Court File No.

ONTARIO
SUPERIOR COURT OF JUSTICE
(DIVISIONAL COURT)

BETWEEN:

VINCENZINA DE SAO JOSÉ, personally and as litigation guardian for MAFALDA MAIONE, and SUSAN MILLS, personally and as litigation guardian for BARBARA MILLS

Applicants

\- and -

ONTARIO (CHIEF MEDICAL OFFICER OF HEALTH and MINISTER OF LONG-TERM CARE)

Respondents

APPLICATION UNDER Rules 14.05, 38, and 68 of the *Rules of Civil Procedure,* R.R.O. 1990, Reg. 194; sections 2(1) and 6(2) of the *Judicial Review Procedure Act*, R.S.O. 1990, c. J.1; and sections 7, 15 and 24(1) of the *Charter of Rights and Freedoms*.

NOTICE OF APPLICATION FOR JUDICIAL REVIEW

TO THE RESPONDENTS:

A LEGAL PROCEEDING HAS BEEN COMMENCED by the applicants. The claim made by the applicants appears on the following pages.

THIS APPLICATION will come on for a hearing on a date to be fixed by the Registrar before a Panel of the Divisional Court at the Court House at 130 Queen Street West, Toronto, Ontario.

IF YOU WISH TO OPPOSE THIS APPLICATION, to receive notice of any step in the application or to be served with any documents in the application, you or an Ontario lawyer acting for you must forthwith prepare a notice of appearance in Form 38A prescribed by the *Rules of Civil Procedure*, serve it on the applicants' lawyer or, where the applicant does not have a lawyer, serve it on the applicant, and file it, with proof of service, in this court office, and you or your lawyer must appear at the hearing.

IF YOU WISH TO PRESENT AFFIDAVIT OR OTHER DOCUMENTARY EVIDENCE TO THE COURT OR TO EXAMINE OR CROSS-EXAMINE WITNESSES ON THE APPLICATION, you or your lawyer must, in addition to serving your notice of appearance, serve a copy of the evidence on the applicants' lawyer or, where the applicant does not have a lawyer, serve it on the applicant, and file it, with proof of service, in this court office as soon as possible, but at least four days before the hearing.

IF YOU FAIL TO APPEAR AT THE HEARING, JUDGMENT MAY BE GIVEN TO IN YOUR ABSENCE AND WITHOUT FURTHER NOTICE TO YOU. IF YOU WISH TO DEFEND THIS PROCEEDING BUT ARE UNABLE TO PAY LEGAL FEES, LEGAL AID MAY BE AVAILABLE TO YOU BY CONTACTING A LOCAL LEGAL AID OFFICE.

Date: August 20, 2020 Issued by______________________

Local registrar

Address of Court Office: 130 Queen Street West
Toronto, ON
M5H 2N5

TO: The Honourable Merrilee Fullerton
Minister of Long-Term Care
Ministry of Health and Long-Term Care (Ontario)
400 University Avenue, 6th Floor
Toronto, ON M7A 1N3

AND TO: Dr. David Williams
Chief Medical Officer of Health
393 University Avenue, 21st Floor
Toronto, ON M5G 2M2

AND TO: Ministry of The Attorney General of Ontario
Constitutional Law Branch
720 Bay Street, 4th Floor
Toronto, ON M7A 2S9

APPLICATION

1. This is an Application for Judicial Review of a decision by the Respondent, represented by the Minister of Long-Term Care and/or the Chief Medical Officer of Health for the Province of Ontario, to issue Directive #3 and various revisions thereof (collectively, the "**Directive**") without expressly including Family Caregivers and Private Caregivers in the definition of "essential visitors", and/or without mandating their access to long-term care homes (the "**Decision**").

2. **The Applicants make application for:**

a) a Declaration pursuant to section 24(1) of the *Canadian Charter of Rights and Freedoms (the "**Charter**")* that the Directive violates the Applicants' rights to life, liberty, and security of the person, as protected by section 7 of the *Charter*, and that this violation is neither in accordance with the principles of fundamental justice, nor justified under section 1 of the *Charter*;

b) a Declaration pursuant to section 24(1) of the *Charter* that the Directive violates the Applicants' rights guaranteed by section 15 of the *Charter* to equality without discrimination based on age, or mental or physical disability, and is not justified under section 1 of the *Charter*;

c) a Declaration pursuant to section 24(1) of the *Charter* that the Decision is unreasonable because it does not proportionately balance the rights protected by sections 7 and 15 of the *Charter* with any relevant statutory objective;

d) a Declaration that the Directive of the Chief Medical Officer of Health (the "**CMOH**") is an unreasonable, arbitrary, vague, improper and capricious exercise of his statutory power under section 77.7 of the *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7 (the "***HPPA***") or otherwise, and is not in accordance with the rule of law;

e) an Order in the nature of *mandamus* pursuant to section 2(1) of the *Judicial Review Procedures Act,* R.S.O. 1990, c. J.1 ("***JRPA***") and section 24(1) of the *Charter*,

directing the Respondent to fulfil its statutory and constitutional duty by issuing forthwith a revised Directive to long-term care homes ("**LTCHs**") expressly including Family Caregivers and Private Caregivers as "essential visitors", and mandating LTCHs to provide said essential visitors unimpeded access to the resident for whom they provide care, subject only to reasonable COVID-19 screening protocols and the wearing of personal protective equipment as is required for LTCH employees generally, with such access to continue regardless of the existence of any outbreak or further community-wide increase in COVID-19 cases;

f) an Order granting leave under section 6(2) of the *JRPA* to have this application heard by a Judge of the Superior Court of Justice, if required to ensure an immediate hearing;

g) if required, an Order abridging the time for service of any materials required for the hearing of this application;

h) an Order that this matter constitutes an urgent request for a hearing pursuant to s. D2(6)(a) of the Divisional Court Directive dated June 29, 2020;

i) an Order, in any event of the cause, that no costs shall be awarded against the Applicants;

j) an Order for costs to be awarded to the Applicants;

k) such further and other relief as counsel may advise and this Honourable Court may grant.

The grounds for the application are:

The Parties

3. The Applicant Mafalda Maione (“**Mafalda**”) is 85 years of age and has resided at Extendicare Rouge Valley, an LTCH located in the City of Toronto, since March 2017. She is represented by her litigation guardian and daughter, Vincenzina De Sao José (“**Vincenzina**”). She speaks Italian as her mother tongue, and has limited command of English.

4. Vincenzina resides in Toronto, Ontario and is a Substitute Decision Maker (“**SDM**”) for the applicant, Mafalda, pursuant to a Power of Attorney for Personal Care dated March 6, 2010. Prior to the lockdown that is the subject of this application, Vincenzina, and/or private caregivers that she retained, provided 15 hours per day, or 105 hours per week, of direct care to Mafalda.

5. The Applicant Barbara Mills (“**Barbara**”) is 84 years of age and resides at The Grove, a long-term care home located in Arnprior, Ontario, to which she moved in March 2019. She is represented by her litigation guardian and daughter, Susan Mills (“**Susan**”).

6. Susan resides in Arnprior, Ontario and is the SDM for the applicant, Barbara Mills, pursuant to a Power of Attorney for Personal Care dated June 30, 2010. Prior to the lockdown, she provided essential care to her mother for approximately 20 hours each week.

7. The Respondent Ontario is represented by the CMOH, currently Dr. David Williams, with respect to issuing directives under the *HPPA*.

8. The Respondent Ontario is further represented by the Minister of Long-Term Care (the “**Minister**”), currently Dr. Merrilee Fullerton, who is responsible for overseeing

LTCHs across Ontario pursuant to the *Long-Term Care Homes Act*, 2007, S.O. 2007, c. 8 (the "***LTCHA***"), and issuing directives thereto.

9. Both Vincenzina and Susan are **Family Caregivers**. For the purpose of this pleading, Family Caregivers are defined as individuals who are not staff or on-site contractors, but who provide care services to one resident of an LTCH to whom they are usually related. They are not casual visitors. **Private Caregivers** are herein defined as individuals who are not staff or on-site contractors, but who are retained by residents or their families to provide care services to one resident of an LTCH.

10. The Applicants Vincenzina and Susan have standing as Applicants in their own right, in the public interest, regardless of any change in their mothers' circumstances. The nature of the dispute is a serious legal issue which has wide-ranging impact on many Ontario LTCH residents and their families, for whom Vincenzina and Susan are representatives. This Application is a reasonable and effective manner of bringing issues of public importance forward for adjudication.

Powers & Duties of the Minister Under the *LTCHA*

11. Pursuant to section 1 of the *LTCHA*, the Respondent is compelled to fulfil its duties under the *Act* in accordance with the following principle:

> The fundamental principle to be applied in the interpretation of this Act and anything required or permitted under this Act is that a long-term care home is primarily the home of its residents and is to be operated so that it is a place where they may live with dignity and in security, safety and comfort and have their physical, psychological, social, spiritual and cultural needs adequately met. 2007, c. 8, s. 1

12. Additionally, an extensive *Residents' Bill of Rights* as detailed in section 3 of the *LTCHA*, confirms residents' dignity and their right to make choices about their own care (or have their SDMs do so), and to "receive visitors of his or her choice…without interference."

13. By virtue of section 174.1(1) of the *LTCHA*, the Minister may issue operational or policy directives respecting LTCHs where the Minister considers it to be in the public interest to do so.

14. Under the *LTCHA*, section174.1(3), it is mandatory for all LTCHs to follow any directives issued by the Minister.

Power of the CMOH to Issue Mandatory Directives Under the *HPPA*

15. Pursuant to the *HPPA*, the CMOH is granted certain powers when an outbreak of infectious disease is occurring or anticipated.

16. Section 77.7 of the *HPPA* sets forth the powers of the CMOH to issue directives to any health care entity, including an LTCH:

> **Directives to health care providers**
>
> **77.7 (1)** Where the Chief Medical Officer of Health is of the opinion that there exists or there may exist an immediate risk to the health of persons anywhere in Ontario, he or she may issue a directive to any health care provider or health care entity respecting precautions and procedures to be followed to protect the health of persons anywhere in Ontario.

17. Pursuant to section 77.7(3) of the *HPPA*, a health care entity that is served with a directive under subsection (1) must comply with it.

The Lockdown Directives & Ensuing Confusion

18. On March 22, 2020, following a provincial declaration of emergency concerning the spread of COVID-19 and pursuant to his apparent authority under section 77.7(1) of the *HPPA*, the CMOH issued Directive #3 to all long-term care homes, as defined under the *LTCH*. The Directive (Version #1) recommended that residents remain on the property and maintain safe social distancing with visitors, and that employees try to minimize the number of different work locations they attended.

19. On March 30, Version #1 of the Directive was rescinded and replaced by a more comprehensive Version #2, requiring that LTCHs immediately close to visitors, except for essential visitors. Specific instructions were given on how to manage essential visitors who could enter the facility even during an outbreak. These were to be distinguished from regular visitors, who were to have no access at all.

20. Version #2 of the Directive defined "essential visitors" to include "*a person performing essential support services (e.g. food delivery, maintenance, and other health care) or a person visiting a very ill or palliative resident*." No mention was made of Family Caregivers. Accordingly, LTCHs denied access to **all** family members, with no distinction between those who had been providing 10-20 hours per week or more of essential care, and casual visitors. This Decision has resulted in dire consequences to the lives and health of elderly residents, particularly as the lockdown has continued over many weeks and months. Elderly residents have not only been cut off from family members who provide essential care, but they have been deprived of third-party oversight to ensure their safety and well-being.

21. On April 8, 2020, Version #3 of the Directive was issued by the CMOH. The definition of essential visitor was modified slightly to include: "*a person performing essential support services (e.g. food delivery, <u>phlebotomy testing</u>, maintenance, and other health care <u>services required to maintain good health</u>*" [emphasis added]. Version #3 included screening protocols that were provided for essential visitors to enter the home but, again, Family Caregivers were not specifically included and as a consequence LTCHs continued to deny Family Caregivers access.

22. On April 15, Version #4 of the Directive was issued by the CMOH which, among other things, quietly changed the definition of essential visitors to include "*a person performing essential support services (e.g. food delivery, phlebotomy testing, maintenance, <u>family or volunteers providing care services</u> and other health care*

services required to maintain good health) or a person visiting a very ill or palliative resident" [emphasis added].

23. Around this time, the number of deaths in LTCHs was increasing – dramatically in some homes. In fact, on April 22, 2020, the Premier of Ontario announced that he was bringing in members of the Canadian military to assist with front-line care in several LTCHs.

24. The Premier further announced on or about May 13, 2020, that the government would deploy teachers on secondment to help in LTCHs.

25. Meanwhile, Family Caregivers who had provided essential care to residents, who were experienced in managing the needs of their loved one, and who historically helped alleviate care burdens on staff, were treated as potential disease vectors and, despite the April 15 change in definition to "essential visitors", were still not permitted access to most LTCHs.

26. A further iteration of the Directive was issued on May 21, 2020 ("Version #5"), which maintained the prior definition of essential visitor. LTCH residents continued, however, to be deprived of the important care of their loved ones. On May 23, 2020, another version of the Directive was issued which contained only minor clarifications ("Version #6").

27. Finally, on June 10, 2020, the most recent version of the Directive was issued with extensive revisions and additions ("Version #7"). Version #7 implemented far more detailed instructions on admissions, testing and other protocols. Importantly, it removed the entire section on "Managing Essential Visitors" and introduced the management of all visitors as a general category, stating that the aim of the Directive was to "balance the need to mitigate risks to residents, staff and visitors with the mental, physical and spiritual needs of residents for their quality of life."

28. LTCHs were instructed to put a visitor policy in place that was compliant with the Directive, however it contained vague and confusing instructions such as stating that policies must “include allowances and limitations regarding indoor and outdoor visiting options.”

29. LTCHs were advised that the policy to be implemented must “clearly state that if the home is not able to provide surgical/procedure masks, no family visitors should be permitted inside the home. Essential visitors who are provided with appropriate PPE [“Personal Protective Equipment”] **from their employer**, may enter the home” [emphasis added]. Family Caregivers, not having an employer, were evidently not to be considered as “essential visitors”.

30. This treatment was confirmed elsewhere in Version #7, which stated that, when the LTCH is in an outbreak, only “essential visitors” were to be permitted in the home, and instructed the LTCHs to specify in their policy that essential visitors be “defined as including a person performing essential support services (e.g., food delivery, inspector, maintenance, or health care services (e.g., phlebotomy)) or a person visiting a very ill or palliative resident.” Family Caregivers were no longer included in the definition.

31. As a direct result of the Respondent’s Decision, elderly and infirm LTCH residents have for more than five months, with no end in sight, been isolated from, or have had only minimal access to, their essential Family Caregivers and SDMs. Any access is inconsistent across the province.

32. The Respondent has been aware for many months of the accumulating damage to residents from isolation and neglect, and from the deprivation of the care and oversight of Family Caregivers. It is also aware that the Directive is unclear and that LTCHs are depriving residents of the essential support of Private and Family Caregivers on the basis of the Directive’s lack of clarity and certainty. The

Respondent has had the power throughout to issue a clear, mandatory and enforceable directive that would bind all LTCHs and provide consistent outcomes across the province, but has refused or failed to do so.

Expert Support for Access to Essential Family Caregivers

33. Despite the weight of authority from published reports by front-line professionals supplied to the Respondent, all of which support the immediate return of Family Caregivers and detailed proposals to ensure the safety and success of their re-introduction, the Respondent has ignored these rational, evidence-based approaches in favour of chaos, finger-pointing, misery, indignity, and untimely death in its Decision not to mandate their return.

34. These expert reports included the following:

a) Provincial Geriatrics Leadership Office, "*Family Presence in Older Adult Care – A Statement Regarding Family Caregivers and the Provision of Essential Care*", dated June 29, 2020;

b) Canadian Foundation for Healthcare Improvement, "*Better Together: Re-Integration of Family Caregivers as Essential Partners in Care in a Time of Covid-19*", dated July 8, 2020;

c) National Institute on Ageing, "*Finding the Right Balance: An Evidence-Informed Guidance Document to Support the Re-Opening of Canadian Long-Term Care Homes to Family Caregivers and Visitors during the COVID-19 Pandemic*", dated July 2020; and

d) Registered Nurses' Association of Ontario, "*Reuniting family with their loved ones in long-term care homes during COVID-19*", dated July 15, 2020.

35. The expert reports highlight the following facts, which were known or ought to have been known by the Respondent Minister, having responsibility for LTCHs:

a) For older adults who cannot independently communicate their hunger, thirst, pain, anxiety or other critical health information, the presence of Family Caregivers can be lifesaving;

b) The impact of lengthy restrictions in health care settings, including the ongoing absence of regular Family Caregivers, places vulnerable residents at risk of harm and death.

c) Family Caregivers regularly provide feeding, grooming and washing, toileting, exercise, social and emotional support, memory support, and mobilization in LTCH and other settings. This care was and is in short supply in LTCHs during the COVID-19 pandemic due to staff illness and increased resident/patient care demands.

d) Family Caregivers are attuned to changes in behaviour and condition in the person in their care that can signal delirium, infection, or acute physical and mental illness. They enable early detection which in turn facilitates early intervention, reducing overall impact of illness.

e) Other outcomes of COVID-19 protocols include loneliness and social isolation for residents, which may contribute to premature mortality and chronic conditions such as heart disease, diabetes, depression and dementia. Not being able to see and help the older adult they usually provide care to also increases anxiety and stress for Family Caregivers.

f) Dying alone is the greatest fear of many older adults. Dying in this way has caused suffering for many, including patients, families and the health professionals who have witnessed this.

g) In LTCHs, time is precious. Many people entering LTCHs are in their final months and years of life. Inclusion of Family Caregivers during this period of an older adult's life should be prioritized.

h) One third of Family Caregivers already carry out technical aspects of care such as changing bandages, monitoring or administering medications, while 18% carry out medical procedures such as changing gastric tubes, and giving injections.

i) Pre-COVID-19, Family Caregivers assisted with about 30% of the care in LTCHs. Family Caregivers have the capacity to learn and carry out infection control procedures and are highly motivated to do so meticulously and safely.

36. The final report listed above, from the Registered Nurses Association of Ontario, presented five simple and cogent recommendations for the safe reintroduction of Family Caregivers. A clear path to solving the problem and ceasing the unreasonable trampling on the constitutional rights of the Applicants and other residents of congregate care has been presented to the Respondent by experts in front-line care; but the Respondent has simply failed or refused to act.

<u>Impact of the Decision on the Applicants</u>

37. The impact of the Decision has been devastating for elderly residents. The Applicant, Mafalda, suffers from dementia and stroke deficits. After Mafalda suffered multiple strokes last year, Vincenzina was told to prepare for her death. Through tireless effort, she rehabilitated her mother's health, even allowing her to use her impacted left arm much better and left leg a little more, but Mafalda was understandably more dependent on care to enjoy her normal activities of daily living.

38. Mafalda's private care before the lockdown included helping with feeding, ambulation, fall prevention, toileting, personal care, physical therapy, memory support, cognitive exercises, calming her anxiety, and articulating her needs to staff.

39. As a result of the lockdown, Mafalda went from having 15 hours per day of one-on-one support (either from Vincenzina or hired Private Caregivers) down to zero. As the lockdown has progressed and her isolation and neglect have increased, Mafalda has become a shell of her former self. Her mobility gains have disappeared. When a brief outdoor visit was finally permitted in mid-June, Mafalda could not speak to Vincenzina. Mafalda's psychological decline was palpable.

40. As a result of her dementia symptoms, which have worsened since her stroke, Mafalda is a high fall risk because she is unaware of having had a stroke and that her legs do not work as they should. With private caregiving present for 15 hours each day, Mafalda could be properly supervised and did not have any falls. Mafalda has suffered at least two falls since her caregivers were banned from her home.

41. As of July 14, 2020, permission was finally granted to permit Mafalda to have access to her Private Caregivers, and as of July 31, 2020 limited permission was granted to permit Mafalda to have access to Vincenzina in her room; however, the access remains limited, restrictive, arbitrary, discriminatory, discretionary, and with no integrated appeal mechanism to challenge the decisions being made by the LTCH.

42. The Applicant, Barbara, has dementia, congestive heart failure, and decreased vision and hearing. In September 2019, she fell and broke her hip, and since then she has been in a wheelchair. Susan has been her Family Caregiver since she was diagnosed with the dementia, and is her support system.

43. As an essential Family Caregiver before the lockdown, Susan spent approximately 20 hours per week at the LTCH providing one-on-one care. This included helping with feeding (which required extra time to avoid choking), personal care, memory support, cognitive exercises, calming her anxiety and articulating her needs to staff.

44. Following Barbara's accident in September 2019, Susan was assisting her with daily physiotherapy exercises. This stopped with the lockdown and Susan was advised that Barbara would receive no further physiotherapy to stand or walk.

45. After the lockdown, Susan asked to be considered an essential visitor on several occasions, but her requests were denied. She was informed that since her mother's medical condition was stable rather than palliative, she could not enter the facility to visit and provide care.

46. Since the lockdown, Susan has attended for daily window visits to provide social contact for her mother. Initially, Barbara could hold the phone and converse. She no longer has the physical strength to hold the phone, nor does she have the capacity to converse at length. Susan has noted a dramatic physical and cognitive decline in Barbara over the last five months. There are have been days when Barbara does not recognize Susan, and others where Susan had to implore her not to give up, since she appeared to have lost the will to live.

47. In June, Susan was allowed a one-hour exception visit as Barbara had choked and required CPR. On August 18, Susan was permitted another one-hour visit as her mother's condition was declining; otherwise, she has not been permitted indoor access. Unlike Mafalda's LTCH which now offers limited access to Family Caregivers, Barbara's LTCH has not recognized Family Caregivers as essential visitors at all. While casual visitors are permitted one weekly 30-minute visit, either outdoors or in a supervised indoor common area, Family Caregivers are limited to the same access. Only family members visiting residents at the end of life are permitted to visit residents in their rooms.

48. The care that previously had been provided by Family and/or Private Caregivers has, in the case of Mafalda and Barbara, and so many others, simply not continued during the lockdown.

49. The Decision has prevented both Susan and Vincenzina from fulfilling their legal duties as substitute decision makers under the *Health Care Consent Act*, 1996, S.O. 1996, c. 2. Section 21(2) requires SDMs to act in the best interest of an incapable person's health when giving or refusing consent on their behalf. The *LTCHA* further recognizes this responsibility at section 6(5), where it requires a LTCH licensee to ensure that SDMs have the opportunity to participate fully in the development and implementation of a resident's plan of care.

50. Family members must be able to consistently evaluate and monitor the condition of their loved ones in order to work with health care and personal services professionals and give informed consent. They are also legally obliged to evaluate whether the least restrictive or intrusive measures are being proposed. As a result of the Decision, the legal rights and responsibilities of all of the Applicants have been impaired.

<u>The Decision is Unreasonable and Unlawful</u>

51. Having exercised his discretion to issue a directive, the CMOH had a duty to do so in a manner that was not arbitrary, unreasonable and contrary to the rule of law. The Respondent erred in its Decision to issue and maintain various conflicting iterations of the Directive, without explicitly including Family and Private Caregivers as "essential visitors", and/or mandating their re-admittance to LTCHs.

52. A Directive is a mandatory order which the LTCHs must follow by law. As such, the rule of law requires that it be clear, enforceable, and applied consistently and equally. Instead, the Directive's language with respect to Family Caregivers has conflicted with associated guidance and messaging from the Respondent, and was internally incoherent, vague and misleading, particularly through the various iterations which arbitrarily and quietly changed important definitions. Accordingly, the Decision was and is unreasonable, arbitrary, improper and capricious.

53. The Decision was and is not supported by the evidence, which overwhelmingly endorses the immediate and uninterrupted return of Family Caregivers to congregate care facilities.

54. The Respondent has been asked repeatedly over last four or more months, by experts, advocates, lawyers, families and residents themselves, to solve the problem by issuing a mandatory Directive permitting Family Caregivers to resume access; but its Decision to ignore the problem or deflect responsibility has necessitated judicial review.

The Directive Violates the *Charter*

55. The Decision by the Minister and/or the CMOH to refuse to revise and enforce the Directive engages the *Charter* by limiting *Charter* protections. The Decision does not reflect a proportionate balancing of the *Charter* protections at play, in light of the statutory objectives.

56. Section 7 of the *Canadian Charter of Rights and Freedoms* guarantees Canadians the right to life, liberty and security of the person. Liberty protects the right to make fundamental personal choices free from state interference. The interference by the Respondent in the individual autonomy and dignity of LTCH residents to make decisions (or have their SDMs make decisions) concerning their bodily integrity and medical care infringes their liberty rights in a manner that is not in accordance with the principles of fundamental justice.

57. Security of the person is engaged by state interference with an individual's physical or psychological integrity, including any state action that causes physical or serious psychological suffering. By expressly prohibiting essential Family Caregivers from attending to the care of their loved ones in LTCHs, the Decision and resulting Directive has forced the elderly Applicants and other vulnerable residents to endure

intolerable suffering—physically, mentally and emotionally— impinging on their constitutional right to security of the person.

58. The denial of access in person to their SDMs over a protracted period is a further violation of the security of the person of the elderly and vulnerable who cannot make decisions for themselves.

59. The Applicants Vincenzina and Barbara have personally suffered an infringement of their section 7 rights to security of the person, as the parent-child bond, particularly at the beginning and end of life, is an intimate connection with which the state cannot unjustifiably interfere.

60. Section 7 *Charter* rights can only be infringed in accordance with the principles of fundamental justice. The deprivation of rights is grossly disproportionate to the objective of the Directive, particularly given the current knowledge of COVID-19 management which was not available in March 2020. The Directive undermines the Respondent's stated objective of preventing harm to vulnerable LTCH residents from COVID-19 by *causing* other forms of serious harm, without proper consideration or balancing of those harms, demonstrating that the Directive is arbitrary and overbroad.

61. Under section 15(1) of the *Charter*, age, mental disability and physical disability are prohibited grounds of discrimination. By confining the elderly in their rooms and depriving them of essential care from Private or Family Caregivers, the Respondent has denied them equal protection and equal benefit under the law. Such treatment is directly contrary to the equality rights of Canadians of all ages. It serves to marginalize, isolate, degrade and diminish the elderly and infirm in a manner that is not inflicted on other citizens.

62. Section 1 of the *Charter* guarantees the rights and freedoms set out in it, subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society. The Directive is a law which implicates the *Charter*.

63. The elderly are no less entitled to these rights than any other Canadian. Where a government violates *Charter* rights, it is required under section 1 of the *Charter* to ensure that there is a rational connection between the measures taken and the objective, and that such measures are proportionate and minimally impairing of the rights of citizens.

64. There is no rational connection between the infringement of rights and what the Directive seeks to achieve. The Directive permits essential visitors such as staff, medical professionals, therapists, cooks, maintenance workers, cleaners, teachers, and the military to enter LTCH facilities, and provides instructions on their need to use PPE and screening procedures. The failure to include Private or Family Caregivers, who can follow the same protocols as other essential visitors and are highly motivated to do so, is not rationally connected to the purpose of limiting the spread of a contagion.

65. The Directive is not minimally impairing. A less-infringing alternative decision is available, which the Respondent has failed to make – namely, that the LTCHs could be mandated to permit access to Private and Family Caregivers with the implementation of reasonable screening and the wearing of PPE, which would adequately address concerns about the spread of COVID-19.

66. The impact and effects of the Decision on the lives and health of the Applicants has been dramatically negative and in no way proportionate to its objective, no matter how pressing the concern appeared in the early stages of the emergency.

The Directive Should be Corrected by an Order of Mandamus

67. The CMOH and the Minister know or ought to know that the LTCHs are interpreting the unclear and contradictory Directive in a manner which prevents essential Family Caregivers and Private Caregivers from providing care to residents like the elderly Applicants, thereby infringing their *Charter* rights.

68. Directives are meant to be followed and enforced. They are not guidelines. The failure of the Respondents to issue a clear, unambiguous, rational, enforceable Directive has purposely or negligently sown confusion, creating a situation of finger-pointing in order to avoid perceived liability, while leaving residents and their caregivers in a state of limbo.

69. Both the Minister and the CMOH are subject to the Court's supervising power to order *mandamus*, where delegated powers are not being exercised reasonably. It is not a lawful exercise of the Respondent's discretion to violate the statutory and *Charter* rights of the Applicants.

70. There was a prior demand for performance of the duty, by way of a demand letter from the Applicants' counsel, dated July 17, 2020. A reasonable period was given to comply with the demand, but no response was received, and no action was taken to fulfill the duty as demanded.

71. The Respondent has failed to act upon relevant considerations provided to it by experts in front-line care for the aged, as well as legal demands.

72. No other adequate remedy is available to the Applicants, and an Order of *mandamus* will provide a benefit to elderly or infirm residents in LTCH and their essential Family Caregivers across the province.

Urgency

73. The Respondent has had ample time to clarify its Directive to ensure that it does not unreasonably limit contact between long-term care home residents and their essential caregivers, but it has failed to do so, necessitating application to this Honorable Court.

74. Pursuant to section 6(2) of the *JRPA*, it is appropriate for this application to be heard on an expedited basis by a Judge of the Superior Court of Justice, instead of by the Divisional Court, as the lives, health and well-being of citizens of Ontario are at stake such that urgent judicial oversight is required.

Costs

75. The Applicants request that no costs be awarded against them.

76. The Applicants (those who are SDMs) are representative of many essential Family Caregivers across Ontario, and bring this proceeding in the public interest in order to protect the rights of their parents and other elderly and/or infirm residents in LTCHs in Ontario.

77. The Applicants have nothing to gain financially from this case, and it is accordingly appropriate not to award costs.

Provisions Engaged

78. *Canadian Charter of Rights and Freedoms,* sections 1, 7, 15(1) and 24(1)*;*

79. *Rules of Civil Procedure*, R.R.O. 1990, Reg. 194, including Rules 14.05, 38 and 68;

80. *Judicial Review Procedure Act*, R.S.O. 1990, c. J.1, sections 2(1), 4, 6, 7and 9.

81. *Long-Term Care Homes Act*, 2007, S.O. 2007, c. 8, sections 1, 3, 6(5) and 174.1;

82. *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, section 77.7;

83. *Health Care Consent Act*, 1996, S.O. 1996, c. 2, section 21(2);

84. Such further and other grounds as counsel may advise and this Honourable Court will permit.

85. The following documentary evidence will be used at the hearing of the application:

a) Affidavit of Vincenzina De Sao José, to be sworn, and the exhibits thereto;

b) Affidavit of Susan Mills, to be sworn, and the exhibits thereto;

c) Additional affidavits, to be sworn, and the exhibits thereto;

d) Record before the Respondent Minister, CMOH and/or their delegates;

e) Factum of the Applicants;

f) Such further and other material as counsel may advise and this Honourable Court may permit.

DATE: August 20, 2020

JUSTICE CENTRE FOR CONSTITUTIONAL FREEDOMS
#253-7620 Elbow Drive SW
Calgary, Alberta
T2V 1K2

LISA D.S. BILDY

Lawyer for the Applicants

Court File No:

MAFALDA MAIONE, et al. ***and*** **ONTARIO (CHIEF MEDICAL OFFICER OF HEALTH et al.)**

Applicants *Respondents*

ONTARIO
SUPERIOR COURT OF JUSTICE
(DIVISIONAL COURT)

Proceeding commenced at Toronto

NOTICE OF APPLICATION FOR JUDICIAL REVIEW

JUSTICE CENTRE FOR CONSTITUTIONAL FREEDOMS

#253-7620 Elbow Drive SW
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