Court File No.: S-222427
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

Between

PHYLLIS JANET TATLOCK, LAURA KOOP, MONIKA BIELECKI, SCOTT MACDONALD, ANA LUCIA MATEUS, DAROLD STURGEON, LORI JANE NELSON, INGEBORG KEYSER, LYNDA JUNE HAMLEY, MELINDA JOY PARENTEAU and DR. JOSHUA NORDINE

Petitioners

and

ATTORNEY GENERAL FOR THE PROVINCE OF BRITISH COLUMBIA and DR. BONNIE HENRY IN HER CAPACITY AS PROVINCIAL HEALTH OFFICER FOR THE PROVINCE OF BRITISH COLUMBIA

Respondents

WRITTEN ARGUMENT OF THE PETITIONERS

Counsel for the Petitioners:	
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Contents

I. ORDERS SOUGHT:

Pursuant to section 2(1), (2), 7, 5, and 17 of the *Judicial Review Procedure Act,* RSBC 1996, c.241 the Petitioners seek:

1. Declarations pursuant to sections 24(1) and 52(1) of the *Constitution Act,* 1982, Schedule B to the Canada Act 1982 (UK) c.11, that:

   (a) The Order entitled "Hospital and Community (Health Care and Other Services) Covid-19 Vaccination Status Information and Preventive Measures – October 5, 2023" (Hospital and Community Order), and any variations thereto, that was issued by the Provincial Health Officer for British Columbia, Dr. Bonnie Henry, under the authority of sections 30, 31, 32, 39 (3), 54, 56, 57, 67 (2) and 69 of the *Public Health Act*, S.B.C. 2008, c.28, is of no force and effect, as it unjustifiably infringes the rights and freedoms of the Petitioners guaranteed by the *Canadian Charter of Rights and Freedoms*, Part 1 of the *Constitution Act*, 1982, Schedule B to the *Canada Act 1982* (UK), 1982, c 11, specifically,

      a. *Charter* section 2(a) (freedom of conscience and religion)

      b. *Charter* section 7 (right to life, liberty and security of the person)

      c. *Charter* section 15(1) (equality rights)

   (b) The Order entitled "Residential Care Covid-19 Preventive Measures – October 5, 2023" (Residential Care Order), and any variations thereto, that was issued by the Provincial Health Officer for British Columbia, Dr. Bonnie Henry, under the authority of sections 30, 31, 32, 39 (3), 54, 56, 57, 67 (2) and 69 of the *Public Health Act,* is of no force and effect, as it unjustifiably infringes the rights and freedoms of the Petitioners guaranteed by the *Charter*, specifically,

      a. *Charter* section 2(a) (freedom of conscience and religion)

      b. *Charter* section 7 (right to life, liberty and security of the person)

      c. *Charter* section 15(1) (equality rights)

   (c) The Orders entitled "Hospital and Community (Health Care and Other Services) Covid-19 Vaccination Status Information and Preventive Measures" – October 14, 2021, October 21, 2021, November 9, 2021, November 18, 2021, September 12, 2022, and April 6, 2023" (the "Hospital and Community Orders"),

that were issued by the Provincial Health Officer for British Columbia, Dr. Bonnie Henry, under the authority of sections 30, 31, 32, 39 (3), 54, 56, 57, 67 (2) and 69 of the *Public Health Act*, S.B.C. 2008, c.28, unjustifiably infringe the rights and freedoms of the Petitioners guaranteed by the *Canadian Charter of Rights and Freedoms*, Part 1 of the *Constitution Act*, 1982, Schedule B to the *Canada Act 1982* (UK), 1982, c 11, specifically,

d. *Charter* section 2(a) (freedom of conscience and religion)

e. *Charter* section 7 (right to life, liberty and security of the person)

f. *Charter* section 15(1) (equality rights)

(d) The Orders entitled "Residential Care Covid-19 Preventive Measures – September 2, 2021,October 4, 2021, October 8, 2021, October 21, 2021, September 12, 2022, and April 6, 2023 (the "Residential Care Orders"), that were issued by the Provincial Health Officer for British Columbia, Dr. Bonnie Henry, under the authority of sections 30, 31, 32, 39 (3), 54, 56, 57, 67 (2) and 69 of the *Public Health Act,* unjustifiably infringe the rights and freedoms of the Petitioners guaranteed by the *Charter*, specifically,

d. *Charter* section 2(a) (freedom of conscience and religion)

e. *Charter* section 7 (right to life, liberty and security of the person)

f. *Charter* section 15(1) (equality rights)

(e) The "Guidelines for Request for Reconsideration (Exemption) Process for Health Care Workers affected by the Provincial Health Officer Orders" (the Guidelines), that was issued by the Provincial Health Officer for British Columbia, Dr. Bonnie Henry, which stipulate the process that must be employed in determining a healthcare worker's application for exemption from the Hospital and Community Order and/or from the Residential Care Order, are of no force or effect, as they unjustifiably infringe the rights and freedoms of the Petitioners guaranteed by the *Charter*, specifically,

a. *Charter section 2(a)* (freedom of conscience and religion*)*

b. *Charter* section 7 (life, liberty and security of the person)

c. *Charter* section 15(1) (equality rights)

2. In the alternative, an Order under sections 2(2)(a) and 7 of the *Judicial Review*

Procedure Act, in the nature of mandamus or certiorari, quashing and setting aside all the Hospital and Residential Care Orders and the Residential Care Orders referred to above, and the Guidelines to the extent they fail to provide religious and conscientious exemptions and reasonable accommodations in accordance with class of worker;

3. A Declaration that all the Hospital and Community Orders~~,~~ and the Residential Care Orders referred to above, and the Guidelines issued by the Provincial Health Officer for British Columbia, Dr. Bonnie Henry, improperly fettered her discretion and breached the principles of natural justice by failing to provide a meaningful process for religious and conscientious exemptions, reasonable accommodations in accordance with class of worker and reconsideration;

4. A Declaration that the inclusion of the Petitioners as persons covered by the Orders was unreasonable under administrative law principles because of the Orders' improper impact on persons in the position of the Petitioners;

5. In the further alternative, an Order pursuant to section 5(1) of the *Judicial Review Procedure Act,* directing Dr. Bonnie Henry, in her capacity as Provincial Health Officer for British Columbia, to provide a meaningful process for exemptions and reconsideration for the Petitioners on the basis of religion, conscience and on an expanded medical basis, and/or to allow for accommodation of those workers affected by all the Hospital and Community Orders and~~,~~ the Residential Care Orders as referred to above, and the Guidelines on the basis of class of worker;

6. In the further alternative, an Order under section 2(2)(a) of the *Judicial Review Procedure Act,* in the nature of mandamus, ordering Dr. Bonnie Henry, in her capacity as Provincial Health Officer, to provide a meaningful process for exemptions and reconsideration for the Petitioners on the basis of religion, conscience and on an expanded medical basis, and/or to allow for accommodation of those workers affected by all the Hospital and Community Orders and the Residential Care Orders, as referred to above, and the Guidelines, on the basis of class of worker;

7. Pursuant to section 2(2)(a) of the *Judicial Review Procedure Act*, an Order prohibiting the Respondents from issuing subsequent public health orders that fail to provide a reasonable process for religious or conscientious exemptions, or reasonable accommodations, on the basis of class of worker.

8. An Order pursuant to section 17 of the *Judicial Review Procedure Act,* that the entire record upon which the Hospital and Community Order**s**, the Residential Care Orders, and the Guidelines, were based on, and are continued, be filed on

this proceeding;

9. An Order that the Petitioners are exempt from the vaccination requirements under the Orders issued by Dr. Bonnie Henry on religious, conscience, and medical grounds, or reasonable accommodation on the basis of class of worker, as applicable to each Petitioner;

10. Damages pursuant to s. 24(1) of the *Charter* as is found to be appropriate and just in the circumstances of each Petitioner, for all orders, as referred to above;

11. Costs of this Petition; and,

12. Such further and other relief as the Petitioners may seek and as this Honourable Court deems just and equitable.

II. INTRODUCTION:

1. Requiring BC healthcare workers to provide proof of having taken two doses of an approved Covid-19 vaccine was not reasonable at the time the Orders were issued in the fall of 2021, and became even more unreasonable over time, particularly when the two April 6, 2023 Orders were issued (the HOSPITAL AND COMMUNITY (HEALTH CARE AND OTHER SERVICES) COVID-19 VACCINATION STATUS INFORMATION AND PREVENTIVE MEASURES – APRIL 6, 2023 (the "Hospital and Community Order") and the RESIDENTIAL CARE COVID-19 VACCINATION STATUS INFORMATION AND PREVENTIVE MEASURES – APRIL 6, 2023 (the "Residential Care Order")).

2. Requiring BC healthcare workers to take the recommended dose or doses of the XBB.1.5-containing formulation of COVID-19 vaccine approved for use by Health Canada and available in the province, pursuant to the October 5, 2023 HOSPITAL AND COMMUNITY (HEALTH CARE AND OTHER SERVICES) COVID-19 VACCINATION STATUS INFORMATION AND PREVENTIVE MEASURES order and the RESIDENTIAL CARE COVID-19 VACCINATION STATUS INFORMATION AND PREVENTIVE MEASURES order is also not reasonable.

3. The Petitioners oppose the orders based on constitutionally protected rights, as enshrined in the *Canadian Charter of Rights and Freedoms,* specifically:

    a. Charter section 2(a) (freedom of conscience and religion)

    b. Charter section 7 (right to life, liberty, and security of the person), and

    c. The duty to accommodate.

4. The standard of review is reasonableness, pursuant to *Canada (Minister of Citizenship and Immigration) v Vavilov*[1], and *Doré v. Law Society of Quebec*[2] and the recent SCC case of *Mason v. Canada (Citizenship and Immigration)*[3].

5. The Petitioners agree with the counsel for the PHO that the PHO's media briefings and the recitals contained in orders are her reasons.

6. The Petitioners do not disagree that the protection of vulnerable populations from acquisition of Covid 19 is a legitimate objective of the PHO. However, the Petitioners say the orders unreasonably breach *Charter* rights:

    a. The orders are overbroad in applying to remote and administrative workers who pose no risk to the populations sought to be protected by the vaccination mandates or to anyone in the work environment within the jurisdiction of the PHO mandates;

7. The PHO has actually stated that there is no reason to apply the mandate to the remote and administrative workers, yet she continues to do so in all orders.

8. The Public Health Service removed the mandates for the public service workers with some limited exceptions:

    https://www2.gov.bc.ca/gov/content/careers-myhr/all-employees/health-safety-and-sick-leave-resources/health/covid-19/vaccine-requirements-in-the-bc-public-service[1] **(page 1 of Condensed Book of Evidence ("CB")**, yet mandates remained in place for health-care workers, including all our Petitioners, some of whom did not even work in health-care settings. In response to a question from a reporter during a media briefing dated March 10, 2023 as to why the mandates ought to be removed for public service workers but not for health care workers **(Affidavit #3 of Emerson, Exhibit "GGG" at pages 2089 and 2091)[2] (CB page 4)**, Dr. Henry responded:

    "Q&A

    Reporter: Minister Dix, if you don't mind, please, can you tell me what has changed that you are allowing people that have already been fired from their jobs to come back? The nurses, the doctors that worked in the medical field and refused the vaccine, they've been dismissed. So are you taking them back now? They can come back to work" Or are they still dismissed?"

[1] 2019 SCC 65
[2] 2012 SCC 12
[3] 2023 SCC 21

Henry: Just to clarify, the public health orders, the provincial health officer orders for health care workers in our system, remain in place. That has not changed.

Reporter: Bill 36 that was passed, can you just explain how its going to affect the future of the doctors and nurses that are not going to get the vaccines that are coming or the vaccines that are already here? How is it going to affect them if they don't want to continue taking shots for the foreseeable future?

…..

BH: The difference between what's happened today in the Public Service Agency, is the type of workplaces we're talking about. You may recall a year ago and two years ago when we're talking about vaccine mandates, and it is a risk assessment done by employers about the risks in their employment settings. The Public Service Agency, we had many conversations about the roles people play, the protection of workers in their workplace. Many of them are public facing workers, and they made the decision as employers to have this in place for employees across the Public Service Agency. They've made the decision – and yes, I was involved in providing advice about risk now given the high rates of immunization and given what we're seeing in terms of the population and the transmission of COVID – that decision was made by the Public Service Agency to remove those mandates.

My responsibility and the responsibility of the minister, public health and my advice applies to health care setting, to the public health care setting. These provincial health officer orders remain in place because that is the highest risk setting for both the health care workers and the patients in our care. Those mandates remain in place as we're not yet through this respiratory season. We're not yet out of that highest risk period for those most vulnerable groups."

9. There also does not seem to be any occupational breakdown of the risk that is useful to assess whether our Petitioners ought to have had the vaccine to prevent transmission to vulnerable populations in the record at all. For instance, in a February 2023 report by the Covid-19 Immunity Task Force, front-line risk assessment compilation of health-care workers studies were only of workers in long-term care **(Affidavit #3 of Dr. Emerson, Exhibit "YY", p. 1971-1972)[3] (CB page 7).**

An overview of the risk and unreasonableness of the orders is as follows:

A. With respect to those of our Petitioners who did have contact with vulnerable populations, the evidence in the record and the PHO's reasons support that

masking and testing, which would have been adequate accommodation would have provided equivalent if not better protection than vaccination;

B. In her reasons the PHO refers repeatedly to masking and rapid testing as effective ways to reduce transmission in the general population but does not offer these options to accommodate the Petitioners and the lower rates of transmissibility of respiratory viruses by Health-Care workers due to PPE as compared to the household studies support that masking and testing is effective in the health-care environment **(Affidavit #3 of Dr. Emerson, Exhibit "EEE", Media Briefing 13 January 2023, page 2056, para. 2[4] (CB page 8); Affidavit #3 of Dr. Emerson, Exhibit "DDD", Media Briefing December 5, 2022, page 2031, para 5)[5] (CB page 9).**

C. In a report by the Public Health Agency of Canada, entitled the Omicron Monitoring Report for January 5, 2022, there is no evidence to support a conclusion that the acquisition of COVID is attributable to health-care workers. Rather, the evidence supports a conclusion that most acquisition is community acquisition, most of the studies of transmission are based on household transmission **(Affidavit #3 of Dr. Emerson, Exhibit "V", at pages 338 and 343)[6] (CB page 10)**. However, in reviewing a household study reported by Baker et al, in which the US Center for Disease Control partnered with four US jurisdictions, the results showed that masking significantly helped to reduce household transmission **(Affidavit #3 of Dr. Emerson, Exhibit "EE", page 1811)[7] (CB page 12).**

D. In any case, even if our Petitioners did acquire COVID in a community setting, for those Petitioners that worked remotely or in an administrative capacity, there is no risk of them transmitting the virus in a healthcare setting to the vulnerable population that the PHO states in media briefings her decisions are directed toward protecting;

E. Alternatively, it is also not reasonable to state that the vaccine absent the booster provides limited protection, and urge the general population to get the boosters to protect members or the vulnerable population such as their grandparents, and then fail to mandate the booster for health-care workers that do work with vulnerable populations;

F. The PHO's reasons March 10, 2023 explicitly say that the focus of her public health measures are protecting the most vulnerable members of the population and most of our Petitioners have no contact with the population vulnerable to serious outcomes from Covid **(Affidavit #3 of Dr. Emerson, Exhibit "GGG", Media Briefing, March 10, 2023, pages 2082 (paragraph 3) and page 2084, paragraphs 6-8)[8] (CB page 13)**.

G. However, on March 10, 2023 in the same Media Briefing, the PHO also admits that she is not following the recommendations of NACI with respect to who ought to be eligible for boosters and states that she makes this recommendation for people who have not had Covid-19 symptoms or a positive test **(Affidavit #3 of Dr. Emerson, Exhibit "GGG" Media Briefing dated March 10, 2023, p. 2085, paras. 1-3)[9] (CB page 15),** NACI recommendations for this stage of the pandemic are set out at **EXHIBIT "F" to the Affidavit of Haley Miller at bottom of page 61**[10] **(CB page 16)** which includes a direction to transition away from the crisis phase towards a more sustainable approach to long term management of COVID-19. The Petitioners say that the approach taken in other provinces and other parts of the world in not mandating vaccination for all health-care workers, and certainly not those in a similar position to most of Petitioners, is consistent with NACI recommendations, while the approach of the PHO in B.C. is clearly not. There is no reasonable balancing of the competing rights. Further the PHO's reason for not following NACI recommendations makes no sense because other documents in the record, such as blood donor records, which are a neutral source of information, indicate almost everyone has had Covid at this stage of the pandemic.

H. **In EXHIBIT "F" of the Affidavit to Haley Smith at page 65 to 66 (see document 10 above,** NACI considers the principles of Ethics, Equity, Feasibility and Acceptability (EEFA) and NACI undertakes a balancing of competing interests and applies medical ethics principles to the science. All the provinces are relying on NACI recommendations in making decisions, yet B.C. continues to mandate vaccines for health-care workers in contrast to most of the other provinces in Canada. The PHO has not adequately explained anywhere in her reasons why B.C. would require a different approach.

I. **At EXHIBIT "K" of Affidavit #1 of Haley Miller, page 118[11] (CB page 19)**, NACI recommendations for the Fall of 2023 are set out halfway down the page of 118 and clearly confine the recommendations for the vaccine to vulnerable groups, and by implication, those who work with them or create a risk of transmission to them. Nothing in the October orders of the PHO is consistent with this restriction. **Exhibit "L" (see document 160 – NACI summary, September 12, 2023) of Affidavit #1 of Haley Miller** is a summary of Exhibit "K" for the Fall of 2023, wherein NACI makes the same recommendations.

J. In a report from the Covid-19 Immunity Task Force dated February 1, 2023, in December of 2022, according to blood donor information, 73.3 per cent of donors overall had infection acquired immunity **(Affidavit #3 of Dr.**

Emerson, Exhibit "WW", p. 1959 at 1960)[12] (CB page 20) This is despite an increasing level of vaccination across the entire population;

K. In **Exhibit "N" to Affidavit #1 of Haley Miller, at page 133[13] (CB page 22)**, in a document entitled "Spotlight on CITF Research", dated June 27, 2023, it was reported that infection-acquired seroprevalence among all Canadians increased from 78.5 % to 81.1 % for all Canadians, and most significantly, increased in adults 60 and over, which are the cohort with the highest vaccination rates, who, according to the report had the largest percentage increase in infection-acquired seroprevalence. The exact increase in this group in this summary is not stated for unknown reasons. The further comment at **page 134 (document 13 above)** that vaccinated persons are more likely to neutralize omicron than unvaccinated individuals, while detail is not provided, we believe this refers to a reduction in severity of illness from vaccination, evidence which the Petitioners have mostly accepted as proven.

L. Despite the above referred to documents, in a Media Briefing, which comprise the PHO's reasons, dated September 28, 2023, The PHO says older people are less likely to have markers of infection **(at paragraph 6) (Exhibit "AA", page 191 of Affidavit #1 of Haley Miller, Media Briefing September 28, 2023)[14] (CB page 24)**.

M. The PHO's statement in the same exhibit as cited above at **page 191**, paragraph 7, again, as with the old orders, provides no scientifically or ethically meaningful explanation for her failure to mandate either the booster or the new vaccine for health-care workers that work with vulnerable populations.

N. At **page 192 (paragraphs 1 and 2)** of the same document, only 40 per cent of the persons who attend hospital after receiving a positive Covid test are in fact there due to COVID. As she fails to identify the age group or co-morbid status of those for whom a positive Covid test are actually the reason for hospital attendance, combined with the evidence in the record of seroprevalence from natural infection, this fact tells us nothing that would support vaccine mandates for anyone at all. Assuming that the 40 per cent who are there for COVID are over the age of 80 and/or have co-morbid conditions which is a reasonable assumption on the evidence in the record, throughout the entire pandemic. Nothing in the reasons support the mandates for most of our petitioners. Further, at **page 193**, paragraph 6, and **page 195**, **paragraph 7**, to the end of the page, the PHO endorses masking and other actions as effective in controlling the spread of all respiratory illnesses that could have been offered as reasonable accommodation to your Petitioners who either had contact with vulnerable populations as part of their

work, or occasional contact with health-care workers who might have some contact with vulnerable populations, but were not.

O. Even earlier on in the pandemic, naturally acquired infection was high among groups that were not recorded as utilizing hospital or medical resources. In a report from the Covid-19 Immunity Task Force dated February 1, 2023, referring to a period December 2022, according to blood donor information, infection acquired immunity was 88 per cent among the 17-24 age group, who have admittedly have a comparatively lower vaccination rate and of which a greater percentage would not be in the workforce, suggesting that acquisition was more likely to be community acquired than in the workplace **(Affidavit #3 of Dr. Emerson, Exhibit "WW", p. 1959 at 1960 (see document 12 above))**.As well, the PHO's reasons repeatedly point out that vaccination up-take is high among all groups, including the group referred to above, the only exception being children under age 12, so there really is no evidence at all that vaccination is protecting anyone from acquiring Covid, and as noted the Petitioners agree that the evidence supports that the older vaccinations may have reduced severity of disease, which according to the record, seems to matter mostly in persons over age 80, or who have other co-morbid conditions. None of these facts supports vaccine mandates for any of our Petitioners.

P. Further, later on in the pandemic, in the evidence reviewed by the PHO in determining whether to impose vaccine mandates admits that prevalence of COVID infection among persons who died while hospitalized, the PHO finally admits that the prevalence of COVID infection does not mean that the person died of COVID, only that they had COVID when they died so we cannot be sure at all of the exact percentage of the elderly that are in fact dying of COVID because at that age, they could be about to die anyway **(Affidavit #3 of Dr. Emerson, Exhibit "K", COVID Situation Report, November 20-26, 2022, page 139 at page 140, bullet point 6)[15] (CB page 28).**

Q. In a media briefing on March 10 2023, the PHO says unvaccinated people remain at greater risk of getting COVID, presumably to justify mandates in the health-care sector as well as to encourage the entire population to get boosters (while not requiring it for her health-care workers who do work with vulnerable populations); despite blood donor records indicating everyone vaccinated or not is acquiring Covid, and persons over 60, who are more likely to be vaccinated are actually even more likely to acquire it. She makes these statements in the context of explaining why she is not following NACI recommendations to prioritize protection of vulnerable populations **(Affidavit #3 of Dr. Emerson, Exhibit "GGG", dated March 10, 2023, page 2082 - 2089 esp 2087, para 4 and para 6, 2084, para 3- p. 2085 para. 4)[16] (CB page 30).**

R. The PHO repeats this error in her reasons in multiple media briefings throughout the pandemic. Despite increasing levels of vaccine uptake by seniors compared to other cohorts, PHO evidence in the record suggests that they were still more vulnerable to acquisition of Covid, not just to increased severity of outcomes, she again relies on this same point in her reasons to support the mandates **(Affidavit #3 of Dr. Emerson, Exhibit "AAA", Covid-19 Immunity Task Force, March 2023, p. 1991,1992)[17] (CB page 38).**

S. For no reason related to concerns about transmission or acquisition in the health-care context, the PHO chose to treat persons who sought medical exemptions differently than those seeking religious or conscientious exemptions. The PHO's failure to provide religious and conscientious exemptions or offer accommodation to any of our Petitioners is not reasonable given the evidence in the record. The PHO provided medical exemptions to the mandates but failed to provide exemptions for religious or conscientious objections and obviously whether a worker is exempted for a medical or a religious/conscientious reason is unrelated to whether they are likely to acquire, transmit or become sick from Covid. The only reason for this distinction can be ideological or in other words a scientifically unjustified decision to ignore both religious and conscientious rights and the legally recognised duties of accommodation in the employment context.

T. The PHO cited lack of resources as her reason for suspending the process for reconsiderations under s. 43 and it is trite law that the Crown may not override constitutionally protected rights with a bare assertion that it has insufficient resources to uphold those rights – specific evidence in relation to the assertion must be led. Further for reasons we address in detail in our argument, the studies on absenteeism in the affidavit of Haley Miller do not support continuation of the mandates **(see documents 162** (Media Briefing, January 14, 2022), **163** (Media Briefing, September 6, 2022), **164** (Covid-19 Immunity Task Force report entitled "Healthcare Workers Had Highter Incidences of SARS-CoV-2 Infection and Mental Health Conditions Compared to the General Population", dated September 1, 2023) and **165** (Covid-19 Immunity Task Force report entitled "Healthcare Workers Had Highter Incidences of SARS-CoV-2 Infection and Mental Health Conditions Compared to the General Population", dated October 2, 2023).

U. In a media briefing dated December 05 2022, and January 13, 2023, the PHO reasons refer to pressure on healthcare systems that arise from RSV or the flu, which the Covid vaccines do not control, and the risk to children and infants from these viruses **(Affidavit #3 of Dr. Emerson, Exhibit "DDD", Media Briefing December 5, 2022, pages 2029-2032[18] (CB page 40); Affidavit #3 of Dr. Emerson, Exhibit "EEE", Media Briefing January 13, 2023, pages 2049-2056[19] (CB page 44); Affidavit #3 of Dr. Emerson,**

Exhibit "DDD", Media Briefing December 5, 2022, page 2037, para 4, page 2038, para 2)[20] **(CB page 52)**. Surely, we ought to consider infants and children a vulnerable group from a public health policy perspective, if we considered the elderly as such or those with co-morbid conditions. While the Petitioners do not endorse vaccine mandates for other respiratory illnesses, we raise this to point out that the PHO's choice to continue COVID vaccine mandates is not reasonable based on the record.

V. Based on her media briefings referred to above **(Exhibits DDD, EEE and GGG of Affidavit #3 of Dr. Emerson)**, there is a clear risk of transmission of all respiratory viruses including Covid-19 absent the boosters, and again the PHO did not mandate boosters for COVID-19, and with respect to other respiratory illnesses such as the flu, the health-care workforce and the public is offered reasonable accommodation. There is no requirement to have either a COVID-19 vaccine or a flu vaccine to attend a hospital for the general public, whether they will have contact with vulnerable groups or not, but masking is mostly required.

W. **References throughout the media briefings, especially Exhibits EEE, Media Briefing January 13, 2023, pages 2055, 2056[21] (CB page 54), para 6, Exhibit GGG, pages 2084 – 2089 of Affidavit #3 of Dr. Emerson** (also see whole exhibits) support a conclusion that the increased strain on the health-care system is due to the fact that the COVID virus has ceased to take up much of the resources and we were able to return to performing the necessary surgical and other hospital procedures that were stalled during the Delta wave of the pandemic.

X. Again as referred to above, the Petitioners say that at this stage of the pandemic and despite the findings set out at **Exhibit "V" to Affidavit #1 of Haley Miller**, dated September 1, 2023, at page 176 in a document entitled "Covid-19 Immunity Task Force" citing a study entitled "Vaccination Helps Reduce Workplace Absenteeism among Canadian Healthcare Workers" **(document 164)**, These findings do not justify a failure by the PHO to provide religious, conscientious and expanded medical exemptions as well reasonable work accommodations. In addition, there are correlational issues with this study that are discussed later in these submissions. The problem of healthcare worker absenteeism is also discussed in more detail later in these submissions.

Y. In further support for this point, the PHO's reasons in her media briefing of January 2023, state that COVID hospitalizations were decreasing while other respiratory viruses were increasing despite high levels of vaccination and natural acquisition **(Affidavit #3 of Dr. Emerson, Exhibit "EEE", Media Briefing, 13 January 2023, p. 2055, para. 5) (document 21)**.

Z. As noted, the PHO has not mandated RSV vaccines for any health-care workers, even though the RSV vaccine was approved by Health Canada in August 2023. It is only available for people aged 60 and older and not persons with co-morbid conditions or infants **(Globe and Mail Article, September 28, 2023)[22] (CB page 56).** Flu vaccines are not required for health-care workers if they are willing to mask, but that policy is not even enforced if the employee does not comply **(Health Employers Association of BC article, December 3, 2019)[23] (CB page 59)**.

AA. The requirement of only two vaccinations to qualify as fully vaccinated under the mandates was not rationally connected to the goals of the orders – which was to prevent the acquisition and transmission of Covid in the worker population - the evidence relied upon to support the mandates by the PHO was that two vaccinations was not effective to reduce acquisition and transmission of Covid-19 and boosters were required as we discuss in further detail in our argument below;

BB. The Petitioners also say that the record fails to provide sufficient evidence with respect to settings in which transmission and acquisition are most likely to occur. The record contains mostly references to transmissibility studies that are conducted among households, and appears to rely upon those studies in summaries to support mandates for health-care workers, many of whom are routinely masked depending on the level of care. In addition what is most relevant for our Petitioners is not whether they are going to acquire COVID but whether they are going to transmit COVID to vulnerable populations and they mostly have no contact at all with vulnerable populations **(Affidavit #3 of Dr. Emerson, Exhibit "V", Omicron Monitoring Report, January 5, 2022, for instance Plesner Lyngse et al, December 27, 2021, page 343, detail at page 358, and page354, U.K. Health Security Agency, December 31, 2021)[24] (CB page 62).**

CC. In continuing her vaccination mandates after Omicron, the PHO ignored evidence that vaccination had little effect on hospital admissions for Covid-19 or admissions to the ICU **(Affidavit #3 of Dr. Emerson, Exhibit "V", page 361, see chart at end of study by Ulloa et al, January 2, 2022, page 362)[25] (CB page 65)**.

DD. Although the PHO began her push for mass population vaccination by stating the goal was to achieve herd immunity and thereby reduce infection absolutely and overall, this has turned out to be totally unachievable and irrelevant to the trajectory of this virus as it is with most viruses of this nature. The PHO. consistently stated that herd immunity through both high

vaccination rates and naturally acquired immunity is one of the goals of all her measures and continues to imply this is a possible outcome of high levels of vaccine uptake **(Affidavit #3 of Dr. Emerson, Exhibit "CCC", Media Briefing November 16, 2022, page 2007[26] (CB page 67); Affidavit #3 of Dr. Emerson, Exhibit "GGG", Media Briefing March 2023, page 2084, paras. 2-3)[27] (CB page 68)**. Despite the high levels of vaccine uptake the prevalence of Covid-19 in the general population was much higher when you would expect it to be lower if you believed the vaccine and repeated infections created herd immunity. At **Exhibit "EEE", Media Briefing January 13, 2023, p. 2055, paras. 3-4**[28] **(CB page 69)**, Dr. Henry states ""We must remember that these new strains may make us more vulnerable to infection, but they don't render us defenceless. The defences we have built through immunization and combinations of vaccine immunity and infection induced immunity means that we have strong defences as a community across this province. We are no longer in a place where we needed to take extraordinary measures because everybody was susceptible and many, many people can get who are seriously ill and need hospital care or die." A report entitled "Covid Immunity Task Force, Spotlight on CITF-Funded Research, March 7, 2023" **(Affidavit #3 of Dr. Emerson, Exhibit "ZZ", p. 1981)[29] (CB page 70)** states that more than ¾ of Canadian Blood donors had infection-acquired antibodies in the first weeks of the new year, and 90 per cent of persons aged 17-24 had them: Canadian Blood Services. And see **Affidavit #3 of Dr. Emerson, Exhibit "YY", Covid-19 Immunity Task Force, February 2023, Chart of Sero-prevalence Mid-January 2023, p.1973[30] (CB page 71)** which states that at least 27 million Canadians were infected with Omicron between December 1, 2021 and January 1, 2023. The report goes on to say that "[o]verall, infection-acquired seroprevalence in Canada rose dramatically between August 2021 and January 15, 2023: from 4.6% (95% credible interval [CrI]: 3.5 to 5.6%) in the pre-Delta wave **to 77. 2%** (95% CrI: 73.0 to 80.9%) by mid-January 2023 - after over a year with circulating Omicron variants."

EE. Vaccine effectiveness after two vaccine doses for Omicron was known to be effectively zero in January 2022 in some studies relied upon by the PHO, and yet the PHO did not mandate the booster in her April 6, 2023 orders for Health Care workers most of whom do work with vulnerable populations **(Affidavit #3 of Dr. Emerson, Exhibit "V", Omicron Report, January 5, 2022, pages 361-363)[31] (CB page 72).**

FF. Although the PHO consistently urges boosters on the basis of evidence that protection from infection and transmission improved as a result of boosters,

she did not mandate boosters for health-care workers working with vulnerable populations. She still has not required it in the new orders for any health-care workers only protected by the old vaccines.

GG. Although the PHO mandated the new vaccine for persons who work for the health care authority or its contractors or covered facilities, who have not received two vaccinations from the previous vaccines, there is no evidence in the record to support the idea that the new XBB.1.5 vaccine will stop transmission or spread of Covid-19 to vulnerable populations which is the PHO's stated focus of all the recent orders.

HH. Again, we want to emphasize the point that even if the new vaccine is more effective against new variants than the previous series, the PHO has failed to require that persons working for the health authority and related services covered by the mandates were required to either take the booster (if they had the two previous shots) or take the new vaccine. From a public health perspective of protecting vulnerable populations from severity of outcomes from COVID-19, this is totally irrational.

II. All evidence in the PHO record with respect to trajectory of Covid-19 and the vaccines developed, support a view that any vaccines developed will only provide transient protection. Further, the XBB.1.5 variant is not the dominant variant in British Columbia, Canada or the world. It was most prevalent earlier in 2023. A NACI advisory statement dated July 11, 2023, stated that "XBB.1.5 is the most prevalent lineage in Canada but is declining as of May 19, 2023 with increases in other XBB* sub-lineages, such as XBB.1.16" **(Affidavit #1 of Haley Miller, Exhibit "I", An Advisory Committee Statement (ACS) National Advisory Committee on Immunization (NACI) Guidance on the use of COVID-19 vaccines in the fall of 2023, page 95)**[32] **(CB page 75)** The virus continuously produces new variants, and vaccines cannot keep up. Finally, even were it to turn out that the XBB.1.5 an effective vaccine, it would be years before the PHO could assemble evidence to establish that fact and that evidence would not change what ought to be this court's findings on the failure to grant or consider religious and conscientious objections or provide alternatives to vaccination for all our Petitioners.

JJ. In **Exhibit "F" of Affidavit #1 of Haley Miller,** an **Advisory Committee Statement (ACS) National Advisory Committee on Immunization (NACI) dated June 9, 2023**, asserts at **page 61**[33] **(CB page 76)** that "some limited direct" evidence is now available supporting the use of the bivalent Omicron containing vaccines for the primary series. In the Petitioners' submission,

given the weakness of this assertion, the PHO has failed to properly balance competing rights at this stage of the pandemic. We have quite a bit of evidence in the record that the previous series of vaccines were complete failures in preventing naturally acquired infection of COVID-19.

KK. Even if the evidence supports that the vaccine is effective, then it would only be justifiable to mandate that health-care workers working with vulnerable populations receive it, with reasonable accommodations allowed for religious, conscience and medical objections.

III. THE PETITIONERS (AND WITNESSES)

Phyllis Janet Tatlock

10. Dir. Operations, BC Cancer, BCCNM, administrative worker, did not work with patients religious reasons (submitted exemption request)

Laura Koop

11. Nurse practitioner with Interior Health - focus on high risk and at-risk populations (substance addiction and mental health) - conscience objection

Monika Bielecki

12. Employee Health & Wellness Advisor with Interior Health - natural immunity - has antibody test - worked remotely - conscience objection

Scott Macdonald

13. Registered Art Therapist with the Dr. Peter Centre - - conscience objection

Ana Lucia Mateus

14. Administrative Assistant with Vancouver Coastal Health, Medical Advisory Committee - not a healthcare worker - worked remotely - conscience objection

Darold Sturgeon

15. Executive Director, Medical Affairs for Interior Health - religious objection (submitted exemption request) – natural immunity not a healthcare worker

Lori Jane Nelson

16. Provider Engagement Lead, Clinical Informatics, BC Provincial Health Services Authority, Vancouver - religious (submitted exemption request), medical &

conscience objection – natural immunity -- not a healthcare worker & worked remotely

Ingeborg Keyser

17. Communications Advisor for Interior Health - aware of IH hiring contract workers not subject to mandate - not a healthcare worker & worked remotely - conscience objection

Lynda June Hamley

18. Residential support worker with Kootenay Society of Community Living - religious grounds (submitted exemption request)

Melinda Joy Parenteau

19. Midwife (lost her hospital privileges) natural immunity has antibody test - conscience objection

Dr. Joshua Nordine

20. Doctor (lost hospital privileges and terminated from position at Bridge Detox Centre) - religious objection – natural immunity

IV. WITNESSES:

Jennifer Koh

21. Organization Development & Change Management Consultant for Interior Health - recruiter contacted her for contract position (not subject to mandate) - religious and conscience objections (submitted exemption request) - not a healthcare worker & worked remotely

Elizabeth Ringrose

22. Double vaccinated – had allergic reaction after 2nd dose was a registered nurse for Dr. Peter Centre (resigned in protest to support colleagues)

V. THE HEALTH AUTHORITIES HIRED REMOTE WORKING WORKERS ON CONTRACT WHO WERE NOT SUBJECT TO THE VACCINE MANDATE

23. The Respondents hired remote working contract workers to do the same work as workers who were fired, but those contract workers were not subject to the vaccination mandate. Both Interior Health and Northern Health sent out Notices to Contractors specifically exempting remote-working contract workers from the

vaccine mandates that remote-working employees were subject to. **Exhibits "C"[34] (CB page 77) and "D"[35] (CB page 79) to Affidavit #2 of Ashley Sexton, pages 86 and 88** contain "notices to contractors" dated November 2, 2021 and November 8, 2021. These notices provide "clarity regarding vaccine requirements of contractors, suppliers, vendors and consultants" (Exhibit "D"). See also **Affidavit #2 of Anneke Pingo, Exhibit "B", page 24[36] (CB page 81)** for the November 2, 2021 notice which includes the Interior Health letterhead (inadvertently omitted in Affidavit #2 of Ashley Sexton).

24. Jennifer Koh, a witness in this proceeding, who, as stated above, was an administrative worker, not a healthcare worker, and worked remotely. She was fired for not taking the vaccine. In her **Affidavit #1, at para 20[37] (CB page 82),** she deposes that on or about November 26, 2021, after being terminated from her job on November 15, 2021, she received a call from a recruiter with a job proposal for two of the other BC health authorities for a remote contract Change Management Consultant position, which was a part of the role she performed as a fulltime employee. When she asked about their policy related to remote workers and the vaccine mandate, she was told that the vaccine mandate did not apply to contract workers who work remotely. She also learned that these same contract workers who are not subject to the vaccine mandate are permitted to enter a healthcare facility, provided they do not enter more than once per month. She also received a general letter dated November 8, 2021**,** which is set out at **Exhibit "H" of her Affidavit #1, page 25**[38] **(CB page 83)** entitled "Northern Health Notice to Contractors, November 8, 2021.

25. Similarly, petitioner Ingeborg Keyser deposes at **para 19 of her Affidavit #1**[39] **(CB page 85)** to learning that Interior Health was hiring contract workers to work remotely, and who could occasionally access a health facility (not more than once per month), and that those contract workers were not subject to the Covid-19 vaccine requirement. Ms. Keyser was a Communications Advisor for Interior Health, and, as such, not a healthcare worker. She worked 100% remotely, but was fired for not taking the vaccine.

VI. THE ORDERS ARE OVERBROAD

26. The orders are overbroad in relation to administrative and remote-working workers. These individuals did not have in-person contact with any patients. They did not create any risk to vulnerable populations. Conversely, as stated above, the government was hiring remote-working workers on contract, and they did not need to be vaccinated.

27. UBC changed its policy based on advice from Dr. Patricia Daly, Chief Medical Health Officer (**Affidavit #2 of Ashley Sexton, Ex "E", page 92)[40] (CB page 86)**

and "F[41]" at **page 90) (CB page 88)** (two letters – one from Dr. Daly to UBC president, Dr. Santa Ono, dated February 16, 2022, and the other from UBC doctors to President Ono, dated February 20, 2022).

28. The advice given to UBC by health officials and scientists contradicts the respondent's position on the efficacy of vaccination. In the letter dated February 16, 2022, authored by Dr. Patricia Daly, Vice President, Public Health, Chief Medical Health Officer, and Dr. Meena Dawar, Medical Health Officer, to UBC President Ono, stated that "[c]urrent scientific evidence, including BC data, indicates that COVID-19 vaccination (2-doses), while effective at preventing severe illness, is not effective at preventing infection or transmission of the Omicron variant of the virus, which now accounts for almost 100% of cases in the province. Therefore there is now no material difference in likelihood that a UBC student or staff member who is vaccinated or unvaccinated may be infected and potentially infectious to others" (**Exhibit "E" to Affidavit #2 of Ashley Sexton, page 92 (document 40 above))**.

29. Similarly, the letter dated February 20, 2022, authored by David Patrick, MD, Sarah (Sally) Otto, FRSC, and Daniel Coombs, Professor, Department of Mathematics, states that "[v]accine effectiveness drops off rapidly since the last dose of a two-dose vaccine regimen, down to <20% by four months [1]. For this reason, the scientific evidence, with respect to Omicron, no longer supports using proof of vaccination (regardless of timing) as evidence that a person is a low risk of transmitting COVID-19 to others" (**Exhibit "F" of Affidavit #2 of Ashley Sexton, page 90 (*note – pages 90 and 91 pages are out of order (documents 40 and 41 above))**.

30. Why is there conflict in the approach between the Chief Medical Health Officer and the Provincial Health Officer?

31. **Dr. Kettner's report (Affidavit #2 of Ashley Sexton, Exhibit "B", page 47)[42] (CB page 90):**

    "The information provided by BCCDC and opinions expressed in these letters from BC authorities have implications for the appropriateness of continuing mandatory vaccine policies in all settings."

A. THE PUBLIC HEALTH ORDERS AND THEIR APPLICATION TO CONSTRUCTIONS WORKERS AND OTHER OCCASIONAL WORKERS:

1. THE HOSPITAL AND COMMUNITY ORDERS AND RESIDENTIAL CARE ORDERS AS THEY PERTAIN TO CONSTRUCTION AND OTHER WORKERS

32. The Hospital and Community Orders and Residential Care Orders prior to the April 6, 2023 orders allowed construction workers, vendors, suppliers, technical specialists, and other occasional workers who did not have close contact with patients, or residents of long-term care homes, to enter care facilities and work if they wore a mask and physically distanced (see **Affidavit #1 of Anneke Pingo, Exhibit "M" (Hospital and Community Order of November 18, 2021), page 283)[43] (CB page 91).** Indeed, even occasional workers who had close contact with patients only had to wear a mask and did not have to physically distance from patients **(see Affidavit #1 of Anneke Pingo, Exhibit "I" (Residential Care Order of October 21, 2021), page 174 and 175)[44] (CB page 92); Affidavit #2 of Ashley Sexton, Exhibit "G" (September 12, 2022 Hospital and Community Order), page 117 and 118[45] (CB page 94) and Affidavit #2 of Anneke Pingo, Exhibit "A" (Residential Care Order of September 12, 2022), page 17[46] (CB page 96).** The Petitioners say that these measures belie the irrationality of the PHO's mandates relation to the PHO's stated goals in the orders.

2. THE APRIL 6, 2023 HOSPITAL AND COMMUNITY ORDER AND THE RESIDENTIAL CARE ORDER AS THEY PERTAIN TO CONSTRUCTION AND OTHER WORKERS

33. The April 6, 2023 orders do not contain any of the clauses pertaining to construction workers and other occasional workers. Unless the construction worker is a staff member, the April 6, 2023 orders do not include construction workers working under contract **(Affidavit #5 of Ashley Sexton, Exhibit "U", page 230[47] (CB page 97) and Exhibit "V", pages 251 and 252)[48] (CB page 98)** . The orders are also silent with respect to other occasional workers, vendors, suppliers and technical specialists. Presumably they can enter medical facilities for work purposes, and they do not even need to wear a mask. Why were construction workers and other occasional workers, vendors, etc. not subject to the proof of vaccine requirement throughout the height of the pandemic? They could enter medical facilities and work. Many of our Petitioners did not need to enter medical facilities to work. They were either administrative workers, who had no contact with patients, or they worked remotely. These construction and other workers were permitted to enter facilities, provided they wore a mask and physically distanced (except construction workers who were staff members – they did not even need to wear a mask unless it was unavoidable to enter other areas of the care location

(see **Affidavit #2 of Ashley Sexton, Exhibit "G", page 115)[49] (CB page 100)**. What changed in April 2023 to cause Dr. Henry to vary the orders to capture construction workers who are staff members, but to release the masking and physical distancing requirements of the other workers? Why are they not subject to the vaccine requirement, while our remote working and administrative workers are? The Petitioners say this reasoning is illogical.

34. In summary, the orders are overbroad because they unnecessarily apply to workers who presented no risk to patients. And the fact that remote working contract workers, construction workers, occasional workers who did not have close contact with patients, vendors, suppliers and technical specialists were not subject to the vaccine requirement raises concerns about inconsistent application of the rule, and the rationality of the stated intention of the orders.

VII. SUSPENSION OF REQUESTS FOR RECONSIDERATION UNDER S.43 OF THE *PUBLIC HEALTH ACT* WAS UNREASONABLE

35. **Affidavit #1 of Dr. Emerson, page 25, para 126 – 127[50] (CB page 101): Para 126**: "[g]iven the amount of the OPHO's time and resources being occupied by this process, resources that are far more efficiently and effectively expended dealing with other facets of managing the ongoing pandemic, the PHO determined that it was necessary, in the interests of protecting public health, for her not to consider requests for reconsideration of those aspects of the Orders, other than on the basis of medical deferral to vaccination. **Para 127**: "Accordingly, on November 9, 2021, the PHO exercised her power under section 54(1)(h) of the Public Health Act to issue a variance indicating she will no longer consider reconsideration requests under s. 43 in respect of the Orders for any reason other than on the basis of a medical deferral to a vaccination. . ."

36. However, the reason Dr. Bonnie Henry gives in her Hospital and Community variation Order of November 9, 2021 **(Affidavit #1 of Anneke Pingo, Exhibit "L", pages 255 – 256)[51] (CB page 102)** was that is was "necessary, in the interest of the public health, that [she] not accept requests for a reconsideration of this Order, except from an individual on the basis of a medical deferral to a vaccination, until the level of transmission of infection and incidence of serious disease decreases, and in particular, until the number of hospitalizations, admissions to intensive care units and deaths, and the strain on the public health and health care systems, are significantly reduced. Except where she discusses resources in the preamble to that Order, she does not state that lack of resources is the reason she stopped allowing requests for reconsideration under s.43 of the PHO.

37. The Petitioners say it is unreasonable for the PHO not to accept requests for reconsideration of the orders. They say that there is no emergency anymore, and Dr. Henry should not be acting under the emergency provisions of the *Public*

Health Act, [SBC 2008] c. 28 (the "PHA"). Part 5 of the PHA sets out the emergency powers the PHO can exercise, if the PHO determines that the criteria is met under s. 51 and 52 of the PHA. Section 54(h), which is a section within Part 5 of the emergency powers, allows the PHO to not consider requests for reconsideration. As we are no longer in an emergency, the PHO should not be acting under the emergency powers of the PHA.

38. At **para 87 of Affidavit #1 of Dr. Emerson**[52] **(CB page 104)**, he attaches as **Exhibit 29 (page 1716)**[53] **(CB page 105)** a World Health Organization ("WHO") Policy Brief titled "COVID-19 and mandatory vaccination: Ethical considerations", dated May 30, 2022. It can be inferred from the inclusion of this document in the respondent's materials that the PHO looks to the WHO for guidance in the imposition of policies and practices regarding COVID-19, including vaccine mandates. The WHO sets out an extensive number of ethical considerations in the implementation of vaccine mandates, including respect for conscientious objections. Conscientious objections include religious objections. The policy brief states, **at page 1716**, that "policies that constrain or eliminate individual choice can be controversial and raise a number of ethical considerations". Also **at page 1716** of **Exhibit 29**, the WHO policy brief states that "the WHO does not presently support the direction of mandates for COVID-19 vaccination, having argued that it is better to work on information campaigns and making vaccines accessible". And **at page 1719**[54] **(CB page 106)** of **Exhibit 29**, the WHO policy brief states, "The extent to which mandatory vaccination policies accommodate conscientious objection may also affect public trust".

39. Dr. Bonnie Henry in fact stated at a press briefing on September 13, 2021 that opposition to the Covid-19 vaccine for "strongly-held belief religious reasons, these will be, there'll be a central process to review these and there'll be opportunities for accommodation and in some cases, that may mean people being reassigned, it may mean people being assigned to separate areas and having to take additional measures. like being tested on a regular basis" **(Affidavit #1 of Benneth Johnson, Exhibit "A", time stamp 44:04 to 44:22)**[55] **(CB page 107)**. She went on to say "but... the ultimate end for people who choose not to be immunized who work in health care is leave without pay" **(Affidavit #1 of Benneth Johnson, Exhibit "A", timestamp 44:31 to 44:36)**[56] **(CB page 108)**. Even "leave without pay" is better than being fired from one's job.

40. **Dr. Kettner's report (Affidavit #2 of Ashley Sexton, Exhibit "B", page 37)**[57] **(CB page 109):** The CPHO provided a list of information and evidence that will be used for reconsideration of these measures…"…with a view to balancing the interests of the public, including constitutionally protected interests, against the risk of harm to residents and staff created by the presence of unvaccinated persons in facilities". I have been unable to find considerations or estimates of the risk of harm prior to making this order or subsequently.

41. **Dr. Kettner's report (Affidavit #2 of Ashley Sexton, Exhibit "B", page 47)[58] (CB page 110):**

"Why has the PHO's commitment to "continue to engage in a process of reconsideration of these measures, based on the information and evidence available" not resulted in any changes of the vaccine mandates specified in the orders dated October 21, 2021, November 18, 2021, February 28, 2022, and March 7, 2022?"

VIII. THE PHO'S REASONS ARE NOT SUPPORTED BY THE EVIDENCE

A) THE SEPTEMBER 12, 2022 HOSPITAL AND COMMUNITY ORDER RECITALS (see Affidavit #2 of Ashley Sexton, Exhibit "G")

42. **Recital C (Affidavit #2 of Ashley Sexton, Exhibit "G", page 96)[59] (CB page 111)**: People over 70 years of age, and people with chronic health conditions or compromised immune systems, are particularly vulnerable to severe illness, hospitalization, ICU admission, and death from COVID-19, even if they are vaccinated;

a) The Petitioners accept that the vaccination may reduce the severity of illness in those over 70 but argue that given vaccination does not prevent transmission or acquisition of Covid -19, it is overbroad to require all healthcare workers be vaccinated, especially in the case of the remote and administrative workers, who even if they did acquire or transmit Covid would be doing so outside the health-care setting. The efficacy of the vaccines is reviewed in significant detail in this argument. However, for an encapsulation of the evidence that vaccination does not prevent transmission or acquisition of Covid-19, see expert report of Dr. Thomas Warren, dated August 6, 2022, set out at **Exhibit "A" of Affidavit #2 of Ashley Sexton[60] (CB page 112)**. Dr. Warren states **at page 10**, that "the effects of vaccination are transient. Several months after vaccination, the risks related to COVID-19 are similar between those vaccinated and unvaccinated". He further states that "vaccination does not affect how long a person is infective or tests positive. Twelve weeks after the second dose of a vaccination series, the rates of transmission are similar between vaccinated persons and unvaccinated persons, as well as the risk of transmission in their contacts" (**pages 10-11 of Affidavit**).

43. The Petitioners submit that given the inefficacy of the original Covid-19 vaccines, testing and masking should have been offered as an alternative to the Petitioners to respect their constitutional rights. There was no identifiable health-care cost in doing so. Masking and physical distancing was deemed adequate for construction workers, occasional workers who didn't have close contact with patients or

residents, vendors, suppliers and technical specialists. In addition, a vaccinated healthcare worker infected with Covid-19 may have reduced symptoms and not know he or she is infected. That healthcare worker, not required to wear a mask, could then unknowingly infect a patient with Covid-19. As such, the Petitioners submit that masking and testing would be more effective in protecting vulnerable patients.

44. However, the Petitioners also bring to the Court's attention deficits in the following recitals to illustrate what the Petitioners assert, which is that requiring them to vaccinate, rather than test or mask, or simply to work remotely unvaccinated, was not a public health policy that was necessary to protect an overtaxed health-care system and its vulnerable patients, but rather an effort to further an agenda of mass vaccination in the entire B.C. population, by imposing unreasonable mandates on a captive work-force.

45. In other words, the mandates do not further the legitimate stated goals of the PHO.

46. **Recital F (Affidavit #2 of Ashley Sexton, Exhibit "G", page 96)[61] (CB page 114)**: Unvaccinated people in close contact with other people promotes the transmission of SARS-CoV-2 to a greater extent than vaccinated people in the same situations, which in turn increases the number of people who develop COVID-19 and become seriously ill.

    a. **Affidavit #1 of Dr. Emerson, Ex 65** (Dr. Dove's review entitled "Impacts of COVID -19 Vaccination on Health Care Worker SARS -CoV-2 Transmission"), **page 2466**[62] **(CB page 115)**: "However, emerging studies of Omicron infection suggest comparable viral loads and duration of viral shedding between vaccinated and unvaccinated individuals."

    b. **Affidavit #1 of Dr. Emerson, Ex 65, page 2468**[63] **(CB page 116)**: Dr. Dove goes on to state "[h]owever, studies during the Omicron wave show similar viral loads and duration of viral shedding between vaccinated and unvaccinated individuals, with a potential reduction observed with booster doses", and [d]uring the Omicron wave, viral loads were comparable between individuals who were vaccinated and unvaccinated, with some reduction observed in boosted individuals" and, further "[w]hile studies earlier in the pandemic observed a lower viral load with vaccination, later research in the Delta and Omicron variant waves suggest viral loads are similar between vaccinated and unvaccinated individuals."

    c. **Affidavit #1 of Dr. Emerson, Ex 67** (Dr. Dove's response to Dr. Warren's report of August 6, 2022), **page 2500**[64] **(CB page 117)**: Dr. Dove repeats her statement above that "[w]hile studies earlier in the pandemic observed

a lower viral load with vaccination, later research in the Delta and Omicron variant waves suggest viral loads are similar between vaccinated and unvaccinated individuals."

47. **Recital G (Affidavit #2 of Ashley Sexton, Exhibit "G", page 96)[65] (CB page 118)**: The ongoing incidence of COVID-19 and serious health consequences that result has been exacerbated over time, first by the arrival of the highly transmissible Delta variant of SARS-CoV-2, which caused significantly more rapid transmission and increased severity of illness, particularly in younger unvaccinated people than earlier variants, and by the arrival of the even more transmissible Omicron variants, the first of which caused a surge in infections, hospitalizations and deaths, and is the dominant variant of SARS-CoV-2 circulating in the province.

    a. **Affidavit #1 of Dr. Emerson, para 150**[66] **(CB page 119)**: "The data suggests that generally less severe illness is associated with Omicron – although this is not the case for people with comorbidities or other pre-existing issues."

    b. Dr. Warren report, August 6, 2022 (**Affidavit #2 of Ashley Sexton, Exhibit "A", page 6)**[67] **(CB page 120)**: "The Omicron variant has resulted in much less severe disease compared to previously dominant variants."

48. **Recital M (Affidavit #2 of Ashley Sexton, Exhibit "G", page 97)[68] (CB page 121):** Vaccines, including doses further to the primary series, have been and continue to be readily available in British Columbia, however, some members of the public remain unvaccinated, and many have not taken advantage of the offer of recommended further doses;

    a. The Petitioners suggest that the PHO used her powers over a captive workforce to pursue a policy of mass vaccination of the general population, which should not be advanced through vaccination mandates for work environments that claim they are directed towards protecting vulnerable populations from transmission of Covid-19 from infected health-care workers.

49. **Recital N (Affidavit #2 of Ashley Sexton, Exhibit "G", page 97 (document 68 above))**: Communities with low vaccination rates have experienced rapid spread of SARS-CoV-2, causing serious illness and increases in hospitalizations and ICU admissions, primarily in unvaccinated people. By contrast, communities with high vaccination rates have seen corresponding less serious illness and lower per capita hospitalization, ICU admission and death rates;

a. Again, Dr. Dove's report (**Affidavit #1 of Dr. Emerson, Ex 65, page 2466)**[69] **(CB page 122)** states that "emerging studies of Omicron infection suggest comparable viral loads and duration of viral shedding between vaccinated and unvaccinated individuals." And at **page 2471**[70] **(CB page 123) of the same exhibit:** "During the Omicron dominant wave in BC, two dose VE estimates declined but remained substantial against serious illness (65-75% vs. hospitalization, 40-50% ER visits), with a notable decline in protection against SARS-CoV-2 infection (to 10-15%)".

50. **Recital O (Affidavit #2 of Ashley Sexton, Exhibit "G", page 97)**[71] **(CB page 124)**: Unvaccinated people have been at greater risk than vaccinated people of being infected with some variants of SARS-CoV-2, and those who have been infected have experienced significantly higher rates of hospitalization, ICU-level care and invasive mechanical ventilation, complications and death when compared with vaccinated people;

a. **Affidavit #1 of Dr. Emerson, Exhibit 65 (Dr. Dove's report entitled "Impacts of COVID-19 Vaccination on Health Care Worker SARS-CoV-2 Transmission", page 2471)**[72] **(CB page 126):** "Global and BC vaccine effectiveness analyses suggest that 2-dose protection against SARSCoV-2 infection has been substantial up to and including the Delta wave but has declined during the Omicron wave."

b. It is obvious that these concerns do not even apply to most of the Petitioners in this action, most of whom worked remotely or in an administrative capacity or who could have more effectively protected vulnerable populations through masking and testing.

51. **Recital Q (Affidavit #2 of Ashley Sexton, Exhibit "G", page 98)**[73] **(CB page 127)**: People who are unvaccinated are a greater risk to other people than vaccinated people. The reasons for this are that unvaccinated people are more prone to carry SARS-CoV-2 compared with vaccinated people, can be infectious for a longer period of time, clear the infection more slowly, and are more likely to have symptoms which spread the virus than a vaccinated person. The result is that an unvaccinated person is more likely to become infected than a vaccinated person and is more likely to transmit SARS-CoV-2 than a vaccinated person;

52. As set out above in Dr. Dove's report, vaccinated and unvaccinated people carry comparable viral loads and viral shedding **(Affidavit #1 of Dr. Emerson, Exhibit 65, page 2466)**[74] **(CB page 128).** Dr. Dove also stated, at **page 2469**[75] **(CB page 129),** "However, a small longitudinal cohort of participants with symptomatic, non-severe COVID-19 disease through the Omicron wave did not find a large difference

in the median duration of viral shedding among participants by vaccination or boosted status".

53. **Recital R (Affidavit #2 of Ashley Sexton, Exhibit "G", page 98)[76] (CB page 130)**: Vaccinated people who are infected with SARS-CoV-2 have been shown to have high levels of protection against severe illness, have a reduced risk of the long-term effects of COVID-19, experience shorter infectious and symptomatic periods and recover from COVID-19 faster than similarly situated unvaccinated people, which, in turn, reduces the risk of transmission to their close contacts and co-workers and minimizes the disruption caused by absenteeism, all of which supports the continued provision of essential services in particular, and the orderly functioning of society as a whole;

54. The evidence suggests that vaccination does not reduce transmission or acquisition of Covid-19, especially with respect to Omicron, only severity of illness. However, evidence shows that vaccination does not necessarily reduce severity of symptoms. In his August 6, 2022 report **(Affidavit #2 of Ashley Sexton, Exhibit "A")**, Dr. Warren states, at **pages 8 – 9**[77] **(CB page 131)**, that "[v]accine effectiveness against laboratory-confirmed COVID-19-associated emergency department and urgent care encounters during the Omicron period is 52% 14-179 days after the second dose of mRNA vaccine, declines to 38% :2:180 days after the second dose of mRNA vaccine. Vaccine effectiveness against laboratory-confirmed COVID-19-associated hospitalizations during the Omicron period is 81 % 14-179 days after the second dose of mRNA vaccine, declines to 57% :2:180 days after the second dose of mRNA vaccine. Vaccine effectiveness of two doses of Pfizer vaccine against hospitalization for COVID-19 decreased from 93% prior to Omicron to 70% during Omicron in South Africa._ The vaccine effectiveness of two doses of mRNA vaccines to prevent hospitalization due to Omicron is only 65-66%, and the vaccine effectiveness to prevent progression to invasive mechanical ventilation or death in those hospitalized with Omicron is 46% (12% to 67%).

55. **Recital S (Affidavit #2 of Ashley Sexton, Exhibit "G", page 98)[78] (CB page 133)**: Staff in the health-care system are regularly encouraged to receive recommended further doses of vaccine;

    a. Why then is there a requirement to show proof of vaccination for two doses, and no requirement for booster doses? Given the evidence of waning immunity, as discussed in this argument, it is not in accordance with the PHO's reasoning to protect public health to require the healthcare workers to have only a primary course of vaccination. Those healthcare workers who fulfilled the two-dose requirement in November 2021 are in

the same position from the perspective of acquisition and transmission of Covid-19 as those people who did not take the vaccination at all according to the evidence of the PHO.

56. **Recital X (Affidavit #2 of Ashley Sexton, Exhibit "G", page 98 – 99)[79] (CB page 134)**: The risk of reinfection and hospitalization is significantly higher in people who remain unvaccinated after contracting SARS-CoV-2 than in those who are vaccinated post-infection. Vaccination, even after infection, remains an important measure in protecting against reinfection by providing a more consistent and reliable immune response than immunity arising from infection alone;

    a. The Petitioners challenge this assertion. In his August 6, 2022 report, Dr. Warren states "[t]he Omicron variant is highly transmissible irrespective of vaccination status" (heading) **(Affidavit #2 of Ashley Sexton, Exhibit "A", page 6 – 7)[80] (CB page 136),** and **"**[o]ne study estimated that Omicron estimate that Omicron eroded 54.1 % of all immunity, whether from prior infection or vaccination. A study from Italy described an Omicron outbreak infecting 15 booster-vaccinated healthcare workers. A paper reported transmission of Omicron from one fully vaccinated and asymptomatic traveler to another fully vaccinated traveler at a quarantine hotel in Hong Kong. There was no direct contact between the individuals and it was concluded that airborne transmission across the corridor is the most probable mode of transmission. Another case was reported with transmission under similar circumstances."

    b. In addition, Dr. Warren states in his report that "In vitro studies have shown that antibodies taken from persons recovered from COVID-19 were > 1 Ox less able to neutralize Omicron, and antibodies from double mRNA vaccinated persons were also unable to neutralize Omicron. Antibodies from vaccinated persons neutralize Omicron much less than other variants and 85% of antibodies previously able to neutralize SARS-CoV-2 were unable to neutralize Omicron in persons who received two doses of the Moderna vaccine, neutralization titres (antibody levels able to inhibit the virus) against Omicron were 35 times lower than against the predominant strain during the first wave of the pandemic (D614G). Similarly, antibodies taken from persons who received two doses of the Pfizer vaccine inhibited Omicron 34 times lower than against the predominant strain during the first wave of the pandemic **(Affidavit #2 of Ashley Sexton, Exhibit "A", page 7 (document 80 above)).**

c. Furthermore, again at **page 7** of Dr. Warren's report, he states that "In persons who have only received two doses of vaccine, the decreased ability of antibodies to neutralize Omicron decreases over time. Five months after the second dose of Pfizer or AstraZeneca vaccination, Omicron is no longer neutralized by antibodies. More than six months after a second dose of mRNA-1273 (Moderna) vaccine, only 55% of persons had antibodies able to neutralize Omicron."

57. **Recital FF (Affidavit #2 of Ashley Sexton, Exhibit "G", page 99)[81] (CB page 138)**: "If it were not for the high level of vaccination in the province, British Columbia would be in a far more challenging situation than it is currently since the increasing levels of transmissibility of the most recent variants means that high vaccination rates are required to mitigate transmission, reduce case numbers, reduce serious outcomes, and reduce the burden on the health-care system, particularly hospital and intensive care admissions";

a. While this may or may not be true, it is irrelevant in assessing whether it was reasonable to disregard the religious and conscientious objections of our Petitioners. As stated, the remote and administrative workers posed no threat to the health care system if they remained unvaccinated. As for the other workers, masking and testing could have achieved, at worst equivalent results, and the Petitioners, submit superior result. Recital FF exposes the true goal of the PHO in issuing vaccine mandates for a captive workforce, which, the Petitioners submit, is mandating mass vaccination for the entire population regardless of personal rights and objections and rational accommodations.

b. At a Media Briefing on April 5, 2022, Dr. Bonnie Henry, in answering a question from a reporter about the use of the vaccine passport to incentivize a fourth booster shot, stated "[i]t is one measure, but it is only one measure that can incentivize people to be immunized and that was one of the ways we used the vaccine card, and it was quite effective in that **(Affidavit #2 of Dr. Emerson, Exhibit "39", Media Briefing April 5, 2022, page 939)[82] (CB page 139)**. Clearly the government's goal was to achieve mass vaccination of the population.

58. **Recital LL (Affidavit #2 of Ashley Sexton, Exhibit "G", page 100)[83] (CB page 140)**: "Significantly, at the end of 2021 and early in 2022, with the occurrence of the Omicron wave of infections, it was the high level of vaccination among the health-care workforce which ensured that the health-care system had the necessary resiliency to respond to the upsurge in hospitalizations and ICU

admissions by protecting the members of the workforce from serious and lengthy illness";

59. The evidence in Dr. Warren's report, as well as the evidence of the Respondent is that "age is the most important risk factor for Covid-19 mortality" Dr. Warren writes "In Canada, the risk of death due to COVID-19 in persons< 50 is less than the risk of death due to a motor vehicle fatality" **(Dr. Warren's report, Affidavit #2 of Ashley Sexton, Exhibit "A", page 6)[84] (CB page 141).** Those at risk from serious illness from Covid-19 are those people over the age of 70, which would include very few of the healthcare workers referred to in Recital LL and to whom the mandates apply.

60. **Recital OO (Affidavit #2 of Ashley Sexton, Exhibit "G", page 101)[85] (CB page 142)**. "Further, since vaccinated health-care and service providers who are infected with SARS-CoV-2 have high levels of protection against severe illness, experience shorter infectious and symptomatic periods, and recover from COVID-19 faster than similarly situated unvaccinated people, this reduces the risk of transmission of infection to their co-workers and minimizes the disruption caused by absenteeism in the hospital and community care sectors";

61. The Petitioners submit that better protection would be provided by not working while infected with COVID, which could be achieved through testing for those of our Petitioners that did have contact with patients, and it is totally irrelevant to our Petitioners who worked remotely or in an administrative capacity."

62. Recital QQ **(Affidavit #2 of Ashley Sexton, Exhibit "G", page 101 (document 85 above))**: "In order to avoid the risk of undermining the ability of the hospital and community care sectors to function safely and to properly care for patients, residents and clients, it is necessary to keep the number of unvaccinated people in the workforce as low as possible, including among the members of the workforce who may have little or no direct contact with patients, residents, clients or other workers on a regular basis";

63. We reiterate our comments made regarding recital OO and also say for the reasons set out above, we say this statement is not supported by the evidence, either in the Emerson affidavits, nor in the expert report of Dr. Warren, and in any case, it fails to balance competing rights.

64. Recital RR **(Affidavit #2 of Ashley Sexton, Exhibit "G", page 101 (document 85 above))**: "Every year respiratory viruses take a significant toll on the health of the elderly and those with chronic health issues and compromised immune systems causing serious illness, which often requires hospitalization and very often results

in death. I am particularly concerned that if the people who work in hospital and community care environments, and those with whom they do or may come into contact in the workforce, are not vaccinated, a combination of seasonal respiratory viruses and infection with SARS-CoV-2 could ravage these vulnerable populations by causing significant illness and cause significant absenteeism among the workforce, thereby putting increased stress on the hospital and community care sectors and the health-care system";

65. For most of the Petitioners, this concern does not even apply to them.

66. Recital UU **(Affidavit #2 of Ashley Sexton, Exhibit "G", page 102 (document 85 above))**: "I recognize the effect which the measures I am putting in place to protect the health of patients, residents, clients and workers in hospital and community care settings may have on people who are unvaccinated and, with this in mind, continually engage in the reconsideration of these measures, based upon the information and evidence available to me, including case rates, sources of transmission, the presence of clusters and outbreaks, the number of people in hospital and in intensive care, deaths, the emergence of and risks posed by virus variants of concern, vaccine availability, immunization rates, the vulnerability of particular populations and reports from the rest of Canada and other jurisdictions, scientific journal articles reflecting divergent opinions, and opinions expressing contrary view to my own submitted in support of challenges to my orders, with a view to balancing the interests of the people working or providing services in the hospital and community care sectors, including constitutionally protected interests, against the risk of harm posed by unvaccinated people working or providing services in the hospital or community care sectors";

    a. **Dr. Kettner's report (Affidavit #2 of Ashley Sexton Exhibit "B", page 26)[86] (CB page 144):** There was inadequate clarity and transparency in the order preambles regarding the basis and justification for the orders and how information and evidence, included in the orders, and shown below, would be used in the stated process of reconsideration of the measures;

        1. *"Infection rates, sources of transmission, the presence of clusters and outbreaks, particularly in facilities, the number of people in hospital and in intensive care, deaths, the emergence of and risks posed by virus variants of concern, vaccine availability, immunization rates, the vulnerability of particular populations and reports from the rest of Canada and other jurisdictions".*

b. **Dr. Kettner's report (Affidavit #2 of Ashley Sexton Exhibit "B", page 27 (document 86 above)):** There was inadequate clarity and transparency of the process and rationale for reconsiderations of orders and mandates in response to evolving epidemiological evidence of changes in the pandemic landscape such as the increased transmissibility and decreased severity of new variants (e.g. Omicron) and decreased effectiveness of vaccines to reduce transmission and occurrence of new infections;

c. **Dr. Kettner's report (Exhibit "B" of Affidavit #2 of Ashley Sexton, page 32)[87] (CB page 146):** "The PHO states that she has 'engaged and will continue to engage in a process of reconsideration of these measures, based on the information and evidence available', including those above.

It is not evident which of these data were used, what estimates were used for their quantities, how they were analyzed for the considerations prior to issuing the orders, or how they will be monitored and assessed for reconsiderations of the orders. Nor is it evident what process the PHO has been or will be engaged in to consider and reconsider the measures. The list of information does not specify the effectiveness of vaccination, the proportion of staff of healthcare facilities that are vaccinated, estimates of the "actual risk" causally associated with unvaccinated persons in specific occupational settings nor does it include or define specific measurements that will be used in assessments of the effectiveness or harms expected from the vaccine mandates."

d. **Dr. Kettner's report (Exhibit "B" of Affidavit #2 of Ashley Sexton, page 47)[88] (CB page 147): "**If the CPHO, in her ongoing reconsiderations, has thought that her orders for health care settings should not be revised, the onus is on her to explain why, including a clear description of estimates used to quantify the expected reductions of hospitalizations and deaths – and reductions of hospital capacity - that have been achieved by the mandates and would be achieved by continuation of the mandates."

B) THE APRIL 6, 2023 HOSPITAL AND COMMUNITY ORDER RECITALS and EXCERPT FROM APRIL 6, 2023 PRESS RELEASE (see Affidavit #6 of Ashley Sexton, Exhibit "A")

67. **Recital A (Affidavit #5 of Ashley Sexton, Exhibit "U" page 215)[89] (CB page 148)**: "On March 17, 2020, I provided notice under section 52 (2) of the *Public Health Act* that the transmission of the infectious agent SARS-CoV-2, which has caused cases, clusters and outbreaks of a serious communicable disease known as COVID-19 among the population of the Province of British Columbia,

constitutes a regional event, as defined in section 51 of the *Public Health Act* and I continue to believe that the criteria described in section 52 (2) of the *Public Health Act* continue to be met for the following reasons:

a) In view of the history of mutation of SARS-CoV-2, and the uncertainty which exists about its future behaviour, there continues to be a reasonable risk that it could have a serious impact on public health;

b) There is a continued reasonable risk of an unexpected occurrence of a new variant of SARS-CoV-2 which could cause serious disease among the population;

c) The infectious agent, SARS-CoV-2, continues to spread in British Columbia, Canada and around the world";

68. The Petitioners challenge the above statements. In her media briefing of September 6, 2022 **(Affidavit #1 of Dr. Emerson, Exhibit 15, Media Briefing, September 6, 2022, page 843)[90] (CB page 149)**, Dr. Henry states "We still have a very uncertain trajectory of the pandemic in the next few months, and while I do believe we are emerging from the pandemic part of it, it is clear that COVID-19 will be with us for the long-term."

69. In the same September 6, 2022 media briefing, **at page 853 of Affidavit #1 of Dr. Emerson (Exhibit 15)[91] (CB page 150)**, Dr. Henry states: ". . . I do believe we are going to be out of the emergency response pandemic phase of living with this new SARS CoV 2 virus, but we're not there yet".

70. In her media briefing of April 6, 2023 (**Affidavit #6 of Ashley Sexton, Exhibit "A",** Dr. Henry says we are "emerging from the pandemic" (**line 17:26, page 14)**[92] **(CB page 151)**, and have been coming out of the emergency phase. She is asked a question by a reporter, and responds as follows **(pages 24 – 25)[93] (CB page 152)**:

30:43

". . . Dr Henry you say

30:48

you were emerging from the pandemic do you have a timeline or you know are we through are we through it can you give

30:54

us give us an idea no I I think we've been coming out of the emergency phase for sure and I think today is a good

31:01

reflection of that that we you know some of the additional restrictions we had in place through this past respiratory

31:06

season have really helped us get through that phase um where we still see quite a lot of

31:12

covet and we saw that in our data today we're seeing that around the world but I think in the next few months we're

31:19

likely to to be able to say we're no longer in a pandemic covet is going to

31:24

be with us and we're going to have to be prepared for the uncertainty of next last year I talked about this a bit in

31:29

the fall you know that we're going to see oscillations that change and we're sort of in a bit more of a steady state now but we still don't know yet about

31:37

the periodicity or the seasonality of this virus we have some ideas that it's

31:43

worse in the winter when other things are worse and a little bit easier in the summer and we're sort of seeing that but

31:49

we'll have to watch that so I I think the that we're in that middle phase I

31:55

think the emergency the the Declaration of a pandemic is likely to be over in

32:00

the next couple of months and then we'll just need to be prepared for next winter season when we're likely to see again

32:08

some combination of influenza and RSV and and covet and so what does that mean . . ."

71. In the same media briefing, Dr. Henry states, "As you know, for the past year, the COVID-19 we've been seeing has been variants of omicron and what we have seen is a levelling off and a decreasing of hospitalizations and the new daily hospitalizations are presented here. And, as you know, these are anyone who is in hospital with a positive COVID-19 test. So we know a good proportion of these

people have incidental findings and the reason for hospitalization is not necessarily related to their COVID" **(Affidavit #3 of Dr. Emerson, Exhibits HHH page 2101)[94] (CB page 154).**

72. A review of a graph showing the trajectory of the BC case numbers, from January 3, 2021 to November 26, 2022 shows case counts are negligible **(Affidavit #3 of Dr. Emerson, Exhibit "K", page 141)[95] CB page 155).**

73. As such, there is no emergency anymore, and Dr. Henry should not be acting under the emergency provisions of the PHA. The PHA provides a statutory right to a person to apply to the PHO for a reconsideration of an order that affects him or her. The emergency provisions set out in Part 5 of the PHA allow the PHO to take that away. They allow the PHO to do things under the PHA that are not otherwise allowed. The emergency provisions are activated under s.51 and s.52 of the PHA, if the PHO determines that current circumstances fall within the definitions described in those sections. S. 54(h) of the PHA allows the PHO to not consider requests for reconsideration. This is a significant power that should be wielded judiciously. In her April 6, 2023 Order, Dr. Henry states she feels conditions are still met under s. 51 and 52(2) of the PHA. Yet, as stated by Dr. Henry in her April 6, 2023 press briefing, we have moved out of the emergency phase of the pandemic. As such, she should not be acting under the emergency powers of the PHA.

C) OCTOBER 5 2023 HOSPITAL AND COMMUNITY (HEALTH CARE AND OTHER SERVICES) COVID-19 VACCINATION STATUS INFORMATION AND PREVENTATIVE MEASURES AND RECITALS

74. Recital E is not supported by the record with respect to transmission of Covid-19, in particular, the Omicron variant. The Respondent's own evidence shows that vaccinated and unvaccinated people transmit Covid-19 equally **(see document 62 (Dr. Dove's report entitled "Impacts of COVID -19 Vaccination on Health Care Worker SARS -CoV-2 Transmission"), page 2466**)). There is no evidence that the new vaccine will be any more effective against transmission of the new variants than the previous vaccines were against Omicron in this respect.

75. Recital G asserts that Omicron was instrumental in the PHO's decision to expand the mandates, but serious outcomes from acquisition for this variant were less in all age groups.

76. Recital H asserts that lower vaccination rates of health-care workers could result in significant illness of health-care workers which would undermine the capacity of the health-care system, when in fact, Omicron caused much less severity of illness

and severity of outcomes in all population groups and the evidence is that almost everyone acquired it as per the references as set out in the summary at the start of these submissions. Further, reasons of the PHO in media briefings indicate that stress on the healthcare system is being caused by Flu and RSV. This is especially true of our Petitioners who are all under the age of 60.

77. Recital I confirms that the WHO has declared an end to the emergency.

78. Recital N. As there is no evidence as to how effective the new vaccine is against any variants, assertions about the effectiveness of the new vaccine are just a guess, as were the same assertions about the old vaccines for emerging variants such as Omicron. While guessing might be justified when there is a pandemic, and the identified variants are causing high rates of death and hospitalization, such as was the case with Delta, as the PHO also must consider and reasonably balance mandates against Charter rights, she cannot "guess" at this point to justify vaccination being mandates for our Petitioners.

D) OCTOBER 5, 2023 RESIDENTIAL CARE COVID-19 VACCINATION STATUS INFORMATION AND PREVENTATIVE MEASURES

79. Recital O: From the perspective of protecting vulnerable populations, given the evidence regarding the earlier vaccines in preventing either the acquisition or transmission of COVID with respect to Omicron, and the assertions that the new vaccine will be more effective with Omicron and strains flowing from it, it makes no sense that health-care professionals working with vulnerable populations would not be required to get the new vaccine, while our Petitioners, most of whom have no contact at all, are required to get the new vaccine.

80. Recital Q: It is our assertion that the PHO's comments apply during the period of the early roll-out of the vaccine, where remote and under-serviced communities both in terms of general access and access to vaccination were the communities that experienced the higher rates of infection of hospitalization.

81. Recital T: While this appears to be true, the fact that those who are vaccinated are more likely to be asymptomatic means that vaccinated persons may be more likely to attend at the workplace when they are contagious. We say a system of masking and testing would provide greater protection than vaccination for vulnerable persons. Of course, this only applies to a few of our Petitioners.

82. Retail BB: This recital refers to not recommending routine PCR testing of asymptomatic people in British Columbia. That is reasonable as it would be expensive. But this vaccine mandate is directed toward health-care workers and

other employed or contracted by public health and related facilities, and the cost would be much less. As for generating false negatives and positives, this is true of all the PCR testing relied upon to support much of the evidence of prevalence in the record. In any case, masking would still be effective. No system is perfect but the PHO has a duty to consider the Charter rights of the Petitioners.

83. Recital DD: Given the evidence of the prevalence of the Omicron virus and the levels of vaccination at the time of its emergence, it is more probable that masking would have been more effective than vaccination.

84. Recital FF: Even if this were true, and we say the evidence does not support that it is, where there is no longer an emergency or a worldwide pandemic and the PHO says her focus in on protecting vulnerable populations, those difficulties and risks have to be weighed and balanced against the infringement of Charter rights imposed by mandates. Almost all of our Petitioners have no contact at all with vulnerable populations.

85. Recital LL: The evidence in the record does not support that vaccination prevented residential health care workers from contracting COVID and there does not appear to be any evidence in the record detailing how many workers in that system took sick days during the period referred to. The evidence in the record suggests that the effectiveness of the vaccines against acquisition of Omicron by anyone was minimal at best. But in any case, most of our Petitioners had no contact with the vulnerable population referred to in this order.

86. Recital MM – This would in fact support the workers in this sector being required to get the new vaccine.

87. Recital OO: Really this recital is just a statement that the PHO would prefer the entire population be vaccinated.

88. Recital PP: The PHO cannot mandate vaccination for anyone unnecessarily to ease fears of persons that are unreasonable or do not reflect a real public health risk.

89. Further under “Therefore I have Reasons to Believe and do Believe that: (d) Expanding the grounds upon which a worker may request an exemption to be vaccinated beyond those based upon a risk to the health of the worker would undermine the high level of vaccination which is currently in place among the residential care workforce by increasing the number of unvaccinated workers in the workforce…” Given her stated goals in recent reasons, the PHO may not seek

to mandate a high level of vaccination on her captive workforce nor the general population (which we note is not subject to vaccine mandates at all) Petitioners

90. Dr. Henry is able to apply mass vaccination mandates to a captive workforce, as employed or contracted for almost any purpose by a provincial health authority, and this was evident in her comment at a media briefing on November 1, 2021, when she said "If people are in our health care system and not recognizing the importance of vaccination then that is probably not the right profession for them, to be frank" **(Affidavit #1 of Dr. Emerson, Exhibit 51, Media Briefing November 1, 2021, page 2152)[96] (CB page 156).** From a public health perspective based on the record filed by the PHO, there is no reason to mandate vaccines for most of our Petitioners, remote and administrative workers, or to fail to accommodate those with some contact with vulnerable populations, with masking and testing, which the PHO either avers or accepts are effective measures with other air-borne infections such as RSV and flu. It is difficult to comprehend why a different regime would be applied to Covid-19 at this stage in the pandemic and given what we know about vaccine effectiveness and transmission.

91. Further support for this submission by the Petitioners can be found in multiple media briefings where the PHO refers to the importance of high vaccination rates for the entire Canadian population, including children, who do not normally suffer ill-effects from Covid-19, while at the same time, not requiring flu vaccination in either health-care workers, or mandating it other settings where children are present, such as schools, despite the clear evidence in the record that flu poses a much greater danger to this important and vulnerable population.

IX. VACCINE EFFICACY WANES QUICKLY

92. The evidence of the Respondents shows that vaccination with the original vaccines does not prevent transmission or infection. This is clear throughout the materials. Dr. Bonnie Henry even states it in the recitals to her orders. See, for example, **Recital Q** of the April 6, 2023 Order, where Dr. Henry states "[p]eople who are vaccinated can be infected with SARS-CoV-2" **(Affidavit #5 of Ashley Sexton, Exhibit "U", page 217)[97] (CB page 157).**

93. **Affidavit #2 of Dr. Emerson, Ex 48 (Public Health Agency of Canada Omicron Monitoring Report, January 11, 2022), page 1283[98] (CB page 158)**:

> **Vaccine effectiveness (VE) against Omicron infection and symptomatic disease after an mRNA primary series is low:**

In a test-negative study in Southern California, overall two-dose VE was **0%,** ranging from **30.4%** at 14 to 90 days after dose 2 to **0%** 181 or more days after dose 2 (Tseng et al.)

In a test-negative study from the United Kingdom in those 65 years of age and older, those who received a Pfizer-BioNTech primary series had VE against symptomatic Omicron of below 40% at 5 or more weeks after the primary series (UK Health Security Agency)

VE against Omicron infection was low after two doses of mRNA vaccines **(24.4%** for Pfizer- BioNTech; **24.9%** for Moderna) in this test negative study in Scotland (in an analysis where time since vaccination was not adjusted for) (Willet et al.)

VE was essentially zero after the second mRNA dose **(6%** at 7 to 59 days after the second dose to **-16%** at .::240 days after the second dose) in Ontario (Buchan et al.)

For both Pfizer-BioNTech and Moderna in England, VE was **below 40%** at 10 to 14 weeks after the second dose and **below 20%** at 15 or more weeks after the second dose (UK Health Security Agency. Technical briefing 33)

VE fell rapidly post-vaccination in Denmark for both Pfizer-BioNTech and Moderna and was essentially zero at 2.5 months after the second dose (Hansen et al.)

-18% VE against symptomatic infection in England 14 days or more after the second Pfizer- BioNTech dose (Ferguson et al.)

34% VE against symptomatic infection in England 6 months or more after the second Pfizer- BioNTech dose (Andrews et al.)

33% VE against infection in South Africa after the second Pfizer-BioNTech dose (Discovery Health)

94. **Affidavit #1 of Dr. Emerson, Ex 5, page 33 (Statement from the Chief Public Health Officer of Canada on September 10, 2021)[99] (CB page 159):** "The intent of a booster dose is to restore protection that may have waned over time in individuals who responded adequately to an initial 1- or 2-dose primary vaccine series."

95. **Affidavit #1 of Dr. Emerson, Ex 65, (Dr. Dove review entitled "Impacts of COVID -19 Vaccination on Health Care Worker SARS -CoV-2 Transmission"),**

page 2470[100] **(CB page 160)**: "Both vaccine and infection can produce an immune response that protects against COVID-19 infection for at least 6 months, however vaccination typically leads to a more consistent and reliable antibody response. Antibody responses to vaccination and prior infection may be subject to waning immunity and immune evasion by novel variants."

96. **Also at page 2470**: "While antibody levels are stable initially, peaking at ~3 months, a waning of antibody titres has been observed at 6-8 months for both vaccination and prior infection".

97. **Affidavit #1 of Dr. Emerson, Ex 65, page 2471**[101] **(CB page 161)**: "Declining vaccine effectiveness is thought to be due to waning immunity combined with increasing immune evasion of variants most evidence during the Omicron wave."

98. **Affidavit #1 of Dr. Emerson, Ex 65, page 2477**[102] **(CB page 162)**: "Decreased protection against novel SARS-CoV-2 variants, such as Omicron, may be due to partial immune escape in combination with waning antibody titres, suggesting that boosting strategies may be key to address emerging variants."

99. **Affidavit #1 of Dr. Emerson, Ex 65, page 2479**[103] **(CB page 163)**: "however vaccine effectiveness has declined over time due to waning immunity and variant immune escape" and "[u]ltimately, evidence accumulated throughout the pandemic largely supports the role of vaccination in promoting the dual pandemic goals of protecting patients from SARS-CoV-2 infection and preserving health system capacity, particularly when considering the role of hybrid immunity and booster doses to strengthen the prevention of SARS-CoV-2 transmission moving forward."

100. **Dr. Warren's report (Affidavit #2 of Ashley Sexton, Exhibit "A", page 7)**[104] **(CB page 164): "**Antibodies produced by vaccination decrease significantly over time. In persons who have only received two doses of vaccine, the decreased ability of antibodies to neutralize Omicron decreases over time. Five months after the second dose of Pfizer or AstraZeneca vaccination, Omicron is no longer neutralized by antibodies. More than six months after a second dose of mRNA-1273 (Moderna) vaccine, only 55% of persons had antibodies able to neutralize Omicron. (Considering the above 2 statements, a portion of the healthcare workers would have been vaccinated or had their last booster shot > 6 Months prior, they would be comparable to the unvaccinated people)."

101. **Dr. Warren's report (Affidavit #2 of Ashley Sexton, Exhibit "A", page 10)**[105] **(CB page 165): "**An epidemiological study from Norway showed Omicron had a 74% attack rate in a fully vaccinated (96%) group44. In Norwegian households early in the Omicron wave, the secondary attack rate in households where the index case was unvaccinated (20.4) was similar to the secondary attack rate in households where the index case was vaccinated (18.9)."

102. **Dr. Warren's report (Affidavit #2 of Ashley Sexton, Exhibit "A", page 10 – 11(document 105 above)): "**The effects of vaccination are transient. Several months after vaccination, the risks related to COVID-19 are similar between those vaccinated and unvaccinated. Vaccination status does not affect time to PCR conversion or culture conversion. That means vaccination does not affect how long a person is infective or tests positive. Twelve weeks after the second dose of a vaccination series, the rates of transmission are similar between vaccinated persons and unvaccinated persons, as well as the risk of transmission in their contacts."

103. **Dr. Warren's report (Affidavit #2 of Ashley Sexton, Exhibit "A", page 11 (document 105 above)): "**The odds of symptomatic Omicron infection are not significantly different three (BNT162b2; Pfizer) to six (mRNA-1273; Moderna) months after receiving the second dose of vaccine compared to unvaccinated persons. Other preliminary data suggest that during the Omicron wave, the risk of admission to hospital, admission to ICU or death may not be statistically different between persons fully vaccinated with booster and persons unvaccinated. There were no differences in the Ct values between vaccinated and unvaccinated patients. Similarly, there were no differences in infectious virus recovery between boosted, fully vaccinated, and unvaccinated groups infected with Omicron."

X. GIVEN THE RECORD, WHY WAS A BOOSTER SHOT NOT MANDATED?

104. The evidence is clear that vaccine-induced immunity wanes significantly after two doses of the original Covid-19 vaccines. The government's own evidence shows significant support for a third or even fourth booster shot of a Covid-19 vaccine. Dr. Henry clearly believed a booster shot was a good idea. Yet Dr. Henry did not impose a booster requirement on the healthcare workers. A healthcare worker who had two doses of the vaccine back in the fall of 2021 has the same immunity to Covid-19 as an unvaccinated healthcare worker. A person who has had Covid-19 has better immunity than an unvaccinated person.

105. **Affidavit #1 of Dr. Emerson, page 27 - 28, para 137[106] (CB page 167):**

"Data available to the PHO shows that for Delta, two doses prevented more than 90% of hospitalizations and more than 80% of infection. A booster dose increase protection up to more than 95% against Delta infection or hospitalization. For Omicron, two doses prevent 65-75% of hospitalizations, which is a reduction of about 2/3 to 3/4 compared to unvaccinated persons. A booster dose increased protection up to more than 90% against hospitalization with Omicron and about 50-60% against Omicron infection. The data also shows that although infection-induced immunity provides some protection, infection induced immunity alone is less effective at protecting against serious illness, hospitalization and death, than

either vaccine-induced immunity or infection- plus vaccine-induced immunity. Data also suggests that previous infection alone does not create sufficient levels of neutralizing antibodies to protect against Omicron, while triple vaccination is associated with greater levels of neutralizing antibodies, indicating that the immune response of vaccines may be greater than infection-induced immunity."

See also **Dr. Emerson's Affidavit #1, Exhibit "60", page 2438 - 2439 (BCCDC data summary, March 8, 2022)** [107] **CB page 169)** referred to in **para 137 above**[4].

106. **Affidavit #1 of Dr. Emerson, Exhibit 65 (Dr. Dove report), page 2469**[108] **(CB page 171)**: "One study found that viral loads were lower for boosted individuals experiencing breakthrough Omicron infections compared to unvaccinated and fully vaccinated individuals. However, a small longitudinal cohort of participants with symptomatic, non-severe COVID-19 disease through the Omicron wave did not find a large difference in the median duration of viral shedding among participants by vaccination or boosted status."

107. **Affidavit #1 of Dr. Emerson, para 52**[109] **(CB page 172):** Earlier in the pandemic it was thought that perhaps achieving around 80% primary vaccination coverage with an effective vaccine would control COVID-19 by sufficiently breaking the chains of transmission, even with children remaining unvaccinated at that time. However, with first Delta and now Omicron circulating in British Columbia, it became apparent that very high levels of primary vaccination coverage and third doses would be needed to mitigate the impacts of the SARS-CoV-2 virus.

108. **Affidavit #1 of Dr. Emerson, para 55 (document 109 above)**: During the Omicron-driven wave, the dynamics changed. Both vaccine-induced and infection-induced immunity became more prevalent in the population. Omicron became the dominant variant precisely because it was able to transmit better in the face of higher prevalence of immunity in the population by comparison with previous immunity It became clear that the effectiveness of immunity from vaccination or infection would tend to decline over time if not boosted by further vaccination or infection.

109. **Affidavit #1 of Dr. Emerson, para 62**[110] **(CB page 174)**: The rise in SARS-Cov-2 cases in British Columbia during the fifth wave was driven primarily by the Omicron variant.

110. **Affidavit #1 of Dr. Emerson, para 83**[111] **(CB page 175)**: Vaccination of staff in the health-care system is the most important measure that can be taken to protect patients, clients, residents workers in these settings, their families and their co-

[4] Paragraphs 137 and 156 are identical in Dr. Emerson's Affidavit #1, as are Exhibits 60 and 63.

workers from severe illness from COVID-19. Keeping health care workers as healthy as possible ensures that patients are protected from preventable illness and allows the health-care system to continue to function, especially at a time when the health-care system was and is experiencing significant strain from the Delta-driven fourth wave and Omicron driven fifth wave.

111. **Affidavit #1 of Dr. Emerson, para 143(d)[112] (CB page 176):** currently-available vaccines in Canada have reduced effectiveness against infection from Omicron, but third doses provide increased protection and two doses continue to provide protection against severe disease, hospitalization, acute care admission, and death;

112. **Affidavit #1 of Dr. Emerson, Ex 6, page 193[113] (CB page 177):**

VACCINATION PHASE 1 Dec 2020 to Feb 2021	VACCINATION PHASE 2 Feb to Apr 2021	VACCINATION PHASE 3 Apr to May 2021	VACCINATION PHASE 4 May to Nov 2021	VACCINATION PHASE 5 Nov 2021to Present
Target populations include resident s, staff and essential visit o rs to long-term care settings; individuals assessed and awaiting a long -term care placement; health care workers providing care for COVID -19 patients; and remote and isolated	Target populations include seniors, age ;;:SO; Indigenous peoples age ;;,55 and Indigenous Elders; Indigenous communities; hospital staff, community general practitioners and medical specialists; vulnerable populations in select congregate settings; and staff in community home support and nursing services for seniors.	Target populations include people aged 60-79 years, Indigenous peoples aged 18-64 and people aged 16-74 who are clinically extremely vulnerable.	Target populations include everyone 12+ years. In September, third dose is available for people who are clinically extremely vulnerable.	Target populations include everyone 5+. Children aged 5-11 are eligible at the end of November. Everyone 18 and older will be invited to get a **booster** dose within 6-8 months of their second dose.

Table of vaccination phases defined by vaccine eligibility of target populations in BC:

Indigenous communities.

113. **Affidavit #1 of Dr. Emerson, Ex 6, page 301**, "**Vaccination Phase 6 [114] (CB page 178) (February 2022 - Present)**

Target populations include everyone 5+. Everyone 12 and older will be invited to get a booster dose within 6-8 months of their second dose.

114. **Affidavit #1 of Dr. Emerson, Ex 6, page 384[115] (CB page 179):**

"**Vaccination Phase 7** (April 2022 - Present)

Target populations include everyone 5+. Everyone 12 and older will be invited to get a booster dose within 6-8 months of their second dose. People in long-term care, assisted living, seniors and Indigenous people can get a second booster 6 months after the date of the first booster.

115. In November 2021, at the time she was issuing the orders against the BC healthcare workers, the PHO believed people needed boosters.

116. **Affidavit #1 of Dr. Emerson, Ex 15, page 848 (Bonnie Henry media briefing September 6, 2022)[116] (CB page 180):** "So as we are beginning this fall respiratory illness season, we need to do so with the best protection we can. If you've just had your booster it's OK to wait three to six months to get another one, and I also encourage all of those who've received their invitation for a booster who are young and healthy and haven't got that third dose, to get it now. It will give you that stronger, longer lasting protection through the fall. And I also want to thank everybody. We are here where we are in BC because everybody has stepped up. So many people have done what we've done to protect ourselves, our family, and our communities, and it's made a tremendous difference."

117. **Affidavit #1 of Dr. Emerson, Ex 15, page 849 (Dr. Penny Ballem speaking (document 116 above)):** "And we want to encourage the 1.3m people who got fully vaccinated, but have yet to have a booster, this is the time to come in and get your first booster. It's really important, as Dr Henry has explained. You are not going to get that same strength of protection, even if you've had a COVID infection, and we just really want to encourage that group, especially, to come and get it. And I'll talk to you about where the different groups will be prioritized for invitations for the fall campaign."

118. **Affidavit #1 of Dr. Emerson, Ex 15, page 850 (Dr. Ballem speaking (document 116 above)):** "First of all, the interval from your last vaccine is a really important indicator. As Dr Henry said, immunity does wane. For those who only go up to dose two, they are well over a year, many of them, since they've had their last vaccination. They may have had COVID in the meantime, but we will be targeting, especially those very high priority individuals in those groups, as early invites to the campaign."

119. **Affidavit #1 of Dr. Emerson, Ex 15, page 851 (Dr. Ballem speaking (document 116 above)):** Get your fall booster with either the existing vaccines that you're familiar with, or with Novavax or Janssen. We really want people to be protected for the respiratory season. NACI's guidance is very clear, as is Dr Henry's, getting a booster dose regardless of which vaccine is chosen is the most important thing for you to do this fall, especially once your six months or more from your last dose.

120. **Affidavit #2 of Dr. Emerson, Ex 39, page 930 (Bonnie Henry media briefing, April 5, 2022)[117] (CB page 184):** "And a reminder for those people who have had two doses of vaccine, if you have not yet have your booster, it is important."

121. **Affidavit #2 of Dr. Emerson, Ex 40, pages 949 - 950 "Fall Booster Campaign Technical Briefing for Media September 6, 2022, Dr. Bonnie Henry, Provincial Health Officer"**[118] **(CB page 185)**

(a) Time for Fall Boosters, Registering Children for their Vaccine

(b) People will begin receiving invitations to book fall 2022 booster doses soon and should book their appointments as soon as the invitation arrives
(c) Parents and guardians should make sure their children's vaccines are up to date and they receive a fall booster, if appropriate
(d) As students go back to school, make sure they are protected against COVID-19 with up-to-date vaccinations

About "Bivalent Vaccines"

(e) "Bivalent" or combination vaccines are very common - the most common is the influenza vaccine which often has three or four combinations of vaccine
(f) Bivalent vaccines offer a combination of protection against different variants of a virus
(g) The bivalent COVID-19 vaccine is an adapted version of the Moderna Spikevax COVID-19 vaccine and targets the original COVID-19 virus including the Omicron variant
(h) It will be more effective to protect people against the Omicron variant, which is the most common variant in B.C. right now
(i) Health Canada approved this vaccine on September 1, 2022 and it is safe and effective and everyone eligible is encouraged to get a booster dose this fall

122. **Affidavit #2 of Dr. Emerson, Ex 44 ("Archived 39: Recommendations on the use of bivalent Omicron-containing mRNA COVID-19 vaccines [2022-09-01]"), page 1164[119] (CB page 187):**

"Available evidence to date suggests three doses of an authorized, original mRNA COVID-19 vaccine continues to provide strong and sustained protection against severe outcomes from COVID-19" and "[w]hile the proportion of Canadians vaccinated with a primary series is high, the proportion who have received at least one additional dose has plateaued at a much lower level, especially in younger age groups."

"NACI continues to recommend a primary series with an authorized mRNA vaccine in all authorized age groups. NACI has also provided recommendations for a booster dose with an authorized COVID-19 vaccine for all adults, adolescents, and children 5 to 11 years of age. Immunization of those who are eligible for vaccination but have not yet received their recommended doses (primary or booster) remains a top priority in Canada."

123. **Affidavit #2 of Dr. Emerson, Ex 47, page 1259[120] (CB page 188):**

"Preliminary evidence suggests infection- and/or vaccine-acquired immunity wanes over time, which supports administration of subsequent vaccine doses" and "NACI continues to strongly recommend a primary series with an authorized mRNA vaccine in all authorized age groups. NACI also strongly recommends a booster dose for all adults, and for adolescents who are considered to be at high risk for severe disease."

124. **Affidavit #2 of Ashley Sexton, Ex G, page 97[121] (CB page 189):**

September 12, 2022 Order:

Recital L (b) and (c) in the September 12, 2022 Hospital and Community Order clearly sets out Dr. Henry's stated beliefs about the booster:

- Recital L (b): most British Columbians have received their primary course of vaccine and booster doses are being implemented in order to reinforce the protection offered by vaccination;

- Recital L (c): evidence continues to mount that to counter-act waning immunity booster doses of vaccine are very important preventive measures;

125. **Dr. Warren's report (Affidavit #2 of Ashley Sexton, Exhibit "A", page 9)[122] (CB page 190):** Fully vaccinated (two doses) and unvaccinated secondary attack rates are similar, but a booster dose lowers the secondary attack rate. The secondary attack rate of household contacts exposed to vaccinated cases of Delta SARS-CoV-2 infection (25%) is similar to the secondary attack rate of household contacts exposed to unvaccinated cases of Delta SARS-CoV-2 infection (23%). Fully vaccinated persons with Delta infection have peak viral loads similar to unvaccinated persons with Delta infection.

126. **Affidavit #2 of Dr. Emerson, Ex 48, pages 1283 - 1411 (Public Health Agency of Canada, Omicron Monitoring Report, Report 5, January 11, 2022):** these studies can be summed up with these statements from various studies: "Vaccine effectiveness (VE) against Omicron infection and symptomatic disease after an mRNA primary series is low **(page 1283)[123] (CB page 191)** and "Vaccine effectiveness (VE) against Omicron infection and symptomatic disease after an mRNA booster dose is higher" (page 1283), "Against Omicron, three-dose schedules were more likely to have measurable titres than two-dose schedules" **(page 1306[124] (CB page 192).** And at **page 1308 [125] (CB page 193): "**In this test-negative study from the United Kingdom in those 65 years of age and older, those who received a Pfizer-BioNTech primary series had the following vaccine effectiveness (VE) against symptomatic Omicron:

Two-dose VE was below 40% at 5 or more weeks after vaccination

Three-dose VE was 65% for Pfizer-BioNTech and 70% for Moderna booster at 2 to 4 weeks after the booster, with evidence of decline over time afterwards.

Vaccine effectiveness after three doses against hospitalization was 94% at 2 to 9 weeks after the booster and 89% at 10 or more after the booster".

There are multiple studies cited in this report that provide similar data.

127. In discussing the rollout of the booster campaign during the September 6, 2022 Media Briefing, Dr. Ballem emphasized how important it was for healthcare workers to have a booster shot of the Covid-19 vaccine. She stated "[h]ealth care workers is the final group that I want to speak to. Our health care workers were a high priority when the first booster came, in order to protect our health care system. Many of them are well over six months since their last dose. We want them to be protected. As Minister Dix says, to protect them from getting sick, but also equally important, from them we need to protect our patients in our institutions and our programs. Health care workers are a really important group" **(Affidavit #1 of Dr. Emerson, Exhibit 15, Media Briefing September 6, 2022, page 850)[126] (CB page 194).**

128. Why didn't the PHO mandate boosters? Given Dr. Bonnie Henry's knowledge about waning vaccine efficacy, and given her position that "vaccination is safe, highly effective, and the single most important preventive measure a person can take to protect themselves, their families, and other persons with whom they come into contact from infection, severe illness and possible death from COVID-19" (Recital L of September 12, 2022 Order), and that "vaccination is the single most important preventive measure people working in hospital or community settings can take to protect patients, residents, clients and the health-care workforce from infection, severe illness and possible death from COVID-19" (Recital PP of the September 12th Order), Dr. Henry should have mandated the booster to be consistent in her reasoning. Two doses of the vaccine were not working. Fully vaccinated healthcare workers (workers with two shots) were catching and transmitting the virus the same as the unvaccinated workers who were fired.

XI. STRAIN ON THE HEALTH-CARE SYSTEM - OUR PETITIONERS ARE OF WORKING AGE

129. The Respondent relies on arguments that without a vaccine mandate, health-care workers themselves would have been an added strain on the healthcare system. The Petitioners submit that the evidence contained in Affidavit # 2 of Dr. Emerson supports the conclusion that vaccination does not prevent infection with or transmission of Covid-19. While the Petitioners agree that a reduction in the

health-care workforce could place a strain on the ability of the healthcare system to provide care for vulnerable populations, there is no evidence that acquisition of Covid would cause serious adverse effects in the health-care workforce, and given the high subscription of health-care workers to vaccination, the provision of religious or conscientious exemptions or accommodation through allowing testing and masking to the small numbers of workers who objected to the mandates would not and will not affect the ability of this group of captive workers to provide care. In a Media Briefing on February 5, 2021, Dr. Henry stated "[a]lso very importantly, is making sure that we protect the circle around those most vulnerable people in long-term care and that's immunizing staff and people who work in care homes and again, we have had very high uptake in most places around the province and we will be looking at this in more detail on a facility-by-facility basis in the coming week (**Affidavit #2 of Dr. Emerson, Exhibit 27, Media Briefing, February 5, 2021, page 668)[127] (CB page 195).** In a Media Briefing September 13, 2021, Dr. Bonnie Henry stated "I will say, as well, the numbers, the percentage of vaccinated health care workers is very, very high. you know, doctors in BC, it's in the high 90s, 96, 97% of physicians across the province are immunized. it's in the high 80s to 90s for nurses. there are pockets, small pockets of people who are not-yet vaccinated **(Affidavit #1 of Benneth Johnson, Exhibit "A", timestamp 46:44 to 47:12)[128] (CB page 196)**.

130. In a media briefing on November 16, 2021, Dr. Henry stated "We do know that there is definitely protection, both from droplets getting out and from you inhaling droplets, when you have a good non-medical mask. Those are widely available. They can be reused. They can be cleaned and washed and hung to dry. So it is really balancing that. And if you're somebody who's vaccinated, who's got a good strong immune system and you're going to be in certain situations, then I think wearing a non-medical mask, as I do, in those indoor public spaces, is perfectly adequate" **(Affidavit #1 of Dr. Emerson, Exhibit 55, Media Briefing November 16, 2021, page 2257)[129] (CB page 198)**. Similarly, in a Media Briefing on November 16, 2022, one year later, Dr. Henry acknowledged that masks work in healthcare and other work settings: The setting where masking continues to be essential are in health care settings and we have a mandate in all of our health care settings across this province at all times, these tools are necessary all the time, so we have vaccination requirements for health care workers across our health care settings in this province and everybody in LTC, hospitals, vaccination clinics, community clinics wear masks throughout this respiratory season" **(Affidavit #3 of Dr. Emerson, Exhibit "CCC", Media Briefing, November 16, 2022, page 2014)[130] (CB page 199).**

131. In addition, given their age, our Petitioners would not be expected to place a strain in the health-care system by succumbing to severe illness. At a Media Briefing on April 5, 2022, Dr. Henry stated "When we look at who are the people who are more likely to end up in hospital -- and are there measures that we can take to help mitigate and prevent them from having that severe illness -- we can see over time that it is our elders and seniors who are more likely to have severe illness and end up in hospital. We see that continues, with people over age 80 through this omicron wave can also be more likely to have more severe disease. That has levelled off and has a slight uptick in the last week. Also when we look at this, we can see how younger people are less likely to end up in hospital" **(Affidavit #2 of Dr. Emerson, Exhibit 39, Media Briefing April 5, 2022, page 929)[131] (CB page 200).**

132. At a Media Briefing on March 10, 2023 **(Affidavit #3 of Dr. Emerson, Exhibit "GGG", Media Briefing March 10, 2023, page 2086)[132] (CB page 201)**, Dr. Henry stated "[o]ur seroprevalence data, what that tells us and that tells us that across the age spectrum we have a really high level of immunity. That's for many people a combination of immunity that they get from vaccination plus having been exposed to and infected with COVID-19.

What does that look like?

If we look at the spectrum across the age groups, for people under age 50, as many as 80% to 90% of people have some combination of protection from both vaccination and infection. That's good and what we're learning as we're going through this whole thing globally is that that level of protection, your immune system remembers that for a longer period of time. While you may still get infected, the second part of our immune system' and I've talked about this before, what we call the memory cells, the cell mediated immunity, our system is primed. So when you are exposed to the virus, it can rapidly ramp up and protect you from getting more severe illness, stop the virus from causing more infection cells, and that is something that most of us have here, particularly younger people.

133. A study referred to in **Affidavit #3 of Dr. Emerson, Exhibit "MM", page 1885**[133] **(CB page 202)**, states that "asymptomatic transmission of SARS-Co V-2 virus is not so common in healthcare students".

134. **Affidavit #1 of Dr. Emerson, para 60**[134] **(CB page 203)**, "From January 15 to August 13, 2022, the median age for hospitalizations has been 67, the median age for critical care admissions has been 63, and the median age for deaths has been 82."

135. **Affidavit #1 of Dr. Emerson, para 64**[135] **(CB page 204)**, “Over the course of the pandemic, the scientific community has learned that older adults are more likely to get sick from COVID-19, are at an increased risk of suffering severe illness from COVID-19, and are more likely to require hospitalization, intensive care, or significant interventions like ventilators. In particular, individuals over the age of 70, especially those with underlying chronic medical conditions, are most at risk of a serious or fatal illness after contracting COVID-19. This trend is consistent with our experience of COVID-19 in British Columbia.”

136. **Affidavit #1 of Dr. Emerson, para 85**[136] **(CB page 205)**, “A recent study conducted by the Canadian Immunization Research Network (CIRN) Serious Outcomes Surveillance Network, and led by Dr. Shelly A. McNeil (Canadian Center for Vaccinology, Halifax) confirmed that frailty and older age are correlated with higher rates of mortality due to COVID-19, with the odds of dying increasing by 5% with each year of age. A link to that study from the CITF website is attached as **Exhibit 28".** However, Exhibit 28 does not discuss Covid-19 **(see document 136).**

137. **Affidavit #1 of Dr. Emerson, para 133**[137] **(CB page 209)**, “Generally speaking, the settings covered by the Healthcare Orders are settings where vulnerable populations reside in communal environments and where people are receiving health care services. Transmission has occurred in these types of settings over the course of the pandemic and the majority of people residing or seeking care in these settings are people who, on account of a variety of factors, including advanced age, being immunocompromised, or experiencing other health challenges, are at high risk of suffering severe illness, hospitalization, critical care admission or death if infected with COVID-19. Requiring staff in these settings to be vaccinated mitigates the risk of transmission and resulting risk of outbreaks and potential serious health consequences for residents and patients, while also mitigating the impact on the healthcare system of clusters and outbreaks of disease, and of staff being absent due to illness from COVID-19.”

138. **Dr. Warren’s report (Affidavit #2 of Ashley Sexton, Exhibit “A”, page 6)**[138] **(CB page 210):** “Age is the most important risk factor for COVID-19 mortality. Compared to persons under age 40, persons over the age of 80 have a greater than 300 times chance of dying from COVID-19. The infection fatality ratio (IFR) in persons over 80 is approximately 1000 times the IFR in those under 20. In Canada, 61 % of deaths are in persons over 80, 82% of deaths are in persons over 70, and 93% of deaths are in persons over 60.

Globally, excess mortality related to COVID-19 is concentrated in persons over age 60, and particularly in persons over age 75; excess mortality related to COVID-19 was generally not seen in age groups less than age 60. The attributable mortality due to COVID-19 is similar to influenza in persons aged less than 60.”

XII. THE PHO'S EVIDENCE DOES NOT SUPPORT HER REASONS GIVEN FOR THE MANDATES: THE VACCINE DOES NOT PREVENT TRANSMISSION OF COVID-19 VARIANTS AND NATURAL IMMUNITY PLAYS A SIGNIFICANT ROLE IN IMMUNITY

139. **Affidavit #1 of Dr. Emerson, para 49[139] (CB page 211):** Prior infection with SARS-CoV-2 also usually triggers immunity that may reduce the likelihood and severity of subsequent infections. This is misleadingly referred to as "natural immunity" - the reason that this is misleading is that vaccine-induced immunity is just as much a product of biological ("natural") processes as infection-induced immunity. Immunity can be additive, so that vaccination and infection together lead to greater immunity than either infection alone or vaccination alone.

140. **Affidavit #1 of Dr. Emerson, para 55[140] (CB page 212)**: During the Omicron-driven wave, the dynamics changed. Both vaccine-induced and infection-induced immunity became more prevalent in the population. Omicron became the dominant variant precisely because it was able to transmit better in the face of higher prevalence of immunity in the population by comparison with previous immunity. It became clear that the effectiveness of immunity from vaccination or infection would tend to decline over time if not boosted by further vaccination or infection. This did not mean that immunity from vaccination became less important. On the contrary, immunity from prior vaccination continued to be the primary factor in reducing the seriousness of the consequences from infection, especially hospitalization and death. Thus, while breakthrough infections from Omicron became more common, for those who had been vaccinated, they tended to be less serious in their impact.

141. **Dr. Warren's report (Affidavit #2 of Ashley Sexton, Exhibit "A", page 10)[141] (CB page 213): "**Natural immunity from infection provides protection similar to vaccination. At the beginning of the Omicron wave, 68% of unvaccinated persons in South Africa had natural immunity to SARS-Cov-2. T cell responses to Omicron are comparable between those vaccinated and those unvaccinated but previously infected with SARS-CoV-2. Documented past infection provides moderate protection against hospitalisation and death due to Omicron, similar to the effect of vaccination. Natural immunity provides robust protection against re-infection (95% lower risk) and hospitalization (87% lower risk) for at least 20 months compared to non-immune individuals. In that study, vaccination did further lower the risk of re-infection and hospitalization in naturally immune persons; however, to prevent one reinfection in those with natural immunity, 767 individuals needed to be vaccinated with two doses."

142. **Affidavit #1 of Dr. Joshua Nordine, Exhibit "J", page 20: From the BC Covid Therapeutics Committee report dated February 1, 2022[142] (CB page**

214): "Previous infection alone is equivalent to 2-dose vaccination without a booster" (Exhibit "J" starts at page 17 of the Affidavit).

143. **Dr. Warren's report (Affidavit #2 of Ashley Sexton, Exhibit "A", page 6)[143] (CB page 215):** Vaccination against SARS-CoV-2 is effective in preventing severe COVID-19 disease (e.g. hospitalization, ICU admission) and death due to COVID-19. The benefit of vaccination is most evident in those at highest risk for severe disease or death (e.g. elderly). Even during the recent Omicron period, some studies have shown that COVID-19 vaccination protected against hospitalization, admission to an ICU, requiring intubation for mechanical ventilation and death. However, the protective effect of vaccination decreases significantly over time, and vaccination has little effect on Omicron transmission.

144. **Dr. Warren's report (Affidavit #2 of Ashley Sexton, Exhibit "A", page 6 - 7) (document 143 above):** The Omicron variant is highly transmissible irrespective of vaccination status. One study estimated that Omicron estimate that Omicron eroded 54.1% of all immunity, whether from prior infection or vaccination. A study from Italy described an Omicron outbreak infecting 15 booster-vaccinated healthcare workers. A paper reported transmission of Omicron from one fully vaccinated and asymptomatic traveler to another fully vaccinated traveler at a quarantine hotel in Hong Kong. There was no direct contact between the individuals and it was concluded that airborne transmission across the corridor is the most probable mode of transmission. Another case was reported with transmission under similar circumstances.

145. **Dr. Warren's report (Affidavit #2 of Ashley Sexton, Exhibit "A" page 8 (document 143 above):** "Vaccine effectiveness of two doses of vaccine against Omicron is poor. Vaccine effectiveness against symptomatic Omicron disease after two Pfizer doses was 65.5% four weeks after receiving the second dose but dropped 8.8% 25 weeks after the receiving the second dose. The vaccine effectiveness of the Moderna vaccine (two doses) against Omicron infection at 14-90 days was 44.0% but declined quickly".

146. The Petitioners submit that masks and social distancing could be considered the most important measure followed by vaccination at best.

147. **Affidavit #1 of Dr. Emerson, Ex 10, page 727 (November 4, 2021 media briefing by Dr. Henry)[144] (CB page 218):** ". . . because I hear all the time that post-infectious immunity is better than vaccination and I've said this also in the last couple of weeks: there has been a number of small studies that show that yes, people who . . . So I think we all agree for a period of time after infection most people have immunity, but that varies. It varies depending on your own immune system. It varies depending on how severe the infection was. Some people who

have very mild infection, it doesn't stimulate the cell mediated response of their immunity, and then some people who have very severe infection, their immune system gets overwhelmed and if they recover they may not have strong immune protection for a long period of time. And we know that it varies how long that protection from infection lasts".

148. Scientific studies have established that vaccine immunity wanes to essentially zero after a primary series (two doses of the original vaccines) of vaccination for Covid-19. Blood donor evidence provided in the Respondent's materials suggests that infection with Covid-19 provides no natural immunity at all from reinfection, nor does vaccination provide immunity. Because the virus mutates so frequently, people simply continue to become sick from whatever new variant is circulating amongst the population.

149. **Affidavit #2 of Dr. Emerson, Exhibit 48, Omicron Monitoring Report, January 11, 2022, page 1357 - 1358[145] (CB page 219):**

Vaccine effectiveness against symptomatic infection using a cohort analysis based on SGTF

Vaccine effectiveness (VE) following 2 doses was essentially zero for both Pfizer-Bioi\NTech (-i8%i and AstraZeneca (-39%) but was **54%** and **55%** respectively 14 days or more following an mRNA booster (see Table 1 Ferguson for detailed data for Pfizer as the primary series).

Table 1 Ferguson: Vaccine effectiveness for primary series of Pfizer-BioNTech for Omicron and Delta with or without an mRNA booster dose using a cohort analysis

	Omicron	Delta
Two doses: 14 or more days after second dose	-18% (95% CI: -26 to -11%)	55.9% (95% CI: 55.5 to 56.3%)
mRNA booster doses: 14 or more days after booster dose	54% (95% CI: 46 to 60%)	88.6% (95% CI: 88.1 to 89.1%)

Vaccine effectiveness against symptomatic infection using a test-negative case control design based on SGTF (data also captured in the preprint by Andrews et al.)

Vaccine effectiveness (VE) following 2 doses was very low for both Pfizer-BioNTech (19%) and essentially zero for AstraZeneca (-5%), however VE 14 or more days following the mRNA booster dose was higher at

77% with Pfizer for the primary series and **73%** with AstraZeneca for the primary series. (See Table 2

Ferguson for detailed data for Pfizer as the primary series)

Table 2 Ferguson: Vaccine effectiveness for primary series of Pfizer-BioNTech for Omicron and Delta with or without an mRNA booster dose using a test-negative case control design (also captured in Andrews et al.)

	Omicron	**Delta**
Two doses: 14 or more days after second dose	**19%** (95% CI: 13 to 24%)	**69.8%** (95% CI: 69.4 to 70.2%)
mRNA booster doses: 14 or more days after booster dose	**77%** (95% CI: 72 to 80%)	**94.3%** (95% CI: 93.9 to 94.6%)

150. **Affidavit #1 of Dr. Emerson, Ex 67, page 2497 (Dr. Dove's review of Dr. Warren's report of August 6, 2022)[146] (CB page 221): "**Omicron is antigenically-distinct from earlier SARS-CoV-2 variants resulting in reduced sensitivity of neutralizing antibodies to key viral proteins. While a 2-dose series of COVID-19 vaccines is less effective at eliciting adequate neutralizing antibodies against Omicron, a booster dose of almost all types of vaccines enhanced Omicron specific humoral responses to a certain degree (with greater effect for heterologous vaccination strategies). Notably, hybrid vaccine induced immunity plus infection induced immunity improves the heterologous antibody response and extends the duration of immunoprotection". And "Antibodies produced by vaccination are much less effective against Omicron."

XIII. SIGNIFICANT ADVERSE REACTIONS WERE BEING REPORTED

151. Adverse reactions were being reported during the rollout of the vaccine, right from the beginning of its rollout. While all vaccines have adverse effects on some persons, the existence of adverse reactions supports the provision of exemptions for religious, conscientious, and medical reasons and the application of the principles of reasonable accommodation to those to whom the mandate applies, as is the case with the general population, who have been free to choose whether to accept vaccination or not.

152. **Affidavit #2 of Dr. Emerson, Exhibit 3 pages 68 – 76 [147] (CB page 222) (original pages are not numbered or they are hidden by the header) (BCCDC**

report, December 13, 2020 to September 24, 2022) sets out numerous adverse events to the Covid-19 vaccines.

153. In addition, adverse reactions are set out in emails with the PHO's office from the time the vaccine was first administered in December 2020 to March 2020 **(Affidavit #2 of Dr. Emerson, Exhibit 52, page 1455 - 1496 (FOI requests))[148] (CB page 231).**

154. Dr. Warren's report of March 3, 2023 reviews several studies about the adverse reactions to the Covid-19 vaccine **(Affidavit #5 of Ashley Sexton, Exhibit "H", page 71 – 73)[149] (CB page 273)**.

155. **Affidavit #3 of Dr. Emerson, Exhibit "QQ", page 1915: "Vaccine side-effects among those with a previous SARS-CoV-2 infection[150] (CB page 276)**. A CITF and Canadian Immunization Research Network (CIRN) funded study, published in Clinical Infectious Diseases, showed that adults who had a previous moderate or severe SARS-CoV-2 infection were more likely to experience side effects from the first vaccine dose. More specifically, they were more likely to have a health event sufficient to impact routine activities or require medical assessment in the week following each of the first three vaccine doses."

XIV. ADDITIONAL OBSERVATIONS ABOUT DR. EMERSON'S AFFIDAVIT #3:

156. There are reporting errors in the case numbers in **Exhibits "D"[151] (CB page 277), "E"[152] (CB page 278) and "F"[153] (CB page 279), pages 61, 72 and 84.**

157. The Petitioners submit that **Exhibits "M", "N", "P" and "Q"** are irrelevant, as they pertain to the use of vaccines in children. This is not relevant to this litigation.

158. **Exhibit "S"** is a duplication of **Exhibit "R".**

159. **Exhibit "W"** is a duplicate of **Exhibit 48** in Dr. Emerson's **Affidavit #2**.

160. The Petitioners submit that **Exhibit "FFF"** is irrelevant, as it is a media briefing with Minister Adrian Dix, and pertains to health care improvements in North Island Health. This is not on point with the matters raised in this litigation, which is whether it was reasonable for Dr. Bonnie Henry to require the Petitioners to take a Covid-19 vaccine.

161. Affidavit #3 of Dr. Emerson confirms repeatedly, throughout the exhibits, that VE wanes quickly, and is particularly ineffective against Omicron.

XV. THE XBB.1.5 VARIANT AND THE OCTOBER 5, 2023 HOSPITAL AND COMMUNITY and RESIDENTIAL CARE ORDERS

162. **October 5, 2023 order, definition of "vaccinated", page 16[154] (CB page 280):**

> "'vaccinated' means to have received, at least 7 days previously, one dose of Janssen vaccine, or two doses of a vaccine or a combination of vaccines,
>
> (a) approved for use in Canada by the department of the federal government responsible for regulating drugs, or
>
> (b) approved by the WHO, with respect to vaccines approved by the WHO but not approved for use in Canada;
>
> or, after this Order comes into effect, in the case of a person who has not been vaccinated as described above, to have received the recommended dose or doses of the XBB.1.5-containing formulation of COVID-19 vaccine approved for use by Health Canada and available in the province (http://www.bccdc.ca/health-info/diseases-conditions/covid-19/covid-19-vaccine/vaccines-for-covid-19)."
>
> From link in order:
>
> > Name: Pfizer-BioNTech Comirnaty® COVID-19 vaccine; Pfizer-BioNTech Comirnaty®Original and Omicron BA.4/BA.5, bivalent COVID-19 vaccine; Pfizer-BioNTech Comirnaty®Original and Omicron BA.1, bivalent COVID-19 vaccine; **Pfizer-BioNTech Comirnaty®Omicron XBB.1.5 subvariant, monovalent COVID-19 vaccine**
> >
> > Name: Moderna Spikevax® COVID-19 vaccine; Moderna Spikevax® Bivalent COVID-19 vaccine (Original/Omicron BA.1); Moderna Spikevax® Bivalent COVID-19 vaccine (Original/Omicron BA.4/5); **Moderna Spikevax® COVID-19 vaccine (Omicron XBB.1.5 subvariant)**

163. **Affidavit #3 of Dr. Emerson, Exhibit "EEE", page 2054-2055 (Dr. Bonnie Henry media briefing, January 13, 2023)[155] (CB page 281):** "I can't overestimate the importance of having those booster doses in effectively blocking the transmission in our communities. Along with that, I want to talk a minute about the XBB1.5 variant because it's been on a lot of people's minds over the last few weeks. To date, we've had 24 confirmed cases. So those are ones where the test has been done and we've done the whole genome sequencing that shows it's this specific subvariant. And it's important to note that this doesn't reflect the total number of cases in the province. This is surveillance data. So this gives us a sense of what proportion of the tests that we're doing, the whole genome sequences, turn

out to be this one. And we saw the first ones in late November, early December and we now have found about -- it's up to about 5% or 6% of the whole genome sequences are this variant. The most that we're seeing here -- 95% of what is causing illness in the province – is still the BQ1.1. All of these are subvariants of omicron and I think that's really, really important. And while this XBB.1.5 has garnered a lot of attention, it still remains a subvariant of omicron. So what does that mean? Any new variant has an advantage and spreads more easily. That's what viruses do. They change to try and reproduce themselves more quickly. And if it spreads more easily it often will replace the ones that went before it. So each new one that spreads, by definition, is the most infectious one to date, and we've seen that with XBB.1.5."

164. **Affidavit #3 of Dr. Emerson, Exhibit "T" (NACI report, March 3, 2023 (Guidance regarding spring boosters), page 305[156] (CB page 283):**

"Omicron sub-lineages continue to be the dominant strains of COVID-19 circulating in Canada. Viral sequencing is currently showing clear dominance of variants BQ.1 and BQ.1.1, while an increase in the XBB.1.5 recombinant sub-lineage is also being observed. Based on neutralization studies, BQ* and XBB* sub-lineages are more immune evasive than earlier sub-lineages (such as BA.2 and BAS), with XBB* described as the most immune evasive sub-lineage."

Query: The XBB variants are the most immune evasive sub-lineages. While it may arguably be reasonable for Dr. Bonnie Henry to have been justified in mandating vaccines during the early stages of the Delta variant, in world pandemic conditions, we are now in a situation where the seroprevalence of covid-19 from natural infection is approximately 78 percent for the adult general population in a circumstances where more than 80 percent of the adult population was vaccinated and we know that currently circulating variants are mutating quickly and evade vaccine, and in any case the proposed new mandated vaccine is directed at a variant that is no longer dominant.

165. **Affidavit #3 of Dr. Emerson, Exhibit "T" (NACI report, March 3, 2023 (Guidance regarding spring boosters), page 309[157] (CB page 284): "**VE and duration of protection are still emerging for more recent variants (i.e., XBB.1.5 and BQ.1)."

Query: Even if the PHO was able to put in a complete record of evidence she relied upon for this judicial review, it would not be possible to assess whether the vaccines were reasonable in non-pandemic conditions.

166. **Affidavit #3 of Dr. Emerson, Exhibit "T" (NACI report, March 3, 2023 (Guidance regarding spring boosters), page 310 (document 157 above): "**There are currently no available data regarding bivalent vaccine protection against severe disease caused by XBB/XBB.1.5."

Query: The previous vaccines were not effective against the new variants. While the PHO did have evidence that supports the earlier vaccines having reduced disease severity among the elderly and the immune-compromised with respect to the early variants, we have no evidence and are unlikely to acquire any in the short-term that the new vaccine will function with these existing variants in the same manner. In fact, the evidence with respect to Omicron supports a conclusion that VE and protection against severe disease will not be robust. And the new variants have developed from the Omicron strain.

167. **October 5, 2023 Hospital and Community and Community and Residential Care orders, Recital N[158] (CB page 286), page 4: "**As the variants of the virus have evolved in the past year and vaccines have been updated to cover the variants now circulating the best protection for unvaccinated people is derived from receipt of one of the updated vaccines tailored to the XBB.1.5 variant of the Omicron strain. Due to the high effectiveness of vaccination, and that seroprevalence data indicates that people who have not been vaccinated have a high probability of having some immune markers from infection, Health Canada has authorized that vaccination with the mRNA based updated vaccines, rather than the vaccines previously recommended, is adequate to provide protection."

Query: If the old vaccines were effective, the PHO would not be mandating new vaccines. The reason the old vaccines are not effective is because the virus is mutating rapidly. And we know that the vaccinations have not been effective to prevent infection due to the high levels of natural acquisition of the virus recorded in blood donor records which are a totally neutral source of information about seroprevalence, either with vaccination or without vaccination. An example of a recent report on seroprevalence in Canada can be found in a document entitled "Spotlight on CITF-Funded Research" dated August 8, 2023 **(Affidavit #1 of Haley Miller, Exhibit "Q", Spotlight on CITF-Funded Research" dated August 8, 2023, page 148)[159] (CB page 287)**. That document states that "[t]he latest CITF-funded report from Canadian Blood Services suggests that the 80% mark in estimated infection-acquired seroprevalence among Canadian adults was reached by June 30, 2023. The percentage of younger donors (ages 17-24) who had infection-acquired seroprevalence surpassed 90%."

168. **October 5, 2023 Hospital and Community and Community and Residential Care orders, Recital N (document 158 above): "**In addition, the National Advisory Committee on Immunization has advised to no longer provide the bivalent or original strain vaccines once the updated vaccines are available. Therefore, I am satisfied that receiving the recommended dose or doses of one of the updated vaccines will provide an unvaccinated person seeking to work, be a student or volunteer in the health-care sector with immunity from infection."

Query: How can the PHO be satisfied that the new vaccines are going to provide any protection from acquisition or transmission of Covid-19, based on the record? The PHO is in fact not "satisfied" that the new vaccines are necessary to protect public health, as she has permitted health-care workers who have contact with vulnerable populations to be exempt from the new vaccine. In fact, the PHO has issued a mandate that is inconsistent with the scientific findings of NACI, which have concluded that the new vaccines are more effective. In fact, NACI recommended in its **Summary of National Advisory Committee on Immunization (NACI) Supplemental Statement of September 12, 2023**[160] **(CB page 288)** (also contained at Exhibit "K" of Affidavit #1 of Haley Miller (with the summary at Exhibit "L")) that "[b]eginning in the fall of 2023 for those previously vaccinated against COVID-19, NACI recommends a dose of the XBB.1.5-containing formulation of COVID-19 vaccine for individuals in the authorized age group if it has been at least 6 months from the previous COVID-19 vaccine dose or known SARS-CoV-2 infection (whichever is later).

Immunization is particularly important for those at increased risk of COVID-19 infection or severe disease, for example:

- Adults 65 years of age or older;
- Residents of long-term care homes and other congregate living settings;
- Individuals with underlying medical conditions that place them at higher risk of severe COVID-19;
- Individuals who are pregnant;
- Individuals in or from First Nations, Métis and Inuit communities;
- Members of racialized and other equity-deserving communities;
- People who provide essential community services"

169. Health-care workers fall into the category of "people who provide essential community services". The guidance states that previously vaccinated people in the groups set out above should take the new XBB.1.5 vaccine. Yet Dr. Henry is not requiring previously vaccinated health-care workers to take this new vaccine. This is incongruent with her stated goals of protecting vulnerable patients.

170. **October 5, 2023 Hospital and Community and Community and Residential Care orders, Recital O (document 158 above):** "Although it is highly recommended that people who were vaccinated with a primary series of vaccine previously recommended by Health Canada be vaccinated with one of the updated vaccines, seroprevalence data from British Columbia indicates that nearly all people in British Columbia have antibodies to SARS CoV-2 virus from combinations of infection and vaccination. This means that people who have been vaccinated with a previously recommended primary series are most likely to have had their immune systems stimulated by subsequent vaccination or infection and therefore continue to have an immunity to infection. Therefore, I am satisfied that it is not necessary to require that a person who was vaccinated with a primary series previously recommended by Health Canada, and who is already working, or is already a student, or is already a volunteer in the health-care sector, be vaccinated with one of the updated vaccines."

171. If "nearly all people in British Columbia have antibodies to SARS CoV-2 from combinations of infection and vaccination", and if Dr. Henry believes vaccinated healthcare workers do not need the new vaccine, then why does anyone need it?

172. Recitals N and O of the October 5, 2023 Orders contradict Recital SS of the Hospital and Community Order, and Recital MM of the Residential Care Order, which states: "[t]o avoid the risk of undermining the ability of the hospital and community care sectors to function safely, and to properly care for patients, residents and clients, it is necessary to keep the number of unvaccinated people in the health-care workforce as low as possible, including among the members of the workforce who may have little or no direct contact with patients, residents, clients or other workers on a regular basis".

173. If Dr. Henry wanted to meet her objectives of protecting patients and workers in the healthcare industry, she would mandate the new XBB.1.5 vaccine for all workers, including previously vaccinated workers. It is not logical that she promote everyone in the Province of British Columbia to take the new vaccine, while not requiring all healthcare workers to take it. She did the same with the booster shots. The healthcare workers who only took two shots are essentially unvaccinated. Why does Dr. Henry tell everyone in the province to take the additional shots, but does not make the healthcare workers do so? In a Media Briefing on September 28, 2023 **(Affidavit #1 of Haley Miller, Exhibit "AA", Media Briefing September 28, 2023, pages 201 – 202)[161] (CB page 293),** Dr. Henry is asked by a reporter why she is not mandating the new XBB.1.5 vaccine for all healthcare workers, Dr. Henry responds as follows:

Henry: “The question in terms of the health care worker mandate. So the zero prevalence tells us we know from data that most health care workers have had at least one booster and also from the data that most health care workers have hybrid immunity, which means there's a whole combination of different types of immunity that's out there right now in our health care workers. And everybody who's working in our public system has that immunity.

So we know that adding additional requirement is not going to … It's not needed, for one thing ... But it would ... How do I say this? ... There's so many different permutations and combinations that there's no one single thing that you could do that would make it work for everybody. So we want to have a period of time between boosters and infection and the updated vaccine. So there's just too many combinations.

And we know that we have a high level of baseline protection for health care workers. So the mandate remains anybody new to the system must get vaccinated with this updated vaccine. So, if you 're unvaccinated, you're coming in through a job in the health care system, you get this updated vaccine and you will be considered protected as we go into this season. So it is a combination.

We don't go back to zero when we have time between doses and we know that we get boosted from being exposed to the virus over time. So that's the rationale behind it. It is the data that shows us that there's a very high level of protection, and, as we're going into this season, we want to ensure that we have added protection with this updated vaccine.”

174. Her answer to the reporter’s question is not, it is submitted, adequate to explain this apparent inconsistency in reasoning. Again, if the healthcare workers do not need the new vaccine, why does anyone else need it? The same question can be posed regarding the previous booster shots.

175. In addition, Dr. Henry’s statement that “we don’t go back to zero when we have time between doses” is not supported by the evidence. A review of documents 27, 93 and 140 in the Petitioners’ condensed book of documents will confirm this.

176. **October 5, 2023 Hospital and Community and order, Recital NN:**
“Significantly, at the end of 2021 and early in 2022, with the occurrence of the Omicron wave of infections, it was the high level of vaccination among the health-care workforce which ensured that the health-care system had the necessary resiliency to respond to the upsurge in hospitalizations and ICU admissions by protecting the members of the workforce from serious and lengthy illness.”

177. The evidence shows that this statement is not accurate. The rate of BC healthcare workers who were off sick in 2022 was approximately double that of 2021. In a media briefing on January 14, 2022, Minister Dix states discusses this issue at length. The media briefing is set out in **Affidavit #1 of Dr. Emerson, Exhibit 14 (Dr. Bonnie Henry Media Briefing, January 14, 2022)**[162] **(CB page 295).** Minister Dix begins discussing the issue of healthcare workers being off sick at pages 830, and concludes his comments at page 831, stating "[a]cross those health authorities, the PHSA, Fraser Health, Providence, and Northern Health, Vancouver Coastal Health, in 2022, this year, 14,591 from January 3rd to 9th. In 2021, that number was 7,573. And in 2020, which is a higher influenza and respiratory illness year, if you recall, 8,802 health care workers called in sick in the equivalent week to January 3rd to 9th of those years. So roughly double the number of sickness, on a base of 188,000 health care workers." All of Minister Dix's comments starting at page 830 are relevant to read in relation to healthcare workers being sick and off work.

178. In another media briefing on September 6, 2023, Minister Dix again discusses the issue of healthcare workers being off sick. He states that "15,800 health care workers in the last week where we provided -- we have information, which the week prior to the week ending in Labour Day, were off sick that week, significantly above the usual numbers. And that has an impact everywhere in our health care system." **Affidavit #1 of Dr. Emerson, Exhibit 15, Media Briefing September 6, 2022, page 842)**[163] **(CB page 297).**

179. In addition, the statement that "[v]accination helps reduce workplace absenteeism among Canadian healthcare workers" **(Affidavit #1 of Haley Miller, Exhibit "V" Covid-19 Immunity Task Force report, September 1, 2023, page 176)**[164] **(CB page 298))** is questionable, not only given the history of absenteeism in healthcare workers in BC, as outlined by Minister Dix, but also in the following further details in Exhibit "V", which state "[a]bsenteeism from work declined with each vaccine dose and also declined when provincial guidelines made provision for early return to work based on clinical necessity (early call-back). Healthcare workers returned to work faster as the pandemic progressed." There is a correlational issue here, as the evidence does not prove that vaccination worked to reduce absenteeism. It could have been the "early call-back" that had healthcare workers back to work sooner.

180. There is also contradictory evidence about healthcare workers becoming sick with Covid-19 during the pandemic. A study in Alberta states that "[w]hen compared to referents, cases among HCWs identified by PCR tests were predominantly higher in the fifth wave of the pandemic, while those from physician

records were much higher in the first wave" **(Affidavit #1 of Haley Miller, Exhibit "W" Covid-19 Immunity Task Force report entitled "Healthcare Workers Had Highter Incidences of SARS-CoV-2 Infection and Mental Health Conditions Compared to the General Population", dated October 2, 2023, pages 178 - 179)[165] (CB page 300).** This study (not peer-reviewed) was conducted between early 2020 and summer 2022. Healthcare workers were becoming sick with Covid-19 despite vaccination.

181. In another Covid-19 Immunity Task Force report entitled "SARS-CoV-2 Antibody Levels Increased In Canadian Healthcare Workers With Each Vaccine Dose, But This Waned Over Time", dated October 2, 2023, it was reported that "[a] CITF-funded study among Canadian healthcare workers, published in preprint and not yet peer-reviewed, found that SARS-CoV-2 anti-receptor binding domain (RBD) lgG levels increased following each COVID-19 vaccine dose and after the first SARS-CoV-2 infection. However, SARS-CoV-2 anti-RBD lgG levels decreased over time, with the sharpest decline observed after the third vaccine dose" **(Affidavit #1 of Haley Miller, Exhibit "X", Covid-19 Immunity Task Force report entitled "SARS-CoV-2 Antibody Levels Increased In Canadian Healthcare Workers With Each Vaccine Dose, But This Waned Over Time", dated October 2, 2023, page 180 – 181)[166] (CB page 302).** The vaccine was not protecting healthcare workers.

182. **October 5, 2023 Hospital and Community and order, Recital SS[167] (CB page 304), page 8:** "To avoid the risk of undermining the ability of the hospital and community care sectors to function safely, and to properly care for patients, residents and clients, it is necessary to keep the number of unvaccinated people in the health-care workforce as low as possible, including among the members of the workforce who may have little or no direct contact with patients, residents, clients or other workers on a regular basis."

Query: The Petitioners submit there is no basis for requiring all workers to be vaccinated, as proposed in Recital SS above. Remote working and administrative workers do not have contact with patients. They do not pose a risk to patients or other co-workers. The Petitioners submit that this requirement is simply in aid of having the entire population of BC vaccinated. Further it is inconsistent with the PHO's decision not to require existing health-care workers who have contact with vulnerable populations to get the new vaccine.

XVI. AFFIDAVIT #1 OF HALEY MILLER

183. Exhibit "D" is a Situation Report that chronicles the current Covid-19 situation in the province regarding Covid cases, hospitalizations, critical care admissions and

deaths. In looking at "severe outcomes" (hospitalizations and death), in the "Interpretation of the Data" section, the report notes the following:

Severe outcomes

- Reported hospitalization numbers are an overestimate of COVID-attributable hospitalizations because they include people who test positive for COVID-19 regardless of the reason for admission.

- Deaths reported are an overestimate of COVID-attributable deaths since the registration of a death is recorded before the underlying cause of death (COVID-19 or non-COVID-19-related) is determined.

(Affidavit #1 of Haley Miller, Exhibit "D", Covid-19 Situation Report, October 26, 2023, page 56)[168] (CB page 305)

184. Indeed, the province changed the way Covid-19 deaths were counted and attributed in April 2022. This is stated many times in the materials, but one specific citation is in **Affidavit #2 of Dr. Emerson, Exhibit 1, Covid-19 Situation Report, August 21 – 27, 2022, page 8[169] (CB page 306)**, which states as follows:

Pre-transition (case line list) deaths include COVID-19 related deaths reported by Health Authorities up to April 1, 2022. As of April 2, 2022, post- transition (automated linkage) deaths are any COVID-19 lab positive cases who died from any cause recorded in Vital Statistics within 30 days of their first positive lab result date. Deaths reported after the system transition use a broader definition and will overestimate the true number of deaths due to COVID-19 since death registration is recorded before the underlying cause of death is determined. Due to the change in data source for death data, the number of pre-transition deaths should not be compared to the number of post-transition deaths.

Since underlying cause of death (UCD) takes approximately 8 weeks to be recorded, all-cause mortality is initially reported and then retrospective evaluations of underlying cause of death are provided here to better understand true COVID-19 mortality. UCD as COVID-19 are deaths that have been determined to be caused by COVID-19 in their Vital Stats record. UCD as non-COVID-19 are deaths that have been determined to be not attributable to COVID-19 in their Vital Stats record that are reported as deaths due to a lab positive COVID-19 test within 30 days of death. UCD pending are all post- transition deaths that do not yet have a recorded UCD.

185. The reporting system, as set out in Exhibit "D" of Ms. Miller's Affidavit #1 and Exhibit 1 of Dr. Emerson's Affidavit #2, raises doubts about the reliability of the

data. This conclusion extends to Exhibit "E" of Ms. Miller's Affidavit #1, which is a BC CDC Epidemiological Summary dated October 5, 2023, that reports on current Covid-19, influenza and RSV cases **(Affidavit #1 of Haley Miller, Exhibit "E" (BC CDC Epidemiological Summary dated October 5, 2023), page 57[170] (CB page 307).**

186. Exhibits "F" and "G" of Ms. Miller's Affidavit #1 pertain to whether the bivalent vaccine (the Omicron-containing booster shot, which is different than the XBB.1.5 vaccine) can be used as a primary series vaccine. The Petitioners submit that these exhibits are of limited value to this proceeding, which is about whether it was reasonable of Dr. Henry to issue orders making a primary series of the Covid-19 vaccine a requirement to work, and now, whether it was reasonable of her to issue orders making the XBB.1.5 vaccine a requirement for new hires.

187. The Petitioners submit that Exhibit "H" of Ms. Miller's Affidavit #1 is also irrelevant. This document is entitled "Guidance on the use of Moderna bivalent BA.1 and BA.4/5 as a booster dose in individuals 6 to 17 years of age". How can this document be of assistance to the court in determining the reasonableness of Dr. Henry's orders relating to healthcare workers?

188. Exhibit "Y" is a June 5, 2023 Media Briefing with Dr. Bonnie Henry and others (Lapointe, Louie and Charlesworth) about toxic drug deaths in British Columbia. Lisa Lapointe reported that since 2016, more than 12,000 people have died of drug overdoses **(Affidavit #1 of Haley Miller, Exhibit "Y", Media Briefing June 5, 2023, page 182)[171] (CB page 308)** In a UBCM speech by Dr. Henry on September 18, 2023 about drug decriminalization, Dr. Henry reported that we are losing six to seven people per day in BC due to toxic drug deaths **(Affidavit #1 of Haley Miller, Exhibit "Z", UBCM drug decriminalization speech, September 18, 2023, page 185)[172] (CB page 309).**

189. The vaccine mandate on the healthcare workers has caused harm to society. Petitioner [redacted] was a clinic physician at the Bridge Detox Centre in Kelowna from 2017 until October 2021, when he lost his job for failing to provide proof of vaccination. Bridge Detox Centre is a clinic operated by Interior Health. Dr. Nordine could be working with drug-addicted patients and making a difference in people's lives. The same can be said for all of the Petitioners who were contributing members of our healthcare system, and who care very much about people, as is clearly evident in their evidence. Instead, they were fired for not taking a vaccine that proved to be ineffective, and which is no longer even being used.

190. In a media briefing on September 28, 2023 regarding a respiratory virus update by Dr. Henry and Minister Dix, Dr. Henry stated, in relation to the new XBB.1.5 vaccine, that "this new, updated vaccine, XBB1.5, it's based on that, shows good protection against all of these ones that we're seeing circulate right now. So that's good news" **(Affidavit #1 of Haley Miller, Exhibit "AA" Media Briefing September 28, 2023, page 192)[173] (CB page 310).** How can Dr. Henry be so sure? The track record of the previous vaccines was poor regarding vaccine efficacy. A Government of Canada report entitled "Regulatory Decision Summary for Spikevax XBB.1.5" dated September 12, 2023 states that the new XBB.1.5 vaccine was only tested for 20 days in terms of safety. The report also states that "[r]esults related to safety and effectiveness from ongoing and planned studies will be submitted as they become available" **(Regulatory Decision Summary for Spikevax XBB.1.5, pages 4 and 6.[174] (CB page 311)** The Petitioners submit that it is not reasonable to have to take a medical treatment that has not been tested and monitored over the long-term.

191. The Petitioners submit that the Respondents have not provided adequate evidence as to the reasonableness of the October 5th orders. There is no evidence about the benefits and risks of the new vaccine. There is no evidence that the XBB.1.5 variant is the dominant variant circulating in British Columbia. Indeed, the Government of Canada's weekly report entitled **"COVID-19 epidemiology update: Testing and variants, dated October 31, 2023"**[175] **(CB page 318)** (https://health-infobase.canada.ca/covid-19/testing-variants.html) clearly shows that EG.5 is the dominant variant circulating in Canada. This is particularly clear at pages 10 and 12 of the report.

XVII. THE LAW

192. This action is for judicial review of Public Health Orders and Guidelines issued by an administrative decision-maker, Dr. Bonnie Henry, Public Health Officer for the Province of British Columbia, who is appointed by the Lieutenant Governor in Council pursuant to section 65 of the British Columbia *Public Health Act*[5] (the "*Public Health Act*"). The Public Health Orders and Guidelines have the force of law and are government action, and, as such, the Charter applies.

193. The Public Health Orders and Guidelines infringe the Petitioners' sections 2(a), 7 and 15 *Charter* rights and the infringements are not reasonable.

194. Section 24(1) of the *Charter* provides that anyone whose rights or freedoms have been infringed may obtain a remedy the court considers just and appropriate.

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[5] SBC 2008, Chapter 28

Section 52(1) of the *Constitution Act,1982*[6] provides that to the extent the impugned law is inconsistent with the *Charter,* it is of no force and effect.

A. 1. Infringement of section 7 of the Charter

195. Ordering vaccination as a condition of employment for the Petitioners interferes with and infringes their rights to medical self-determination. Section 7 *Charter* rights to life, liberty and security of the person encompass the right of medical self-determination: *Carter v. Canada (Attorney General)*[7]; *AC v. Manitoba (Director of Child and Family Services*[8]; *B(R) v. Children's Aid Society of Metropolitan Toronto*[9]. Section 7 is also engaged by state interference with an individual's physical or psychological integrity: *Chaoulli v. Quebec (Attorney General)*[10]; *New Brunswick (Minister of Health and Community Services) v. G.(J.)*[11].

196. Section 7 does not promise that the state will not interfere with life, liberty and security of the person, but that it will not do so except in accordance with the principles of fundamental justice: "While the Court has recognized a number of principles of fundamental justice, three have emerged as central in the recent s. 7 jurisprudence: laws that impinge on life, liberty or security of the person must not be arbitrary, overbroad, or have consequences that are grossly disproportionate to their object"[12]: *Carter v. Canada (Attorney General)*.

197. The Petitioners accept that they do not have a constitutionally protected right to practice their profession, or a common-law right to work[13], however, the Petitioners argue that on the specific evidentiary facts of this case, the interference with their *Charter* rights is not reasonable.

198. In assessing whether an impugned law violates the principles of fundamental justice, the object of the law must be given a precise and narrow definition: *Carter v. Canada (Attorney-General)*[14]. The Petitioners understand that the constitutional object of the Public Health Orders and the Guidelines is to reduce transmission of Covid-19 to vulnerable persons. Dr. Bonnie Henry, the Public Health Officer for

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[6] *Constitution Act,* section 52
[7] *Carter v. Canada (Attorney General)* 2015 1 SCR 5 at para 64-69
[8] *AC v. Manitoba (Director of Child and Family Services)*2009 SCC 30 at para. 39-45
[9] *BR v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 SCR 315 Lamer CJC at 342-350, LaForest, J at 456-367
[10] *Chaoulii v. Quebec (AttorneyGeneral)* 2005 SCC 35 at para 116
[11] *New Brunswick (Minister of Health and Community Service) v. G(J)*[1999] 3 SCR 46 at 58
[12] *Ibid* at note 4 at para 73 - 78
[13] *The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario,* 2018 ONSC 579 at paras 85-197, affirmed 2019 ONCA 393
[14] *Ibid* at note 4 at para 73-78

BC, refers to the concern about protecting vulnerable individuals several times in her orders (see recitals C, E, BB, RR of the September 12, 2022 order, and recitals C, D, CC, NN and SS of the April 6, 2023 order). Dr. Henry says that "any limits on constitutionally protected rights and freedoms arising from this Order are proportionate and reasonable in the interests of protecting public health" (see paragraph WW of the September 12, 2022 order, and paragraph XX of the April 6, 2023 order). Her concern is to protect vulnerable populations. The Petitioners accept that these recitals and her press conferences constitute "reasons" as is meant in administrative law jurisprudence.

199. The Petitioners say the object of the law is worthy, but the law goes too far. The orders are arbitrary and overbroad and, have disproportionate effects, and therefore, they do not employ a least intrusive measure approach. The Petitioners say the PHO has not been reasonable in the application of her orders.

200. In *Syndicat des Metallos, Section Locale 2008 c. Procureur General du Canada*[15], the Quebec Superior Court concluded that with respect to the constitutionality of Transport Canada's vaccination policies, the employees' statements showed the seriousness of the infringement and that "[translation] [i]t would be wrong to minimize or trivialize the pressure this caused" by the threat of termination. The Court found that the vaccination requirement engaged the employees' right to the security of the person. Of note, imminent harm is sufficient for a claim under section 7.

201. In the case at bar, the Petitioners have in fact suffered harm.

202. Once the Petitioners establish that a section 7 rights is engaged, the Court must move to consider whether the deprivation of those rights is in accordance with the principles of fundamental justice.

203. The Public Health Orders and Guidelines are overbroad, arbitrary, and disproportionate. The Public Health Orders and Guidelines require vaccination of persons who work remotely, or in an administrative capacity, or with persons that are not vulnerable to the deleterious effects of Covid-19. For those workers who are in contact with vulnerable persons, the orders do not provide for other options to mandatory vaccination, such as re-assignment of workers to work-places not dealing with vulnerable persons, and/or masking or rapid testing prior to attending the workplace. Finally, the Public Health Orders and Guidelines permit third-party contractors doing work similar to the work of the remote-working Petitioners to remain unvaccinated. Those contract workers were even permitted to enter

[15] 2022 QCCC 2455, at para. 174

facilities approximately once per month (see Exhibits “C” and “D” of Affidavit #2 of Ashley Sexton, sworn September 21, 2022).

1. Arbitrariness

204. The remote or administrative workers posed the same level of risk as the contract workers doing comparable work. Yet the employees lost their jobs for not showing proof of vaccination, and the BC government actively sought contract workers, and specifically stated they were not required to show proof of vaccination. The irony is that the contract workers likely took over for the remote workers who were fired. In fact, it is arguable that the contract workers may have presented more risk, because they were permitted to enter facilities approximately once per month.

205. The provision of a medical exemption means that workers who for medical reasons cannot have the vaccine, are treated differently than workers who decline the vaccine on the basis of religion or conscience. This distinction was characterized as arbitrary in the recent decision of Annex I — Constitutionality of the Canadian Armed Forces COVID-19 vaccination policy, dated July 18, 2023.[16] A healthcare worker granted a medical exemption is allowed to work, yet a healthcare worker with a religious or conscience objection is fired from his or her job. In keeping with the PHO’s reasoning, an unvaccinated healthcare worker granted an exemption to the vaccine on medical grounds presents a risk of spreading Covid-19. The PHO is arbitrarily creating two classes of workers by treating medical objections differently than religious or conscience objections.

206. The removal of the statutory process for reconsideration set out under section 43 of the *Public Health Act,* except for a request for reconsideration on the basis of a medical deferral on the basis of:

> “weighing the interests of persons who receive and provide care and services in hospital or community settings against the interests of unvaccinated person in light of the risk of the transmission of infection posed by the presence of unvaccinated persons in the health-care workforce, or providing care or services or engaged in research or receiving training in care locations, and taking into account the vulnerability of persons receiving care and services, the importance of maintaining a healthy and resilient health-care workforce, the stress under which the public health and health-care systems are currently operating and the impact this is having on the provision of health care to the population, the continuing reasonable probability of a resurgence of disease transmission with increases in serious outcomes, clusters and outbreaks of

[16] Constitutionality of the Canadian Armed Forces COVID-19 vaccination policy, dated July 18, 2023

> COVID-19, and resulting strain this would place upon already overburdened public health and health care systems, and the risk inherent in accommodating persons who are not vaccinated" (April 6, 2023 Hospital and Community Order ,Affidavit #5 of Ashley Sexton, Exhibit "V", page 242)

is not in accordance with the principles of fundamental justice. It implies that an emergency still prevailed as of the date of the last public health order of April 6, 2023. However, by April 6, 2023, indeed, even by September 12, 2022 (the order prior to April 6, 2023), on the Respondent's own affidavit materials, there was no longer an emergency so pressing that applications for reconsideration needed to be suspended or limited to requests for reconsideration on the basis of a medical deferral. Dr. Henry stated in her press briefing of April 6, 2023 that "we've been coming out of the emergency phase for sure" (time stamp 30:54 of the transcript attached as **Exhibit"A" to Affidavit #6** of Ashley Sexton, **page 24**).

207. The PHO can only refuse to reconsider orders under the emergency powers provisions of the *Public Health Act* set out in Part 5. Section 54(h) of the *Public Health Act* states that in an emergency, the PHO may "not reconsider an order under section 43". Given an emergency no longer exists regarding the pandemic, the PHO is not permitted to act under the emergency powers of Part 5 of the *Public Health Act*, and she is not permitted to refuse to consider reconsideration requests. To do so is arbitrary and *ultra vires* the law.

208. As stated by the respondent in his Response to Petition at paragraph 68, the decision of the public health officer not to consider exemptions for non-medical reasons was rejected "on the basis that "no other measures are nearly as effective as vaccination in reducing the risk of contracting or transmitting SARS-Co-2, and the likelihood of severe illness and death." This is patently incorrect as applied to the Petitioners in this action. What is more effective than vaccination is isolation and lack of contact with vulnerable populations, and many of the Petitioners in this action had no contact with vulnerable populations. The orders are arbitrary in the application to workers who enter medical facilities operated by BC health authorities. See, for example, the section entitled "II. OTHER PREVENTIVE MEASURES" at pages 21-22, "II. OCCASIONAL OTHER OUTSIDE PROVIDERS WHO DO NOT HAVE CLOSE CONTACT WITH A PATIENT, RESIDENT OR CLIENT", at page 24, "G. CONSTRUCTION WORKERS WHO ARE NOT STAFF MEMBERS" at page 25, and "H. VENDORS, SUPPLIERS OR TECHNICAL SPECIALISTS" at page 25 of the September 12, 2022 order (Affidavit #2 of Ashley Sexton, Exhibit "G", pages 114 – 115 and 118 – 119 of the Affidavit). Construction workers who were staff, occasional workers (who did not have close contact with patients), contracted construction workers, vendors, suppliers and technical

specialist were not subject to having to show proof of vaccination to enter facilities. They would have presented more risk than the remote working workers or administrative workers who did not enter facilities. Yet the remote and administrative workers were fired for not showing proof of vaccination.

209. The April 6, 2023, order no longer includes the specific provisions relating to construction workers who are staff, occasional workers, vendors, suppliers and technical specialists, and which allowed them to enter facilities to work. The order does refer to construction workers on contract. Those workers are not subject to the proof of vaccination requirement. It is unclear how the other workers are treated. The April 6, 2023 order was made when the pandemic had ended and the emergency was over (as stated by Dr. Bonnie Henry in her press release of the same date – time stamp 30:54 and 31:55 of the transcript attached as **Exhibit "A"** to **Affidavit #6** of Ashley Sexton **pages 24 and 25**).

2. Overbreadth

210. As stated above, to avoid overbreadth, policies must be tailored to use the least restrictive means to achieve their purpose. There must be a rational connection between the means chosen and the adverse impacts of the policy: *Canada (Attorney General) v Bedford*[17], ; *R v Appulonappa*[18], ; *Carter*[19] ;and *R v Ndhlovu*[20]. .

211. The orders are overbroad because they apply to workers who do not work with patients. They apply to workers who only saw their patients by electronic means. How were those workers creating a risk of transmission? The Petitioners who worked remotely are Monika Bielecki, Ana Lucia Mateus, Lori Jane Nelson, Ingeborg Keyser, and witness Jennifer Koh.

212. The orders also applied to administrative workers. Those individuals did not work with patients, and many did not work in facilities. The Petitioners who worked in administrative positions are those that are set out above, as well as Darold Sturgeon.

213. The orders applied to these groups of workers, yet did not apply to the construction workers, occasional workers or vendors, as discussed above, or those able to secure a medical exemption. The orders are overbroad in their

[17] 2013 SCC 72 at paras 112-113
[18] 2015 SCC 59 at paras 26-27
[19] Ibid at note 4 at para 85
[20] 2022 SCC 38 at paras 77-78, 98-99, 103-108

application.

B. 2. Infringement of section 2(a) of the *Charter*

a. Religious and Conscientious Objections

214. Vaccine mandates that fail to provide religious and conscientious exemptions infringe section 2(a) *Charter* rights. Section 2(a) of the *Charter* protects the right to freedom of conscience and religion. "Freedom, in a broad sense, embraces both the absence of coercion and constraint, and the right to manifest beliefs and practices. Freedom means that, subject to such limitations are necessary to protect public safety, order, health, or morals, or the fundamental rights and freedoms of others, no-one is forced to act in a way contrary to his beliefs or his conscience": *R v. Big M Drug Mart Ltd*[21]. Freedom of religion includes the right to ascribe to sincerely held beliefs or conduct that "are not objectively recognised by religious experts as being obligatory tenets or precepts of a particular religion"[22]: *Syndicat Northcrest v. Amselem*.

215. The Petitioners say that the orders clearly infringe the section 2(a) rights of the Petitioners even though neither the common-law nor the *Charter* protect the right to work.[23]

216. The Federal Court found in *Lavergne-Poitras (Attorney-General)* [24]2021 1232 at paragraph 61 that section 7 rights can be engaged by a vaccination requirement as a condition of employment.

217. Although the law is clear that section 2(a) of the *Charter* does not protect the right to work, the Federal Court found in *Lavergne-Poitras (Attorney-General)* [25]2021 1232 at paragraph 61 that section 7 rights can be engaged by a vaccination requirement as a condition of employment.

218. At paragraph 87 of Affidavit #1 of Dr. Emerson, he attaches as Exhibit 29 a World Health Organization ("WHO") Policy Brief titled "COVID-19 and mandatory vaccination: Ethical considerations", dated May 30, 2022. It can be inferred from the inclusion of this document in the respondent's materials that the PHO looks to the WHO for guidance in the imposition of policies and practices regarding COVID-19, including vaccine mandates. The WHO sets out an extensive number of

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[21] *R v. Big M Drug Mart*, 1985 CanLII 69 (SCC) at para 95
[22] *Syndicat Northcrest v. Amselem,* 2004 SCC 47 at paras 43-51
[23] Ibid at note 9, paras 85-197
[24] 2021 1232 at para. 61
[25] 2021 1232 at para. 61

ethical considerations in the implementation of vaccine mandates, including respect for conscientious objections. Conscientious objections include religious objections[26]. The policy brief states, at page 1716, that "policies that constrain or eliminate individual choice can be controversial and raise a number of ethical considerations". Also at page 1716 of Exhibit 29, the WHO policy brief states that "the WHO does not presently support the direction of mandates for COVID-19 vaccination, having argued that it is better to work on information campaigns and making vaccines accessible". And at page 1719 of Exhibit 29, the WHO policy brief states, "The extent to which mandatory vaccination policies accommodate conscientious objection may also affect public trust".

219. Other cautions and comments of the WHO policy brief are as follows:

    a. "Mandatory vaccination policies that require unvaccinated health workers to stay at home or require vaccination as a condition of employment or hospital privileges might have significant negative consequences for already overburdened health systems" (page 1721);

    b. "Individual liberties should not be restricted for longer than necessary in order to achieve the most favourable balance between the values of protecting the health and well-being of the public and individual liberty. This can be achieved, for example, by introducing 'sunset' clauses indicating the conditions that would warrant the removal of a mandate. Policy makers should therefore frequently re-evaluate the mandate to ensure it remains necessary and proportionate to achieve important objectives" (page 1717).

    c. "Policy makers should consider specifically whether vaccines authorized for emergency or conditional use (as opposed to receiving full market licensure from a national regulatory authority) meet an evidentiary threshold for safety sufficient for a mandate" (page 1718).

    d. "Even when the vaccine is considered sufficiently safe, mandatory vaccination should be implemented with no-fault compensation schemes to address any vaccine-related harm that might occur. This is important because it would be unfair to require people to seek legal remedy from harm resulting from a mandatory intervention" (page 1718).

220. Despite the WHO's cautions and recommendations regarding vaccine mandates, the PHO denied all religious and conscientious objections. She also did not follow

the WHO's recommendations in making the vaccine mandate time limited. Furthermore, the removal of a meaningful process for applying for reconsideration, as stated above in the arguments made with respect to the breaches of section 7 *Charter* rights, is a prima facie breach of s. 2(a). As stated by the Respondent in his Response to Petition at paragraph 68, the decision of the public health officer not to consider exemptions for non-medical reasons was rejected "on the basis that "no other measures are nearly as effective as vaccination in reducing the risk of contracting or transmitting SARS-Co-2, and the likelihood of severe illness and death." This is patently incorrect as applied to the Petitioners in this action. What is more effective than vaccination is isolation and lack of contact with vulnerable populations, and many of the Petitioners in this action did not have any in-person work-related contact with vulnerable populations.

221. Freedom of conscience includes the right to act in accordance with a coherent set of beliefs but does not require that the individual asserting freedom of conscience ascribe to an organised religion: *R. v. Morgenthaler*[27] ; *Carter v. Canada (Attorney-General)*[28].

222. The PHO failed to offer the workers who refused the vaccine any alternatives to vaccination. For example, a vaccination policy was not considered disproportionate where it offered employees the option of testing to work, and then if they refused that accommodation, they would be terminated: C*anadian Union of Public Employees v Allan Klippenstein*[29] .

223. However, the PHO did allow construction workers, occasional workers, vendors, etc. an option if they didn't show proof of vaccination. They only needed to wear a mask and physically-distance from others. No such alternatives to vaccination were offered to those Petitioners who had contact with the patient population. As for the Petitioners who did not have in-person contact with the patient population, the arguments made under s, 7 are more applicable; the policies are obviously disproportionate: *Electrical Safety Authority*[30],

224. The unavailability of exemptions or alternatives to vaccination, on the basis of religion or conscience from the vaccine mandates contained in the Public Health Orders and Guidelines is more than a trivial or insubstantial interference with the Petitioners' section 2(a) *Charter* rights, and consequently, is an infringement of *Charter* section 2(a).

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[27] *R v. Morgenthaler,* [1988] 1 SCR 30 at p. 37
[28] *Ibid* at note 4 at para 132
[29] 2022 CanLII 44759 (SK LRB), at paras 38-39
[30] 2022 CanLII 343 (ON LA), at para 81

225. The Respondent concedes that the Petitioners' beliefs are sincerely held. At paragraph 85 of the Response to Petition, the respondent addresses the question of whether with respect to these Petitioners there is a sufficient nexus between their beliefs and religion.

- Tatlock – the position of the Pope with respect to vaccination is not spoken as doctrine and therefore is not infallible; each Catholic must make their own judgement with respect to matters of conscience and the fact that the entire church does not make the same judgement does not remove this decision from the nature of a religious belief: *Amselem*[31] ;

- Sturgeon - the position of the Pope with respect to vaccination is not spoken as doctrine and therefore is not infallible; each Catholic must make their own judgement with respect to matters of conscience and the fact that the entire church does not make the same judgement does not remove this decision from the nature of a religious belief: *Amselem*[32]*,*

- Koh – witness - objects to the vaccine on the basis that fetal cell-lines were used in the development of the vaccine and this position is supported by the evidence tendered in this case. The law is clear that not every religious or conscientious objection must be shared by the entire church*, Amselem*[33]*,*

- Nelson – objects on the basis of religion and conscience;

- Hamley – objects on the basis of religion;

- Nordine – objects on the basis of conscience and religion *, Amselem*[34]

- Keyser – objects to the vaccine on the basis of conscience (see discussion below);

- Mateus – objects to the vaccine on the basis of conscience (see discussion below);

- Bielecki – objects to the vaccine on the basis of conscience (see discussion below);

- Koop – objects on the basis of conscience (see discussion below)

[31] Ibid note 31 at para 43-46
[32] Ibid note 31 at para. 43-46
[33] Ibid at note 31 at para. 43-46
[34] Ibid at note 31, para 43-46

- Parenteau – objects on the basis of conscience (see discussion below)

226. Section 2(b) of the *Charter* prohibits burdens or impositions on religious practice that are non-trivial. As stated in *Edward Books*[35]:

> "All coercive burdens on the exercise of religious beliefs are potentially within the ambit of s. 2(*a*).
>
> "This does not mean, however, that every burden on religious practices is offensive to the constitutional guarantee of freedom of religion. . . . Section 2(*a*) does not require the legislatures to eliminate every minuscule state-imposed cost associated with the practice of religion. Otherwise the *Charter* would offer protection from innocuous secular legislation such as a taxation act that imposed a modest sales tax extending to all products, including those used in the course of religious worship. In my opinion, it is unnecessary to turn to s. 1 in order to justify legislation of that sort. . . . The Constitution shelters individuals and groups only to the extent that religious beliefs or conduct might reasonably or actually be threatened. For a state-imposed cost or burden to be proscribed by s. 2(*a*) it must be capable of interfering with religious belief or practice. In short, legislative or administrative action which increases the cost of practising or otherwise manifesting religious beliefs is not prohibited if the burden is trivial or insubstantial: see, on this point, *R. v. Jones*, 1986 CanLII 32 (SCC), [1986] 2 S.C.R. 284, *per* Wilson J. at p. 314."

227. In *Amselem*[36], the Supreme Court stated:

> " 62 Freedom of religion, as outlined above, quite appropriately reflects a broad and expansive approach to religious freedom under both the Quebec *Charter* and the Canadian *Charter* and should not be prematurely narrowly construed. However, our jurisprudence does not allow individuals to do absolutely anything in the name of that freedom. Even if individuals demonstrate that they sincerely believe in the religious essence of an action, for example, that a particular practice will subjectively engender a genuine connection with the divine or with the subject or object of their faith, and even if they successfully demonstrate non-trivial or non-insubstantial interference with that practice, they will still have to consider how the exercise of their right impacts upon the rights of others in the context of the competing rights of private individuals. Conduct which would potentially cause harm to or interference with the rights of others would not automatically be protected. The ultimate protection of any particular *Charter* right

[35] [1986] 2 SCR 713 at para 759
[36] Ibid at note 31 at paras 62-63

must be measured in relation to other rights and with a view to the underlying context in which the apparent conflict arises.

63 Indeed, freedom of religion, like all other rights, applicable either as against the State or, under the Quebec *Charter*, in its private dimension as against another individual, may be made subject to overriding societal concerns. As with other rights, not every interference with religious freedom would be actionable, in accordance with the limitations on the exercise of fundamental rights recognized by the Quebec *Charter*."

228. The Petitioners submit it is clear that the fundamental question for this court is whether respecting the rights of the Petitioners would conflict with rights of others. This is a case about competing rights. It is incumbent on this court to consider the evidence tendered by the Attorney General and assess whether restriction of the Petitioners' rights is reasonable.

229. The Petitioners say it is clearly not reasonable under the *Vavilov/Doré* framework. As noted, in *Amselem*[37], the question for the court is whether the Attorney-General has established that the rights of competing groups would be harmed by respecting the religious rights of the Petitioners, and in the case of the remote and administrative workers, the answer to that question is clearly no.

230. With respect to those Petitioners who did not work in a remote capacity, the Petitioners submits that other, less overbroad measures could have been employed that protected the Petitioners *Charter* rights while at the same time ensuring no harm came to other competing interests. The decision to remove the option for a measured and evidentiary consideration of these competing interests under s. 43 of the *Act,* was a decision to circumvent he very legislative checks that were written into the legislation in order to ensure it was compliant with the *Charter.* Further, testing prior to work by unvaccinated workers would have made those workers less of a risk to the workplace than vaccinated workers, as the Attorney-General evidence clearly shows that persons contract Covid-19, even when fully vaccinated. The option of providing a more nuanced application of the mandates was completely eschewed by the Public Health Officer.

231. The Attorney General is sure to assert that as there is no right to work protected by the *Charter,* the Petitioners cannot advance their claims as their only harm was to be unable to work. The Petitioners do not assert a right to work; rather, like as in *Amselem*[38]*,* where there is likewise no right to choice of residence, the infringement

[37] Ibid at note 31
[38] Ibid at note 31

of the Petitioners' rights was more than non-trivial and not reasonable given any assessment of the potential harm to other interests that can be made on the evidence before the Court.

b. Freedom of Conscience Jurisprudence

232. Jurisprudence delineating the scope of freedom of conscience in Canadian law is limited. In crafting this argument, the Petitioners have relied upon the academic work entitled: A Test for Freedom of Conscience under the Canadian Charter of Rights and Freedoms: Regulating and Litigating Conscientious Refusals in Health Care[39]. In *R v. Big M Drug Mart*[40],] the Supreme Court of Canada stated at 337:

"Freedom in a broad sense embraces both the absence of coercion and constraint, and the right to manifest beliefs and practices. Freedom means that, subject to such limitations as are necessary to protect public safety, order, health, or morals or the fundamental rights and freedoms of others, no one is to be forced to act in a way contrary to his beliefs or his conscience".

233. Freedom of conscience can therefore be conceptualized as a subset of freedom of religion at 346-347:

"The values that underlie our political and philosophic traditions demand that every individual be free to hold and to manifest whatever beliefs and opinions his or her conscience dictates, provided inter alia only that such manifestations do not injure his or her neighbours or their parallel rights to hold and manifest beliefs and opinions of their own. Religious belief and practice are historically prototypical and, in many ways, paradigmatic of conscientiously-held beliefs and manifestations and are therefore protected by the Charter. Equally protected, and for the same reasons, are expressions and manifestations of religious non-belief and refusals to participate in religious practice. It may perhaps be that freedom of conscience and religion extends beyond these principles to prohibit other sorts of governmental involvement in matters having to do with religion. For the present case it is sufficient in my opinion to say that whatever else freedom of conscience and religion may mean, it must at the very least mean this: government may not coerce individuals to affirm a specific religious belief or to manifest a specific religious practice for a sectarian purpose."

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[39] 2017 CanlII Docs 104.

[40] [1985], 1 SCR 295 at 337

234. Justice Tarnopolsky of the Ontario Court of Appeal attempted to apply the analysis for freedom of religion to freedom of conscience in *R v. Videoflicks*[41]:

> "In my view, essentially the same reasoning would apply to the fundamental freedom of conscience, except that freedom of conscience would generally not have the same relationship to the beliefs or creed of an organized or at least collective group of individuals. None the less, and without attempting a complete definition of freedom of conscience, the freedom protected in s. 2(a) would not appear to be the mere decision of any individual on any particular occasion to act or not act in a certain way. To warrant constitutional protection, the behaviour or practice in question would have to be based upon a set of beliefs by which one feels bound to conduct most, if not all, of one's voluntary actions. While freedom of conscience necessarily includes the right not to have a religious basis for one's conduct, it does not follow that one can rely upon the Charter protection of freedom of conscience to object to an enforced holiday simply because it happens to coincide with someone else's sabbath. Rather, to make such an objection one would have to demonstrate, based upon genuine beliefs and regular observance, that one holds as a sacrosanct day of rest a day other than Sunday and is thereby forced to close one's business on that day as well as on the enforced holiday. No appellant informed this Court of any such fundamental belief based upon conscience rather than religion."

235. Justice Tarnopolsky's reasoning was affirmed in R v. *Edwards Books and Art Ltd*[42]. In *R v. Morgenthaler*[43], the Court states, citing Neil MacCormick, "Civil Liberties and the Law" in Legal Right and Social Democracy: Essays in Legal and Political Philosophy (Oxford: Oxford University Press, 1984) 39 at 41:

> "It seems to me, therefore, that in a free and democratic society "freedom of conscience and religion" should be broadly construed to extend to conscientiously-held beliefs, whether grounded in religion or in a secular morality. Indeed, as a matter of statutory interpretation, "conscience" and "religion" should not be treated as tautologous if capable of independent, although related, meaning. Accordingly, for the state to take sides on the issue of abortion, as it does in the impugned legislation by making it a criminal offence for the pregnant woman to exercise one of her options, is not only to endorse but also to enforce, on pain of a further loss of liberty through actual imprisonment, one conscientiously-held view at the expense of another. It is to deny freedom of

[41] (1984) OR 2d 395 at 422
[42] [1986] SCR SCR 713 at 761 citing *Videoflicks* atr note 37
[43] [1988] 1 SCR 30 at 179

conscience to some, to treat them as means to an end, to deprive them, as Professor MacCormick puts it, of their "essential humanity".

236. However, in a number of cases, the Supreme Court of Canada has recognized that freedom of conscience is protected by the *Charter,* and this is undeniably true given the expansive wording of section 2. In *Carter*[44] the court implicitly recognised the freedom of conscience rights of health-care providers of MAID, as competing rights to be balanced against the section 7 rights of persons seeking MAID.

> *"132.* In our view, nothing in the declaration of invalidity which we propose to issue would compel physicians to provide assistance in dying. The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures. However, we note – as did Beetz J. in addressing the topic of physician participation in abortion in Morgentaler – that a physician's decision to participate in assisted dying is a matter of conscience and, in some cases, of religious belief. In making this observation, we do not wish to pre-empt the legislative and regulatory response to this judgment. Rather, we underline that the Charter rights of patients and physicians will need to be reconciled".

> « In *Doré v. Barreau du Québec, supra,* at para. 36, Justice Abella stated: "As explained by Chief Justice McLachlin in *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37… the approach used when reviewing the constitutionality of a law should be distinguished from the approach used for reviewing an administrative decision that is said to violate the rights of a particular individual. When *Charter* values are applied to an individual administrative decision, they are being applied in relation to a particular set of facts. *Dunsmuir v. New Brunswick*[45]*,* tells us this should attract deference (para. 53; see also *Suresh v. Canada (Minister of Citizenship and Immigration)*, 2002 SCC 1…at para.39). When a particular "law" is being assessed for *Charter* compliance, on the other hand, we are dealing with principles of general application."

3. The violations of sections 2(a), and 7 *Charter* rights are not reasonable or proportionate

237. The Petitioners submit that the Public Health Orders and Guidelines are decisions by an administrative body that engage section 2(a), section 7 and section 15(1) *Charter* rights and are thus subject to a review by the court to determine if the decisions were reasonable, employing the *Doré/Loyola* framework: *Beaudoin v.*

[44] Ibid at note 9 at para. 132
[45] 2008 SCC 9

British Columbia[46]; *Baker v. Canada (Minister of Citizenship and Immigration)*[47].

238. Delegated authority must be exercised "in light of constitutional guarantees and the values they reflect" (*Doré,v. Barreau Du Quebec*[48]). In *Loyola High School v. Quebec (Attorney General)*[49], this Court explained…"*Charter* values help determine the extent of any given infringement in the particular administrative context, and, correlatively, when limitations on that right are proportionate in light of the applicable statutory objectives": *Law Society of British Columbia v. Trinity Western University*[50]; *Doré v. Barreau du Québec*[51]; and *Canada (Minister of Citizenship and Immigration) v. Vavilov*[52].

239. The Supreme Court of Canada recently released a decision that clarified the reasonableness standard in application to judicial review of the decisions of a specialized administrative body, in *Mason v. Canada (Citizenship and Immigration)*[53]. According to the principle of responsive justification, where the impact of a decision on the affected individual's rights and interests is severed, the reasons provided to that individual must reflect the stakes. The reasons given by the PHO for these decisions with respect to our Petitioners are irrational, contradictory, and, in the case of the refusal to consider requests for reconsideration under s.43, non-existent.

240. Comparing the test applied in *R. v. Oakes,* supra, to the review as to whether a decision of an administrative body is reasonable, the Supreme Court of Canada said "In assessing whether an adjudicated decision violates the *Charter,* however, we are engaged in balancing somewhat different but related considerations, namely, has the decision-maker disproportionately, and therefore unreasonably, limited a *Charter* right. In both cases, we are looking for whether there is an appropriate balance between rights and objectives, and the purpose of both exercises is to ensure that the rights at issue are not unreasonably limited": *Doré v. Barreau du Québec*[54].

241. The Public Health Orders and the Guidelines are unreasonable. The objectives of the Public Health Orders and Guidelines could be met with measures that do not

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[46] *Beaudoin v. British Columbia,* 2021 BCSC 512 at paras 119-126
[47] *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 SCR 817
[48] Ibid at note 25 at para 35
[49] *Loyola High School v. Quebec (Attorney General),* 2015 SCC 12
[50] *Law Society of British Columbia v Trinity Western University,* 2018 SCC 32 at para 57.
[51] Ibid at note 25 at para 35, 24-58
[52] 2019 SCC 65 at paras. 1-142
[53] 2023 SCC 21 AT PARAS 39-73, 76
[54] Ibid at note 25 at para 6

disproportionally limit the Petitioners' *Charter* rights.

242. The failure to consider other reasonable alternatives for health-care workers rather than forcing them to vaccinate against their religious or conscientious objections is not reasonable.: *Electrical Safety Authority v. Power Workers Union*[55], . Also see *FCA Canada In v. Unifor, Locals 195, 444, 1285*[56], where the arbitrator notes that, as is the case here, there is no evidence that a tow-vaccine regime protects anyone from transmission to any greater degree than no vaccine at all.

243. Distinguishing *Beaudoin v. British Columbia,* 2021 BCSC 512 (CanLII), affirmed *Beaudoin v. British Columbia*[57]*,*

- the PHO provided evidence that explicitly demonstrated that the persons gathering for religious services were transmitting COVID-19 (para. 15-18) – in the case at bar no evidence at all has been led that the remote workers present any threat whatsoever with respect to transmission of the virus, nor that the administrative workers present any threat of transmission of the virus to the vulnerable populations that the Public Health orders are directed to protect;
- The PHO explicitly stated that there was no evidence of transmission in restaurants where COVID safety plans were being followed (para36) – in the case at bar no evidence has been led that option to test and mask, or put in place screens, for those administrative workers who objected to the vaccine on religious and conscientious grounds were ever given the opportunity to have their concerns reconsidered under se. 43;
- Unlike in the case at bar, Dr. Henry did not suspend the availability for consideration of religious or conscientious objections under s. 43 (para 62)

244. The reason given by the PHO in the case at bar for failing to continue to consider requests for reconsideration under s. 43 of the *Public Health Act*, except for limited medical criteria, was lack of resources due to alleged emergency conditions. At paragraph 126 of Dr. Emerson's Affidavit #1, he states "[g]iven the amount of the OPHO's time and resources being occupied by this process, resources that are far more efficiently and effectively expended dealing with other facets of managing the ongoing pandemic, the PHO determined that it was necessary, in the interests of protecting public health, for her not to consider requests for reconsideration of those aspects of the Orders, other than on the basis of medical deferral to vaccination." No concrete proof has been offered with respect to the lack of

[55] 2022 CanLII 343 (ON LA)
[56] 2022 CanLII 52913 (ON LA) at para. 107
[57] 2022 BCCA 427

resources reason, and, the PHO specifically stated in her April 6, 2023 media briefing that we had come out of the emergency. It is settled law that for the Crown to assert lack of resources to justify infringing *Charter* rights, it must do more than simply assert it – evidence must be led[58]. The only evidence proffered by the respondent was in relation to the numbers of requests for reconsideration to her other orders, not the orders pertaining to the healthcare workers (see paragraphs 123 and 124 of Dr. Emerson's Affidavit #1). No evidence at all was provided by the respondents as to the numbers of requests for reconsideration by healthcare workers impacted by the Hospital and Community, Residential Care or other orders targeting healthcare workers.

245. Although the British Columbia Supreme Court in *Maddock v. British Columbia*, concluded that the suspension of non-medical exemptions under s.43 was reasonable in the context of allowing unvaccinated persons access to public spaces, for the purposes of conducting business, in the context of the Vaccine Card Order, the court explicitly noted that Maddock could have conducted his business remotely. [59]. In *Pacific Centre for Reproductive Medicine v. British Columbia (Medical Services Commission), [60]* the Court concluded that a failure to provide a medical service was a reasonable limit on a *Charter* rights, but in that case the expert body had submitted adequate evidence to justify its argument that lack of resources prevented expansion of the service.

246. In addition, in her November 18, 2021 Hospital and Community Order, the PHO states at Recital AA: "I am also mindful that the volume of requests for reconsideration of my Orders, and the time and expertise which considering them entails, has become beyond my capacity and that of my office and team of medical health officers to manage, and is using resources which are better directed at assessing and responding to the protection of the public as a whole". Again, no evidence was led as to why the requests for reconsideration were beyond the PHO's capacity and that of her office and team of medical health officers, or why resources were better directed at assessing and responding to the protection of the public as a whole. The PHO must have realized that she was going to lose a substantial number of healthcare workers over the ultimatum of taking the vaccine or losing their jobs. The Petitioners submit that the PHO would have been better equipped at assessing and responding to the protection of the public by allowing reconsideration and exemption requests so that she wouldn't lose so many healthcare workers. The loss of healthcare workers in the system contributed to the previously existing shortage of healthcare workers and the overtaxed

[58] *R v. Jordan,* 2016 SCC 27 (CanLII); *Blencoe (Human Rights Commission),* 2000 SCC 44
[59] [2022] BCJ No. 1772 paras. 61-101
[60] [2018] BCJ No 3151 at paras 15-57

healthcare system in BC as a whole.

247. As stated above, the suspension of reconsideration requests under section 43 of the Public Health Act, together with the stringent restrictions on medical requests for exemptions (which were really only deferrals), is not in accordance with the principles of fundamental justice.

248. The Petitioners are unable to seek review under section 43 of the *Public Health Act* or apply for any exemptions other than the narrow medical exemption provided for by the Public Health Orders and Guidelines. Some of the Petitioners work remotely, others in an administrative capacity, or not even in a health-care setting. No provision was made for Petitioners that do not work with persons who are vulnerable to the deleterious effects of the virus. For Petitioners who do attend facilities where vulnerable persons are present, there is no consideration of whether use of additional personal protective equipment and rapid testing prior to attending the workplace would meet the objectives of the Public Health Orders, not even where the Petitioners attend the workplace occasionally or rarely. No provision for alternate employment was made for those Petitioners who chose not to be vaccinated for religious reasons or reasons of conscience, or other medical reasons, and who do work with vulnerable persons. The Public Health Orders and Guidelines do not consider the impact of natural immunity on infections with, and transmissibility of, Covid-19. Finally, third-party contractors doing similar work to the Petitioners are not required to be vaccinated.

249. Many of the Petitioners in this action did not have contact with vulnerable persons and did not work in health facilities. The effect of the Public Health Orders and Guidelines with respect to these Petitioners is to coercively require vaccination, not to protect the health of vulnerable persons.

All of Which is Respectfully Submitted this 8th Day of November, 2023

Karen Bastow

Charlene Le Beau

XVIII. AUTHORITIES INDEX

TAB	AUTHORITY
1.	*Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65
2.	*Doré v. Barreau du Québec*, 2012 SCC 12
3.	*Mason v. Canada (Citizenship and Immigration)*, 2023 SCC 21
4.	*Public Health Act* , SBC 2008, c 28
5.	*Constitution Act*, RSC 1985, App II, No 44, Sched B, Pt VII
6.	*Carter v. Canada (Attorney General)*, 2015 SCC 5
7.	*AC v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30
8.	*BR v. Children's Aid Society of Metropolitan Toronto*, [1995] 1 SCR 315
9.	*Chaoulii v. Quebec (Attorney General)*, 2005 SCC 35
10.	*New Brunswick (Minister of Health and Community Service) v. G(J)*, [1999] 3 SCR 46
11.	*The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2018 ONSC 579
12.	*Syndicat des Metallos Section Locale 2008 c. Procureur General du Canada*, 2022 QCCS 2455
13.	*Canada (Attorney General) v. Bedford*, 2013 SCC 72
14.	*R v. Appulonappa*, 2015 SCC 59
15.	*R v. Ndhlovu*, 2022 SCC 38
16.	*R v. Big M Drug Mart*, [1985] 1 SCR 295
17.	*Syndicat Northcrest v. Amselem*, 2004 SCC 47
18.	*Lavergne-Poitras v. Ag (Attorney-General)*, 2021 FC 1232
19.	*R v. Morgentaler*, [1988] 1 SCR 30
20.	*Canadian Union of Public Employees v. Allan Klippenstein*, 2022 CanLII 44759 (SK LRB)
21.	*Electrical Safety Authority v. Power Workers' Union*, 2022 CanLII 343 (ON LA)
22.	*R v. Edwards Books and Art Ltd.*, [1986] 2 SCR 713
23.	Canadian Charter of Rights and Freedoms: Regulating and Litigating Conscientious Refusals in Health Care, 2017 CanLiiDocs 104
24.	*R v. Videoflicks*, (1984), OR 2d 395

25.	*Dunsmuir v. New Brunswick*, 2008 SCC 9
26.	*Beaudoin v. British Columbia*, 2021 BCSC 512
27.	*Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 SCR 817
28.	*Loyola High School v. Quebec (Attorney General)*, 2015 SCC 12
29.	*Law Society of British Columbia v. Trinity Western University*, 2018 SCC 32
30.	*FCA Canada Inc. v. Unifor, Locals 195, 444, 1285*, 2022 CanLII 52913 (ON LA)
31.	*Beaudoin v. British Columbia, 2022 BCCA 427*
32.	*R v. Jordan*, 2016 SCC 27
33.	*Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44
34.	*Maddock v. British Columbia*, 2022 BCSC 1605
35.	*Pacific Centre for Reproductive Medicine v. British Columbia (Medical Services Commission)*, 2019 BCCA 315

XIX. APPENDIX A- SUMMARY OF PETITIONER AFFIDAVITS

Phyllis Janet Tatlock

Affidavit #1:

1. The Petitioner Phyllis Janet Tatlock lives in Prince George, British Columbia. She is 55 years of age. Ms. Tatlock was a Director of Operations, BC Cancer, under the Provincial Health Services Authority (PHSA) and was employed in that position from March 8, 2021. She worked in an administrative capacity, and did not have contact with patients. Other positions Ms. Tatlock has held are as follows:

    a. Manager, Alberta Health Services (January 2021—March 2021)

    b. Executive Director, Alberta Health Services (July 2019-January 2020)

    c. Director, Public Health, April 2011-July 2019 Island Health,

    d. Director, Maternal/Child Services, Quinte Health Care (Ontario) April 2008-April 2011

    e. Manager Research and Community Health Services, Carrier Sekani Family Services (May 2006-April 2008

    f. Manager, Home and Community Health Services Northern Health (October 2003--May 2006)

    g. Manager Community Health Services Carrier Sekani Family Services (September 1999-October 2003)

    h. various nursing positions in the Emergency Department in Northern Health as well as in California, Texas, Washington states from 1993 until 1999

2. On October 26, 2021, Ms. Tatlock was placed on unpaid leave by her employer PHSA, and was advised by PHSA that she would be terminated on November 15, 2021, if she did not comply with the Hospital and Community Order that mandates vaccination against Covid-19 as a condition of employment. She was then terminated from her employment as threatened by her employer.

3. Ms. Tatlock is opposed to the Covid-19 vaccine on the basis of her sincerely held religious beliefs. Her reasons are set out in her Affidavits #1, 2 and 3. Ms. Tatlock provided a request for a religious exemption to the Occupational Health department of PHSA on October 22, 2021. She has sincerely held religious beliefs that prevent her from taking the Covid-19 vaccine. She is a baptized and confirmed Catholic, but has moved away from the Catholic religion for a number of reasons, most notably because of the current Pope's views and advice to

parishioners in endorsing the Covid-19 vaccine. However, she maintains a strong belief in Christianity, and abides by the Bible's teachings in her day-to-day life. Ms. Tatlock's request for a religious exemption was denied by the Senior Director of Workplace Health with the Provincial Health Services Authority. No reason was given, except that it was denied as per the mandate.

4. Ms. Tatlock is concerned that there is compelling data that the approved Covid-19 vaccines are not effective in preventing, acquiring or spreading the virus. She is personally aware of seven staff members in her workplace, all fully vaccinated, who contracted Covid-19 from late August 2021 until October 2021, when she was put on leave.

5. Ms. Tatlock has suffered significant emotional upset and anxiety because of the vaccine mandate.

6. Ms. Tatlock received a generic email from her Human Relations department advising her that there were supports available through her employee benefits to "help during what must be a stressful time".

7. On November 19, 2021, the BC government issued an Order of the Lieutenant Governor in Council which states that Public Service Employees can be terminated for refusing the vaccine, and it will be considered, "just cause". As a result, Ms. Tatlock does not qualify for Employment Insurance benefits.

8. Ms. Tatlock has never been fired from a position for just cause. She has never had any limitations, warnings, or disciplinary actions filed against her registration as a nurse. It is extremely concerning to her, as it has the potential to impact the remainder of her working career and has significantly limited her opportunities to work as a Registered Nurse in this province.

<u>Affidavit #2:</u>

9. Ms. Tatlock relies on the letter of Archbishop Carlo Maria Viganò, dated October 26, 2021, to describe her position opposing the Covid-19 vaccines. She attaches a copy of Archbishop Viganò's letter to her Affidavit as "Exhibit "A".

10. In addition, Ms. Tatlock's beliefs align with those of the National Catholic Bioethics Center (the "NCBC"). The NCBC "provides education, guidance, and resources to the Church and society to uphold the dignity of the human person in health care and biomedical research". A PDF printout of the NCBC website is attached to her Affidavit as Exhibit "B".

11. Ms. Tatlock deposes that the NCBC has posted three statements about Covid-19 vaccine mandates to date. Their statement was updated on April 28, 2022

(https://www.ncbcenter.org/ncbc-news/updatedvaccinestaement). A PDF version of the update is attached as Exhibit "C" to her Affidavit. The NCBC opposes vaccine mandates, and states that "[t]he Church has consistently pointed out the ethical problems with vaccines produced and/or tested using abortion-derived cell lines. The Church has judged it permissible for people to either accept (under protest) or reject the use of such vaccines. In other words, there is no universal moral obligation to accept or refuse them, and it should be a voluntary decision of the individual. Catholic institutions, in particular, should respect the decisions of people to decline use of vaccines dependent on abortion-derived cell lines. This is especially relevant when there are other means of mitigating risk"

12. In its update, the NCBC further states that "[i]f any institution mandates COVID-19 vaccination, the NCBC strongly urges robust, transparent, and readily accessible exemptions for medical, religious, and conscience reasons. Safeguarding the well-formed judgments of conscience (see CCC, nn. 1776—1802) of all individuals affiliated with the institution helps establish trust and avoid undue pressure during the important and personal process of deciding about appropriate medical care and serving the common good".

13. On September 10, 2021, Dr. Joseph Meaney, President of the NCBC, published an article on the NCBC website entitled "COVID, The Common Good, Conscience and Charity" (https://www.ncbcenter.org/messages-from-presidents/catholicspiritualsupport-2sket). In the article, Dr. Meaney states that "the common good will never be advanced if the rights of conscience are trampled upon. A basic condition of improving the well-being of humanity is vigilantly upholding basic human rights like those of conscience". And further, that "our society cannot come through this pandemic well if we do not keep the common good of all people in mind and respect their well-formed consciences". Ms. Tatlock attaches this article as Exhibit "D" to her Affidavit.

Affidavit #3:

14. Ms. Tatlock is opposed to taking the new XBB.1.5 COVID-19 vaccine required for a person who is seeking work as a staff member, as defined in the order entitled "HOSPITAL AND COMMUNITY (HEALTH CARE AND OTHER SERVICES) COVID-19 VACCINATION STATUS INFORMATION AND PREVENTIVE MEASURES – OCTOBER 5, 2023".

15. The reasons she is opposed to taking the new vaccine are the same as set out in her Affidavit #1 and Affidavit #2. In addition, she is opposed to taking the new XBB.1.5 vaccine for the following reasons:

    a. The vaccine is still tested using fetal cell lines and she therefore cannot

agree to taking it, based on her sincerely held religious beliefs. Furthermore, the XBB.1.5 Covid-19 vaccine is tailored to the XBB.1.5 variant, which is no longer the dominant variant in the population. This is the issue with corona virus in the first place; it mutates so quickly that any 'new' vaccine is almost immediately ineffective as the strain of the day has already mutated.

b. Ms. Tatlock is not satisfied that the level of testing the new XBB.1.5 vaccine has undergone assures its safety. The Government of Canada has published an article entitled “Regulatory Decision Summary for Spikevax XBB.1.5”, dated September 12, 2023. Ms. Tatlock attaches this document to her Affidavit as Exhibit “A”. The article states that “[r]egarding safety, the median follow-up time in the interim analysis was 20 days”, meaning 20 days after vaccination with the XBB.1.5 vaccine. She does not believe that 20 days is a long enough period to assess the safety of a new vaccine, even though similar to the previous vaccines. In any event, there is overwhelming evidence, obvious to any lay person, of the harms the previous Covid-19 vaccines caused. My research shows that all-cause mortality is up 42%, cancers are on the rise as well as heart disease, blood clots and strokes.

c. In addition, the article states that “[r]esults related to safety and effectiveness from ongoing and planned studies will be submitted as they become available”. Ms. Tatlock is not agreeable to taking a new medication that has not undergone rigorous and long-term studies and testing.

16. As an accommodation for not taking the new XBB.1.5 COVID-19 vaccine, Ms. Tatlock would agree to wear a mask if entering a patient care area, provided mask-wearing was a requirement for all workers, whether vaccinated for Covid-19 or not.

Laura Koop

Affidavit #1:

17. The Petitioner, Laura Koop, lives in Canyon, British Columbia. She is 56 years of age. Ms. Koop was a Primary Care (Family) Nurse Practitioner, with a focus on high risk and at-risk populations, such as drug and alcohol abuse, and mental health. She was employed by the Interior Health Authority and held this position from September 2014, until November 2021 when she was fired. Her office was in Creston, BC

18. Prior to her employment with Interior Health, Ms. Koop was employed in the following capacities:

    a. Nurse Practitioner (family) in remote clinics;

    b. Clinical Coordinator for remote nursing clinics;

    c. Remote Nurse with Certified Remote Nursing Practice;

    d. Nurse Manager in long-term Care;

    e. Instructor (both Care Aide and LPN program) in community college; and,

    f. Staff nurse in long-term care.

    g. Ms. Koop has now been terminated from her position for failing to provide proof of Covid-19 vaccination to her employer, as mandated by the Hospital and Community Order.

    h. Ms. Koop has the following educational and training achievements:

    i. Long Term Care Aide (1986);

    j. Registered Nurse Diploma – BCIT (1989)

    k. BScN – University of Victoria (1993);

    l. Remote Certified Nurse / Primary Care Clinical Nursing Certificate (1999)

    m. Masters in Nursing – Family Nurse Practitioner stream from University of Victoria (2008)

19. On October 26, 2021, Ms. Koop's employer placed her on a three-week unpaid leave for not providing proof of vaccination against Covid-19. Her employer further threatened her that at the conclusion of those three weeks, she may be disciplined or terminated.

20. Ms. Koop is opposed to the Covid-19 vaccine requirement. Her reasons are set out in her Affidavit #1. She has serious concerns about the safety of the Covid-19 vaccines, the lack of informed consent, the lack of transparency from pharmaceutical corporations and all levels of Canadian (and international) governments, the continued changing goals and directives regarding the Covid-19 vaccines (i.e. the changing directive of what percentage of the population needs to be vaccinated to reach herd immunity) (70%, then 75%, now 80%, etc.).

21. Ms. Koop is concerned about the vaccine contents, including the mRNA technology, use of fetal tissue in development, and the unknown ingredients that the pharmaceutical companies are not disclosing.

22. Ms. Koop is also very much opposed to the lack of freedom of choice regarding the Covid-19 vaccine and the requirement that healthcare workers take the vaccine to work in facilities run by provincial health authorities.

23. Ms. Koop noted that some of her patients experienced adverse reactions to the Covid-19 vaccine, post-injection.

24. Although Ms. Koop has not taken a Covid-19 vaccine, she is not opposed to vaccines in general, and had the usual course of recommended vaccines when she was a child, and various vaccines during her adult life. She agrees with any vaccines that have been proven safe and effective.

25. On October 26, 2021, Ms. Koop's employer placed her on a three-week unpaid leave for not providing proof of vaccination against Covid-19. Her employer further threatened her that at the conclusion of those three weeks, she may be disciplined or terminated.

26. Ms. Koop was not clear that she was to be terminated after the three-week unpaid leave. As such, she attended work at her office in Creston, BC on November 16, 2021, as scheduled. She found a letter on her desk addressed to her from her employer dated October 26, 2021, which advised that she was not permitted to work if she was not vaccinated against Covid-19 by October 26, 2021. She contacted her employer who advised her to go home.

27. Ms. Koop later realized that the October 26, 2021 letter had also been sent to her Interior Health email address, rather than her personal email address, during her three weeks of forced unpaid leave, but she inadvertently missed that email.

28. On November 17, 2021, Ms. Koop's employment was terminated by her employer for failing to provide proof of Covid-19 vaccination to her employer, as mandated by the Hospital and Community Order. During the termination meeting, Ms. Koop was advised that she would be paid a half-day's salary for inadvertently attending work on November 16, 2021. To date, Ms. Koop has not received payment.

29. Ms. Koop is experiencing stress and anxiety because of the vaccine mandate that caused her to lose her job. Ms. Koop is also experiencing moral distress about having been removed from her practice in such a manner as to prevent her from the opportunity to close her relationship with her patients in an appropriate and honourable manner. She was not only unable to say goodbye and explain why she was leaving the practice, but she was also prevented from ensuring that careful follow up and transfer of care for patients who required ongoing care was

made. This has left her feeling as though she has ethically and morally abandoned her duties as a Nurse Practitioner and left many already at-risk patients at even greater risk of not receiving appropriate care. As well, she is upset that her reputation as a Nurse Practitioner, not only with her patients, but also with other health care professionals and community members, has likely been tarnished by her sudden and unexplained departure.

30. Further, Ms. Koop has experienced stress and concern about future employment options. Obtaining a positive reference from her most recent employer of seven years which describes her as bringing positive abilities and assets to a place of employment has now become potentially unattainable as it seems she has been "terminated for just cause". This is despite very strongly positive and high scoring annual personnel reviews with consistent attainment of performance measures, which qualified her for the annual pay increases in each year they were granted since her employment with Interior Health Authority. In November 2021, Ms. Koop requested a letter of reference from her employer, Louann Janicki. Her request was referred to the Human Resources department who said she could have a "letter of confirmation" only. Ms. Koop has requested this letter, but has not received it to date. She also requested her Record of Employment but has not received that document. Ms. Janicki advised Ms. Koop that she would personally provide a telephone reference.

31. As the primary wage earner in the household Ms. Koop is suffering financially because of the vaccine mandate. Expenses are now having to come from of her husband's retirement savings as she is unable to work as a Nurse Practitioner in any Health Authority or Primary Care funded positions in BC. She is limited to considering private practice options, which for a single Nurse Practitioner, are difficult to manage due to the professional responsibility of providing access to care for patients outside of regular office hours and during any office closures for vacation or illness. While working for the Health Authority, it was accepted that the local emergency department would see Ms. Koop's patients for emergent or urgent care outside of regular office hours or if the office was temporarily closed. This working relationship is difficult to establish when working outside the Health Authority system. Further, private practice as a Nurse Practitioner in BC requires that the patient pay for the services, as there is no means of billing Medical Services Plan like there is for physicians. This will limit some patients' ability to seek Ms. Koop's service.

32. Being terminated prior to her earliest date of retirement means Ms. Koop has lost her sick benefit payout. This payout consists of a portion of her accrued sick hours. Ms. Koop had a substantial sick time accrual of 1160 hours, demonstrating solid work attendance for many years.

33. Further, being terminated means a loss of Municipal Pension Plan accrual to Ms. Koops's retirement funds, as well as a loss of health, dental and life insurance benefits. Benefits are able to be purchased by Ms. Koop, but come at a significant monthly cost at a time that her income has been reduced to zero.

Affidavit #2:

34. Ms. Koop is opposed to taking the new XBB.1.5 COVID-19 vaccine required for a person who is seeking work as a staff member, as defined in the order entitled "*HOSPITAL AND COMMUNITY (HEALTH CARE AND OTHER SERVICES) COVID-19 VACCINATION STATUS INFORMATION AND PREVENTIVE MEASURES – OCTOBER 5, 2023*".

35. The reasons she remains opposed to taking the mRNA vaccine, now called the XBB.1.5 vaccine, are the same as those set out in her Affidavit #1. The new vaccine is still an mRNA vaccine, and there is no significant difference between it and the previous vaccines. It would pose similar risks of adverse reactions like the previous vaccines for COVID-19.

36. As well, the continued use of fetal cells in the production of these mRNA vaccines offends her conscience. Simply being told she only needs to take "one" instead of "two" injections with the same product does nothing to change her mind. Ms. Koop further deposes that it also does nothing to change the facts about her risk of acquiring COVID-19 or becoming very sick with it (which she believes is low), the efficacy of the previous vaccines, or the risks in taking the vaccine.

Monika Bielecki

Affidavit #1:

37. The Petitioner, Monika Bielecki, resides in Kelowna, British Columbia. She is 48 years old. Ms. Bielecki was an Employee Health and Wellness Advisor with BC Interior Health. She held this position from October 2015 until October 2021. She was terminated from her position for failing to provide proof of Covid-19 vaccination to her employer, as mandated by the Hospital and Community Order. Ms. Bielecki was placed on unpaid leave, effective October 26, 2021, and then terminated on November 15, 2021.

38. Ms. Bielecki holds Bachelor of Arts degree in Psychology. She is also qualified as a Certified Vocational Rehabilitation Professional. She has extensive experience, since 2001, in claims adjudication, rehabilitation services, disability management, and workplace accommodation process.

39. In her role as an Employee Health and Wellness Advisor with Interior Health, Ms. Bielecki worked remotely from February 10, 2016. Since that day, she did not have a designated workspace in any of the Interior Health sites and worked entirely from home via phone and email up to the time of termination of employment. A Flexible Work Location Participation Agreement and Safety Checklist was formally signed by Ms. Bielecki's manager, Karyn Greengrove, on September 30, 2019.

40. Between 2016 and 2019, Ms. Bielecki attended the occasional team meeting in the office, but as members of their team were from various cities in the Interior Health region, there always was an option to attend by teleconference and some of Ms. Bielecki's teammates did so. As the pandemic began, they started using Zoom meetings and in-person meetings were not organized by her department up to the time her employment was terminated.

41. Ms. Bielecki is opposed to taking a Covid-19 vaccine on the basis of conscience, as set out in her Affidavit #1, particularized as follows:

42. She states that acceptance of any medical intervention is her personal choice, based on her health status and risk factors;

43. She had Covid-19 at the beginning of 2020 when testing was not available to the general public. She is prepared to test for antibodies and T-cell immune response to show she is immune to Covid-19. She believes that without medical assessment of her naturally acquired immunity to the virus, she cannot make an informed decision about any potential benefit of accepting the Covid-19 vaccine.

44. Science on SARS-Co V-2 is still evolving and there are ample studies indicating that immune response following natural infection is durable and long-lasting. Having had the Covid-19 infection, she is already protected from the virus.

45. She has an elementary school-aged child that has been attending school since September 2020. The school has 600 students and her child's age group has not used masks in the past year. Despite this, she has remained healthy and has not had any respiratory illness since her initial Covid-19 infection in the early part of 2020.

46. She is responsible for maintaining her health, and is very interested and keeps up with research on nutrition, stress management, longevity, exercise, etc.

47. She is conscious of her diet, activity level, sleep hygiene, stress management strategies and despite a very stressful time since the pandemic commenced, she has remained healthy. She does not have any chronic medical conditions, she maintains a healthy body mass index, and has continued to work without any

significant amount of sick time off work.

48. She does not believe that her employer is in a position to mandate her to take the Covid-19 vaccine for her own protection.

49. Vaccination does not prevent infection or transmission of the virus.

50. The Covid-19 vaccines have known adverse reactions that are serious.

51. The use of the Moderna vaccine has been paused in Iceland after review of new data from the Nordic countries, which showed an increased incidence of myocarditis and pericarditis. Sweden, Norway and Denmark have restricted use of Moderna in certain age groups.

52. Studies the Covid-19 vaccines provide diminishing immunity to Covid-19 over a short period of time, and now booster shots are being recommended.

53. The vaccine products are in phase 3 trial study phase.

54. Both vaccinated and unvaccinated individuals can become infected by SARS-Co V-2, become ill, hospitalized and infect others.

55. Vaccination is not the only way to control the spread of virus and it is not the least intrusive way of preventing transmission. There are testing options such as antigen-based testing (often called a “rapid test”).

56. Ms. Bielecki deposes that there are effective medications that can be used as treatment for Covid-19.

<u>Affidavit #2:</u>

57. Ms. Bielecki is opposed to taking the new XBB.1.5 COVID-19 vaccine required for a person who is seeking work as a staff member, as defined in the order entitled “*HOSPITAL AND COMMUNITY (HEALTH CARE AND OTHER SERVICES) COVID-19 VACCINATION STATUS INFORMATION AND PREVENTIVE MEASURES – OCTOBER 5, 2023*”.

58. The reasons she is opposed are as follows:

    a. Her primary reasons are as set out in her Affidavit #1. She is not willing to take a vaccination or any medical treatment as a condition of employment. She believes she would be giving up her human rights in doing so.

    b. Furthermore, with the passage of time, new information about the poor performance of the Covid 19 vaccination products gives her further reason to not take the new XBB.1.5 vaccine.

c. In addition, as Ms. Bielecki understand its, vaccine mandates for workers, including for healthcare workers, have been cancelled in most other jurisdictions around the world, including in most other Canadian provinces.

59. As an accommodation for not taking the new XBB.1.5 COVID-19 vaccine, Ms. Bielecki would be willing to mask and rapid test for COVID-19 if she entered a patient care area.

Scott Macdonald

60. The Petitioner, Scott Macdonald, resides in Vancouver, BC. He is 55 years old. Mr. Macdonald was a Registered Art Therapist at the Dr. Peter Centre in Vancouver, which is a care facility for persons with HIV and/or AIDS. He was employed in this position for 11 years. He has been terminated from his position for failing to provide proof of Covid-19 vaccination to his employer, as mandated by the Residential Care Order.

61. Mr. Macdonald previously worked for 10 years as an Art Therapist for Vancouver Coastal Health Detox and Daytox programs and the Vancouver School Board.

62. Mr. Macdonald holds a Bachelor of Physical Education from the University of British Columbia, as well as a Diploma from the Vancouver Art Therapy Institute.

63. Mr. Macdonald believes in an individual's right to consent to whether a substance is put into his or her body. He believes he is not in a demographic of high risk for Covid-19, nor is the prevalence of severe symptoms/death of Covid-19 (alone) statistically significant.

64. Mr. Macdonald is concerned that the vaccines were rushed to market by the pharmaceutical companies, and that they raced against each other to be the first to offer the vaccine. He says these vaccines are experimental.

65. Mr. Macdonald is aware that the vaccines do not prevent infection of Covid-19, nor do they prevent the spread of the virus.

66. Mr. Macdonald attempted to discuss the Covid-19 vaccine mandate with his employer and found an overall unwillingness by his employer to discuss the matter, or to consider questions in general about vaccine or protocol options. There was no response from his employer on questions regarding alternate treatment options or concessions for special needs populations.

67. Mr. Macdonald is very concerned about government and health officials openly inciting hatred and segregation of people who choose not to take the Covid-19

vaccine. Former Premier Horgan called them “stupid”, Dr. Bonnie Henry stated she has no time for people who choose not to take the vaccine, and Prime Minister Trudeau threatened that there will be consequences. There were consequences.

68. Mr. Macdonald is opposed to taking a Covid-19 vaccine. His reasons are set out in his Affidavit #1. He is not opposed to vaccines in general. He has had previous vaccines throughout his life.

69. Mr. Macdonald has had adverse reactions to the flu vaccine in the past. He felt physically ill each time he received the flu vaccine, so stopped taking it for a few years. As a result, he had to wear a mask at work each year during flu season. His colleagues then stared and commented on the mask, making him feel ostracized in his workplace. In or about 2016, he succumbed to the pressure and again took the flu shot. In addition to feeling physically ill again from taking the flu vaccine, he felt emotionally and mentally crushed, asking himself questions such as “what he had done, how could he have let them violate him, and who is he now?”.

70. Mr. Macdonald has observed many residents and outpatients at the Dr. Peter Centre experience adverse reactions after taking a Covid-19 shot. He has direct reports of people being unable to get out of bed, having severe headaches, body tremors and even hospitalization.

71. Mr. Macdonald saw fully vaccinated people become infected with Covid-19.

72. On October 5, 2021, Mr. Macdonald was placed on medical leave by his employer in relation to a workplace event which had been ongoing during the previous month. A change had occurred on September 30, 2021 in relation to the incident, which caused him to see Dr. Larry Barzelai, his general practitioner on October 4, 2021. He received a medical note from Dr. Barzelai to support the medical leave, and the medical leave commenced the following day. Despite being placed on medical leave by his employer, he was told he would not be welcome on the workplace property as of October 12, 2021, if he had not complied with the mandate to obtain the Covid-19 vaccines.

73. On Thursday, October 7, 2021, Mr. Macdonald was involved in a motor vehicle accident and sustained injuries. These injuries rendered Mr. Macdonald unable to work, and, as such, constituted a further medical leave. He underwent treatment supported through ICBC.

74. Despite being on medical leave for two separate incidents, Mr. Macdonald’s employer only recognized the medical leave for the dates October 7 and 8, 2021.

Notwithstanding the medical leave, and the fact that Mr. Macdonald was not working, he was placed on unpaid leave on October 12, 2021.

75. Mr. Macdonald was terminated by his employer on October 26, 2021, for failing to comply with the Covid-19 vaccine requirement.

Affidavit #2:

76. Mr. Mcdonald is opposed to taking the new XBB.1.5 COVID-19 vaccine required for a person who is seeking work as a staff member, as defined in the order entitled "*HOSPITAL AND COMMUNITY (HEALTH CARE AND OTHER SERVICES) COVID-19 VACCINATION STATUS INFORMATION AND PREVENTIVE MEASURES – OCTOBER 5, 2023*".

77. His reasons for not taking the initial mandated COVID-19 vaccines, as set out in his Affidavit #1, remain the same for the XBB.1.5 vaccine.

78. In addition, Mr. Mcdonald deposes that the mountain-sized pile of data, studies, released information from the pharmaceutical companies, and the government contradicting prior claims and promises of safety and efficacy are other reasons he will not agree to take the XBB.1.5 vaccine.

79. Mr. Mcdonald would be willing to consider reasonable accommodations applied to other contagious respiratory illnesses if he entered a patient care area.

Ana Lucia Mateus

Affidavit #1:

80. The Petitioner, Ana Lucia Mateus, resides in Burnaby, British Columbia, and was employed by Vancouver Coastal Health (VCH). She is 53 years old. Ms. Mateus worked as an Administrative Assistant for the Health Authority Medical Advisory Committee. She is not a healthcare worker and did not have contact with patients. She did not work in a healthcare setting. The advisory committee consists of approximately 50 members of all senior levels in the organization and reports to the Board. Ms. Mateus also provided credentialing and privileging support to all the sites throughout VCH, in the department of Physician Relations and Compensation. She had always worked in the corporate areas of administration for VCH.

81. On October 26, 2021, Ms. Mateus was placed on unpaid leave by her employer for failing to provide proof of vaccination against Covid-19. She was terminated by her employer on November 16, 2021, for failing to comply with the Covid-19

vaccine mandate.

82. Ms. Mateus has a Legal Assistant diploma from Capilano College in North Vancouver, BC.

83. Ms. Mateus worked for VCH for over 16 years (since May 2005). She first started as a Legal Assistant in VCH's legal department before moving to Physician Relations and Compensation.

84. Ms. Mateus had worked full time from home since March 13, 2020 due to the Covid-19 pandemic and the consequential public health protocols implemented by her employer.

85. Ms. Mateus received an email from her employer on Friday, October 15, 2021, stating that if she does not receive the first Covid-19 vaccine dose by October 25, 2021, then she will be placed on unpaid leave effective October 26, 2021.

86. In response to the email communication on October 15, 2021, Ms. Mateus sent the HR Team at VCH an email stating that there is nothing in the Hospital and Community Order that requires her to be on unpaid leave. There was only a requirement that she not physically be at work. She asked them to provide her with information to confirm she was subject to the Order. She also suggested that she be permitted to take vacation time from October 26 to November 14, 2021.

87. Ms. Mateus states that the Covid-19 pandemic impacted her workload, as her department became busier since March 2020 dealing with the additional medical staff being credentialed and privileged to deal with the pandemic at VCH. She states that the department was already short-staffed, and now that she is on unpaid leave, people will need to take on her workload.

88. Ms. Mateus is not opposed to vaccines in general. She had her childhood vaccines, as well as the Avaxim (Hepatitis A) vaccine during her adult life. She does not take the flu vaccine, however. She states that her workplace was aware that she never received the flu vaccine, given the staff must report on that decision annually. VCH's policy for influenza only stated that those staff who are not vaccinated for the flu must wear a mask in patient care areas during flu season.

89. Ms. Mateus is opposed to taking the Covid-19 vaccines on the basis of conscience. Her reasons are set out in her Affidavit #1. She believes that vaccines should only be taken if necessary, and where they have undergone stringent studies and trials to ensure their safety, not where the vaccines are experimental and authorized for emergency use. She believes there are too many

unanswered questions regarding the Covid-19 vaccines, and that they were rushed to market. She is also concerned that the pharmaceutical companies have no liability and no accountability in relation to these Covid-19 vaccines.

90. Ms. Mateus is opposed to complying with the Covid-19 vaccine mandate. She believes in freedom of choice. She also believes in self-care, nutrition, and the ability of her immune system to take care of her as she nourishes and takes care of it. She believes there needs to be more research and studies conducted on the adverse reactions people are having to the Covid-19 vaccines. She questions why the medical authorities are still concerned with cases when the herd immunity via vaccination is greater than 80%. She does not agree with the narrative that the unvaccinated are to blame for the pandemic continuing. She believes it makes no sense that 10 to 20% of the population is causing all the issues.

91. Ms. Mateus is concerned there is little to no guidance by the Health Authorities in BC regarding early treatments for Covid-19 that one can do from home to help your immune system fight and heal from it.

92. Ms. Mateus takes her employment responsibilities very seriously and has a high work ethic. Over the past 16 years, Ms. Mateus has learned and evolved through her experiences at VCH and built many friendships and positive work relationships.

93. Ms. Mateus has suffered anxiety and significant emotional upheaval due to the Covid-19 vaccine mandate. After the first Hospital and Community Order was granted on October 14, 2021, Ms. Mateus felt the timeline between October 15 and October 25, 2021, was too short to make a sound decision about the vaccine. She had been hoping that a vaccine exemption or accommodation would have been included in the Order for staff like her who work remotely from home and do not have contact with patients. However, no exemption was provided in the Hospital and Community Order, so Ms. Mateus was under significant pressure to decide whether to accede to the mandate to save her job. It was a very emotional time for her, and she was unable to think through the matter clearly to make a sound decision. She was also very busy updating her files and providing direction for work underway, knowing she would be placed on unpaid leave from October 26 to November 14, 2021. It was difficult for her to believe that mandatory vaccination was the province's position after what the health workers went through since the pandemic began in March 2020. She was further surprised that the vaccines were mandated, considering 95 to 98% of those working at VCH had been vaccinated by their own freewill. She felt that she was being blackmailed, coerced, and forced to choose between her values and her job.

Affidavit #2:

94. Ms. Mateus is opposed to taking the new XBB.1.5 COVID-19 vaccine required for a person who is seeking work as a staff member, as defined in the order entitled "*HOSPITAL AND COMMUNITY (HEALTH CARE AND OTHER SERVICES) COVID-19 VACCINATION STATUS INFORMATION AND PREVENTIVE MEASURES – OCTOBER 5, 2023*".

95. The reasons for her opposition are the same as set out in her Affidavit #1. In addition, she deposes that the safety and effectiveness of this new XBB.1.5 vaccine has not been established. As outlined in Health Canada's Regulatory Decision Summary for Spikevax XBB.1.5 (dated September 12, 2023), it states that "results related to safety and effectiveness from ongoing and planned studies will be submitted as they become available" https://covid-vaccine.canada.ca/info/RDS1694116967823-spikevax-xbb-1-5-en.html.

96. Ms. Mateus attaches a copy of the document entitled "Regulatory Decision Summary for Spikevax XBB.1.5" as Exhibit "A" to her Affidavit.

97. As an accommodation for not taking the new XBB.1.5 COVID-19 vaccine, Ms. Mateus would comply with reasonable accommodations applied to other contagious respiratory illnesses.

Darold Sturgeon

Affidavit #1

98. The Petitioner, Darold Sturgeon, resides in West Kelowna and was an Executive Director, Medical Affairs for Interior Health. He is 52 years old. Mr. Sturgeon held senior director positions with Interior Health for 14.5 years.

99. Previous positions held by Mr. Sturgeon are Corporate Director Financial Services for Interior Health BC, VP Finance, Chief Financial Officer (Cypress Health Region – Saskatchewan), Chief Financial Officer (Regional Municipality of Wood Buffalo - Alberta), and VP Finance & Administration (East Central Health District – Saskatchewan).

100. Mr. Sturgeon holds a Bachelor of Administration (Distinction), from the University of Regina. He is also a Chartered Professional Accountant in British Columbia.

101. Mr. Sturgeon was an administrative employee. He did not provide health care or services in a care location since the beginning of the pandemic.

102. On October 26, 2021, Mr. Sturgeon was placed on an unpaid leave by his employer for failing to provide proof of vaccination against Covid-19. He was terminated by his employer on November 15, 2021, for not providing such proof of vaccination.

103. Mr. Sturgeon holds sincerely held religious beliefs that prevent him from taking the Covid-19 vaccine. His reasons are clearly stated in his Affidavit #1 and Affidavit #2.

104. On August 17, 2021, Mr. Sturgeon was diagnosed with the Covid-19 virus and thus has natural immunity. His wife had Covid-19 several months prior to Mr. Sturgeon. Mr. Sturgeon's symptoms were more severe than his wife's (2 weeks of fever, chills, aches, with no respiratory struggles), however through effective treatment he avoided hospitalization.

105. In addition, since the beginning of the pandemic, Mr. Sturgeon also worked 100% remotely, causing no health risk to others.

106. Not only does Mr. Sturgeon have sincerely held religious beliefs that prevent him from taking a Covid-19 vaccine, but he also has grave concerns about the vaccine's long-term impacts.

107. Mr. Sturgeon is opposed to the mandate that makes vaccination against Covid-19 mandatory, as the mandate removes his rights and freedoms to make a free choice.

108. Mr. Sturgeon is not generally opposed to vaccines, but he believes prudence requires thorough research into the potential harms of vaccines in order to properly understand their effects, and to enable individuals to give informed consent before receiving a vaccine.

109. Mr. Sturgeon was given one vaccine during childhood, to which he had a severe reaction.

110. Mr. Sturgeon has always received very favourable performance evaluations and his most recent performance evaluation stated that he "consistently exceeds expectations". This resulted in a larger pay increase for the 2021/22 fiscal year for Mr. Sturgeon.

<u>Affidavit #2:</u>

111. Mr. Sturgeon has subscribed to more traditional and orthodox views of the Catholic Church throughout his life. He and his family are currently discerning whether to

join the Traditional Latin Mass community in Kelowna, British Columbia, which they recently learned about. This more traditional subset of the Catholic Church is more in line with his conscientiously held beliefs that include prohibitions against abortion and forbids members from condoning, cooperating with, or participating in abortions.

112. Based on conscientiously held beliefs, he is unable to receive COVID-19 vaccines. As a strong pro-life advocate (he is a father of seven showing his openness to life and his strong moral convictions), he cannot, in good conscience, admit an abortion-tainted vaccine into his body. COVID-19 vaccines are abortion-tainted. The source for abortion-tainted vaccines can be found at the following link: https://immunizebc.ca/ask-us/questions/do-covid-19-vaccines-contain-aborted-fetal-cells. A PDF version of the contents of that webpage is attached as Exhibit "A" to his Affidavit. He would never want to go against his conscience and condone abortion by using a product that uses fetal cell lines in the development and/or testing of a product or vaccine.

113. Mr. Sturgeon's conscientiously held beliefs are in line with the "Bethlehem Declaration", an appeal to the Holy Father Pope Francis and members of the Catholic Church challenging the moral liceity of the abortion-tainted experimental injections for COVID-19 and calling for universal opposition to vaccine mandates. A PDF version of the declaration is attached as Exhibit "B" to his Affidavit. This declaration is signed by an Archbishop, Bishops, Priests, and other Catholic leaders.

114. Mr. Sturgeon deposes that the stand of the Catholic Church is very clear: even though some vaccines are morally permissible for Catholics to receive, no one should be coerced or forced to take them. The source of his assertion is published by the Congregation for the Doctrine of Faith, in the following link entitled "Note on the morality of using some anti-COVID-19 vaccines": https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20201221_nota-vaccini-anticovid_en.html. A PDF version of that link is attached to his Affidavit as Exhibit "C". Paragraph 5 of Exhibit "C" states that "practical reason makes evident that vaccination is not, as a rule, a moral obligation and that, therefore, it must be voluntary."

115. Mr. Sturgeon understands that Pope Francis has encouraged vaccination and has provided the Catholic faithful with comfort in receiving vaccines. He is thankful that the Pope has given guidance to Catholics. However, he deposes that it is clear Catholics are not obligated to follow the Pope's opinions on COVID-19 vaccinations, especially given the clear messaging from the Congregation for the

Doctrine of Faith in Paragraph 5 of Exhibit "C" that states "practical reason makes evident that vaccination is not, as a rule, a moral obligation and that, therefore, it must be voluntary." A pope's opinions are not the same as infallible teachings. Infallible teachings are rare as described in the following link entitled "When Does the Pope Speak Infallibly?": https://canonlawmadeeasy.com/2011/02/17/when-does-the-pope-speak-infallibly/. A PDF version of that link is attached as Exhibit "D" to his Affidavit. The article describes how "[t]he Pope only speaks infallibly when he addresses dogmatic issues, and intends that his pronouncement constitutes a definitive statement which all Catholics must accept as the Church's teaching". The Pope's opinion on COVID-19 vaccinations is not an infallible teaching of the Church. Catholics don't have to believe, agree with, or even pay attention to everything a pope says; people are free to use their conscience and the formal infallible teachings of the Church to guide our decisions and actions.

116. Mr. Sturgeon was hospitalized from a reaction to the only vaccine he received as a child. He has not received any other vaccine since. His seven children have had all their childhood vaccines and two of his children have received COVID-19 vaccines.

117. Mr. Sturgeon deposes that the Catholic Church teaches that he has a moral obligation to protect his life. This is set out in "Evangelium Vitae: Encyclical by Saint Pope John Paul II", Section 76, paragraph 2, which states "The Creator has entrusted man's life to his responsible concern, not to make arbitrary use of it, but to preserve it with wisdom and to care for it with loving fidelity". He attaches a copy of the encyclical to his Affidavit as Exhibit "E".

118. Mr. Sturgeon's decision to not receive the COVID-19 vaccines is firmly grounded in conscientiously-held beliefs, especially considering his personal safety concerns. This principle is set out in the document entitled "Catechism of the Catholic Church", at paragraph 1782: "Man has the right to act in conscience and in freedom so as personally to make moral decisions. He must not be forced to act contrary to his conscience." This document is attached as Exhibit "B" to his Affidavit #1 filed in these proceedings.

119. Mr. Sturgeon's conscientiously-held beliefs prevent him from participating in coercive mandates that go directly against his moral conscience. This belief is reinforced by the third paragraph in Section 27 of the "Pastoral Constitution on the Church in the Modern World *Gaudium Et Spes"* promulgated by his Holiness, Pope Paul VI on December 7, 1965, which states "…whatever violates the integrity of the human person, such as …attempts to coerce the will itself …are infamies indeed [and] …are supreme dishonor to the Creator." Mr. Sturgeon attaches a

PDF version of this document to his Affidavit as Exhibit “F”. Mr. Sturgeon does not wish to dishonour his Creator and condemn himself by going against his moral conscience by participating in coercive mandates. Coercive mandates interfere with his ability to act in accordance with his conscientiously-held beliefs.

Affidavit #3:

120. Mr. Sturgeon is still opposed to mandated COVID-19 vaccination programs including the use of the new XBB.1.5 COVID-19 vaccine required for a person who is seeking work as a staff member, as defined in the order entitled “*HOSPITAL AND COMMUNITY (HEALTH CARE AND OTHER SERVICES) COVID-19 VACCINATION STATUS INFORMATION AND PREVENTIVE MEASURES – OCTOBER 5, 2023*”.

121. The reasons he is opposed are as follows:

    a. His moral conscience guides his life. Based on his sincerely held religious beliefs, and through prayerful discernment, he determined that mandated COVID-19 vaccination policies are immoral for three reasons:

        i. He is accountable to God to protect his life to ensure he can care for his family;

        ii. Attempts to coerce the will are infamies and are a supreme dishonour to God;

        iii. COVID-19 vaccines have used fetal cell lines in either their production or in their testing. He refers to Exhibit “A” of his Affidavit #2 in which he set out a BC government website called “Immunize BC” (https://immunizebc.ca/ask-us/questions/do-covid-19-vaccines-contain-fetal-cells-were-abortions-performed-make-vaccines-0). That article states, in relation to a query about whether the COVID-19 vaccines contain fetal cell lines, that “[t]he purification process removes nearly all the cell components so that only trace amounts of DNA and protein may be present in the vaccine.”

    b. No matter how trace it is, Mr. Sturgeon is morally opposed to all products that use fetal cells in its production or testing. He will not condone abortion by using a product that uses fetal cell lines in the development and/or testing of a that product.

    c. Mr. Sturgeon notes that the BC government links to the Catholic Church’s documents regarding the Catholic church’s views on the use of fetal cell lines

in vaccines. He deposes that it is not fully comprehending the contents of those documents.

d. As stated in the BC government article attached as Exhibit “A” to his Affidavit #2, “the Vatican's Pontifical Academy for Life declared in 2005, and reaffirmed in 2017, that in the absence of alternatives, Catholics could, in good conscience, receive vaccines made using historical human fetal cell lines.”

e. The key to the above statement is “in the absence of alternatives”. There are clear scientifically-based alternatives to the vaccines to treat COVID-19. Also, the Catholic Church allows each of its members to decide for themselves based on their conscience, what is morally right in these specific circumstances. The reference the BC government used from the Congregation of the Faith in 2020, clearly states that the vaccines must be voluntary. The document also states that the vaccines are assumed to be clinically safe and effective, which is also disputable.

f. Mr. Sturgeon included, as Exhibit “C” to his Affidavit #2, a “Note on the morality of using some anti-Covid-19 vaccines”, written by the Vatican’s Congregation for the Doctrine of the Faith. He refers to statement #5, which states “[a]t the same time, practical reason makes evident that vaccination is not, as a rule, a moral obligation and that, therefore, it must be voluntary.”

122. As an accommodation for not taking the new XBB.1.5 COVID-19 vaccine, Mr. Sturgeon would be willing to mask and rapid test for COVID-19 if he entered a patient care area.

Lori Jane Nelson

Affidavit #1:

123. The Petitioner, Lori Jane Nelson, resides in Surrey, BC, and was a Provider Engagement Lead, Clinical Informatics, for the British Columbia Provincial Health Services Authority (PHSA) in Vancouver, BC. She is 48 years old.

124. Ms. Nelson has worked for the PHSA for 25 years. Other positions she has held with the PHSA are General Duty Nurse, Clinical Nurse Coordinator, Program Manager, Senior Director, Patient Care Services, and a Clinical Transformation Leader, Redevelopment Project.

125. Ms. Nelson was terminated from her position for failing to provide proof of Covid-19 vaccination to her employer, as mandated by the Hospital and Community

Order.

126. Ms. Nelson holds a Bachelor of Science in Nursing (UBC, 1996), as well as a Master of Science in Nursing (UBC, 2005). She is also a Certified Health Executive (CHE) with the Canadian College of Health Leaders and has held this certification for over 15 years. Ms. Nelson is a life-long learner, and has taken numerous courses, workshops, and webinars over the years.

127. Ms. Nelson worked solely from home and had a Work from Home Agreement. She did not have contact with patients or public while working and had no need to be within a facility to do her work. However, she was put on unpaid leave as of October 26, 2021, with the threat of termination if she didn't receive at least one dose of a Covid-19 vaccine by November 15, 2021. Ms. Nelson did not accede to this coercion. She was terminated by her employer on December 2, 2021.

128. Ms. Nelson is opposed to the vaccine mandate on religious, medical and conscience grounds. Her reasons are set out in her Affidavits #1 and #2. She believes it goes beyond demonstrably justifiable means to protect the health and safety of the public. Within her job, she was at zero risk to the public, yet was still coerced and under duress to take a substance that is still in clinical trials.

129. After detailed analysis, Ms. Nelson has assessed that the Covid-19 vaccine is of greater risk to her than not having it. She has severe allergies, and has had multiple systemic and anaphylactic reactions in the past. She had reactions to the flu shot in past years, such that she stopped receiving it. Ms. Nelson believes she knows her body best and does not believe that a Covid-19 vaccine would be of benefit to her. Ms. Nelson was referred to an allergist by her doctor, but he was reluctant to discuss her concerns about the Covid-19 vaccines, her history of allergies, and stated he does not sign any PHO forms.

130. Ms. Nelson is not opposed to vaccines in general. She has had vaccines in the past, although, as set out above, stopped taking the flu vaccine due to adverse reactions she experienced.

131. Ms. Nelson is suffering financial hardship from losing her job. She does not qualify for Employment Insurance benefits, as, according to her employer, she was terminated for just cause.

Affidavit #2:

132. Ms. Nelson was baptized in Glad Tidings Church in Chilliwack, BC. She has attended protestant, largely non-denominational churches her entire adult life. The

structure of the non-denominational churches she attends have pastor(s) and elders.

133. The issue of whether to take the Covid-19 vaccine is a divisive one in some churches. She is uncomfortable with identifying all the churches she attends because her position on the Covid-19 vaccine has not been revealed to other parishioners. However, she is comfortable stating that she attends a Bible study at Riverside Calvary Chapel in Langley, BC. Her impression is that most of the congregation are opposed to the vaccine. This church was fined and in the news for refusing to abide by the mandates.

134. Ms. Nelson deposes that it is important to understand that there is no clear line of doctrinal authority in most of the churches she attends. As such, individual congregants can make up their own minds about whether to take the Covid-19 vaccine. None of the churches she currently attends have released a position statement on taking the Covid-19 vaccine. However, Brent Smith, pastor at Riverside Calvary Chapel (Langley location), wrote a letter, at her request, "To whom it may concern" dated October 20, 2022, in which he states that "It is not [his] responsibility to force [his] personal religious convictions regarding this matter [Covid-19 vaccination) on other persons, as [he] believe[s] whether to receive a COVID-19 shot is a personal decision to each individual person (Romans 14). Where Scripture does not expressly instruct on a particular matter, [he] believe[s] that [he is] required to search the Scripture [himself] for related Truths (Romans 15:4) and to seek personal guidance from the Holy Spirit (Acts 2:38-39; Romans 8)".

135. Pastor Smith further states in his letter that "[a]nother significant reason why the acceptance of these vaccines would be considered sinful, centres around the fact that the fetal system cell lines from aborted babies were used in either the initial development and/or testing of the COVID-19 shots. By receiving the COVID-19 shots presently available, Ms. Nelson believes it would constitute a complicit action in the act of abortion. She believes that abortion is murder and is strictly prohibited in the Bible (Exodus 20:13; Psalm 139:13-16; Jeremiah 1:5; Isaiah 49:15). Psalm 127:3 says that "Children are a heritage from the Lord, offspring a reward from Him." The fact that aborted stem cells were involved in the origination of the three COVID-19 shots, makes the consumption of this vaccine an unthinkable act to her.

136. Ms. Nelson attaches a copy of Pastor Smith's October 20, 2022 letter as Exhibit "A" to her Affidavit.

137. Ms. Nelson also attends online worship services Calvary Chapel, Kaneohe, Hawaii. At her request, senior pastor, J.D. Farag, wrote a letter, "To Whom it May

Concern", dated October 12, 2022, supporting her in her objection to take a Covid-19 vaccine. In his letter, Pastor Farag states "[w]e are convinced that the nature of many other contaminants within vaccines should be a reason to grant exemptions to believers whose bodies are, as the Scripture states, the 'temple of the Lord'". Ms. Nelson attaches a copy of Pastor Farag's letter as Exhibit "B" to her Affidavit.

138. In addition, Ms. Nelson has reviewed the position statement of the New West Community Church ("NWCC") elders in the following link entitled "Letter from Elders re: Mandatory Vaccines": https://www.newwestcommunitychurch.com/letter-mandatory-vaccines/, and notes it is consistent with her beliefs. The New West Community Church holds the same beliefs as she does theologically, and the structure is similar to that of the churches she attends. In their letter, the elders state that "[a]s Elders of NWCC we want to state unequivocally that vaccine passports and other coercive measures regarding COVID-19 vaccines are contrary to scripture and gospel principles". They go on to state the reason for their opposition in the letter, and conclude by stating that "[t]aken together, these gospel principles lead to the conclusion that vaccine passports and coercive vaccine policies are contrary to God and his law. They ought to be opposed by all Christians, even by those who are persuaded that COVID vaccination is the best course of action". A PDF version of that linked letter is attached to Ms. Nelson's Affidavit as Exhibit "C".

Affidavit #3:

139. Ms. Nelson is opposed to taking the new XBB.1.5 COVID-19 vaccine required for a person who is seeking work as a staff member, as defined in the order entitled "*HOSPITAL AND COMMUNITY (HEALTH CARE AND OTHER SERVICES) COVID-19 VACCINATION STATUS INFORMATION AND PREVENTIVE MEASURES – OCTOBER 5, 2023*".

140. Her original reasons for opposing the Covid-19 vaccine based on sincerely-held religious beliefs still applies to this new vaccine.

141. In addition, she is also concerned about medical risk and well documented adverse reactions to the previously required Covid-19 injections.

142. As an accommodation for not taking the new XBB.1.5 COVID-19 vaccine, Ms. Nelson would be willing to consider reasonable accommodations applied to other contagious respiratory illnesses if she entered a patient care area.

Ingeborg Keyser

Affidavit #1:

143. The petitioner, Ingeborg Keyser, resides in Kelowna, BC, and was a Communications Advisor for Interior Health. She is 40 years of age. Ms. Keyser an administrative worker. She is not a healthcare professional. Ms. Keyser held this position from April 2017.

144. Ms. Keyser was terminated from her position by her employer for failing to comply with the vaccine mandate set out in the Hospital and Community Order.

145. Ms. Keyser graduated from the Tshwane University of Technology in Pretoria, South Africa in 2007, with an International Diploma (three-year course) in Public Relations.

146. Ms. Keyser also completed a bridging course at the University of South Africa to complete all 4th year degree subjects in Communications. In 2011, Ms. Keyser immigrated to Canada.

147. Ms. Keyser occupied a permanent, half-day position in her position with Interior Health. In February 2021, Ms. Keyser's employer directed her to work entirely from home, due to Covid-19. Before being ordered to work from home, she worked on the 5th floor of the corporate office of Interior Health, 505 Doyle Avenue, Kelowna, BC.

148. Ms. Keyser is opposed to taking a Covid-19 vaccine on the basis of conscience. Her reasons are set out in her Affidavit #1. Her view is that not only is it illegal to force a person to receive an injection to keep his or her job, but she strongly feels that there is not enough data to confirm the safety and long-term side effects of the vaccine. Although approved by Health Canada, the medical trials are still underway, and not set to be completed until 2023.

149. Ms. Keyser also feels that the vaccine is not a "one-size fits all" solution, and that the vaccine was designed/developed for people who already have underlying health conditions including seniors. She is also opposed to the Covid-19 vaccine being tied to a health passport that is now the only means of enabling a person to travel by plane or train, and to enter a restaurant, gym, or movie theatre, which violates basic human rights that are protected under the *Charter*.

150. Another significant reason Ms. Keyser is opposed to the vaccine mandate, is because she was pregnant at the time the orders were issued. She is unable to know what is right for herself and her unborn baby, given the lack of long-term

data regarding the Covid-19 vaccines. She felt coerced into taking a vaccine that was developed in less than eight months, in order to save her job. She needs a job to provide food and shelter for her family. When she signed her employment contract with Interior Health in 2017, she did not sign or give her consent to receive a vaccine.

151. Ms. Keyser is not an “anti-vaxxer”. Her children are vaccinated with approved childhood vaccines. They are all up-to-date with their vaccinations. These childhood vaccines have gone through lengthy and vigorous trials for many years. Childhood vaccines are also not forced on children.

152. Ms. Keyser suffered a miscarriage in the spring of 2021, at nine weeks’ gestation. When the Covid-19 vaccine mandate was announced in September 2021, compelling Ms. Keyser to receive her first dose of an approved Covid-19 (emergency) vaccine by October 25, 2021. Her manager, Chris Shewchuck, contacted her on October 20th, to announce that he could see on her personal health record that she was not yet vaccinated. This was personal information, and Ms. Keyser takes exception to this information being available to her employer. Mr. Shewchuk pressed her as to why she was not vaccinated and whether she was planning on getting vaccinated. Due to her miscarriage earlier in the year (which he and the Vice President of Communications, Jenn Goodwin, were aware of), she explained her status and queried him regarding the safety of the vaccine for pregnant women and a fetus. She advised him she had heightened concerns, due to her history of having had a miscarriage earlier this year, and the emotional toll it had taken on her mental health. However, Ms. Keyser’s questions went unanswered. The first dose of the vaccine was mandatory by October 25th, to keep working (from home), otherwise she would be placed on unpaid leave. On Friday, October 22, 2021, she emailed both Mr. Shewchuck and Vice President of Communications, Jenn Goodwin with an open letter which included a list of questions regarding: the safety of the vaccine in pregnancy (especially first trimester pregnancy), how her role as a Communications Advisor fit into this Public Health Order, whether Interior Health would take any liability for any adverse reactions from the vaccine, and a request that she be given the opportunity to give informed consent before taking the vaccine. Ms. Keyser did not receive a response from Mr. Shewchuck or any other individual associated with Interior Health.

153. With no response to her October 22, 2021 email to Mr. Shewchuck and Vice President Goodwin, on October 28, 2021, Ms. Keyser sent an email to various Interior Health directors, including Karen Bloemink, the Director of Pandemic Response, Mike Jackson, Director of Employee Pandemic Relations, and Vicki

Horton, Employee Pandemic-Related Questions. She copied Dr. Sue Pollock on the email, asking the same questions about the safety of the vaccine during pregnancy. To date, Ms. Keyser has not received a response from any of the recipients to whom she sent the email.

154. On October 26, 2021, Mr. Shewchuck advised Ms. Keyser that she was being placed on unpaid leave for failing to provide her proof of Covid-19 vaccination. On Friday, November 12, 2021, at 12:45 p.m., Mr. Shewchuck forwarded an email to Ms. Keyser which was originally sent from Dr. Fenton, someone unknown to Ms. Keyser, with a list of resources to each of the vaccine safety questions set out in her emails of October 22, 2021. There was no consultation options in relation to the information provided. Ms. Keyser felt coerced into making a crucial, potentially life-altering decision in relation to the Covid-19 vaccines by the November 14th deadline. Ms. Keyser reviewed the resources to the best of her ability. She noted the information in those resources stated that the Covid-19 vaccination is recommended, not mandatory, for pregnant woman. This resource then also confirmed that pregnant women were excluded in the phase II and phase III clinical trials for this vaccine. Ms. Keyser also notes that in recent news, the number of stillborn births in vaccinated women, in Canada, has increased dramatically. In the end, Ms. Keyser concluded that it is her choice whether to take the vaccine, and she opted not to take it. In regards to Ms. Keyser's question about liability, Dr. Fenton stated that "this would be best directed to the PHO who issued the mandatory vaccination order".

155. Ms. Keyser was terminated on November 17, 2021, for failing to comply with the Covid-19 vaccine mandate. In her termination letter, it clearly states: "The Provincial Health Officer has communicated that this step was not taken lightly and was done because of the continued risk of COVID-19 to *our patients and employees* (in a hospital community setting as per the original PHO order)." Ms. Keyser is not a healthcare worker; she had no contact with hospital staff or patients – she worked from home. Ms. Keyser has subsequently learned that Interior Health is hiring contract workers to work remotely, and who can occasionally access the health facility (not more than once per month), and that these contract workers are not subject to the Covid-19 vaccine mandate. Yet Ms. Keyser was fired despite working 100% remotely.

156. Ms. Keyser is suffering economic hardship because she was terminated. She does not qualify for Employment Insurance benefits because her employer says she was terminated for just cause. Ms. Keyser disputes this claim.

<u>Affidavit #2:</u>

157. Ms. Keyser is opposed to taking the new XBB.1.5 COVID-19 vaccine required for a person who is seeking work as a staff member, as defined in the order entitled "HOSPITAL AND COMMUNITY (HEALTH CARE AND OTHER SERVICES) COVID-19 VACCINATION STATUS INFORMATION AND PREVENTIVE MEASURES – OCTOBER 5, 2023".

158. The reasons for her opposition are as set out in her Affidavit #1. She sets out the following additional reasons:

    a. Dr. Bonnie Henry's orders that require BC healthcare workers to take the COVID-19 vaccine to be allowed to work have had a very serious impact on Ms. Keyser and her family. However, it has turned out that the original COVID-19 vaccines did not work. Numerous reports and updates have been published that are easily available to the public that talk about the low efficacy of the COVID-19 vaccine.

    b. Similarly, there is significant evidence available to the public about adverse reactions to the COVID-19 vaccine, including long-term detrimental side effects.

    c. Ms. Keyser states that they now have a new vaccine (the XBB.1.5-containing formulation of COVID-19) that they say will work. Given the poor track record of the previous vaccines for COVID-19, she does not trust the new vaccine in relation to safety or efficacy.

    d. Ms. Keyser deposes that getting vaccinated is a personal choice that should not be forced or coerced in order to be hired or keep a job.

    e. In addition, Ms. Keyser believes that both unvaccinated or vaccinated workers should stay home when they are ill, rather than attending work when they are sick, even if they are wearing a mask all day. Vaccinated workers still get sick and still transmit COVID-19 and other respiratory illness. The best means of limiting transmission to others is to stay home when sick.

    f. In addition, there are effective treatments available to treat COVID-19. Ms. Keyser also believes that her healthy lifestyle assists her in building her immune system to fight off viruses. Certain individuals who are at high-risk for COVID-19 may want to take the vaccine. However, she is not in that category of persons. If she were to become ill, she would stay home so as not to spread her illness to others.

159. As an accommodation for not taking the new XBB.1.5 COVID-19 vaccine, Ms. Keyser would agree to wear a mask, if entering a patient care area, provided mask-wearing was a requirement for all workers, whether vaccinated for COVID-19 or not.

Lynda June Hamley

Affidavit #1:

160. Ms. Hamley resides in Nelson, British Columbia. She is 48 years old. Ms. Hamley was employed by Kootenay Society of Community Living ("KCLS") as a residential support worker. KCLS provides care to young men and women with developmental disabilities, living in a group home setting. Ms. Hamley was hired by KCLS in December 2020. She started as a casual support worker and obtained a full-time position with KCLS in November 2021.

161. On December 10, 2021, Ms. Hamley was placed on unpaid leave by her employer for failing to provide proof of vaccination against Covid-19, contrary to the Hospital and Community Order. She had until January 13, 2022 to become fully vaccinated against Covid-19, otherwise her employment would be terminated.

162. Ms. Hamley is also a certified Classroom and Community Support Worker. She has worked supporting children with disabilities and challenging behaviours in the school system for 13 years.

163. Until December 9, 2021, Ms. Hamley was supporting three young men and a young woman in their homes. Now that she is on unpaid leave, the men and woman that were in her care are being cared for by other workers that have picked up extra shifts.

164. Ms. Hamley is opposed to taking a Covid-19 vaccine, and has not done so. Her reasons are set out in her Affidavits #1 and 2. She has sincerely held religious beliefs that prohibit her from taking the vaccine. She has been a practicing Christian for 17 years. She attends the Seventh-Day Adventist Church weekly. She also volunteers at her former church's soup kitchen when she is available and needed. She also helps with church's musical program, as she did with her former church. It is her view that it is unethical to force a person to take a novel medical intervention that has risks. She believes that because it is unethical, it is unjust, and further, that any unjust mandate coming from the government is not sanctioned by God, who is a just God.

165. Ms. Hamley is not opposed to all vaccines. She believes vaccines have helped humanity, by keeping certain diseases in check. She is leery of the vaccine schedule for babies, so did not get her young children vaccinated as babies.

166. Ms. Hamley is aware that the Hospital and Community Order specifically allows applications for exemptions from the vaccine mandate only for medical reasons. However, she fervently believes that there should be provision for applications for exemptions based on sincerely held religious beliefs. She says that to prevent her from seeking exemption based on her religious beliefs is discriminatory and in violation of her Charter rights, and, in addition, in violation of her human rights under the BC Human Rights Code.

167. On or about Nov. 29, 2021, Ms. Hamley delivered a request by email for an exemption from the Covid-19 vaccine requirement, to Bonnie Henry's Public Health Office, based on sincerely held religious beliefs. She also notified her employer of her request. Her employer advised that religious exemptions were not being considered. On November 29, 2021, Ms. Hamley received an automated reply to her email from the Public Health Officer email address, stating that only requests for medical deferrals to the vaccine mandate will be considered, and also setting out the manner by which a request for medical deferral is to be submitted.

168. Ms. Hamley is a single mother and caregiver of a 17-year-old daughter. Her adult son also resides in the home.

169. Ms. Hamley has not received official notice that her position at KCLS was terminated. She understands she is still on unpaid leave. She is experiencing financial hardship from being laid off without pay. She resigned from her position at School District 8, where she had worked since 2008, and which gave her five weeks' vacation per year, as well as accrued sick time in the amount of 60 hours, in order to accept the job at KCLS. When she accepted the position at KCLS, she received a document entitled "E.D. Communication, October 2021" written by Kathleen Elias, Executive Director of KCLS, that KCLS would not be mandating the Covid-19 vaccine at this time, despite other employers, including government employers, doing so.

170. Ms. Hamley has been rehired by School District 8 and has a temporary position until the end of April 2022 at a school in the next town over, one hour's drive away from her home. She has lost the job security and seniority she had when previously employed by School District 8. In addition, School District 8 just asked their staff for their vaccine status. Ms. Hamley will be applying for an exemption should the school mandate the Covid-19 vaccine. For now, staff will have to do

rapid tests if they are unvaccinated. Ms. Hamley fears that her temporary position with School District 8 will not be extended after April 2022.

171. Ms. Hamley is suffering from significant emotional stress and anxiety due to the financial ramifications of being placed on unpaid leave, as well as the unthinkable situation of being forced to choose between providing for her family, which would force her to submit to a vaccine that goes against her sincerely-held religious beliefs, and being unable to provide for her family which would be the case if she stands firm in her religious beliefs by refusing the vaccine.

Affidavit #2:

172. In response to the Respondents' assertion that there is no nexus between Ms. Hamley's objection to taking a Covid-19 vaccine and her religious beliefs, she asked her pastor, Doug Pond, to write a further letter explaining the doctrinal and theological basis for her religious objection to the Covid-19 vaccine. She attached as Exhibit "A" a copy of an email to her from Pastor Pond, dated October 25, 2022, in which he explains the doctrinal and theological basis for her religious objection to the Covid-19 vaccine.

Affidavit #3:

173. Ms. Hamley will not take the new XBB.1.5 Covid-19 vaccine, as required for a person who is seeking work as a staff member, as defined in the order entitled "*HOSPITAL AND COMMUNITY (HEALTH CARE AND OTHER SERVICES) COVID-19 VACCINATION STATUS INFORMATION AND PREVENTIVE MEASURES – OCTOBER 5, 2023*".

174. She relies on the reasons set out in her Affidavits #1 and #2 for objecting to taking the COVID-19 vaccine, including this new XBB.1.5 vaccine. As she has stated, she has sincerely held religious beliefs that prevent her from taking the vaccine. She relies on God to provide the immunity she needs for all diseases of this world of His creation.

175. As an accommodation for not taking the new XBB.1.5 COVID-19 vaccine, Ms. Hamley would be willing to mask and take a rapid test for Covid-19 if she entered a patient care area.

Melinda Joy Parenteau

Affidavit #1:

176. The Petitioner, Melinda Joy Parenteau resides in Nelson, BC. She is 39 years of age. Ms. Parenteau is a registered midwife, and previously worked as a private contractor for Apple Tree Maternity ("Apple Tree") in Nelson, BC. She worked for there between July 1, 2020, and October 25, 2021.

177. Mrs. Parenteau holds an associate degree in the Science of Midwifery, which she obtained through the National College of Midwives in Taos, New Mexico, USA. In addition, Mrs. Parenteau has completed the International Midwifery Pre-Registration Bridging Program at Ryerson University in Toronto, to enable her to be a registered midwife in Canada

178. Mrs. Parenteau's hospital privileges were removed on October 26, 2021, because she failed to show proof of vaccination for Covid-19 as required by the Hospital and Community Order. She has never had a complaint or disciplinary action taken against her, neither by her College, health authority, or hospital. She has been registered as a midwife in both Manitoba and B.C.

179. Mrs. Parenteau is opposed to the Covid-19 vaccine requirement. Her reasons are set out in her Affidavit #1. She says it violates a fundamental right to make an informed choice, without coercion, to a medical treatment. She has not taken the Covid-19 vaccine. She will not take the vaccine under the current order, as she says it puts her in a position of duress and coercion.

180. Mrs. Parenteau is not opposed to vaccines in general and has received many throughout her life. She recognizes there are benefits to vaccines that have been thoroughly tested and proven safe.

181. Mrs. Parenteau personally knows various community members who suffered myocarditis, tremor disorder, convulsions, and on-going severe nerve pain after being vaccinated with a Covid-19 vaccine.

182. Mrs. Parenteau is no longer able to practice midwifery, as her license depends on having hospital privileges. Mrs. Parenteau is experiencing financial hardship because she has lost her hospital privileges, and thus her ability to work in her chosen field. She was a significant contributor to her household income. Her husband and her have two small children and a mortgage on their home. The financial deficit resulting from the loss of her job has caused a significant amount of stress. This stress not only applies to her current financial situation, but to the prospects of future financial stability and success as she will need to start from scratch in a new professional endeavor that does not require her to take a Covid-19 vaccine.

183. Mrs. Parenteau has experienced tremendous grief and some bouts of depression never previously experienced before, all due to the unreasonable loss of her job

and ability to make an income in her chosen profession. She spent many years investing in her education and training to practice midwifery. In addition, the social isolation and degradation of being pushed out of the health care has resulted in a loss of respect and a loss of her reputation amongst health care colleagues and others within the community. Such people as herself are referred to by the media and the Prime Minister as “anti-vaxxers, misogynist, racist and unscientific”. This has been a very distressing situation for Mrs. Parenteau.

Affidavit #2:

184. Ms. Parenteau is opposed to taking the new XBB.1.5 COVID-19 vaccine required for a person who is seeking work as a staff member, as defined in the order entitled “*HOSPITAL AND COMMUNITY (HEALTH CARE AND OTHER SERVICES) COVID-19 VACCINATION STATUS INFORMATION AND PREVENTIVE MEASURES – OCTOBER 5, 2023*”.

185. The reasons she is opposed are as follows:

    a. Her understanding is that the safety and efficacy study of the XBB.1.5 vaccine was completed on a small number of mice only. No randomized controls have been done with this vaccine on humans.

    b. In addition, her understanding of the data is there is no evidence of benefit for taking the new XBB1.5 vaccine compared to the immunity people acquire when they have already been infected with Covid-19.

    c. Furthermore, she is not aware of any evaluation of harms associated with cumulative doses of these Covid-19 vaccines.

    d. She is concerned there has not been adequate testing or studies conducted in relation to impact on human reproduction.

    e. Ms. Parenteau does not believe that the government has provided any evidence of necessity for these new XBB.1.5 vaccines, given we are no longer in a pandemic, and given what she understands is a very high level of seroprevalence for Covid-19 in the Canadian population.

186. As an accommodation for not taking the new XBB.1.5 COVID-19 vaccine, Ms. Parenteau would comply with reasonable accommodations applied to other contagious respiratory illnesses.

Dr. Joshua Nordine

Affidavit #1:

187. Dr. Nordine resides in Kelowna, BC. He is 39 years of age.

188. Dr. Nordine was a clinic physician at the Bridge Detox Centre in Kelowna from 2017 until October 2021, when he lost his job for failing to provide proof of vaccination. Bridge Detox Centre is a clinic operated by Interior Health. He was initially placed on unpaid leave from the Bridge Clinic on October 26, 2021, because he failed to show proof of vaccination. He also lost his hospital privileges at that time for the same reason.

189. Dr. Nordine is also a family physician, practicing at Rutland Medical Associates, a private clinic in Kelowna. He has practiced there since 2016.

190. On November 16, 2021, Dr. Nordine's employment with the Bridge Detox Centre was terminated by Interior Health for not having taken the Covid-19 vaccines, as mandated by the Hospital and Community Care Order. His hospital privileges were revoked for the same reason.

191. Between 2013 and 2016, Dr. Nordine was a family physician at Edmonton Imagine Health in Edmonton, AB.

192. Dr. Nordine obtained his medical degree from Jagiellonian University Medical College in Poland. Dr. Nordine is also a licentiate of the Medical Council of Canada

193. Dr. Nordine is a Christian. He objects to taking a Covid-19 vaccine, including Novavax, on religious grounds. His reasons are set out in his Affidavits #1 and 2. Dr. Nordine also objects to taking a Covid-19 vaccine on medical grounds. He submitted a request for an exemption to the vaccine mandate, but it was denied.

194. In addition, in January 2022, Dr. Nordine was diagnosed with the Covid-19 virus. He now has natural immunity to Covid-19. Dr. Nordine points out that the BC Covid therapeutics Committee states natural immunity is the same as having had two doses of a Covid-19 vaccine.

195. While working as a family physician, Dr. Nordine observed many patients suffer adverse reactions to the Covid-19 vaccines. When requested by his patients to do so, Dr. Nordine has reported those adverse reactions to the Canadian Adverse Events Following Immunization office.

196. Dr. Nordine notes there is a general doctor shortage in BC, and this has been the case since before the pandemic. Similarly, he states that hospitals were short-staffed and operating at over-capacity limits prior to Covid-19.

<u>Affidavit #2 (paragraphs 1 – 8):</u>

197. Dr. Nordine was baptized and raised in the Lutheran church but more recently would describe himself as non-denominational evangelical protestant Christian.

198. He opposes the vaccine because it was developed through the use of historical fetal tissue cell lines. He attaches as Exhibit "A" to his Affidavit a copy of a letter authored by Jeff Gunnarson, National President of Campaign Life Coalition, which fairly sets out his position in relation to the Covid-19 vaccine. He is a member of this advocacy group and has also donated to its causes. Locally, he is a member of the Kelowna Right to Life Society and has donated regularly for the last several years to its causes since moving back to Kelowna in 2016. The Kelowna Right to Life Society collaborates with the Campaign Life Coalition events such as the yearly "Life Chain". Dr. Nordine's family has been involved with the local Kelowna Right to Life Society since his early childhood attending many various fundraising events.

199. As a non-denominational evangelical protestant, it is his personal relationship with Jesus and personal understanding of the Bible that dictates his religious beliefs and actions.

200. Dr. Nordine views the Church as one place among many where he can go fellowship among other believers to grow his faith.

201. Dr. Nordine deposes that just because he attends a particular Church, it does not mean he must align with its overarching doctrine as a whole. He has attended the following churches in Kelowna First Lutheran Church, Ridgeview Evangelical Church, Willow Park South, Calvary Chapel Kelowna, Kelowna Church of the Nazareen, Kelowna Gospel Fellowship, SunRidge Community Church, Willow Park Church Hwy 33, Grace Reformed Church, Trinity Church. He considers his home church to be Willow Park Church, Hwy 33.

202. Dr. Nordine and his wife have some doctrinal differences, and they recently baptized their daughter at First Lutheran church in Kelowna on October 16, 2022. The reason they chose that church is because it practices infant baptism, unlike many of the non-denominational evangelical protestant churches they have attended, including their current home church Willow Park Hwy 33.

203. Dr. Nordine is also opposed to the Medical Assistance in Dying (MAID) legislation, performance of abortions for the same Christian doctrinal and theological reasons.

<u>Affidavit #4:</u>

204. Dr. Nordine is opposed to taking the new XBB.1.5 COVID-19 vaccine required for a person who is seeking work as a staff member, as defined in the order entitled

"*HOSPITAL AND COMMUNITY (HEALTH CARE AND OTHER SERVICES) COVID-19 VACCINATION STATUS INFORMATION AND PREVENTIVE MEASURES – OCTOBER 5, 2023*".

205. The reason for his opposition to the new vaccine is as follows:

    a. Both Pfizer BioNTech (Comirnaty) and Moderna (Spikevax) used fetal cell lines in various lab testing for vaccine approval that originated from an aborted child. Therefore, any subsequent vaccine development or booster that has this process as part of its foundational base would be morally corrupt and he would have to object to it based on his faith.

    b. COVAXIN is a vaccine developed by India for Covid-19 but is not commercially available in Canada. To the best of Dr. Nordine's knowledge, no fetal cell lines were used in the testing or production of the COVAXIN vaccine. Aborted fetal cell line use is his number one objection to taking the Covid-19 vaccine that is offered in Canada, and to date he is not aware of any offering in BC or Canada that does not use aborted fetal cell lines in its testing.

    c. In addition, separate from his religious objection to the new XBB.1.5 vaccine, as set out in his Affidavit #1, he has a skin and hair condition called Lichen Planopilaris. He does not want to risk flaring up his immune system by taking the XBB.1.5 vaccine, as this may cause a worsening of his medical condition.

206. Dr. Nordine would be willing to mask and rapid test for Covid-19 when entering a patient care area as a reasonable accommodation.

WITNESSES:

<u>Jennifer Koh</u>

<u>Affidavit #1:</u>

207. Jennifer Koh was an Organization Development & Change Management Consultant for the Interior Health Authority ("Interior Health"). She is 55 years of age. Ms. Koh held this position for two years. She was <u>not a healthcare worker, and also worked from home</u>. Prior to this position, Ms. Koh was an Organizational Development Consultant for the Northern Health Authority for approximately 3.5 years.

208. On October 26, 2021, Ms. Koh was put on unpaid leave by her employer for failing to show proof of vaccination against Covid-19, as mandated by the Hospital and Community Order. On November 15, 2021, Ms. Koh's employment was terminated for the same reason.

209. Between March and June 2020, Ms. Koh went into Interior Health twice and facilitated two workshops, after which the team was instructed that they were no longer permitted to do any in-person facilitating or consulting. Between approximately July 2020 and November 2021 she worked 100% remotely, except to pick up supplies from the office on about three occasions. She had no contact with any patients, and very rarely with co-workers during this time. Part of Ms. Koh's position with Interior Health was to facilitate workshops for Interior Health staff. Those individuals were mostly team leaders, supervisors, managers and directors, as well as healthcare teams, where she stood at the front of a meeting room but also walked around the room. Of the two workshops she facilitated in-person, early in the pandemic (the spring of 2020), she followed Interior Health's in-person Covid-19 protocols: she socially distanced, used sanitizer and she only removed her mask when facilitating (which was standing at the front of the room and not walking around the conference room). Ms. Koh's work as a workshop facilitator is comparable to that of lecturers at BC colleges such as College of New Caledonia and Okanagan College, where the facilitators are not required to be vaccinated against Covid-19, and they can choose to wear a mask and be socially distanced from students. Ms. Koh points out that the same principle could apply to a facilitator/consultant with Interior Health.

210. A large portion of Ms. Koh's work between March 2020 and November 2021 was to convert several in-person leadership development course materials to virtual/online materials so that she and other facilitators/consultants could present these leadership courses remotely online during that period and in the future.

211. Ms. Koh is opposed to taking the Covid-19 vaccine on the basis of religion and conscience. She has sincerely-held religious beliefs that prevent her from taking the Covid-19 vaccine. The particulars of her objection are set out in her Affidavits #1 and #2. . Ms. Koh is aware of multiple studies which have shown the adverse effects of the experimental injection, including death, disability, and stillborn births. She is also aware of the number of deaths and adverse reactions reported by the Vaccine Adverse Event Reporting System (VAERS) in the United States. She is aware that the vaccine companies assume no liability for adverse reactions, and that she will solely bear the burden of any adverse reactions to the vaccine if she takes the injection.

212. Ms. Koh submitted an exemption request (due to the remote nature of her work, and the risk to her health and safety in taking an experimental injection) to the PHO Exemption Office on October 25, 2021. She received an automatic reply stating that only approved medical exemptions would be considered.

213. Ms. Koh had considered requesting a religious exemption, due to her strong spiritual faith, belief system and moral conscience. However, when she learned from the Public Health Order that there was no possibility of religious exemptions, she did not apply on those grounds. Upon further research, after her termination, she realised that it would be within her rights to demand a faith-based exemption.

214. Ms. Koh was raised with the teachings of the Catholic faith. As an adult, since undergoing extensive training in various Vedic meditation and yoga practices, to become a yoga and meditation instructor from 2010 onwards, she has also followed the Vedic scriptures very closely, and as a result has a strong spiritual faith. In accordance with her Christian upbringing and the Vedic practices, she believes her body is a temple of the Holy Spirit and it is her responsibility to take good care of it as she is ultimately accountable to God (1 Corinthians 3:17-20, 6:19-20, 7:1, and Romans 12:1).

215. Ms. Koh has also been taught through Christianity to love one's neighbour which also means resisting injustice and oppression (whether by the state, an individual, an agency or bureaucracy, including resisting immoral or unethical treatment, which includes coercion of any healthcare treatment. (Isaiah 1:17, Matthew 22:39, and James 5:14).

216. Ms. Koh believes that the principle of "therapeutic proportionality"; and obeying one's conscience by rejecting oppression and injustice, are two moral issues upheld by the Catholic faith that support her refusal to take the COVID-19 injection.

217. Furthermore, as a yoga instructor in the Vedic tradition, Ms. Koh has committed, to the best of her ability, to adhere to the practices of *'ahimsa'* (non-violence) and *'satya'* (truthfulness) as outlined in the Vedic scriptures. Practicing the art of *'*ahimsa*'*, involves refraining from the intention of causing physical and psychological pain to any living being, including oneself and the conscious integration of compassion into every aspect of daily life. It is not merely a passive state of refraining from violence - ahimsa implies the active expression of compassion. This includes refraining from causing harm to one's body which is considered a precious gift from God. Ms. Koh has been an active member and volunteer of the Art of Living Foundation since 2009, where she has taken over 1,000 hours of yoga and breathwork instructor training, participates in weekly

meetings studying the scriptures, meditating, and practicing yoga. She also teaches weekly classes. She feels it would be hypocritical to do harm to herself by agreeing to a toxic injection, while teaching her students the principle of non-violence towards themselves. The Art of Living Foundation is a volunteer-based, humanitarian, spiritual and educational non-governmental organization that welcomes all faiths. Committing to 'satya' (truthfulness), and practicing satya in daily life, means being true to oneself and others, honest communication, and living a life of integrity as the foundation for all of one's relationships: with oneself, with others, and with society as a whole. Ms. Koh practices and teaches yoga, meditation and breathwork so that she can take care of her body, mind, and spirit. She believes that injecting a toxic/foreign substance into her body would interfere with her belief system and potentially risk her health, thereby impacting her ability to continue her personal practice which brings her closer to the Divine, and her ability to teach and share these practices with others.

218. Ms. Koh has seen from multiple studies that natural immunity is superior to the short-term immunity offered by the Covid-19 injection. She works hard on her personal health and keeps her immunity strong. She is aware of treatments to treat Covid-19 that are prohibited by the medical colleges, as well as preventative measures, and believes it is her right to consider alternative treatments as per the *Health Care (Consent) and Care Facility (Admission) Act*, RSBC 1996, c.181 (the "Health Care Consent Act"). She says her right to informed consent, as set out in the Health Care Consent Act, has been abrogated.

219. Ms. Koh also states that her privacy rights were violated, as protected by FIPPA, when her employer was given access to her private medical records. She states that a list was created by Interior Health's health records department of all staff who were not showing a Covid-19 vaccination on their health record, and that this information was provided to her manager.

220. Ms. Koh believes the work she did for Interior Health was critical to healthcare employees, as it helped relieve stress, build resilience, build teams and leaders, and helped them navigate change more effectively. The work gave great meaning and satisfaction to her.

221. On or about November 26, 2021, after being terminated from her job on November 15, 2021, Ms. Koh received a call from a recruiter with a job proposal for two of the other BC health authorities for a remote contract Change Management Consultant position, which is essentially a part of the role she performed as a full-time employee. When Ms. Koh asked about their policy related to remote workers and the vaccine mandate, she was told that the vaccine mandate did not apply to

contract workers who work remotely. She also learned that these same contract workers who are not subject to the vaccine mandate are permitted to enter a healthcare facility, provided they do not enter more than once per month.

222. Ms. Koh points out how this hypocrisy highlights the unjust nature of the healthcare workers' termination, as many of them, including Ms. Koh, were working 100% remotely. She is of the view that there was no logical reason to be terminated and the fact that contract workers are not subject to the vaccine mandate makes the psychological abuse, poor treatment, and termination of unvaccinated employees even more reprehensible.

223. Ms. Koh also states that Health Authorities pay more than double the hourly rate in addition to recruiter's fees for change management consultant contract workers on projects. This is taxpayers' money.

224. Ms. Koh believes she is making an informed decision not to be vaccinated voluntarily, without coercion, undue influence, or duress.

225. Ms. Koh is of sound mind and believes she has the requisite capacity to refuse or consent to treatment in accordance with the Health Care Consent Act.

<u>Affidavit #2:</u>

226. Ms. Koh is a Catholic and is opposed to the vaccine on theological principles.

227. She agrees with and supports the position taken by Campaign Life, which is set out in an open letter dated January 14, 2022, authored by Jeff Gunnarson, national president of Campaign Life Coalition, to the Canadian Conference of Catholic Bishops. The letter confirms the Coalition's stance on Covid-19 vaccine mandates. Mr. Gunnarson states that "[t]he Congregation for the Doctrine of the Faith (CDF), aware of the controversy of using vaccines connected to abortion, stated in a 2020 note that 'vaccination is not, as a rule, a moral obligation and that, therefore, it must be voluntary'." He implores the Canadian Cardinals and Bishops to "respect your priests and lay-faithful who have decided in good conscience to refuse COVID-19 vaccines because they are tainted by abortion. Please respect and accommodate their consciences along with their free and informed decision". Ms. Koh attache a copy of Mr. Gunnarson's open letter of January 14, 2022 to her Affidavit as Exhibit "A".

228. Ms. Koh understands that the Pope has endorsed the vaccine, and she accepts the infallibility of the Pope on matters of faith and doctrine. Her understanding is his position on the Covid-19 vaccine is that it is not a matter of faith and doctrine,

and therefore she must turn to her personal conscience in making her choice about whether to take the Covid-19 vaccine.

Elizabeth Ringrose

229. Elizabeth Ringrose resides in Vancouver, BC. She was a Registered Nurse in the Day Health Program at the Dr. Peter Centre in Vancouver, BC.

230. Ms. Ringrose has taken two doses of the Pfizer Covid-19 vaccine. She was in fact initially opposed to taking the Covid-19 vaccines due to their experimental nature. However, she did so because Dr. Bonnie Henry said we needed 78% of the population vaccinated to reach herd immunity. Ms. Ringrose believed it was important to help achieve that goal. As it turned out, Dr. Henry changed the number needed for herd immunity, such that it seems almost 100% of eligible people are expected to be vaccinated.

231. Ms. Ringrose took the first dose of the Covid-19 vaccine on or about January 6, 2021. She took the second dose on or about February 19, 2021. Ms. Ringrose suffered a severe allergic reaction after the second dose of the Covid-19 vaccine in that within 72 hours after that injection, she could not stand up for a period of six hours and had to crawl to the bathroom. She has experienced dizzy spells on and off since this time.

232. On October 1, 2021, Ms. Ringrose took a medical leave because of the adverse reaction she had to the second dose of the Covid-19 vaccine.

233. Ms. Ringrose states that her employer was indifferent to the serious adverse reaction she suffered, and simply told her to come back to work when she felt better.

234. Ms. Ringrose resigned from the Dr. Peter Centre on December 1, 2021. She did not want to return to work without her unvaccinated colleagues also returning to work.

235. While still employed, Ms. Ringrose tried to send an adverse reaction form for a person in her care, but the office listed on the BCCDC website did not seem to receive it after 10 facsimile attempts, and then would not confirm it got to the right place. Ms. Ringrose's manager told her to stop asking the office if it got to the right place.

236. Ms. Ringrose is trained to deal with adverse events after a vaccine is administered. Although there is an adverse event reporting system in Canada, she says the system is inadequate. She says that vaccine adverse events often go unreported or are underreported. In addition, through her work, she is aware

that the medical system is unresponsive and uncaring towards people who suffer adverse reactions to vaccines.

237. After her Covid-19 vaccine adverse event, Ms. Ringrose did not seek medical care or attempt to follow her reaction through the vaccine adverse event reporting system based on her knowledge that the medical system would likely not help her.

238. Ms. Ringrose states that it is antithetical to work in a system that honours autonomy in healthcare decision-making for those she cares for, while personally being coerced by the same system into taking a medical treatment to which she is opposed. She is also saddened by seeing some of her coworkers lose their jobs for making the decision not to take the Covid-19 vaccines, and does not want to work in such an environment.