICE OF MOTION

TAKE NOTICE THAT the Plaintiffs Neil Allard, Tanya Beemish, David Herbert and Shawn Davey hereby apply to the Court in writing under Rule 369 of the *Federal Court Rules 1998.*

THE MOTION IS FOR an Order, pursuant to Rule 240 and 241 of the *Federal Court Rules,* requiring the Defendant to answer the Plaintiff's written examination for discovery questions, and costs.

THE GROUNDS FOR THE MOTION ARE:

1. A person being examined for discovery shall answer, to the best of their knowledge, information, or belief, any question that is relevant to any unadmitted allegation of fact in a pleading filed by the party being examined or by the examining party. Consequently, questions exploring relevant issues between the parties, in order to deal with allegations that have not yet been admitted, are proper;

2. The Defendant has refused to answer 47 of the Plaintiffs' questions.

3. Answers have been provided to the remaining questions by the Defendant's chosen representative, Jeanine Ritchot, by way of affidavit affirmed on August 13, 2014

4. The Defendant has refused to answer the 47 questions on the basis that they are improperly asked in discovery. The Defendant's objections focus primarily on one or more of the following grounds: legal question; argumentative, seeks "opinion" and asks for evidence;

5. The Plaintiffs avers that the questions posed are permissible within discovery; do not seek legal conclusions nor opinion but agreement or disagreement with sets of facts which are within the knowledge/scope of the Defendant (her servants or agents) and relevant to the issues in dispute.

6. The Plaintiffs also point to the extensive and detailed content of the first affidavit of Jeannine Ritchot and say the Plaintiffs' questions should be considered against the background of this previously proffered evidence dated February 14, 2014.

7. The Plaintiffs seek an order requiring the Defendant to serve, within 14 days, responses to the 47 refused questions or such questions as the court directs should be answered;

8. In addition, in the event that the Honourable Court considers that the current wording of the refused questions means it ought not be ordered to be answered, the Plaintiffs seeks an order permitting the Plaintiffs to serve rephrased questions dealing with each or any of such questions as the court

directs within 14 days of the court's decision and requiring the Defendant to respond within 14 days of service of the rephrased questions thereafter;

9. The Plaintiffs also seek an order for costs, on a solicitor-client basis, or in the alternative on a party-to-party basis or such basis as the Honourable Court thinks fit, including by way of lump sum, to be payable forthwith, pursuant to *Rule 401* of the *Federal Court Rules.*

10.

THE FOLLOWING DOCUMENTARY EVIDENCE will be used at the hearing of the motion:

1. Affidavit of Danielle Lukiv, sworn September 10, 2014;
2. Written representations; and
3. Any such further material as the Plaintiffs may advise and this Honourable Court may permit.

DATED: September 10, 2014

John W. Conroy, QC
Counsel for the Plaintiffs
CONROY & COMPANY
Barristers and Solicitors
Tel: (604) 852-5110
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To: Jan Brongers
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DEFENDANT

AFFIDAVIT OF DANIELLE LUKIV

I, DANIELLE LUKIV, legal assistant at Conroy & Company, 2459 Pauline Street, Abbotsford, British Columbia, MAKE OATH AND SAY AS FOLLOWS:

1. I am a legal assistant to John W. Conroy, Q.C., counsel for the Plaintiffs, and as such have personal knowledge of the matters and facts hereinafter deposed to, except where stated to be based on information and believe, and where so stated I verily believe them to be true.

2. By letter dated July 25, 2014, the Plaintiffs served their written examination for discovery questions on the Defendant. Now produced and marked as Exhibit "A" to this my Affidavit is the schedule of questions.

3. By letter dated August 14, 2014, the Defendant informed the Plaintiffs of its refusal to answer 47 of the Plaintiffs' questions and set out is grounds for objection. Now produced and marked as Exhibit "B" to this my Affidavit is a copy of that letter.

4. The Plaintiffs were served with the Defendant's remaining answers by way of an affidavit from the representative chosen by the Defendant: Jeanine Ritchot, affirmed on August 13, 2014. Now produced and marked as Exhibit "C" to this my Affidavit is that Affidavit and Exhibits.

5. The Defendant's representative, Ms. Ritchot, previously provided a more detailed history of her professional knowledge and experience in the first 2 pages of her 32 page first affidavit sworn in these proceedings sworn February 7, 2014. Now produced and marked as Exhibit "D" to this my Affidavit is that Affidavit.

6. I swear this affidavit in support of an order to compel the Defendant to answer the Plaintiffs' outstanding examination for discovery questions.

SWORN BEFORE ME at the City of Abbotsford, in the Province of British Columbia, this 10th day of September 2014)

A Commissioner for taking affidavits within British Columbia)

Danielle Lukiv

DANIELLE LUKIV

RUBINDER (ROB) DHANU
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HER MAJESTY THE QUEEN IN RIGHT OF CANADA

DEFENDANT

WRITTEN EXAMINATION

TO: **HER MAJESTY THE QUEEN IN RIGHT OF CANADA**

The Plaintiffs have chosen to examine the Defendant Her Majesty the Queen in right of Canada for discovery.

You are required to answer the questions in the schedule by affidavit in Form 99B prescribed by the *Federal Court Rules*.

The affidavit containing the answers is to be served on all other parties by August 15th, 2014 pursuant to the Court's Order of May 2, 2014.

Dated: July 25, 2014

JOHN W. CONROY, Q.C.
Solicitor for Plaintiffs
Conroy & Company
2459 Pauline Street
Abbotsford, BC V2S 3S1
Telephone: 604-852-5110
Facsimile: 604-859-3361

This is Exhibit "A" referred to in the affidavit of Samuel Lakin sworn before me at Abbotsford BC this 10th day of Sept. 2014

A Commissioner for taking affidavits for British Columbia

SCHEDULE

General Context – Parker to the *MMAR*

1. As a result of the decision of the Ontario Court of Appeal in R. v. Parker (2000), the government of Canada was required within one year from that decision to amend the *Controlled Drugs and Substances Act* (*CDSA*) and to put in place a "constitutionally viable medical exemption" to the prohibition against the possession and cultivation of cannabis (marihuana) in the *CDSA* in order to provide reasonable access for medical purposes to medically approved patients so that such patients would not have to choose between their "liberty" if they broke the law and their "health" if they went without their medicine, isn't that correct ?

2. In response, the government of Canada ultimately promulgated the Marihuana Medical Access Regulations (*MMAR*) in 2001 that enabled such medically approved patients to cultivate or produce dried cannabis (marihuana) for themselves or have a designated grower do so for them at a specified production site, including a dwelling house, in amounts determined according to a formula set out in the regulations that depended upon the number of grams per day authorized by the medical practitioner, isn't that correct?

3. The *MMAR* made various provisions with respect to production either indoors or outdoors, but not both at the same time, with some limitations with respect to production site location in so far as schools and playgrounds are concerned, but not otherwise and allowed a patient to possess up to a 30 day supply on their person at any time, and made provision for administrative changes to these licenses, including changes of production site addresses and other amendments, depending upon the individual circumstances, and required annual renewal through Health Canada, isn't that correct?

MMAR Program Statistics

4. How many patients held authorization's to possess (ATPs) as of March 21, 2014?

5. How many patients were authorized within the previous 12 months from March 31, 2013 until March 20, 2014 and lost their ability to possess cannabis (marihuana) for medical purposes simply because they failed or were unable to renew their of license on or before September 30, 2013 and/or it expired prior to the interlocutory injunction ordered March 21, 2014?

6. How many patients with a valid ATP's held a valid Personal Use Production License (PUPL) on

   (a) September 30, 2013? ;

   (b) March 21, 2014? ;

   (c) March 31, 2014?.

7. How many patients with a valid ATP had a valid Designated Grower(DGL) producing for them as of:

   (a) September 30, 2013?;

   (b) March 21, 2014?;

   (c) March 31, 2014?.

8. How many patients with a valid ATP's were purchasing their cannabis (marihuana) as medicine from the government source Prairie Plant Systems as of:

   (a) September 30, 2013? ;

   (b) March 21, 2014? ;

   (c) March 31, 2014?.

9. As of April, 2013, Health Canada authorized the production of 188,189 kg of cannabis (marihuana) to be produced under the *MMAR* under the various licenses during the year 2012, broken down as follows:

   - 15,752.88 kg: for patients needing to use one to 5 g per day;
   - 42,054.31 kg: for patients needing to use 6 to 10 g per day;
   - 89,127.44 kg: for patients needing to use 11 to 20 g per day;
   - 12,795.62 kg: for patients needing to use 21 to 50 g per day;
   - 3,195.21 kg: for patients needing to use 51 200 kg per day; and
   - 4,854.87 kg: for patients needing to use 101,050 g per day

Isn't that correct and are updated figures available for 2013 or until March 31st,2014?

10. Also, as of April, 2013, there were 89 persons in Canada with authorizations to possess with dosage levels of 150 g or more per day, weren't there and did this number change up to March 31st,2014?

The Government Supply under the *MMAR*

11. Since the promulgation of the *MMAR* there were several court challenges to various aspects of them including *Wakeford* (s.56, exemptions and government supply)(1998); *Krieger* (Right to produce pre government supply) (2000); *Hitzig* (government supply and the DG limit to grow for one only) (2003); *Sfetkopoulos* (The DG limit to grow for one only) (2008); *Beren* (3 licenses in one place limit struck)(2009); *Smith* (BC only -the dried marihuana limitation) (2012); and *Mernagh* (the doctor boycott)(2013), and some of them included an effort to have the government come up with a supply and ultimately the government made available as its supply the product made by Prairie Plant Systems, initially for research purposes, and approximately 20% of the approved patients accessed the supply, but many expressed a poor opinion about its suitability for their particular ailments and it suffered a poor reputation generally amongst patients, didn't it?

12. Consequently, for a period of time, approximately 10 years, medically approved patients were able to access a supply from government through Health Canada or produce for themselves or have a designated person grow for them as the sources of supply of their medicine, apart from the black or grey illicit markets, is that correct?

13. Some of the patients purchased the government supply, but were unable to pay for the product and were therefore cut off from that supply and became indebted – please provide the full details as to the number of such patients, the amounts owed and what steps were taken to collect the amounts owed and what the ultimate results of such efforts were to both the patient and Canada?

14. How many patients who were purchasing their cannabis (marihuana) as medicine from the government source Prairie Plant Systems (PPS) over the course of the program commencing July 8, 2003 under the "Interim Policy" until March 31, 2014, found they were unable or were found to be unable to afford the cost of the government source of supply so were cut off from the government supply and how much did they owe, individually and collectively, and what steps if any were taken to collect the amounts owed individually or collectively?

MMAR transition to _MMPR_ - the new model

15. On June 7, 2013 the Marihuana for Medical Purposes Regulations (*MMPR*) were promulgated and ran concurrently with the *MMAR* until March 31, 2014, when they would have the effect of repealing the *MMAR* in their entirety, and existing patients under the *MMAR* were required to complete any renewals or changes to their permits under the *MMAR* on or before September 2013, isn't that correct?

16. The *MMPR* by repealing the *MMAR* eliminated the ability of patients to produce for themselves or have a designated grower do so for them, and compels them to obtain their medicine only from government Licensed Producers (LP's) at market prices and by obtaining a medical document from a medical practitioner and providing it to the LP in order to have that LP ship to them a labeled package of medicine and it is the label that constitutes the proof of lawful possession by the individual, isn't that correct?

Affordability and Cost of Production

17. The evidence in these proceedings to date from the Plaintiffs indicates that they have been able to produce for themselves at $.50 to $3 per gram – don't you agree that these individuals are not part of the license producer's target market, as they, the Licensed Producers are unable to produce cannabis (marihuana) for that cost in accordance with the *MMPR* provisions and that therefore the target for the LPs are those who can afford $3 a gram and up – isn't that correct?

18. The *MMPR* creates a government authorized supply for those who can afford market prices and makes no provision for those patients who cannot afford those prices do they?

Medical or other insurance for the poor and disabled

19. No provision is made in the *MMPR* or elsewhere by the government of Canada or in conjunction with the Provinces to ensure reasonable access to their medicine by those who cannot afford the LP market prices, is there?

20. There is no provision in the *MMPR* or elsewhere under the jurisdiction of the Federal government of Canada that will provide financial assistance, or insurance to those patients who cannot afford the Licensed Producer prices – is there?

21. The plight of those who simply cannot afford or will not be able to afford the Licensed Producer prices was not considered or addressed in the preparation for or in the proposed *MMPR* nor is there any such provision in the legislation itself is there?

22. As indicated in paragraph 36 of the Defence, 'dried marijuana' is not an 'approved' drug for sale in Canada and this means it does not have a DIN number and patients cannot claim coverage under any provincial insurance scheme for reimbursement of the cost of purchase, isn't that correct?

23. The concept of an 'approved drug' under the *Food and Drugs Act* relates to being 'approved for sale' not simply approved for personal use, isn't that right? ,

24. The *MMPR* limit production and possession to "dried marihuana" only and the patient is only permitted to possess up to 30 times their daily limit or 150 g, whichever is less, whereas the *MMAR* allowed possession up to 30 times the daily limit with no limit to 150 g, isn't that correct?

Dried Marihuana limitation

25. The reasons why the government has limited the use of Cannabis (marihuana) to its dried form only in the *MMAR* and has continued that limitation in the *MMPR and added it to the NCR, are set out in paragraphs 89 through 94 of the Statement of Defence and raise the following questions;*

    (a) What is the "limited clinical evidence" referred to in paragraph 91 regarding the use of marihuana for medical purposes?;

    (b) What is known about the risks and benefits of unapproved cannabis derivatives and preparations?

    (c) What are the "serious threats to health and public safety" alleged in relation to the 'production of marihuana' for medical purposes?"

    (d) What are the "serious threats to health and public safety" alleged in relation to the 'possession of marihuana' for medical purposes?

    (e) What are the "serious threats to health and public safety" and what evidence exists to support this allegation in relation to patients who produce for themselves or their designated grower caregivers and that do not "distribute" to others?

    (f) The extraction of cannabis active components and preparations from marihuana plant material through chemical processes involving the use of volatile solvents is limited to the extraction of cannabis oil and does not apply to all other derivatives or preparations, isn't that correct?

(g) So long as the patient has in his or her possession, an appropriate authorization document or certificate to possess cannabis in any of its forms, why is it any more difficult for law enforcement officials to determine that the product has been produced from a legal source than if they are limited to "dried marihuana"?

26. Please provide details of any specific problems that arose during the course of the *MMAR* program with respect to the use of cannabis (marihuana) in forms other than "dried marihuana"?

27. Isn't it true that ingesting cannabis based medicine orally tends to provide (a) slower onset of effect; (b) lengthier plateaus of effective doses of cannabinoids in the system as opposed to smoking or vaporizing dried marihuana which (a) takes effect quickly but; (b) also wears off quickly?

28. How many reports of negative effects from medical consumption of cannabis resin (hashish) has HC received from licensed *MMAR* patients since the decision of the Court in R v. Smith? For each such report, please provide a detailed description of the incident any HC's response to the incident.

29. How many reports of negative effects from medical consumption of cannabis-based derivative medicines consumed orally (e.g., cannabis cookies or other edibles) has HC received from licensed *MMAR* patients since the decision of the Court in R v. Smith? For each such report, please provide a detailed description of the incident and HC's response to the incident.

30. How many reports of negative effects from medical consumption of cannabis-based derivative medicines consumed topically (e.g., cannabis lotion) has HC received from licensed *MMAR* patients since the decision of the Court in R v. Smith? For each such report, please provide a detailed description of the incident and HC's response to the incident.

The 150 gm Limit on possession

31. Please provide details of any specific problems that arose during the course of the *MMAR* program with respect to a patient possessing more than 150 g on their person so as to warrant that limitation in the *MMPR*?

32. How many patients were attempted to be or were in fact robbed or assaulted in order to steal the marihuana they possessed on their person, throughout the history of the program?

33. Bearing in mind the above program statistics, this limitation may work for those with dosages in excess of 5 g per day who can possess 150 g or a 30 day supply on their person at any time when out and about under the *MMPR*, but all of those with greater than 5 g per day authorizations become more and more limited in their ability to be away from their home or storage site as their dosage increases to the point where those with 150 g a day authorizations or greater will remain virtually housebound – isn't that correct?

34. This will also mean that those with greater than 5 g per day authorizations will require multiple shipments from an LP at greater shipping costs to fulfill the requirements, as there is no provision for storage, and may have difficulties picking up and transporting their allowances from the local post office to their residences and other such complications because of that possession limitation to 150 gm. – isn't that correct?

Basis for the Change and the evidence in support

35. The reasons put forward by the government of Canada for the change to the *MMPR* from the *MMAR* involves a policy to try and treat cannabis (marihuana) like any other "prescribed drug" (the Oxycontin model) and because it is asserted that home production is "inherently dangerous" due to alleged problems with "toxic mold, fire and electrical safety, and public safety" and for no other reasons, is that correct?

36. Are there any other reasons asserted and if so, what are they in detail and what is the basis for them?

37. Please provide details, including statistics, of the basis for each alleged problem asserted, or found to be occurring at a Health Canada approved *MMAR* production site during the history of the program?

38. In the case of each problem found in an approved Health Canada production site please advise whether or not the production site was in compliance with local government bylaws and had been subject to inspection by them or not?

39. Can you point to any particular problem arising in any of these circumstances where the problem could not have be prevented by initial licensing, permitting and inspections followed by regular inspections or the problem could not be remediated or fixed and reoccurrence prevented?

40. Exactly how many complaints regarding smell from licensed *MMAR* producers did HC receive for the period 2001 - 2013? For each such complaint, provide: a) the

date of the complaint; b) the geographic location of the complaint; c) a description of the complaint; d) a description of all steps HC took to ameliorate the issue resulting in the complaint.

41. Exactly how many incidents of diversion from *MMAR* license holders to the black market were proven in court (resulting in a verdict of guilty for trafficking, possession for the purpose of trafficking or production) during the period 2001 through 2013. For each such incident, provide a) the date of the conviction or plea; and b) the court location, level and file number.

42. Exactly how many incidents of fire in *MMAR* licensed production facilities were reported during the period of 2001 - 2013 and exactly how many of those incidents were conclusively linked to the marijuana production itself? For each such incident, provide a) the date of the incident; b) the location of the incident; c) a description of the incident.

43. Exactly how many incidents of "grow rips" from licensed *MMAR* facilities were reported in the period 2001 - 2013? For each such incident, provide a) the date of the incident; b) the location of the incident; c) a description of the incident?

44. Exactly how many incidents of 'problems with toxic chemicals' and specific problems experienced by children, or either, from licensed MMAR facilities were reported n the period 2001 -2013? For each such incident, if any, provide a)the date of the ncident ; b)the location of the incident;c0 a description of the incident?

45. When Health Canada received numerous complaints about the smell of cannabis (marihuana) from various legal producers it did nothing about them and did not even notify the Licensees of the problem taking the position that it was not within their jurisdiction to regulate smell – isn't that correct?

46. The number of complaints about smell relative to the total number of authorized production sites is relatively small isn't it indicating most have been able to control without offending or impacting others haven't they?

47. There are various types of filters and other devices available on the market to reduce and control smell so that any smell problem can be mitigated - isn't that correct?

48. What is the source of the average daily amount authorized for possession as at December 12, 2013 as being 17.7 grams of dried marihuana day as indicated in paragraph 45 of the Statement of Defense and how was this figure arrived at or calculated?

49. In paragraph 46 of the Statement of Defense it is asserted that 1 gm of marihuana produces between 3 and 5 marihuana cigarettes (joints) – what is the source of this assertion, and what is the size of the cigarettes (joints) given the various different sizes of cigarette rolling papers available in the market?;

50. What evidence is there that the average 17.7 grams of dried marihuana per day is being smoked as opposed to put into edibles or other extracts or derivatives and consumed in that fashion?

51. What evidence do you have as to how much a person might consume per day in edibles or other extracts or derivatives, including juicing?

52. How do you determine that individuals who purchased their dried marihuana from Health Canada have on average purchased between 1-3 grams per day and please provide the basis for the determination?

53. Health Canada is not able to determine whether a particular patient that is authorized to possess a certain amount either consumes all or only a portion of that amount are they?

54. What is the source of the formula in the *MMAR* that determined the number of plants a person could produce depending upon their authorized grams per day?

55. That formula does not specify the size of the plants to be produced nor does it provide for a maximum upper limit on the number of plants does it?

56. Other countries and particularly individual States in the USA do not use such a formula but set a specific number of plants instead don't they?

57. Did you do any investigation into the other countries or States to determine how they were regulating the use and production of medical marihuana and whether or not they were having any similar problems and if so, how they addressed them.

58. The Regulations can be amended to change the formula to limit the number of plants or their sizes couldn't they?

59. Why did the government require an inspector to obtain permission or a warrant before entering a private dwelling to determine whether or not a licencee is conducting their operation in accordance with the licence granted to them by Health Canada?

60. Why didn't or hasn't Health Canada sought to work out an arrangement with local government officials who regularly inspect premises for various reasons and who do not require permission or a warrant to do so?

61. Please provide whatever documentation exists with respect to the number of inspections carried out over the course of the program and provide details of any problems or other issues that arose during the course of such inspections.

Inherent dangerousness

62. Is it the government's position that Cannabis (marihuana) cannot be safely produced in:

    (a) any dwelling house by a patient under any circumstances?;

    (b) any outbuilding by a patient under any circumstances?:

    (c) in a collective garden by a group of patients in an agricultural or industrial or commercial zone subject to local government regulation?

    (d) Are these concerns limited to large marijuana production facilities in private dwellings that are not constructed for such and not to small production facilities in such dwellings that are at least partially constructed for such?

63. If not, please provide the factual basis in detail of the government's position and how it applies to all dwelling houses including those that have carried out specific construction to enable such production?

Analogy to Natural Health Care Products and Food

64. The Food and Drugs Act has regulations governing "Natural Healthcare Products" and whereas cannabis (marihuana) is excluded from those regulations because it is a controlled substance under the *Controlled Drugs and Substances Act* (*CDSA*), nevertheless, those products are defined as "A plant or a plant material, an alga, a bacterium, a fungus or a non-human animal material" and those regulations govern the sale of such items to others or to the public and do not regulate anyone from personally producing such for themselves – is that correct?

65. Similarly, there is nothing in the Food and Drugs Act that regulates or limits an individual's ability to produce one's own food for one's own consumption or for the consumption of one's family and friends, so long as the food produced is not sold to the public – is that correct?

66. There are no federal regulations under any federal statutes that preclude an individual from producing his or her own food or herbs or flowers for one's own personal use in one's own home or garden, including an outbuilding or other location, so long as the substances are not for public distribution and are not controlled under the *CDSA*, are there?

67. Cannabis (marihuana) that is grown is a plant and harvested as such, and then perhaps used in dried form or in other forms such as edibles, juices, but not in a pill form, is much more analogous to a natural healthcare product than the usual prescribed drugs that are usually in pill form, wouldn't you agree?

68. Wouldn't you agree that people who produce food or other substances for their own consumption will naturally and understandably take steps (perhaps not always successfully) to ensure that they follow best practices to avoid any problems to their own health?

Strains and individual availability

69. The evidence in these proceedings from the Plaintiffs and others indicates that some of them have spent considerable time and effort trying to develop a particular strain or strains of cannabis (marihuana) that is effective for their particular illness and that they wish to continue doing so and fear the loss of the use of the strain if compelled to cease production and resort solely to the products available to Licensed Producers – is it Health Canada's position that these Licensed Producers will be able to produce the individual strains for the individual patients on an individual basis economically or is it expected that the patients will simply be limited to those strains made available by the License Producers and no others?

No Outdoor

70. The basis for the *MMPR* precluding any production of outdoor whatsoever is set out in paragraph 88 of the Defence as intended to decrease the risk of diversion and prevent cross contamination of nearby crops, particularly industrial hemp –

    (a) What evidence is there of any such problems having arisen under the MMAR by those who were permitted to grow outdoors or both?;

    (b) Doesn't industrial hemp look very similar to cannabis (marihuana)?

    (c) Have there been any documented incidents of persons stealing industrial hemp thinking it was cannabis (marihuana) and/or trying to sell such hemp as marihuana into the market?;

(d) Is the risk of cross contamination limited to 'nearby crops' only and if so what is the required distance between crops to prevent contamination?;

(e) What other 'crops' are at risk if any?

(f) What procedures, practices or devices or other requirements exist in the agricultural industry to prevent such cross contamination between crops that are currently produced outdoors in Canada and why can't they be applied to the production of marihuana?;

(g) What steps have been or were considered to mitigate any concerns that form the basis for this prohibition against outdoor production?

Licenced Producers update

71. The evidence as of March 21, 2014 indicated that the government mounted a publicity campaign to encourage applications for potential LPs and that as of February 4, 2014. Health Canada had received 454 LP applications, 8 of which had been issued, 10 had been withdrawn, 24 refused and the rest in various stages of review or screening and with an indication that some 25 new applications were being received each week -what has happened since to all of these applications?

72. How many applications for LP status have been received by HC? Of these, identify: a) how many have been approved; b) how many have been refused; c) how many have resulted in Health Canada issuing a "ready to build" letter to the applicant; d) how many of those applicants have successfully completed the build out and received an LP license?

73. How many of the existing LPs are actually selling dried marihuana to clients and what is the total production output of saleable dried marihuana for each LP to date? Please provide the answer by individual LP.

74. How many *MMAR* licensed producers have provided Health Canada with reports of destruction of medicine subsequent to March 31, 2014 and how much dried marihuana was reported destroyed?

75. Please provide details of any problems encountered by LPs in the transition period, including in particular any testing of product that has not met the required standards for production or consumption resulting in a recall or any other problems?

76. Is it true that only some 6,200 patients of registered with LPs to date and if not, what is the correct number of registrants?

77. Can you verify that the following information with respect to the current 13 LPs approved to date is accurate and correct?;

(1.) That On July 7, 2014 the website of the LP known as Bedrocan Canada Ltd. at www.bedrocan.ca indicated:

A. Bedrocan is currently registering new clients.

B. Bedrocan currently has five strains of cannabis available for sale.

C. The price for all five strains is $7.50 per gram with free shipping on the first order placed each month. Bedrocan does not state shipping prices for subsequent orders.

D. Bedrocan does not appear to offer any discount for low income or disabled individuals.

(2.) On July 7, 2014 the website of the LP known as Canna Farms Ltd. at www.cannafarms.ca indicated that:

A. Canna Farms is currently registering new clients.

B. Canna Farms currently has two strains of cannabis for sale.

C. The price for Canna Farms' strains vary from $7.50 to $8.00 per gram. Canna Farms does not indicate whether shipping is included in these prices.

D. Canna Farms does not appear to offer any discount for low income or disabled individuals.

(3.) On July 7, 2014 the website of the LP known as CanniMed Ltd. at www.cannimed.ca indicated that:

A. CanniMed is currently registering new clients.

B. CanniMed currently has five strains of cannabis available for sale.

C. One strain (CanniMed 12.0) is $4.88 per gram, whereas the other four strains vary from $7.15 to $8.78 per gram. These prices are discounted 35% off the regular price with the requirement that purchases are made online. Regular prices for purchases not made online are $7.50 per gram and $11.00 to $13.50 per gram respectively. Shipping for all orders is an additional $13.50 for a shipping time of up to four days and $25.00 for a shipping time of up to three days.

D. CanniMed does not appear to offer any discount for low income or disabled individuals.

(4.) On July 7, 2014 the website of the LP known as Delta 9 Bio-Tech Inc. at www.delta9.ca and information from a representative by phone at 855-245-1259 indicated that:

A. Delta 9 is not currently registering new clients.

B. Delta 9 currently has approximately twenty strains of cannabis available for sale to registered clients.

C. The price for Delta 9's strains vary from $5.00 to $9.00 per gram. A discount of $1.00 per gram is applied to orders of at least 30 total grams. Delta 9 does not indicate whether shipping is included in these prices.

D. Delta 9 offers a discount of 50% to qualified low income or disabled clients. Delta 9 does not specify what constitutes low income status or a disability, but rather has a committee that evaluates each client's request for a discount and grants the discount based on the company's capacity to afford the subsidy at the time. For those individuals who qualify, it appears Delta 9's strains would cost $2.50 to $4.50 per gram.

(5.) On July 7, 2014 the website of the LP known as In The Zone Produce Ltd. at www.inthezoneproduce.com and it indicated that:

A. In The Zone is not currently registering new clients.

B. In The Zone appears to have no strains of cannabis currently available for sale.

C. The price for In The Zone's strains is projected to be $5.00 to $8.00 per gram. In The Zone does not indicate whether shipping is included in these prices.

D. In The Zone does not appear to offer any discount for low income or disabled individuals.

(6.) On July 7, 2014 the website of the LP known as Mettrum Ltd. at www.mettrum.com indicated that:

A. Mettrum is currently registering new clients.

B. Mettrum currently has four strains of cannabis available for sale.

C. The price for all four strains is $7.60 per gram. Mettrum does not indicate whether shipping is included in these prices.

D. Mettrum offers a 30% discount on the first 30 total grams ordered each month to clients on provincial or federal income assistance or who have a total pre-tax annual income of less than $30,000.00. For those individuals, it appears the first 30 grams of Mettrum's strains ordered each month would cost $6.08 per gram.

(7.) On July 7, 2014 the website of the LP known as MedReleaf Corp. at www.medreleaf.com indicated that:

A. MedReleaf is currently registering new clients.

B. MedReleaf currently has no strains of cannabis available for sale.

C. The price for MedReleaf's strains is projected to be $7.60 per gram with free shipping on first order placed each month. MedReleaf does not state shipping prices for subsequent orders.

D. MedReleaf anticipates offering a discount to low income clients, but details of the program are not yet specified.

(8.) On July 7, 2014 the website of the LP known as OrganiGram Inc. at www.organigram.ca indicated that:

A. It is unclear whether OrganiGram is currently registering new clients due to an inability to reach a customer service representative.

B. OrganiGram currently has no strains of cannabis available for sale.

C. The price for OrganiGram's strains is projected to be $6.00 to $9.00 per gram including free shipping.

D. OrganiGram offers a 25% discount to clients on social assistance or government disability programs. For those individuals, it appears OrganiGram's strains would cost $4.80 to $7.20 per gram.

(9.) On July 7, 2014 the website of the LP known as The Peace Naturals Project Inc. at www.peacenaturals.com indicated that:

A. Peace Naturals is not currently registering new clients.

B. Peace Naturals currently has no strains of cannabis available for sale.

C. The price for Peace Natural's strains vary from $6.00 to $9.50 per gram. Peace Naturals also offers two "milled varieties" which are a coarsely ground mixture of several different strains for $4.50 per gram. Peace Naturals does not indicate whether shipping is included in these prices.

D. Peace Naturals does not appear to offer any discount for low income or disabled individuals.

(10.) On July 7, 2014 the website of the LP known as Thunderbird Biomedical Inc. at www.thunderbirdbiomedical.com indicated that:

A. Thunderbird Biomedical is not currently registering new clients.

B. Thunderbird Biomedical currently has no strains of cannabis available for sale.

C. There is no information of the projected price of Thunderbird Biomedical's strains. There is no information as to whether shipping will be included in Thunderbird Biomedical's prices.

D. There is no information as to whether Thunderbird Biomedical will offer any discount for low income or disabled individuals.

(11.) On July 7, 2014 the website of the LP known as Tilray at www.tilray.ca indicated that:

A. Tilray is currently registering new clients.

B. Tilray currently has ten strains of cannabis available for sale.

C. The price for Tilray's strains vary from $8.00 to $12.00 per gram. Tilray currently charges a flat rate of $5.00 for shipping.

D. Tilray does not appear to offer any discount for low income or disabled individuals.

(12.) On July 7, 2014 the website of the LP known as Tweed Inc. at www.tweed.com indicated that:

A. Tweed is not currently registering new clients.

B. Tweed currently has one strain of cannabis available for sale.

C. The price for Tweed's one available strain is $7.00 per gram including free shipping.

D. Tweed offers a discount of 20% to clients who have a total pre-tax annual income of less than $29,000.00. For those individuals, it appears the one available strain would cost $5.60 per gram.

(13.) On July 7, 2014 the website of the LP known as Whistler Medical Marijuana Corp. at www.whistlermedicalmarijuana.com and it indicated that:

A. Whistler Medical Marijuana is not currently registering new clients.

B. Whistler Medical Marijuana currently has four strains of cannabis available for sale to registered clients.

C. The price for Whistler Medical Marijuana's strains is $10.00 per gram including free shipping.

D. Whistler Medical Marijuana does not appear to offer any discount for low income or disabled individuals.

78. What feedback either positive or negative has Health Canada received regarding the *MMPR* program to date and in particular regarding individual LPs and their product and service from a reasonable access perspective or otherwise?

Impact of legalization in USA and elsewhere on supply/demand and public safety

79. In the past the major source of demand for illicit Canadian produced cannabis (marihuana) was the USA (about 80% of our market and about 5% of theirs as most of theirs is grown by Americans for Americans in America and the rest comes through the Mexican border) and this demand has been substantially reduced not only by the legalization of cannabis (marihuana) in Washington State and Colorado for all purposes, but also by virtue of the legalization of access to cannabis (marihuana) for medical purposes in some 22 states – hasn't it?

80. This reduction in overall demand in the illicit market coupled with some abuse by a minority of *MMAR* Licensees diverting their product into the illicit market has resulted in an overall glut or oversupply that has reduced prices and resulted in the closing down of many illegal operations, hasn't it?

81. This in turn has reduced the risk of violence associated to "Grow rips" or break and enters for such purposes themselves, given that the robbers will be unable to sell the product easily given the lesser demand and oversupply, isn't that correct?

82. Legal operations under the *MMAR* are/were required to have in place acceptable security systems to prevent against robberies and the evidence is that these were effective and that legal operators would call the police in the event of such attempted robberies, whereas those engaged in the illicit market would not – is that correct?

The Indoor Growing Industry and products

83. Those who wish to grow any type of plant indoors have available to them a wide array of products to produce any such plants indoors safely from any electrical and fire risks, and from a toxic mold risks by use of dehumidifiers and other devices and from security risks by the use of various alarms, cameras and other devices

and including devices to reduce smell or odor and including entire indoor growing tents or containers as an entire industry or number of industries exist to supply all of these things to the legal market – isn't that correct?

Consultation Feedback

84. During the consultations leading up to the *MMPR*, isn't it true that HC received many comments from stakeholders to the effect that HC should permit the production and sale of cannabis resin and/or cannabis-based medicines? Please provide the total number of persons making similar comments.

85. Isn't it true that, generally, the consultations leading up the *MMPR* resulted in stake holders representing law enforcement urging HC to implement high levels of restrictions/regulations whereas stakeholders representing patients urged HC to lessen the regulatory burdens?

86. Isn't it true that, generally, the consultations leading up the *MMPR* resulted in stakeholders representing compassion clubs (medical cannabis dispensaries) urging HC to lessen the regulatory burdens?

87. Isn't it true that, generally, the consultations leading up the *MMPR* resulted in stakeholders representing persons or entities interested in entering the LP industry urging HC to lessen the regulatory burdens imposed by the *MMPR*?

Interim Administrative Changes to Licenses

88. The *MMAR* provided for notification of a change in the production site address, requiring the consent of the owner/landlord if the property was not owned by the patient/applicant, and one of the purposes of keeping a record of the production site was to provide a database accessible by the police to keep law enforcement informed as to which sites are legal and which ones were not when engaged in the general enforcement of the *CDSA* – isn't that correct?

89. If personal production or production by a caregiver is permitted to continue it would be relatively simple to devise a process whereby a person could change their production site address if necessary and give notice thereof to Health Canada or any other government department or agency, including the police – wouldn't it?

90. If not, why not?

91. If an MMPR patient is unhappy with the product, such as the License Producer being unable to produce a strain that works for them, or the product is otherwise ineffective, apart from complaining to the Licensed Producer the patient will have

to re-attend on his medical practitioner to obtain a new medical document in order to attempt to access medicine from a different Licensed Producer, is that correct?

Department of Justice Ministère de la Justice
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Our File: 4387565

August 14, 2014

BY COURIER

John W. Conroy, Q.C.
Conroy & Company
Barristers & Solicitors
2459 Pauline Street
Abbotsford, British Columbia
V2S 3S1

This is Exhibit "B" referred to in the affidavit of Danielle Lukey sworn before me at Abbotsford BC this 10th day of Sept 2014

A Commissioner for taking Affidavits for British Columbia

Dear Mr. Conroy:

Re: ALLARD, Neil et al. v. Canada
Federal Court File No. T-2030-13
Service of Answers to Written Examination for Discovery Questions

Please find enclosed for service the Defendant Canada's answers to the Plaintiffs' written examination for discovery questions dated July 25, 2014. As required by the *Federal Courts Rules*, the answers to questions in respect of which no objection is made are set out in Exhibit "A" to the affidavit of Canada's representative, Jeannine Ritchot.

The Defendant Canada objects to answering the following questions: 1-3, 11, 12, 15-21, 22 (in part), 23, 24, 25(e)(in part), 33, 34, 39, 46, 47, 50, 51, 54-56, 58, 59, 62-69, 70(a), 78-83, and 88-91.

The reasons for objecting to these questions are set out below.

Reasons for Objections

Q1-3: These are legal questions that cannot be asked on discovery.

Q11: The question calls for an expression of opinion that cannot be asked on discovery.

Q12: This is a legal question that cannot be asked on discovery.

Q15-16: These are legal questions that cannot be asked on discovery.

Q17: This question, based on the erroneous proposition that there has already been "evidence" led that has conclusively established certain facts for the purpose of these proceedings, calls for an expression of opinion that cannot be asked on discovery.

Q18-21: These are legal questions and cannot be asked on discovery.

Q22 (the portion that reads: "…patients cannot claim coverage under any provincial insurance scheme for reimbursement of the cost of purchase [dried marijuana], isn't that correct?): This is a legal question and/or a request for third party information that cannot be asked on discovery.

Q23-24: These are legal questions and cannot be asked on discovery.

Q25(e)(the portion that reads: "..and what evidence exists to support this allegation [serious threats to health and public safety]): It is not proper to ask on discovery what "evidence" exists to support a particular allegation in a pleading.

Q33-34: These questions seek to elicit argument and opinion, and are based on speculative hypotheses. They cannot be asked on discovery.

Q39: This question seeks to elicit argument and opinion, and would require engaging in speculation. It cannot be asked on discovery.

Q46-47: These questions seek to elicit argument and opinion. They cannot be asked on discovery.

Q50-51: It is not proper to ask on discovery what "evidence" exists to support a particular allegation in a pleading.

Q54-56: These are legal questions and cannot be asked on discovery.

Q58-59: These are legal questions and cannot be asked on discovery.

Q62-63: These questions seek to elicit argument and opinion. They cannot be asked on discovery.

Q64-66: These are legal questions and cannot be asked on discovery.

Q67-69: These questions seek to elicit argument and opinion. They cannot be asked on discovery.

Q70(a): It is not proper to ask on discovery what "evidence" exists to support a particular allegation in a pleading.

Q78: This question is irrelevant. Public opinion regarding the impugned MMPR provisions following their adoption is not germane to whether or not they are constitutionally valid.

Q79-83: These questions seek to elicit argument and opinion. They cannot be asked on discovery.

Q88: This a legal question and cannot be asked on discovery.

Q89-90: These questions seek to elicit argument and opinion. They cannot be asked on discovery.

Q91: This a legal question and cannot be asked on discovery.

Yours sincerely,

Jan Brongers
Senior General Counsel,
B.C. Regional Office

JB/sb

Encl.

This is the 2nd affidavit
of Jeannine Ritchot
in this case and was made on
Wednesday, August 13, 2014

Court File No.: T-2030-13

FEDERAL COURT

BETWEEN:

NEIL ALLARD
TANYA BEEMISH
DAVID HEBERT
SHAWN DAVEY

Plaintiffs

and

HER MAJESTY THE QUEEN IN RIGHT OF CANADA

Defendant

AFFIDAVIT # 2 OF JEANNINE RITCHOT

I, Jeannine Ritchot, Senior Director of Surveillance and Analysis with the Public Health Agency of Canada, of the City of Ottawa in the Province of Ontario AFFIRM THAT the answers set out in Exhibit A to this affidavit to the questions dated July 25, 2014 submitted by the Plaintiffs in the above captioned action (Neil Allard, Tanya Beemish, David

This is Exhibit "C" referred to in
the affidavit of Danielle Laukiv
sworn before me at Abbotsford BC
this 10th day of Sept 2014

A Commissioner for taking Affidavits
for British Columbia

Hebert and Shawn Davey) are true, to the best of my information, knowledge and belief.

Affirmed before me at the City of Ottawa in the Province of Ontario, this 13th day of August, 2014.

Commissioner for taking Affidavits in and for the Province of Ontario

Jeannine Ritchot

This is **Exhibit "A"** referred to in the
Affidavit of **JEANNINE RITCHOT**
Affirmed before me
at the City of Ottawa,
in the Province of Ontario,
this 13th day of August 2014.

Commissioner for Taking Affidavits

Counsel for the Attorney General of Canada instructed me to refrain from addressing questions 1, 2, 3, 11, 12, 15, 16, 17, 18, 19, 20, 21, 23, 24, 33, 34, 39, 46, 47, 50, 51, 54, 55, 56, 58, 59, 62, 63, 64, 65, 66, 67, 68, 69, 70(a), 78, 79, 80, 81, 82, 83, 88, 89, 90 and 91.

My responses to the remaining questions appear below.

4. *How many patients held authorization's to possess (ATPs) as of March 21, 2014?*

Response:

33,122 individuals were authorized to possess marijuana for medical purposes as of March 21, 2014.

5. *How many patients were authorized within the previous 12 months from March 31, 2013 until March 20, 2014 and lost their ability to possess cannabis (marihuana) for medical purposes simply because they failed or were unable to renew their of license on or before September 30, 2013 and/or it expired prior to the interlocutory injunction ordered March 21, 2014?*

Response:

Health Canada cannot answer this question as it does not have access to the reasons underlying individuals' change in status under the MMAR. There were many possible causes for an individual to cease being authorized to possess marijuana for medical purposes under the MMAR. For example, individuals may have moved out of Canada, they may have decided (in consultation with their doctors) that it was medically inappropriate to continue consuming marijuana for medical purposes, they may have commenced ordering through Licensed Producers under the MMPR and therefore no longer require a renewal of their authorization to possess, or they may no longer have wished to continue consuming marijuana for any number of other personal reasons.

6. *How many patients with a valid ATP's held a valid Personal Use Production License (PUPL) on*

(a) September 30, 2013? ;

(b) March 21, 2014? ;

(c) March 31, 2014?.

Response:

(a) as of September 30, 2013, 25,809 individuals with valid ATPs also held a PUPL;

(b) as of March 21, 2014, 21,001 individuals with valid ATPs also held a PUPL;

(c) as of March 31, 2014, 20,273 individuals with valid ATPs also held a PUPL.

7. *How many patients with a valid ATP had a valid Designated Grower (DGL) producing for them as of:*

(a) September 30, 2013?;

(b) March 21, 2014?;

(c) March 31, 2014?.

Response:

(a) as of September 30, 2013, 4,231 individuals with valid ATPs had a designated person producing for them;

(b) as of March 21, 2014, 3,273 individuals with valid ATPs had a designated person producing for them;

(c) as of March 31, 2014, 3,160 individuals with valid ATPs had a designated person producing for them.

8. *How many patients with a valid ATP's were purchasing their cannabis (marihuana) as medicine from the government source Prairie Plant Systems as of:*

(a) September 30, 2013? ;

(b) March 21, 2014? ;

(c) March 31, 2014?

Response:

Without conducting an impractical manual search, Health Canada cannot provide data on how many individuals purchased the marijuana produced by Prairie Plant Systems on the various dates set out in this question.

Health Canada can, however, determine how many orders for dried marijuana were processed in a particular month. These numbers are affected by the fact that an individual had the option to order multiple times within a particular monthly period.

In the month of September 2013, Health Canada processed and supplied 1,275 orders for supply of marijuana for medical purposes (there were 1239 orders for dried marijuana; of these 28 individuals re-ordered; so 1211 individuals ordered dried marijuana; 73 ordered seeds; note inconsistencies in numbers reflect that an individual may order both seeds and dried marijuana at one time) from Prairie Plant Systems. From March 1, 2014 to March 12, 2014, Health Canada placed 388 orders for supply of marijuana for medical purposes: of these orders, 382 were for dried marijuana, with only 1 individual ordering more than once, and 4 orders for seeds from Prairie Plant Systems.

As the MMAR were repealed on March 31, 2014, Health Canada had to ensure that all deliveries of dried marijuana were received by individuals by that date, therefore, March 12, 2014 was the last date Health Canada accepted orders.

9. *As of April, 2013, Health Canada authorized the production of 188,189 kg of cannabis (marihuana) to be produced under the MMAR under the various licenses during the year 2012, broken down as follows:*

- *15,752.88 kg: for patients needing to use one to 5 g per day;*
- *42,054.31 kg: for patients needing to use 6 to 10 g per day;*

- *89,127.44 kg: for patients needing to use 11 to 20 g per day;*
- *12,795.62 kg: for patients needing to use 21 to 50 g per day;*
- *3,195.21 kg: for patients needing to use 51 200 kg per day; and*
- *4,854.87 kg: for patients needing to use 101,050 g per day*
- *Isn't that correct and are updated figures available for 2013 or until March 31st,2014?*

Response:

This does not appear to be correct as this question refers to authorized *production*, as opposed to authorized *possession*.

The figures cited in this question were provided by Health Canada in response to a request pursuant to the *Access to Information Act*. The request that triggered this disclosure sought information with respect to authorized possession amounts during the year 2012, not, as this question suggests, *production* amounts. As a result, the numbers set out in the question above do not represent the amount of dried marijuana that Health Canada authorized to be produced. Instead, they are based on authorized "daily amounts" of dried marijuana that were supported by a doctor.

Health Canada applications refer to "daily amounts", therefore, the daily amount supported by a physician on an Authorization to Possess ("ATP") applicant's "Form B" were used to generate the information in response to the above-reference request. In order to generate the annual numbers of kilograms, the daily amount was multiplied by 365. This formula was applied to each ATP that fell within the parameters of the request and that were issued in the calendar year specified. This calculation assumed, therefore, that each of these ATPs was licensed to possess dried marijuana for medical purposes for the entire calendar year.

With regard to *production* amounts, Health Canada can provide the following estimates for the full 2012 and 2013 years (data up until March 31, 2014 is not presently available). These estimates were arrived at by adding the total number of kilograms of dried marijuana that were authorized to be produced pursuant to Personal Use Production Licenses ("PUPL") and Designated Person Production Licenses

("DPPL") and then grouping those amounts based on the daily amounts of their associated ATPs:

2012	Daily Grams	KGs Authorized
	1-5g	15,752.88
	6-10g	42,054.31
	11-20g	89,127.44
	21-50g	12,795.62
	51-100g	3,195.21
	101-150g	4,854.87
	Total	167,780.33

2013	Daily Grams	KGs Authorized
	1-5g	13,339.40
	6-10g	34,120.67
	11-20g	37,330.59
	21-50g	39,697.40
	51-100g	12,878.66
	101-150g	4,219.04
	Total	141,585.76

For purposes of answering this question, amendments seeking to increase daily amounts in the same calendar year have not been included. Therefore, if an individual with an ATP originally applied to possess 10 grams of dried marijuana per day in January, and then in November of the same year obtained authorization to double that daily amount to 20 grams, the estimated annual amount authorized for this ATP will reflect a daily amount of 10 grams for a 365 day period.

With regard to numbers as of March 31, 2014, individuals with PUPLs and DPPLs were authorized to produce up to 123,187.305 kg of dried marijuana under the MMAR.

10. *Also, as of April, 2013, there were 89 persons in Canada with authorizations to possess with dosage levels of 150 g or more per day, weren't there and did this number change up to March 31st,2014?*

Response:

As of April 17, 2013, there were 48 individuals authorized to possess marijuana for medical purposes with a daily amount equal to or greater than 150 grams per day.

As of March 31, 2014, that number increased to 158 individuals.

13. *Some of the patients purchased the government supply, but were unable to pay for the product and were therefore cut off from that supply and became indebted – please provide the full details as to the number of such patients, the amounts owed and what steps were taken to collect the amounts owed and what the ultimate results of such efforts were to both the patient and Canada?*

Response:

Prior to November 30, 2009 Health Canada took several steps to advise individuals of their account status and repayment options. First, at 30 days overdue Health Canada sent individuals notice that their accounts were in arrears. This notice indicated that payments would need to be made in order to continue to receive further shipments. Then, if no such payments were made, individuals would again be advised at 60 days that their accounts were overdue and shipments would no longer be sent to them.

If individuals made no attempts to repay arrears after 90 days, the individual's debt would then be sent to a collections agency. As of June, 2009, a total of 31 accounts had been sent to a collections agency, with approximately $2,000 of debt having been recovered.

Because Health Canada was not having success collecting arrears, on November 30, 2009, the department put into place a new payment process requiring individuals to pay in advance for all products ordered and supplied. Individuals in arrears wishing to continue to order were required to establish a repayment plan before any future orders would be processed or shipped.

As of July 31, 2014, there were 896 individuals in arrears with a total amount owing of $1,448,219.67. These individuals owed between $2 and $37,764.24, as set out in the list appended at Annex 1. The general distribution of the debts is as follows:

Supply Accounts in Arrears

Debt Amounts	Number of Clients
$20, 000 - $40, 000	1
$10, 000 - $20, 000	3
$5, 000 - $10, 000	57
$1, 000 - $5, 000	340
$2 - $1, 000	495
TOTAL: $1,448,219.67	896

While 896 individuals were in arrears as of July 31, 2014, Health Canada did not accept orders for marijuana for medical purposes after March 12, 2014. Individuals who previously ordered from Health Canada may have decided to stop ordering from Health Canada for any number of reasons. For example, they may have decided to obtain their marijuana through a PUPL, a DPPL or from a licensed producer or they may have decided to stop using marijuana for medical purposes altogether.

14. *How many patients who were purchasing their cannabis (marihuana) as medicine from the government source Prairie Plant Systems (PPS) over the course of the program commencing July 8, 2003 under the "Interim Policy" until March 31, 2014, found they were unable or were found to be unable to afford the cost of the government source of supply so were cut*

off from the government supply and how much did they owe, individually and collectively, and what steps if any were taken to collect the amounts owed individually or collectively?

Response:

See the response to question 13, above.

22. *As indicated in paragraph 36 of the Defence, 'dried marijuana' is not an 'approved' drug for sale in Canada and this means it does not have a DIN number and patients cannot claim coverage under any provincial insurance scheme for reimbursement of the cost of purchase, isn't that correct?*

Response:

It is true that dried marijuana is not an approved drug or medicine and as such does not have a drug identification number ("DIN").

25. *The reasons why the government has limited the use of Cannabis (marihuana) to its dried form only in the MMAR and has continued that limitation in the MMPR and added it to the NCR, are set out in paragraphs 89 through 94 of the Statement of Defence and raise the following questions;*

(a) What is the "limited clinical evidence" referred to in paragraph 91 regarding the use of marihuana for medical purposes?

Response:

In 2011, Health Canada asked a group of international scientists with expertise in cannabis and cannabinoids research to peer-review the existing *"Information for Healthcare Professionals: Marijuana"* document published by Health Canada. In 2012, the revised document, incorporating the feedback from this peer-review, was then submitted for a secondary peer-review by an Expert Advisory Committee (EAC), composed of Canadian scientists and clinicians with expertise in cannabis and cannabinoids research and on the use of cannabis and cannabinoids for therapeutic purposes. The feedback

obtained from the EAC was then used to produce a final document, published in the spring of 2013 (see *"Information for Healthcare Professionals: Cannabis and the Cannabinoids"*, which is Defendant's Document #172). The details of the "limited clinical evidence" referred to in this question are discussed in that document.

More generally, it must be recognized that modern medicine makes use of evidence-based information to balance the risks and benefits of medical treatment and to make clinical decisions that should ultimately maximize benefit and minimize harm to each individual patient. When involving a drug product, these evidence-based clinical decisions are based on information gathered from well-conducted pre-clinical, clinical, and post-market pharmacovigilance studies and other safety monitoring activities.

Clinical studies or *trials* of a drug gather medical and scientific evidence of medical benefit (or efficacy), as well as harm, from healthy humans subjects as well as patients. This medical and scientific evidence is gathered under strictly controlled, well-established, and defined conditions in order to determine, as precisely and reliably as possible, the therapeutic efficacy and adverse effects of the test drug.

For smoked or vapourized dried marijuana, the evidence gathered from clinical studies is considered to be limited for a number of reasons outlined below:

The concentrations and ratios of the active ingredients (cannabinoids) in the dried marijuana product are often times not known or can be highly variable and inconsistent. In contrast, the concentrations of the active ingredient(s) and the chemical composition of approved pharmaceutical products are well characterized and consistent.

The number of patients enrolled in individual clinical studies of efficacy and safety of dried marijuana for a particular medical symptom/condition has generally been under 30 per study. By contrast, in clinical studies for efficacy and safety for standard pharmaceutical products, the number of patients enrolled can reach into the hundreds or thousands per study.

The number of clinical studies for efficacy and safety of dried marijuana has been very small, a total of 10 studies thus far, with the majority of these focusing specifically on chronic neuropathic pain, and

the balance focusing on spasticity associated with multiple sclerosis, and weight loss in HIV/AIDS infection. This dearth of studies poses serious limits on the ability to generalize the findings gathered from these few clinical studies to medical conditions or symptoms other than those that have been investigated.

The duration of study for clinical studies of efficacy and safety of dried marijuana has seldom exceeded 5 days. By contrast, for standard pharmaceutical products, clinical studies for efficacy and safety can last for much longer periods, up to months or years.

There is essentially no reliable, standardized information relating a particular dose to a therapeutic response for dried marijuana as there is for approved pharmaceutical products.

There is very little peer-reviewed scientific information on drug-drug interactions for dried marijuana for therapeutic purposes compared to the kind of information that is available for approved pharmaceutical products.

All of the clinical studies of dried marijuana for medical purposes have used patient subjects that have had previous experience with dried marijuana (recreationally or therapeutically) raising the strong possibility that these subjects may have known when they were receiving either dried marijuana or a placebo. The ability to distinguish the test drug from a placebo in a clinical study (that is ideally supposed to be randomized, double-blind and placebo-controlled) can call into question the validity and reliability of the results and therefore overestimate the efficacy of dried marijuana. Furthermore, because the clinical studies with dried marijuana used patient subjects with previous experience with marijuana, the incidence and prevalence of adverse effects could have also been underestimated (see additional information on adverse effects below).

The quality of the placebo used in clinical studies of dried marijuana for medical purposes has also sometimes been called into question. This factor, in combination with the use of patients having previous experience with marijuana increases the possibility that study subjects may have known when they were receiving dried marijuana or placebo. Such study "unblinding" can further call into question the quality of the evidence gathered from clinical studies of dried marijuana for medical

purposes and contribute to overestimating the efficacy of dried marijuana.

There is considerably little information available regarding the incidence and prevalence of adverse effects associated with the use of dried marijuana for medical purposes compared to the volume of information available for most approved pharmaceutical products. While some adverse effects manifest acutely, others may take weeks, months or even years to appear. In addition, there is the concern that the incidence and prevalence of adverse effects associated with dried marijuana has been underestimated given the small number of study subjects for dried marijuana for medical purposes in clinical studies and the fact that the majority of the subjects had previous experience with marijuana. Furthermore, given that the majority of clinical studies with dried marijuana have lasted only 5 days, there is really no information on the incidence or prevalence of adverse effects that may appear in the medium to longer-term with dried marijuana. In contrast, for approved pharmaceutical products, information on safety is gathered from hundreds of study subjects over weeks, months and even years.

(b) *What is known about the risks and benefits of unapproved cannabis derivatives and preparations?*

Response:

As limited as is the evidence with respect to the risks and benefits of consuming dried marijuana for therapeutic purposes, there is even less evidence-based, peer-reviewed, scientific or medical information available on the risks and benefits that are specific to the use of unapproved cannabis derivatives and preparations for therapeutic purposes.

Evidence in the scientific literature suggests that cannabis derivatives such as cannabis oil could contain very high concentrations of cannabinoids. Furthermore, scientific evidence relating to the pharmacokinetics of cannabinoids (and generally discussed in the *"Information for Healthcare Professionals: Cannabis and the Cannabinoids"*) also suggests that delivery, by way of inhalation (smoking/vapourizing), of derivatives such as cannabis-oil containing high concentrations of cannabinoids could lead to a rapid overdose with very high levels of cannabinoids in the blood and associated

adverse effects. In the case of oral ingestion of products made from derivatives containing high levels of cannabinoids, the scientific evidence suggests that the slow onset of effects associated with oral administration could lead to overconsumption of such products and when combined with ingestion of a product containing very high levels of cannabinoids could lead to an overdose and associated adverse effects.

Health Canada is also aware of publicly available anecdotal information coming from the United States, regarding the use of harmful solvents to produce and/or store unapproved derivatives, the use of unsanitary methods to prepare unapproved derivatives, and the use of storage conditions that could support the growth of toxicogenic microorganisms in these unapproved derivatives and that could all potentially put the health and safety of patients at risk.

In addition, Health Canada is aware that other jurisdictions have expressed concern about risks with respect to accidental ingestion of edibles containing marijuana (e.g. brownies, cookies, lollipops, rice crispies, etc.) by children given the potential attractiveness of such products to them.

(c) *What are the "serious threats to health and public safety" alleged in relation to the 'production of marihuana' for medical purposes?"*

Response:

The "serious threats to health and public safety" alleged in relation to the production of non-dried marijuana for medical purposes are set out at para. 93 of Canada's Statement of Defence, which says "the extraction of cannabis active components and preparations from marihuana plant material through chemical processes involves the use of volatile solvents that can trigger health problems and can cause explosion and fire. This poses serious health and safety hazards, including severe life threatening burns. The carrying out of such potentially dangerous processes is of particular concern in clandestine residential laboratories."

During consultations by Health Canada with law enforcement during the development of the MMPR, concerns were expressed about the potential of explosions or fires resulting from extraction procedures, as

well as risks of diversion due to lack of security standards and disposal requirements.

(d) What are the "serious threats to health and public safety" alleged in relation to the 'possession of marihuana' for medical purposes?

Response:

As mentioned in the response to Question 25(b) above, there is a paucity of evidence-based, peer reviewed, scientific or medical information available on the risks and benefits of unapproved cannabis derivatives and preparations for therapeutic purposes. As such, their possession (for medical purposes) could pose a risk to the health of users.

Indeed, Health Canada's consultations during the development of the MMPR revealed that provincial and territorial officials, representatives of medical associations and individual physicians were generally opposed to permitting the use of marijuana-based products within the program, given (in addition to the uncertainty regarding efficacy of dried marijuana itself) the lesser knowledge base regarding the risks and effects associated with the use of such products.

In addition, cannabis derivatives and extracts, such as cannabis oil, could contain high concentrations of cannabinoids.

Cannabis derivatives and extracts also pose particular problems with respect to law enforcement. Consider the following example in which an individual receives support from a health care practitioner to possess 1 gram of marijuana per day (which corresponds to 30 grams at any one time under the MMPR). The individual converts his or her dried marijuana to oil and then bakes cookies using that oil that weigh 150 grams. A police officer would have no way of determining, on sight, that the cookies contain marijuana at all. Even if the officer somehow learned that the cookies did contain marijuana, Health Canada is not aware of any tests that could ascertain how much marijuana was contained in the cookies, therefore compromising capacity to ascertain whether or not the individual possessing the

cookies was adhering to his or her authorized amount. The same is true with respect to all other non-dried marijuana extracts and derivatives.

As a result of these concerns (among others), during the development of the MMPR, representatives of various police departments expressed continuing opposition to the production and sale of marijuana-based products (such as oils, edibles, lotions etc.).

(e) What are the "serious threats to health and public safety" and what evidence exists to support this allegation in relation to patients who produce for themselves or their designated grower caregivers and that do not "distribute" to others?

Response:

The meaning of this question is unclear. However, to the extent that it is asking about the threats to health and public safety that stem from the possession and production of marijuana, marijuana derivatives and extracts, the answer is set out above in response to Questions 25(c) and (d).

(f) The extraction of cannabis active components and preparations from marihuana plant material through chemical processes involving the use of volatile solvents is limited to the extraction of cannabis oil and does not apply to all other derivatives or preparations, isn't that correct?

Response:

During consultations by Health Canada with law enforcement during the development of the MMPR, concerns were expressed about the potential of explosions or fires resulting from cannabis extraction procedures. Whether these concerns related solely to the extraction of cannabis oil was not made clear. As such, these concerns may or may not apply to the processes involved in other extractions as well.

(g) *So long as the patient has in his or her possession, an appropriate authorization document or certificate to possess cannabis in any of its forms, why is it any more difficult for law enforcement officials to determine that the product has been produced from a legal source than if they are limited to "dried marihuana"?*

Response:

Please see the answer to Question 25(d), above.

26. *Please provide details of any specific problems that arose during the course of the MMAR program with respect to the use of cannabis (marihuana) in forms other than "dried marihuana"?*

Response:

The MMAR did not authorize the use of marijuana other than dried. Individuals who converted their dried marijuana to derivatives would have been doing so in contravention of the regulations, and could have been subject to action by law enforcement.

Health Canada became aware of problems that arose with respect to the use of the cannabis derivatives through media reports of explosions taking place in the homes of license holders. Law enforcement also provided Health Canada with evidence of problems that occurred in the course of converting dried marijuana to a derivative. The CACP report, provided as part of the HC discovery process, speaks to these problems.

27. *Isn't it true that ingesting cannabis based medicine orally tends to provide (a) slower onset of effect; (b) lengthier plateaus of effective doses of cannabinoids in the system as opposed to smoking or vaporizing dried marihuana which (a) takes effect quickly but; (b) also wears off quickly?*

Response:

As is set out in *"Information for Health Care Professionals: Cannabis and the Cannabinoids"*, which is Defendant's Document #172, smoking or

vapourizing dried marijuana is associated with a very rapid increase (within a few minutes) in the blood levels of cannabinoids such as delta-9-tetrahydrocannabinol (THC), and is also associated with a rapid decrease in the blood levels of THC to baseline levels (within the span of one hour or so). In contrast, oral ingestion of THC is associated with a much slower rise in blood levels of THC (over a span of 1-2 hrs), a plateau phase, and a gradual decrease in blood levels of THC over the span of another few hours.

However, the information suggests that blood levels of cannabinoids (i.e. THC) do not neatly correlate with the psychoactive or potential therapeutic effects. Generally, studies of smoked/vapourized dried marijuana for therapeutic purposes have used the duration of psychoactive effects associated with smoking/vapourizing (2-3 hrs) as a very crude indicator of the duration of therapeutic effects, however there have actually been no studies that have carefully examined the true duration of therapeutic effects associated with smoking/vapourizing herbal marijuana for medical purposes.

Two clinical studies that have used only once daily administration of smoked dried marijuana to treat HIV/AIDS associated loss of appetite and food intake (Haney et al. 2005) or multiple sclerosis-associated spasticity and pain (Corey-Bloom et al. 2012) reported clinical improvement suggesting that, despite this administration method and schedule, the therapeutic effects of smoking/vapourizing dried marijuana can be maintained longer than would be predicted based simply on the pharmacokinetics of blood THC and psychoactive effects.

28. *How many reports of negative effects from medical consumption of cannabis resin (hashish) has HC received from licensed MMAR patients since the decision of the Court in R v. Smith? For each such report, please provide a detailed description of the incident any HC's response to the incident.*

Response:

Health Canada is unable to determine the answer to this question for several reasons.

First, Health Canada has never authorized the production or distribution of products containing cannabis resin (hashish). Nor has the Health Canada producer been involved in the production and distribution of such products.

Second, there was no regulatory requirement under the MMAR for collection or recording of incidents pertaining to negative effects from medical consumption of these products.

Third, while the Canada Vigilance Adverse Reaction Online Database contains information about suspected adverse reactions (also known as side effects) to health products that are reports provided by consumers, health professionals, manufacturers and distributors, the database does not track whether an individual who is the subject of a suspected adverse reaction is a licensed MMAR patient.

Between April 13, 2012 (the date *R. v. Smith* was decided) and June 30, 2014, (the last day the database was updated), there are no domestic adverse reaction reports in the database involving "hashish." There are, however, 149 adverse reaction reports involving "cannabis" or "marijuana". Some examples of reactions listed in cases where marijuana was suspected of causing or contributing to an adverse reaction include "drug dependence," "substance abuse," "suicidal behavior," "dizziness", "pallor", "mental impairment", "nausea", "vomiting", "malaise", "memory impairment" and "psychomotor skills impaired". In many of these cases both the dosage form and route of administration are unknown. In 25 of the 149 cases the route of administration is specified as "inhalation" and in three cases it is specified as "oral."

For more details on the foregoing, please see the attached printout from a search of the Canada Vigilance Adverse Reaction Online Database, which is attached as Annex 2.

29. *How many reports of negative effects from medical consumption of cannabis-based derivative medicines consumed orally (e.g., cannabis cookies or other edibles) has HC received from licensed MMAR patients since the decision of the Court in R v. Smith? For each such report, please provide a detailed description of the incident and HC's response to the incident.*

Response:

See answer to question 28. The Canada Vigilance Adverse Reaction Online Database does not produce any results involving the search terms "cookies" or "edibles."

30. *How many reports of negative effects from medical consumption of cannabis-based derivative medicines consumed topically (e.g., cannabis lotion) has HC received from licensed MMAR patients since the decision of the Court in R v. Smith? For each such report, please provide a detailed description of the incident and HC's response to the incident.*

Response:

See answer to question 28. The Canada Vigilance Adverse Reaction Online Database does not produce any results involving marijuana or cannabis and "lotion" or "topical."

31. *Please provide details of any specific problems that arose during the course of the MMAR program with respect to a patient possessing more than 150 g on their person so as to warrant that limitation in the MMPR?*

Response:

At the time that the MMPR were developed, Health Canada was advised by law enforcement that there were serious concerns with diversion and targeting of marijuana home cultivation operations for theft of marijuana in cases that involved authorized users and producers under the MMAR (i.e. grow rips). Health Canada was also provided with several reports from the RCMP which contained details about specific instances of diversion and grow rips (see, for example, An Analysis of National Cases Related to the Marihuana Medical Access Regulations, Prepared on behalf of the CACP by the RCMP, November 2010, which is #46 on the Defendant's List of Documents).

32. *How many patients were attempted to be or were in fact robbed or assaulted in order to steal the marihuana they possessed on their person, throughout the history of the program?*

Response:

Health Canada did not collect and does not have this information.

35. *The reasons put forward by the government of Canada for the change to the MMPR from the MMAR involves a policy to try and treat cannabis (marihuana) like any other "prescribed drug" (the Oxycontin model) and because it is asserted that home production is "inherently dangerous" due to alleged problems with "toxic mold, fire and electrical safety, and public safety" and for no other reasons, is that correct?*

Response:

It is correct that the government had as a central policy objective to treat cannabis like other prescribed drugs containing narcotics as much as possible. It is equally correct that the reduction of public health, safety, and security risks associated with growing marijuana in homes was an important objective of the reform. However, it is incorrect to state that these were the only reasons for the development of the MMPR. The answer to question 36, below outlines the numerous policy objectives that led the Government to undertake this regulatory initiative.

36. *Are there any other reasons asserted and if so, what are they in detail and what is the basis for them?*

Response:

The MMPR represent a comprehensive response to a number of concerns raised over the years and during consultations leading up to the MMPR. . The applicable Regulatory Impact Analysis Statement ("RIAS"), which is #5 on the Defendant's List of Documents, sets out in detail the manner in which the MMPR address a spectrum of issues through the systemic changes set out therein.

The objectives of the MMPR as a whole include:

- Protecting individual and public health, safety and security;
- Treating dried marijuana for medical purposes as much as possible like other narcotics that are used for medical purposes;
- Returning Health Canada to its traditional role as a regulator, rather than as a producer and service provider.

  In its role as regulator under the MMPR, Health Canada is responsible for regulating quality/sanitation standards for the production, packaging and shipping of a product that is intended to be used by ill and immune-compromised patients, creating and implementing an inspection regime for licensed producers that includes the ability to require recalls where products do not meet the applicable standards.

- Eliminating the need for individuals to apply to Health Canada for their authorization to possess marijuana for medical purposes.
- Eliminating costs to government and taxpayers associated with the continued production and distribution of dried marijuana and seeds as well as the administration of a constantly growing program; and
- Increasing the choices of dried marijuana available to individual consumers through the offerings of a variety of strains by a number of different licensed producers.
- Ensuring that persons who require marijuana for medical purposes have increased access to quality controlled marijuana and a more secure product for medical use

37. *Please provide details, including statistics, of the basis for each alleged problem asserted, or found to be occurring at a Health Canada approved MMAR production site during the history of the program?*

Response:

As is mentioned in response to question 61, below, Health Canada conducted a number of inspections of MMAR authorized cultivation sites in May and June of 2010. Document #47 in the Defendant's List of

Documents describes some of the problems that were encountered by inspectors during these inspections.

In addition, information provided to Health Canada by law enforcement identified concerns with diversion and targeting of marijuana home cultivation operations for theft of marijuana in cases that involved authorized users and producers under the MMAR (i.e. grow rips) as well as concerns relating to faulty electrical set ups, fire and mould (see, for example, An Analysis of National Cases Related to the Marihuana Medical Access Regulations, Prepared on behalf of the CACP by the RCMP, November 2010, which is #46 on the Defendant's List of Documents).

Health Canada also received many complaints from municipal representatives, municipal zoning coordinators, MPs, lawyers, city administrators and local fire chiefs across the country expressing concern with MMAR-licenced production sites.

For example, on 1 April, 2011, the City of Surrey Fire Chief wrote to Health Canada and indicated that violations of municipal regulations were found at all 15 MMAR-licensed production sites that the City had inspected, as well as additional violations of the provincial electrical code, building code and fire code. The Fire Chief also expressed concern regarding home remediation for unsuspecting buyers of previous medical grow residences and potential threats to their health and safety. A copy of this letter is attached and marked as Annex 3.

*Similarly, on March 2, 2012, the Mayor of the City of Calgary sent Health Canada a letter in which he indicated:

"The City of Calgary is facing a challenge regarding the safety of [MMAR cultivation] operations in our city. On January 18, 2012 and again on February 15, 2012, The City of Calgary's Safety Codes Officers used search warrants to enter two Health Canada licensed medical grow operations. The officers discovered multiple safety code infractions in both houses, including: building and electrical code infractions, compromised air intake, toxins, pesticides, herbicides, fertilizer and potential contamination of drinking water. In the second house, the safety codes offers also discovered that the electrical and water maters had been bypassed.

In each of these cases, Alberta Health Services (AHS) public health officials also inspected the home and issued an Executive Officer's Order

declaring the premises unfit for human habitation until remediated to the satisfaction of the AHS."

A copy of the letter from the Mayor of Calgary dated March 2, 2012 is attached and marked as Annex 4.

On July 9, 2014, the Mayor of Calgary again wrote to Health Canada and indicated that "[s]ince 2012, The City of Calgary's Coordinated Safety Response Team (CSRT) has inspected 28 federally licensed residential grow operations. In all cases the owners' operation was closed due to identified safety risks and violations."

A copy of this letter is attached and marked as Annex 5.

38. *In the case of each problem found in an approved Health Canada production site please advise whether or not the production site was in compliance with local government bylaws and had been subject to inspection by them or not?*

Response:

Health Canada is unable to answer this question as compliance with local government bylaws falls outside the scope of Health Canada's mandate and jurisdiction.

However, for some examples of instances of which Health Canada is aware in which local officials have found MMAR authorized grow operations to have contravened local and provincial laws, see the answer to question 37, above.

40. *Exactly how many complaints regarding smell from licensed MMAR producers did HC receive for the period 2001 - 2013? For each such complaint, provide: a) the date of the complaint; b) the geographic location of the complaint; c) a description of the complaint; d) a description of all steps HC took to ameliorate the issue resulting in the complaint.*

Response:

In August 2011, the Marihuana Medical Access Program (MMAP) made improvements to its correspondence tracking and management system so as to track more robust information about correspondence received by the Program. As a result, it is not possible to provide a robust estimate on the number of complaints regarding odours received by the Program between 2001 and August 2011.

Between August 2011 and 2013 Health Canada received approximately 177 written complaints regarding smell (odour, indoor/outdoor air quality) resulting from licensed MMAR producers. The date, province and description of each of these 177 complaints are set out in the attached spreadsheet, which is attached as Annex 6.

Health Canada provided correspondents with a written response addressing their individual concerns. The standard responses pertaining to smell informed the correspondents of several points including: (1) all licence holders had been asked by Health Canada to be discreet in their production under MMAR; (2) Health Canada only had the power to inspect for compliance within the CDSA and its associated regulations; and (3) local by-law enforcement officials should be contacted regarding this issue.

41. *Exactly how many incidents of diversion from MMAR license holders to the black market were proven in court (resulting in a verdict of guilty for trafficking, possession for the purpose of trafficking or production) during the period 2001 through 2013. For each such incident, provide a) the date of the conviction or plea; and b) the court location, level and file number.*

Response:

The Public Prosecution Service of Canada ("PPSC") has advised that this information is not currently available due to limitations in the nature of the records maintained by the various regional PPSC offices.

Health Canada understands that PPSC's electronic databases do contain information concerning persons convicted of trafficking, possession for the purpose of trafficking or producing marijuana contrary to the provisions of the CDSA during the years sought, including:(a) the date of the conviction

or plea; and (b) the court location, level and file number. However, PPSC does not collect information indicating whether or not the persons convicted are MMAR license holders or whether the offence(s) were committed or connected to an activity carried out by an MMAR license holder.

Health Canada further understands that a manual review of all PPSC files containing convictions for those offences is impracticable and would not necessarily yield information about the existence of MMAR licenses needed to answer the question.

The RCMP is currently attempting to search various databases to which it has access in an effort to answer this question. If the RCMP is able to answer this question, the Defendant undertakes to provide it to the Plaintiffs. If the RCMP is not able to do so, the Defendant undertakes to provide an explanation as to why.

42. *Exactly how many incidents of fire in MMAR licensed production facilities were reported during the period of 2001 - 2013 and exactly how many of those incidents were conclusively linked to the marijuana production itself? For each such incident, provide a) the date of the incident; b) the location of the incident; c) a description of the incident.*

Response:

Health Canada does not keep records of these incidents.

43. *Exactly how many incidents of "grow rips" from licensed MMAR facilities were reported in the period 2001 - 2013? For each such incident, provide a) the date of the incident; b) the location of the incident; c) a description of the incident?*

Response:

Health Canada does not keep records of these incidents.

44. *Exactly how many incidents of 'problems with toxic chemicals' and specific problems experienced by children, or either, from licensed MMAR facilities were reported in the period 2001 -2013? For each such incident, if any, provide a) the date of the incident; b) the location of the incident; c) a description of the incident?*

Response:

Health Canada does not keep records of these incidents.

45. *When Health Canada received numerous complaints about the smell of cannabis (marihuana) from various legal producers it did nothing about them and did not even notify the Licensees of the problem taking the position that it was not within their jurisdiction to regulate smell – isn't that correct?*

Response:

As noted in the answer to question 40 above, Health Canada provided correspondents with a written response addressing their individual concerns.

The standard responses pertaining to smell informed the correspondents of several points including that: (1) all licence holders had been asked by Health Canada to be discreet in their production under the MMAR; (2) Health Canada only had the power to inspect for compliance within the CDSA and its associated regulations; and (3) local by-law enforcement officials should be contacted regarding this issue.

48. *What is the source of the average daily amount authorized for possession as at December 12, 2013 as being 17.7 grams of dried marihuana day as indicated in paragraph 45 of the Statement of Defense and how was this figure arrived at or calculated?*

Response:

Health Canada maintains a data processing system to process information, including applications, Authorizations to Possess ("ATP") and licenses to produce issued under the MMAR.

Average daily amounts are calculated based on information retrieved from the database at a given point in time. In order to calculate an average daily amount for all individuals with ATPs at a given moment in time, a list of all daily amounts for every individual with an ATP is extracted from the database; these daily amounts are added together and divided by the number of individuals at issue. This procedure was followed to arrive at the 17.7g per day figure by extracting the requisite information from the database on December 12, 2013.

49. *In paragraph 46 of the Statement of Defense it is asserted that 1 gm of marihuana produces between 3 and 5 marihuana cigarettes (joints) – what is the source of this assertion, and what is the size of the cigarettes (joints) given the various different sizes of cigarette rolling papers available in the market?*

Response:

Health Canada recognizes that individual marijuana cigarettes (joints) can vary significantly in size. The assertion that 1 gram of marijuana can produce between 3 and 5 joints came from P.M. Brauti and B.G. Puddington, Prosecuting and Defending Drug Offences (Aurora: Canada Law Book, 2003) at p. 373.

In Kilmer, B., & Pacula, R. (2009). *Estimating the size of the global drug market: A demand-side approach*. TR-711-EC. Santa Monica, CA: RAND Corporation. Retrieved August 8, 2014, from http://www.rand.org/pubs/technical_reports/TR711.html the authors found (at pp. 12-13) that a number of studies reported that each joint contained from 0.3 to 0.5 grams of dried marijuana (which would result in 2-3 joints per gram).

Health Canada has also in the past used a model where 1 gram of dried marijuana can convert to 1-2 joints.

52. *How do you determine that individuals who purchased their dried marihuana from Health Canada have on average purchased between 1-3 grams per day and please provide the basis for the determination?*

Response:

To clarify: Health Canada estimates that the average amount of marijuana that was purchased from its supplier was1.2 grams per day. The 1-3 grams per day figure referred to in the question refers to the scientific evidence set out in the Information for Health Care Professionals (see Defendant's document #172) document, which indicates that the majority of people using smoked or orally ingested marijuana for medical purposes use approximately this amount each day.

For the purposes of calculating the average amount of dried marijuana purchased from Health Canada's supplier (Prairie Plant Systems), Health Canada examined the orders of all individuals who placed repeat orders for marijuana with Health Canada between January of 2012 and July of 2013. This totaled 1,694 individuals.

Calculating the average daily amount that was purchased required looking at the size of the orders that were placed and their frequency. So, for example, an individual who ordered 30 grams of dried marijuana every month would be estimated to consume at the same rate as an individual who ordered 60 grams every two months. Health Canada excluded from its calculation the orders of individuals who placed a single order and never re-ordered, because without two or more orders over a given period of time, the average rate of consumption could not be estimated.

53. *Health Canada is not able to determine whether a particular patient that is authorized to possess a certain amount either consumes all or only a portion of that amount are they?*

Response:

Correct.

57. *Did you do any investigation into the other countries or States to determine how they were regulating the use and production of medical marihuana and whether or not they were having any similar problems and if so, how they addressed them.*

Response:

Health Canada did review the approaches of other countries and states to determine how they were regulating the use and production of marijuana for medical purposes (see #24 on the Defendant's List of Documents).

60. *Why didn't or hasn't Health Canada sought to work out an arrangement with local government officials who regularly inspect premises for various reasons and who do not require permission or a warrant to do so?*

Response:

Health Canada did indeed consider the possibility of such an arrangement as a general solution to the public health and safety problems associated with the cultivation of marijuana in private dwelling places in residential areas. These approaches were not pursued primarily out of a concern that they would be ineffective, particularly given the possibility that they might be subject to legal challenges.

On various occasions, Health Canada was asked by municipal officials concerned about the dangers posed by marijuana cultivation by MMAR licensees in their communities to identify locations where MMAR grow operations had been authorized. However, Health Canada advised that it was unable to provide municipalities with information about licensed production sites, including their location, as a result of the operation of the *Privacy Act* and the MMAR.

61. *Please provide whatever documentation exists with respect to the number of inspections carried out over the course of the program and provide details of any problems or other issues that arose during the course of such inspections.*

Response:

Health Canada conducted a number of inspections of MMAR participants in May and June of 2010. Document #47 in the Defendant's List of Documents describes these inspections in detail.

70. *The basis for the MMPR precluding any production of outdoor whatsoever is set out in paragraph 88 of the Defence as intended to decrease the risk of diversion and prevent cross contamination of nearby crops, particularly industrial hemp –*

(b) *Doesn't industrial hemp look very similar to cannabis (marihuana)?*

Response:

Yes, it does.

(c) *Have there been any documented incidents of persons stealing industrial hemp thinking it was cannabis (marihuana) and/or trying to sell such hemp as marihuana into the market?;*

Response:

Health Canada is not aware of any such incidents.

(d) Is the risk of cross contamination limited to 'nearby crops' only and if so what is the required distance between crops to prevent contamination?

Response:

This falls outside the expertise of Health Canada.

(e) What other 'crops' are at risk if any?

Response:

This answer to this question falls outside of Health Canada's expertise.

(f) What procedures, practices or devices or other requirements exist in the agricultural industry to prevent such cross contamination between crops that are currently produced outdoors in Canada and why can't they be applied to the production of marihuana?

Response:

This answer to this question falls outside of Health Canada's expertise.

(g) What steps have been or were considered to mitigate any concerns that form the basis for this prohibition against outdoor production?

Response:

Health Canada did not consider steps to mitigate the concerns regarding diversion and cross contamination stemming from outdoor production in light of the fact that during the consultations that preceded the promulgation of the MMPR, very few potential licensed producers anticipated that they would wish to grow outdoors. This is because marijuana grown outdoors is generally of lower quality when compared to that grown indoors due to exposure to the elements such as temperature, air quality, bugs/pests, etc. Outdoor production also produces a higher likelihood of batch inconsistency, as quality is highly dependent on environmental factors that licensed producers would have little to no control over such as the amount/intensity of light, the amount of water and nutrients, temperature, bugs and pests.

By contrast, indoor cultivation of marijuana was chosen for use in the MMPR because it provides consistent access to a year round supply of marijuana for patients, consistent product quality, and would not be openly visible to members of the public and would be easier to physically secure than an outdoor cultivation site.

71. *The evidence as of March 21, 2014 indicated that the government mounted a publicity campaign to encourage applications for potential LPs and that as of February 4, 2014. Health Canada had received 454 LP applications, 8 of which had been issued, 10 had been withdrawn, 24 refused and the rest in various stages of review or screening and with an indication that some 25 new applications were being received each week - what has happened since to all of these applications?*

Response:

As of July 28, 2014, 21 applicants had obtained licenses from Health Canada under the MMPR.

Since March 21, 2014, the number of applications received has continued to increase steadily with 955 applications having been received as of July 28, 2014. These applications are now at various stages of the process, with some having been either been withdrawn or refused.

72. *How many applications for LP status have been received by HC? Of these, identify: a) how many have been approved; b) how many have been refused; c) how many have resulted in Health Canada issuing a "ready to build" letter to the applicant; d) how many of those applicants have successfully completed the build out and received an LP license?*

Response:

As indicated above in response to Question 71, as of July 28, 2014, Health Canada had received 955 license applications, of which 21 have been granted and 183 have been refused.

The "ready to build" letter is not a mandatory step in the application process and applicants with such a letter are not guaranteed a license. Ready to build letters are requested occasionally by applicants under both the *Narcotics Control Regulations* and the *Marihuana for Medical Purposes Regulations* for project management purposes. The letter attests that the physical security requirements, as presented in an applicant's proposal, would meet Health Canada's requirements as of the date of the issuance of the letter. That said, a total of 34 applicants have obtained a ready to build letter. 13 of these 34 became licensed producers.

73. *How many of the existing LPs are actually selling dried marihuana to clients and what is the total production output of saleable dried marihuana for each LP to date? Please provide the answer by individual LP.*

Response:

Although there are presently 21 licensed producers, only 13 of these are licensed to sell to clients. Of these 13, 8 had actually made sales to clients by June 30, 2014. These 8 licensed producers had collectively sold a total of 537 kg by that date.

As of June 30, 2014, licensed producers that produced domestically (i.e. as opposed to importation) had 1134 kg of dried marijuana in inventory, out of the 1795 kg that they had collectively produced to date. This total is divided among 10 licensed producers as follows:

LPs with Dried Marihuana Production (kg) as of June 30, 2014	Total Dried Marihuana Production (kg) as of June 30, 2014	Had sales as of June 30, 2014	Notes
LP #1	24	No.	Has produced dried marijuana but did not yet have registered clients
LP #2	24	Yes	
LP #3	36	No	Has produced dried marijuana but had license to sell suspended due to issues with good production practices
LP #4	43	Yes	
LP #5	50	No	Was required to conduct a recall and had license to sell suspended due to issues with good production practices
LP #6	72	Yes	
LP #7	163	Yes	
LP #8	175	Yes	
LP #9	266	Yes	
LP #10	942	Yes	
Total	**1,795**		

In addition, an 11th licensed producer has not produced any marijuana domestically, but had imported 116kg of dried marijuana as of June 30, 2014. The total amount of dried marijuana that had been imported and

produced domestically by all licensed producers by June 30, 2014 was 1,910kg.

74. *How many MMAR licensed producers have provided Health Canada with reports of destruction of medicine subsequent to March 31, 2014 and how much dried marihuana was reported destroyed?*

Response:

As of March 31, 2014, Health Canada had received 439 attestations of destruction. The total amount of dried marijuana reported destroyed was 77,252 grams, and the total number of plants reported destroyed was 6,417.

75. *Please provide details of any problems encountered by LPs in the transition period, including in particular any testing of product that has not met the required standards for production or consumption resulting in a recall or any other problems?*

Response:

A significant problem encountered by licensed producers during the transition period was the fact that many of the plants and dried marijuana that they purchased from individuals licensed to cultivate marijuana under the MMAR were found to contain various contaminants including mould, heavy metals and pesticides.

As a result, as of April 30, 2014, licensed producers had to destroy a total of 766 kg of marijuana acquired from MMAR producers prior to March 31, 2014. During the transition period (i.e. until April 1 2014), one recall was requested by Health Canada as a result of issues with a licensed producer's production practices. These included an inability to provide evidence that the dried marijuana produced was not treated by pesticides as required by the MMPR. This recall was published on Health Canada's website on April 18, 2014.

76. *Is it true that only some 6,200 patients of registered with LPs to date and if not, what is the correct number of registrants?*

Response:

No. As of June 30, 2014, 7,918 individuals had registered with licensed producers.

77. *Can you verify that the following information with respect to the current 13 LPs approved to date is accurate and correct?*

(1.)That On July 7, 2014 the website of the LP known as Bedrocan Canada Ltd. at www.bedrocan.ca indicated:

A. *Bedrocan is currently registering new clients.*

B. *Bedrocan currently has five strains of cannabis available for sale.*

C. *The price for all five strains is $7.50 per gram with free shipping on the first order placed each month. Bedrocan does not state shipping prices for subsequent orders.*

D. *Bedrocan does not appear to offer any discount for low income or disabled individuals.*

(2.)On July 7, 2014 the website of the LP known as Canna Farms Ltd. at www.cannafarms.ca indicated that:

A. *Canna Farms is currently registering new clients.*

B. *Canna Farms currently has two strains of cannabis for sale.*

C. *The price for Canna Farms' strains vary from $7.50 to $8.00 per gram. Canna Farms does not indicate whether shipping is included in these prices.*

D. *Canna Farms does not appear to offer any discount for low income or disabled individuals.*

(3.)On July 7, 2014 the website of the LP known as CanniMed Ltd. at www.cannimed.ca indicated that:

A. *CanniMed is currently registering new clients.*

B. *CanniMed currently has five strains of cannabis available for sale.*

C. *One strain (CanniMed 12.0) is $4.88 per gram, whereas the other four strains vary from $7.15 to $8.78 per gram. These prices are discounted 35% off the regular price with the requirement that purchases are made online. Regular prices for purchases not made online are $7.50 per gram and $11.00 to $13.50 per gram respectively. Shipping for all orders is an additional $13.50 for a shipping time of up to four days and $25.00 for a shipping time of up to three days.*

D. *CanniMed does not appear to offer any discount for low income or disabled individuals.*

(4.)On July 7, 2014 the website of the LP known as Delta 9 Bio-Tech Inc. at www.delta9.ca and information from a representative by phone at 855-245-1259 indicated that:

A. *Delta 9 is not currently registering new clients.*

B. Delta 9 currently has approximately twenty strains of cannabis available for sale to registered clients.

C. The price for Delta 9's strains vary from $5.00 to $9.00 per gram. A discount of $1.00 per gram is applied to orders of at least 30 total grams. Delta 9 does not indicate whether shipping is included in these prices.

D. Delta 9 offers a discount of 50% to qualified low income or disabled clients. Delta 9 does not specify what constitutes low income status or a disability, but rather has a committee that evaluates each client's request for a discount and grants the discount based on the company's capacity to afford the subsidy at the time. For those individuals who qualify, it appears Delta 9's strains would cost $2.50 to $4.50 per gram.

(5.)On July 7, 2014 the website of the LP known as In The Zone Produce Ltd. at www.inthezoneproduce.com and it indicated that:

A. In The Zone is not currently registering new clients.

B. In The Zone appears to have no strains of cannabis currently available for sale.

C. The price for In The Zone's strains is projected to be $5.00 to $8.00 per gram. In The Zone does not indicate whether shipping is included in these prices.

D. In The Zone does not appear to offer any discount for low income or disabled individuals.

(6.)On July 7, 2014 the website of the LP known as Mettrum Ltd. at www.mettrum.com indicated that:

A. *Mettrum is currently registering new clients.*

B. *Mettrum currently has four strains of cannabis available for sale.*

C. *The price for all four strains is $7.60 per gram. Mettrum does not indicate whether shipping is included in these prices.*

D. *Mettrum offers a 30% discount on the first 30 total grams ordered each month to clients on provincial or federal income assistance or who have a total pre-tax annual income of less than $30,000.00. For those individuals, it appears the first 30 grams of Mettrum's strains ordered each month would cost $6.08 per gram.*

(7.)On July 7, 2014 the website of the LP known as MedReleaf Corp. at www.medreleaf.com indicated that:

A. *MedReleaf is currently registering new clients.*

B. *MedReleaf currently has no strains of cannabis available for sale.*

C. *The price for MedReleaf's strains is projected to be $7.60 per gram with free shipping on first order placed each month. MedReleaf does not state shipping prices for subsequent orders.*

D. *MedReleaf anticipates offering a discount to low income clients, but details of the program are not yet specified.*

(8.)On July 7, 2014 the website of the LP known as OrganiGram Inc. at www.organigram.ca indicated that:

A. *It is unclear whether OrganiGram is currently registering new clients due to an inability to reach a customer service representative.*

B. *OrganiGram currently has no strains of cannabis available for sale.*

C. *The price for OrganiGram's strains is projected to be $6.00 to $9.00 per gram including free shipping.*

D. *OrganiGram offers a 25% discount to clients on social assistance or government disability programs. For those individuals, it appears OrganiGram's strains would cost $4.80 to $7.20 per gram.*

(9.)On July 7, 2014 the website of the LP known as The Peace Naturals Project Inc. at www.peacenaturals.com indicated that:

A. *Peace Naturals is not currently registering new clients.*

B. *Peace Naturals currently has no strains of cannabis available for sale.*

C. *The price for Peace Natural's strains vary from $6.00 to $9.50 per gram. Peace Naturals also offers two "milled varieties" which are a coarsely ground mixture of several different strains for $4.50 per gram. Peace Naturals does not indicate whether shipping is included in these prices.*

D. *Peace Naturals does not appear to offer any discount for low income or disabled individuals.*

(10.) On July 7, 2014 the website of the LP known as Thunderbird Biomedical Inc. at www.thunderbirdbiomedical.com indicated that:

A. *Thunderbird Biomedical is not currently registering new clients.*

B. *Thunderbird Biomedical currently has no strains of cannabis available for sale.*

C. *There is no information of the projected price of Thunderbird Biomedical's strains. There is no information as to whether shipping will be included in Thunderbird Biomedical's prices.*

D. *There is no information as to whether Thunderbird Biomedical will offer any discount for low income or disabled individuals.*

(11.) On July 7, 2014 the website of the LP known as Tilray at www.tilray.ca indicated that:

A. *Tilray is currently registering new clients.*

B. Tilray currently has ten strains of cannabis available for sale.

C. The price for Tilray's strains vary from $8.00 to $12.00 per gram. Tilray currently charges a flat rate of $5.00 for shipping.

D. Tilray does not appear to offer any discount for low income or disabled individuals.

(12.) On July 7, 2014 the website of the LP known as Tweed Inc. at www.tweed.com indicated that:

A. Tweed is not currently registering new clients.

B. Tweed currently has one strain of cannabis available for sale.

C. The price for Tweed's one available strain is $7.00 per gram including free shipping.

D. Tweed offers a discount of 20% to clients who have a total pre-tax annual income of less than $29,000.00. For those individuals, it appears the one available strain would cost $5.60 per gram.

(13.) On July 7, 2014 the website of the LP known as Whistler Medical Marijuana Corp. at www.whistlermedicalmarijuana.com and it indicated that:

E. Whistler Medical Marijuana is not currently registering new clients.

F. Whistler Medical Marijuana currently has four strains of cannabis available for sale to registered clients.

G. The price for Whistler Medical Marijuana's strains is $10.00 per gram including free shipping.

H. Whistler Medical Marijuana does not appear to offer any discount for low income or disabled individuals.

Response:

Health Canada does not keep records of Licensed Producer websites. As such, it cannot confirm the accuracy of all of the information set out in this question.

Health Canada can confirm that on July 7, 2014, the following thirteen companies were licensed to sell marijuana under the MMPR:

1. Bedrocan Canada Inc.
2. CanniMed Ltd.
3. Delta 9 Bio-Tech Inc.
4. In The Zone Produce Ltd.
5. Mettrum Ltd.
6. MedReleaf Corp.
7. OrganiGram Inc.
8. The Peace Naturals Project Inc
9. ThunderBird Biomedical Inc.
10. Tilray
11. Tweed Inc.
12. Whistler Medical Marijuana Corp.
13. Canna Farms

84. *During the consultations leading up to the MMPR, isn't it true that HC received many comments from stakeholders to the effect that HC should permit the production and sale of cannabis resin and/or cannabis-based medicines? Please provide the total number of persons making similar comments.*

Response:

Health Canada held two formal public consultations periods and engaged in numerous face to face consultations with stakeholders, all of which informed the development of the MMPR.

In June 2011, the Minister announced the Government's intention to improve the Marihuana Medical Access Program, and announced a 45-day public consultation period. Health Canada welcomed written input from stakeholders and a letter was sent to all program participants inviting them to submit comments. Input was accepted until July 31 by email, fax, letter mail and through submissions of a web-based comment form. Approximately 2,214 written responses were received; there were insufficient responses regarding production and sale of cannabis derivatives to tabulate. See the following table, taken from the *Changes to Marihuana Medical Access Regulations: Summary of Stakeholder Input* of October 10, 2011, which provides a qualitative overview of stakeholder positions on key aspects of the proposed changes. Quantitative and detailed analysis can also be found in this report.

Table	N*	Elimination of qualifying categories / symptoms	Phase out of personal and designated production	Introduction of commercial market	Elimination of Health Canada authorization / Physician as gatekeeper	Elimination of ID cards
Users, growers and private citizens	*2,068*	*Neutral*	*Strongly opposed*	*Moderate opposition***	*Neutral****	*Moderate opposition*
Fire services	*25*	*Neutral*	*Strong support*	*Support*	*Neutral*	*Neutral*
Law enforcement	*27*	*Neutral*	*Strong support*	*Support with concerns*	*Support with concerns*	*Moderate opposition*
Municipalities	*17*	*Neutral*	*Strong support*	*Neutral*	*Neutral*	*Neutral*
Physicians	*11*	*Support with concerns*	*Neutral****	*Neutral*	*Support with concerns*	*Neutral*
Pharmacists	*5*	*Neutral*	*Neutral*	*Neutral*	*Neutral*	*Neutral*
Health associations	*16*	*Neutral*	*Mildly Opposed*	*Neutral*	*Support with Concerns*	*Neutral*
Civil associations	*35*	*Support*	*Mixed*	*Support*	*Support*	*Oppose*

** Submissions from each stakeholder group.*
*** Related to commercial market as only option. *** Concerns expressed about affordability of medication under new system. **** Seen as unworkable due to de facto physician opt-out from MMAR*

Between June and November 2011, Health Canada consulted with key stakeholders to get their views on the proposed changes to gain information and knowledge to inform the development of the regulations. Stakeholder groups included: authorized and licensed individuals under the MMAR, compassion clubs and cannabis dispensaries, physicians (including associations and colleges), municipalities, law enforcement officials, fire officials, pharmacists and Canadians with an interest in the program.

Overall, the proposal to create a regulated industry was well received, though some program participants asked Health Canada to allow them to maintain their personal and/or designated production license. Stakeholders were supportive of elements that would improve and simplify the application process as well as measures to increase outreach and information for physicians.

Following publication of the draft regulations in Part I of the *Canada Gazette* in December 2012, a 75-day consultation period was also held.

1663 comments were received during this period, 139 referred to products in general, and 73 referred specifically to oils, lotions, edibles, etc and indicated they preferred that HC make access to these products available.

85. *Isn't it true that, generally, the consultations leading up the MMPR resulted in stake holders representing law enforcement urging HC to implement high levels of restrictions/regulations whereas stakeholders representing patients urged HC to lessen the regulatory burdens?*

Response:

This question is unclear as there is no indication as to what is meant by "high levels of restrictions/regulations" and "lessen regulatory burdens". It is also unclear what is meant by stakeholders representing patients. However, to the extent that the question is about comments received regarding the level of regulatory burden, the following information can be provided.

As described above in question 84, Health Canada held two public consultation sessions and a number of face-to-face sessions, during which

it received a broad base of comments that were considered during the drafting of the MMPR.

Following the June 2011 consultation period, Health Canada received 2,214 comments. The summary table presented above in Question 84 demonstrates that program participants and private citizens expressed moderate opposition to the introduction of a commercial market. Fire services and law enforcement expressed support.

During the consultation period following the publication of the draft MMPR in *Canada Gazette*, Part I, 1,663 comments were received, the largest number or which came from current program participants and individual Canadians. Comments were also received from law enforcement, municipalities, fire officials, potential industry, individual Canadians, provincial/territorial governments, health care practitioners, pharmacists, and various associations and non-governmental organizations. These comments from program participants and individual Canadians as well as municipalities, law enforcement and fire officials can be summarized as follows.

Program participants and individual Canadians (1,434 Comments)

The highest response rate came from current program participants and individual Canadians. Overall, these two groups made up 86 percent of the total number of comments received. The tone of comments from these groups was mixed. Program participants and individuals were vocal about their concerns over the elimination of personal production and the impact that would have on an individual's ability to afford to purchase marijuana from commercial licensed producers. Some requested that Health Canada consider grandfathering current personal production licences to ensure that these individuals could continue to afford their treatment.

The greatest number of positive comments received was from individual Canadians. 47 comments were received in favour of the elimination of home production citing a number of concerns and risks associated with this aspect of the current Marihuana Medical Access Program. Many were neighbours of licensed sites and voiced concerns that they were subjected to a number of public health and safety risks as a result of living in proximity to these sites, for example, strong odours, risk of theft or vandalism, and Health Canada's inability to monitor or remedy these unintended consequences.

Municipalities, law enforcement and fire officials (54 Comments)
Comments were received from municipalities, law enforcement agencies and fire officials from across Canada, including associations such as the Federation of Canadian Municipalities, the Canadian Association of the Chiefs of Police and the Canadian Association of Fire Chiefs. These groups were very supportive of the overall framework, viewing the elimination of personal production as a means to significantly reduce public health, safety and security risks in their communities. In the absence of pharmacy distribution (their preferred method of distribution), the move to commercial licensed production was well-received. These groups raised the issue that applicants are not required by regulation to demonstrate to Health Canada that they comply with local zoning, fire, health, building and other bylaw and safety regulations prior to getting a licence. Furthermore they wanted to be notified when a licence is granted, modified, revoked or suspended.

Fire officials and municipalities highlighted that the MMPR failed to address the remediation of buildings that were damaged as a result of personal production use under the MMAR.

86. *Isn't it true that, generally, the consultations leading up the MMPR resulted in stakeholders representing compassion clubs (medical cannabis dispensaries) urging HC to lessen the regulatory burdens?*

Response:

This question is unclear as there is no indication as to what is meant by "lessen regulatory burdens".

Following the June 2011 announcement that Health Canada was considering improvements to the Marihuana Medical Access Program, Health Canada conducted listening sessions with a variety of stakeholders, including compassion clubs

Overall, participants from compassion clubs were supportive of Health Canada's recommendation to create a regulated industry. Many participants in these consultation sessions indicated a desire to become a regulated license producer under the eventual MMPR. They were also supportive of elements of the proposal that would reduce administrative burdens on participants (i.e. no more categories of conditions, no need to apply to Health Canada for authorizations to possess marijuana for medical purposes). Finally, there was much support for the creation of an

Expert Advisory Committee and for other measures that Health Canada could undertake to increase outreach and education for physicians.

However, specific concerns raised by compassion clubs related to the lack of a role for medical dispensaries in Health Canada's proposed model, the elimination of personal production, and the potential for higher priced marijuana as a result of the changes.

During the comment period for the draft regulations that were published in Part 1 of the Canada Gazette that ended on February 28, 2013, comments from "compassion clubs" and "dispensaries" were mixed. While many opposed the end of personal production, some did not oppose a licensed and regulated market..

87. *Isn't it true that, generally, the consultations leading up the MMPR resulted in stakeholders representing persons or entities interested in entering the LP industry urging HC to lessen the regulatory burdens imposed by the MMPR?*

Response:

No, this does not appear to be an accurate characterization of the overall tenor of the input received from prospective licensed producers. While some expressed concerns with certain regulatory requirements (e.g. mail only delivery and lack of storefronts), many prospective licensed producers indicated a desire for stricter requirements in the areas of quality assurance and security.

For example, Prairie Plant Systems Inc. argued that in order to ensure that products are safe for clients, stricter "Good Manufacturing Practices" ("GMP") should be required instead of "Good Production Practices". With regard to security, Prairie Plant Systems advocated in favour of stricter requirements including that: (1) all staff (not just the applicant and officers of a corporation) employed by a licensed producer should be required to obtain security clearance; and (2) there be a requirement that licensed producers' security systems be monitored by an accredited company and security guard to process security checks for employees.

Bedrocan B.V. (a producer of marijuana for medical purposes in the Netherlands) did argue in favour of allowing flexibility for a licensed producer to determine whether an odour or pollen filter is required and where. However, it also argued that the following additional regulatory

requirements be placed on licensed producers: (1) microbiological and chemical content should be required to be within generally accepted tolerance limits for pharmaceutical products used in the respiratory tract; (2) the percentage of cannabinol (CBN) should be specified on labels; (3) the sale of cannabis that is less than 2 months to expiry should be prohibited; (4) stability testing and expiry date on products should be mandated within 18 to 24 months after the regulations come into force; (5) a pharmacist should have to be on staff; and (6) products should have to be standardized.

The Canadian Association of Medical Cannabis Dispensaries did request to include (1) authority for licensed producers to sell (non-dried) cannabis-based products; (2) make provision for provinces and territories to regulate storefronts; and (3) allow any patient (not just the homeless) to designate a mailing address for receiving dry marijuana shipments.

Annex 1

As of July 31, 2014

Outstanding Balance	
Customer #	**Total**
1	37764.24
2	12401.24
3	10517.28
4	10355.50
5	9632.51
6	9600.92
7	9574.83
8	9508.04
9	9354.02
10	9170.82
11	9062.61
12	9036.65
13	8901.58
14	8664.53
15	8272.53
16	8144.36
17	8092.38
18	7993.00
19	7948.86
20	7940.79
21	7916.25
22	7777.02
23	7634.05
24	7573.94
25	7454.79
26	7249.83
27	7247.69
28	7134.45
29	7121.10
30	7096.85
31	7079.96
32	7061.12
33	6936.52
34	6790.04
35	6788.30
36	6783.31
37	6574.69
38	6483.16
39	6389.63
40	6365.43
41	6302.00
42	6045.93
43	6040.85

44	5985.34
45	5980.11
46	5891.45
47	5603.97
48	5551.20
49	5314.02
50	5292.52
51	5209.20
52	5204.80
53	5200.04
54	5183.25
55	5167.19
56	5143.20
57	5132.95
58	5124.71
59	5109.04
60	5010.50
61	5002.03
62	4989.21
63	4920.36
64	4868.71
65	4826.05
66	4804.71
67	4798.63
68	4786.42
69	4777.02
70	4763.19
71	4740.40
72	4727.67
73	4714.88
74	4711.24
75	4648.08
76	4636.87
77	4587.27
78	4560.30
79	4535.90
80	4478.25
81	4472.45
82	4458.84
83	4450.54
84	4418.30
85	4402.51
86	4359.84
87	4321.69
88	4314.29
89	4250.89
90	4165.74

91	4116.85
92	4079.68
93	4045.49
94	4040.83
95	4039.60
96	4038.09
97	4031.54
98	4026.25
99	4023.93
100	4018.64
101	3992.70
102	3989.96
103	3989.96
104	3959.40
105	3912.86
106	3912.19
107	3896.33
108	3874.41
109	3846.18
110	3838.79
111	3838.04
112	3837.38
113	3811.06
114	3769.34
115	3715.49
116	3696.32
117	3692.22
118	3669.56
119	3606.28
120	3589.50
121	3587.63
122	3568.61
123	3557.64
124	3497.40
125	3489.46
126	3486.47
127	3475.18
128	3459.89
129	3444.82
130	3439.20
131	3433.38
132	3428.18
133	3427.16
134	3415.32
135	3378.92
136	3363.78
137	3302.04

138	3283.84
139	3280.76
140	3280.59
141	3184.84
142	3162.98
143	3132.12
144	3124.44
145	3123.22
146	3109.73
147	3105.23
148	3095.96
149	3092.77
150	3061.48
151	3057.88
152	3057.42
153	3044.40
154	3029.36
155	3019.48
156	3003.62
157	2983.69
158	2973.21
159	2945.22
160	2922.56
161	2917.57
162	2917.32
163	2914.05
164	2906.55
165	2872.41
166	2866.23
167	2771.53
168	2762.90
169	2751.40
170	2750.92
171	2721.08
172	2692.68
173	2689.12
174	2678.36
175	2638.70
176	2609.34
177	2581.09
178	2577.42
179	2571.38
180	2557.84
181	2552.24
182	2551.47
183	2540.41
184	2535.67

185	2526.83
186	2517.34
187	2495.32
188	2480.70
189	2479.84
190	2462.16
191	2459.72
192	2452.87
193	2432.39
194	2430.35
195	2422.98
196	2418.03
197	2408.05
198	2402.11
199	2401.92
200	2401.76
201	2399.19
202	2392.47
203	2384.63
204	2380.19
205	2367.81
206	2355.25
207	2347.44
208	2331.11
209	2328.04
210	2321.24
211	2319.57
212	2318.20
213	2305.37
214	2304.42
215	2298.26
216	2295.50
217	2280.10
218	2276.55
219	2243.14
220	2241.05
221	2224.09
222	2216.40
223	2204.93
224	2193.61
225	2172.05
226	2169.70
227	2165.37
228	2147.65
229	2144.56
230	2135.79
231	2126.10

232	2115.97
233	2107.68
234	2106.11
235	2105.14
236	2104.97
237	2099.31
238	2096.50
239	2093.84
240	2087.32
241	2084.71
242	2082.10
243	2043.63
244	2034.95
245	2027.32
246	2010.30
247	2007.73
248	2001.88
249	1988.66
250	1983.31
251	1971.29
252	1957.93
253	1945.34
254	1943.19
255	1931.40
256	1928.63
257	1923.64
258	1914.83
259	1908.07
260	1864.64
261	1859.31
262	1853.89
263	1853.05
264	1850.50
265	1848.36
266	1836.96
267	1833.49
268	1823.03
269	1817.67
270	1813.09
271	1806.55
272	1801.40
273	1786.77
274	1786.62
275	1777.04
276	1768.74
277	1764.91
278	1764.71

279	1764.29
280	1753.23
281	1748.07
282	1737.05
283	1729.21
284	1728.09
285	1720.79
286	1720.15
287	1717.25
288	1713.23
289	1704.22
290	1699.87
291	1691.34
292	1690.57
293	1677.13
294	1676.39
295	1672.14
296	1641.33
297	1639.57
298	1638.84
299	1634.56
300	1633.63
301	1628.31
302	1568.70
303	1553.01
304	1540.99
305	1528.30
306	1507.37
307	1498.75
308	1490.83
309	1471.50
310	1443.70
311	1440.56
312	1437.01
313	1423.47
314	1421.92
315	1418.66
316	1417.70
317	1408.07
318	1408.07
319	1402.97
320	1400.50
321	1399.49
322	1399.30
323	1396.19
324	1387.74
325	1383.97

326	1373.22
327	1370.85
328	1346.47
329	1338.76
330	1330.30
331	1325.74
332	1312.09
333	1307.38
334	1304.73
335	1286.26
336	1284.90
337	1284.50
338	1275.22
339	1261.98
340	1252.84
341	1246.41
342	1237.41
343	1192.46
344	1188.24
345	1184.69
346	1181.21
347	1179.47
348	1172.37
349	1171.39
350	1171.00
351	1169.82
352	1168.95
353	1168.94
354	1168.94
355	1167.25
356	1166.23
357	1147.51
358	1145.08
359	1143.08
360	1137.21
361	1133.46
362	1125.24
363	1123.59
364	1119.69
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765	148.98
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782	112.42
783	112.42
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816	56.18
817	55.64
818	55.64
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820	53.14
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822	51.04
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831	29.85
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862	10.54
863	10.29
864	10.00
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866	7.00
867	6.58
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869	6.00
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871	5.54
872	5.07
873	4.38
874	4.27
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876	4.00
877	3.79
878	3.50
879	3.49
880	3.48
881	3.46
882	3.44
883	3.32
884	3.32
885	3.23
886	3.18
887	3.14
888	3.07
889	3.07

890	3.03
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895	2.00
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Annex 2