Original filed 15 September 2022

No. 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

AMENDED RESPONSE TO PETITION

Filed by: The Respondent the Provincial Health Officer for the Province of British Columbia (the "PHO")

THIS IS A RESPONSE TO the petition filed March 16, 2022 and the amended petition filed August 23, 2022 and the amended petition filed November 1, 2023.

Part 1: ORDERS CONSENTED TO

The PHO consents to the granting of **NONE** of the orders set out in Part 1 of the petition.

Part 2: ORDERS OPPOSED

The PHO opposes the granting of **ALL** of the orders set out in Part 1 of the petition.

Part 3: ORDERS ON WHICH NO POSITION IS TAKEN

The PHO takes no position on the granting of **NONE** of the orders set out in Part 1 of the petition.

Part 4: FACTUAL BASIS

Overview

1. This Petition challenges a number of orders made by Dr. Bonnie Henry, the Provincial Health Officer (PHO), including:

    a. the *Hospital and Community (Health Care and Other Services) Covid-19 Vaccination Status Information and Preventative Measures Order* as made October 21, 2021 and its replacements (the "Hospital and Community Order") and

    b. the *Residential Care Covid-19 Preventive Measures* – as made October 21, 2021, and its replacements (the "Residential Care Orders"),

2. The Hospital and Community Order and the Residential Care Orders (collectively, the "Health Care Orders") were made under the authority of the *Public Health Act,* S.B.C. 2008, c. 28.

3. The Health Care Orders had the effect of requiring individuals working in the health-care system and long-term care (LTC) facilities to provide proof of vaccination, exemption or exemption request to employers in order to work. The only exemptions allowed under the Health Care Orders are for medical reasons. Such exemptions are determined under s. 43 of the *Public Health Act* by medical health officers (MHOs). None of the petitioners claim a medical exemption.

4. The reasoning for the Health Care Orders are set out in two forms:

    a. detailed written recitals, which have been amended as the COVID-19 pandemic has developed (the "Recitals"), and

    b. public statements by Dr. Henry (the "Public Statements") (collectively, the "Reasons").

5. In her Reasons, Dr. Henry recognized that the Health Care Orders – like other orders that have proved necessary earlier in the COVID-19 pandemic – limit interests protected by the *Canadian Charter of Rights and Freedoms* (*Charter*). Dr. Henry recognized that the Health Care Orders require some people to choose between their sincere opposition to vaccination and continuing to work in BC's health care sector. Some of those sincere beliefs have a connection to religion or

conscience, while others would be based on personal medical belief or preference. Public health ethics permits vaccination mandates – in the sense of limiting some activities and employment to vaccinated persons – provided they are necessary and proportionate to protect public health in the circumstances. Dr. Henry recognized that limitations on medical autonomy, whether specifically protected by the *Charter* or not, had to be justified in light of compelling public health needs.

6. Vaccination mandates, while appropriately controversial, are effective in increasing the rate of vaccination. The central rationale for requiring vaccination of LTC and health care workers is that it protects the health of patients, clients and residents of care facilities. A vaccination requirement in settings where vulnerable patients receive care also promotes the integrity of the health care system, including preserving its ability to respond to all care needs, in two ways:

a. first, as a statistical matter, a vaccinated healthcare workforce is less likely to get sick and will likely have less severe sickness. Since epidemics and pandemics, including the COVID-19 pandemic, put pressure on the capacity of the healthcare system – and since this pressure is correlated with outbreaks of COVID-19 – a vaccinated workforce will be better able to provide health care for COVID and non-COVID care needs for all British Columbians at times of extreme stress on the health care system; and

b. second, a vaccinated healthcare workforce will be less likely to infect vulnerable patients and LTC facility residents and thereby more likely to keep them healthy and safe from preventable COVID-19 infection, severe outcomes and death.

7. While the immunological profile of the population and the dominant variant of SARS-CoV-2 (the "Virus") has changed – and with that many aspects of COVID-19 strategy, Dr. Henry continued to consider the balance to support the Health Care Orders.

8. Three ~~Two~~ time frames are particularly relevant.

a. In the Fall of 2021, the dominant variant of the Virus was the "Delta" variant, which was more highly transmissible than previous variants of the Virus. Vaccines available in British Columbia provided durable and highly effective protection against infection by Delta. In her Reasons at this time, Dr. Henry found that vaccination was the single most important

preventive measure for providers of care or services in hospital or community settings, and the staff or contractors of an organization which provides care or service in hospital or community settings can take to protect patients, residents, clients and the health care and personal care workforce from infection, severe illness and possible death from COVID-19. She found that while there were clear, objective criteria for determining whether a person has a medical deferral and few people fall into that category, there were difficulties and risks in accommodating other unvaccinated persons. Dr. Henry considered the effect on unvaccinated people and on their constitutionally-protected interests. Dr. Henry found that the volume of requests for reconsideration was beyond the capacity of her office to address and was using resources better directed at the public health emergency of COVID 19. The Orders were very effective in getting high rates of vaccination among the employees to whom it applied. Some employees, including the petitioners, resisted on various grounds, and were therefore unable to continue to work.

b. In the course of 2022, the Omicron variant of the Virus – which is better able to cause "breakthrough" infections of those who already have some immunity as a result of vaccination or prior infection – became the dominant variant in British Columbia. In September 2022, Dr. Henry set out new recitals and explained why, in her view, the Health Care Orders continue to be required to maintain the BC health care system and to protect vulnerable patients. In her September 2022 Reasons, she set out the following rationales for continuing the course:

    i. While Omicron infection is a real possibility for everyone, unvaccinated workers in the healthcare system are more likely to get sick for longer, and are more likely to transmit infection to other healthcare workers, patients, clients and residents than if they were vaccinated, all other things being equal and taking into account the precautionary principle.

    ii. It is not practical to provide exemptions based on past infections or job duties. There is no reliable way of knowing how many times an individual has been infected with the Virus. Employees in the health care system who do not themselves have patient-facing duties often interact with those who do and may share physical space and ventilation with clinical health care workers. Designing

specific exemptions and monitoring compliance with those exemptions is not practical, given the PHO's many duties in respect of public health at a population level.

c. By fall 2023, the XBB sublineages had become the most prevalent lineage in Canada. These sublineages had been demonstrated as some of the most immune evasive variants to date, based on neutralizing antibody data from those vaccinated with the Omicron-targeted vaccines, according to the National Advisory Committee on Immunization (NACI). NACI also referred to modelling that suggested an additional vaccine dose offered in fall 2023 could prevent thousands of hospitalizations and deaths across the country over the year. NACI issued strong recommendations that individuals aged 5 and over be immunized with the primary series mRNA vaccine, and that beginning fall 2023, a dose of the XBB formulation be available for individuals at least six months from their previous COVID-19 vaccine dose or known infection (whichever was later). On September 12, 2023, Health Canada authorized an XBB.1.5-containing mRNA COVID-19 vaccine for use in individuals aged 6 months and older. Dr. Henry issued new Health Care Orders on October 5, 2023, and in her Reasons set out, among the rationales for continuing a vaccination requirement for health care workers:

   i. the continuing emergence of variants leading to changes in British Columbia and elsewhere, the unique vulnerability of those receiving health care in hospital or community settings in that those individuals are often of advanced age or have chronic health conditions or compromised immune systems making them particularly vulnerable to severe illness and death from COVID-19 even if vaccinated.

   ii. that slippage in vaccination of the health care workforce could result in significant illness within that workforce which would undermine the health care system's capacity to respond to a resurgence of disease.

   iii. with COVID-indicators in British Columbia increasing since late July 2023 (including hospitalization and deaths), the critical priority of preserving the health care and public health systems

ability to protect and care for the needs of the population (both COVID-19 and non-COVID-19 care needs).

9. The question for this court on judicial review is whether Dr. Henry's conclusions in Fall 2021 ~~and in~~ Fall 2022, and Fall 2023 were a reasonable and proportionate way of balancing the interests at stake.

Emergence of the SARS-CoV-2 Pandemic in BC

10. The first diagnosis of a case of COVID-19 in British Columbia occurred on January 27, 2020.

11. On March 11, 2020, the World Health Organization ("WHO") declared the COVID-19 outbreak a pandemic. The WHO declaration ~~remains in effect~~ was ended on May 5, 2023.

12. On March 17, 2020, Dr. Henry issued a Notice of Regional Event under s. 52(2) of the *Public Health Act*, designating the transmission of the infectious agent SARS-CoV-2, which "has caused cases and outbreaks of a serious communicable disease known as COVID-19" among the population of British Columbia, a regional event as defined under s. 51 of the *Public Health Act*.

13. The designation of a regional event allowed the PHO to exercise powers under Parts 5 and 6 (see specifically s.67(2)) of the *Public Health Act*, including the power to make oral and written public health orders in response to the COVID-19 pandemic. The Notice of Regional Event issued under the *Public Health Act* continues to be in effect.

14. SARS-CoV-2 is highly infectious and has evolved to become more so over time. The Virus can be spread by people who do not have symptoms. Without public health interventions, it has a high transmissibility and infectivity. While immunity resulting either from vaccination or infection significantly reduced the transmissibility of earlier variants, the Virus has continued to evolve and has become better able to transmit despite the existence of immunity, although immunity considerably reduces virulence. As long as the number of additional people each infected person transmits the virus to is greater than 1, the Virus will spread exponentially, ultimately potentially overwhelming the health system.

15. Since the Virus first emerged it has mutated, resulting in variants. Variants that pose a greater threat to public health than the original virus are called "variants of concern". ~~Five~~ Several variants of concern have emerged in BC: Alpha, Beta, Gamma, Delta, ~~and~~ as of late November 2021, Omicron, and the XBB sublineages by fall 2023.

16. From late July 2021 to late December 2021, the Delta variant was the most common variant of concern in BC. The Delta variant is significantly more infectious and induces a higher severity of illness, particularly in vulnerable populations, than the original strain of SARS-CoV-2 or its earlier variants.

17. As of late December 2021, Omicron became the most common variant of concern in BC. By comparison with Delta and previous variants, Omicron is more likely to lead to "breakthrough" infections in people who already have some immunity as a result of vaccination or prior infection. However, prior immunity remains highly effective at reducing the severity of illness and there is evidence that it reduces transmission in close settings. Acquired immunity is cumulative – with each dose of vaccine or infection tending to increase it – but it also tends to decline over time. There is more predictable durability to acquired immunity from vaccination than from infection. Vaccination remains the most important preventive measure an individual can take to protect against COVID-19.

18. Preventing and controlling transmission of the Virus is essential to maintaining the provincial health system's ability to deliver quality care and continue the safe delivery of essential health services.

19. Throughout the COVID-19 pandemic, the Province and the PHO have been actively preventing and containing the transmission of COVID-19 through a series of comprehensive public health measures, including health promotion, prevention, testing, case identification, isolation of cases and contact tracing, and vaccination, all based on the best available scientific evidence.

20. Dr. Henry has made a number of orders under the *Public Health Act* in response to the COVID-19 regional event, including new orders and orders revoking or amending prior orders, to respond to the ever-changing circumstances of the COVID-19 pandemic in British Columbia.

21. The overriding goal of the public health response to the SARS-CoV-2 pandemic has and continues to be to protect the most vulnerable members of society, and the health care system's ability to continue to deliver care for COVID-

19-related and other illness, while minimizing social disruption, which includes interference with autonomy over medical decisions among many other social values.

22. In a public health emergency, the need to take action to protect the public in face of changing circumstances does not permit all decisions to be made with scientific certainty. Dr. Henry therefore relies on the generally accepted scientific and epidemiological evidence available to her at the relevant time, and the precautionary principle, when making public health orders under the *Public Health Act*.

Requests for Reconsideration of PHO Orders

23. Under s. 43 of the *Public Health Act*, a person affected by a public health order can request reconsideration if that person:

a. has relevant information that was not available to the PHO at the time the order was made;

b. has a proposal that was not presented to the PHO when the order was made and if implemented, would meet the objective of the order (or be suitable for a written agreement under s. 38 of the *Public Health Act*); or

c. requires more time to comply with the order.

24. Under s. 54(l)(h) of the *Public Health Act*, the PHO can, in an emergency, elect not to reconsider an order.

25. Under s. 56(2) of the *Public Health Act,* if the PHO makes an order under s. 56 of the *Public Health Act,* a person to whom the order applies is required to comply unless that person provides to the PHO or MHO:

a. A written notice from a medical practitioner stating that the health of the person who must comply would be seriously jeopardized if the person did comply; and

b. A copy of each portion of that person's health record relevant to these statement in paragraph (a), signed and dated by the medical practitioner.

Vaccination in General

26. Vaccination is the deliberate triggering of the immune system through the introduction of a substance into the body in order to protect against the likelihood and severity of future infection. Vaccines are evaluated for “safety” (the probability and severity of negative effects) and “efficacy” (the reduction in probability and extent of illness as a result of future infection). A safe and efficacious vaccine is one that does not have unacceptable side effects but reduces either the likelihood or severity of infection in the population.

27. Vaccination protects at both individual and community/population levels. High vaccination coverage in a community or population reduces spread of the virus, limits severe outcomes (including hospitalization and death), and helps prevent new variants from emerging.

28. The introduction of vaccines often goes together with “vaccine hesitancy” among part of the population. The extent of vaccine hesitancy will typically vary. To the extent possible, health authorities respond to vaccine hesitancy through education, i.e., providing accurate information about the scientific understanding of safety and efficacy in as understandable a fashion as possible.

29. A vaccine “mandate” exists where there are some legal consequences for not being vaccinated. Mandates have been found to increase the rate of vaccination. Public health ethics requires that mandates be evaluated for proportionality between benefit and impact on those subject to them.

30. A sequence of doses of a vaccine is a “series”. The “primary series” of vaccination against SARS-CoV-2 consists of two doses of a Health Canada-approved vaccine (or one dose of the Janssen vaccine). The primary series may have higher amounts of antigen and must be given prior to additional doses. A person is considered to be vaccinated once they are at least 7 days post-receipt of the primary series of the vaccine.

31. Vaccination is the single most effective measure to provide protection against infection, severe illness, hospitalisation, intensive care (“ICU”) admission and death from the Virus. Vaccination also plays a key role in limiting transmission of SARS-CoV-2. However, vaccination does not provide complete protection from infection, and protection from infection and severe outcomes can wane over time, particularly in elderly populations and those with pre-existing conditions or risk factors that make them vulnerable to severe illness and death from SARS-CoV-2.

32. All individuals living or visiting British Columbia who are six months of age and older are eligible to receive a Health Canada-approved vaccine for SARS-CoV-2. As of August 15, 2022, 92% of people in British Columbia six months and older have received the primary series of vaccination against the Virus.

33. In British Columbia, third doses are available to individuals who are 18 years of age or older, and at least 6 months post-second dose of their initial course of vaccine. Third doses were prioritized for vulnerable populations and healthcare workers. Fourth doses have been made available, as noted in the PHO's September 6, 2022 press conference. The only mandates have been for the primary series and, more recently, for a single dose of the updated mRNA vaccine tailored to the XBB.1.5 variant.

Residential Care Facilities, Hospitals and Community Care Settings

34. Throughout the COVID-19 pandemic, long-term care and assisted living residents and staff have experienced a disproportionate share of cases, severe illness, and deaths from COVID-19. Residents of these facilities are typically elderly and often suffer from chronic health conditions or compromised immune systems, which make them particularly vulnerable to severe illness and death from SARS-CoV-2, even if vaccinated.

35. At various material times from March 2020 onwards, LTC facilities have been subject to significant restrictions to mitigate the impacts of SARS-CoV-2 on their staff and residents, including restricting visitors to, restricting staff working in these facilities to work at one site only, and – once vaccines became available - prioritizing vaccination for staff and residents.

36. Following the commencement of the COVID-19 vaccination program for residents and staff in LTC facilities, the number of COVID-19 outbreaks in these settings decreased dramatically. The risk of breakthrough infection remains, however.

37. Persons receiving care in hospital or community settings are also often of an advanced age, have chronic health conditions or compromised immune systems and are thus particularly vulnerable to severe illness and death from COVID-19, even if they are vaccinated.

Protection of the Health Care System

38. The health-care system has finite resources and therefore a certain planned capacity to address health care needs (“demand”). Epidemics and pandemics can overload the health-care system in two ways: first, they can create surges in demand for care and second they can make it harder for the system to respond, both as a result of overwork and use of resources and because health care workers get sick.

39. The health-care system has been experiencing high demands for care throughout the COVID-19 pandemic. In addition, the health-care and public health systems typically experience a seasonal increase in care needs during the fall and winter respiratory virus seasons. Finally, local outbreaks of any disease, including COVID-19, create high local demands.

40. Vaccination of health professionals in hospitals and community care settings is the most important measure that can be taken to ensure the continued functioning of the public health and health-care systems and their ability to prevent disease and deliver care across the systems for both COVID-19 and other illness, particularly in circumstances where those systems are under extreme duress.

British Columbia’s Delta-Driven Fourth Wave and the Omicron waves

41. From July to October 2021, the number of COVID-19 cases in British Columbia increased significantly, resulting in the fourth wave of the pandemic in British Columbia. The rise in SARS-CoV-2 cases in British Columbia during the fourth wave was comprised primarily of cases of persons infected with the Delta variant, which is more infectious and spreads faster than early forms of SARS-COV-2.

42. In or about late December 2021, Omicron became the dominant variant circulating in British Columbia, and began driving a fifth wave of the pandemic that has resulted in case rates and hospitalizations far in excess of any prior wave of the pandemic. Omicron is less virulent but more infectious than Delta. Vaccination continues to be the most effective measure to reduce the virulence of an Omicron infection. Since December 2021, a larger proportion of British Columbians have been infected with the Virus, usually Omicron, leading to a combination of infection-induced and vaccine-induced immunity in the population. On an individual and population basis, a combination of infection-induced and vaccine-induced immunity has the highest efficacy.

43. Omicron, which has sub-variants, was the dominant variant circulating in British Columbia until the arrival of the XBB sublineages.

Fall 2023 – The XBB Sublineages

44. The XBB sublineages had become prevalent in British Columbia by fall 2023, among them some of the most immune evasive variants to that point. These sublineagues provoked increased hospitalizations and more severe illness compared to the immediate prior period.

The Health Care Orders

45. By approximately mid-July 2021, the risk presented by COVID-19 in British Columbia changed, particularly by way of the emergence of the Delta variant of SARS-CoV-2. The number of new cases, hospitalizations and the reproduction rate of SARS-CoV-2 all increased in late summer of 2021.

46. By mid-August 2021, LTC Facilities were experiencing a rise in outbreaks, many of which may have been caused by the presence of unvaccinated persons in those settings. These outbreaks caused severe illness in both vaccinated and unvaccinated individuals, at least one death in the immediate period, and caused significant disruption to the lives of staff, residents, and their families.

47. In response to the risks presented by COVID-19 in LTC Facilities, Dr. Henry implemented new public health measures for residents, staff, and other persons providing services in LTC Facilities.

48. On September 9, 2021 Dr. Henry issued the *COVID-19 Vaccination Status Information and Preventive Measures Order* (the "Vaccination Status Order"), which provided as follows in material part:

> Q. I have reason to believe and do believe that
>
> (i) a lack of information about the vaccination status of resident and staff interferes with the suppression of SARS-CoV-2 in facilities and constitutes a health hazard under the *Public Health Act*;
>
> (ii) the presence of an unvaccinated staff member or an unvaccinated outside provider in a facility constitutes a health hazard under the *Public Health Act*;

(iii) in order to mitigate the risk of the transmission of SARS-CoV-2 arising from the presence of unvaccinated persons in facilities, operators, medical health officers and I need information about the vaccination status of residents and staff, and employers need information about the vaccination status of staff;

(iv) in order to confirm the vaccination status of residents in facilities, I need to

a. collect personal information about residents from admitters and operators; and

b. match this information with information in the Provincial Immunization Registry;

(v) in order to confirm the vaccination status of staff in facilities, I need to

a. collect personal information about staff from employers;

b. provide this information to the Minister of Health, so that the Minister may match it with information in the Enterprise Master Patient Index for the purpose of validating or providing me with the personal health numbers of staff; and

c. upon receiving the personal information of staff from employers, and the validation of or the personal health numbers of staff from the Minister of Health, match this information with information in the Provincial Immunization Registry.

49. The Vaccination Status Order:

a. required operators and admitters of LTC Facilities to collect from residents and staff certain personal, information, including legal first and last names, birthdates, and personal health numbers or, in certain circumstances, addresses;

b. imposed vaccination requirements effective September 16, 2021 that staff of LTC Facilities, outside health care providers and personal care providers abide by certain preventative measures, including rapid testing and mask wearing; and

c. prohibited certain persons from attending LTC Facilities absent proof of vaccination, including outside support or personal service providers, and regular other outside providers who have close contact with residents and, effective October 12, 2021, outside health care or personal care providers, regular other outside providers who do not have close contact with residents, and occasional other outside providers who have close contact with residents.

50. For those with less proximity to persons residing in LTC Facilities, the Vaccination Status Order imposed less stringent requirements, including complying with preventative measures such as physical distancing and mask wearing.

51. On September 27, 2021, the Vaccination Status Order was repealed and replaced. In the September 27 Vaccination Status Order, Dr. Henry exercised her discretion Under s. 54(1)(h) of the *Public Health Act* to refuse requests for reconsideration of the order, except for the purpose of a medical exemption to vaccination for COVID-19.

52. On October 21, 2021, Dr. Henry issued the *Residential Care COVID-19 Preventive Measures* order (the "Residential Care Order"), which provided as follows in material part:

> S. I have reason to believe and do believe that
>
> (i) the presence of an unvaccinated staff member, provider or visitor in a facility constitutes a health hazard under the *Public Health Act*;
>
> […]

53. The Residential Care Order imposed vaccination requirements on staff members of LTC Facilities and a variety of health care personnel who might come into contact with residents of LTC Facilities, including outside health care, personal care and personal service providers.

54. Depending on the degree of proximity to residents of LTC Facilities, the Residential Care Order required many of these classes of persons to have received two doses of COVID-19 vaccine by October 26, 2021, or they would not be permitted in a LTC Facility.

55. Persons who had not received a full dosage prior to October 26, 2021 could, pending full vaccination, attend a LTC Facility if they complied with certain preventative measures, including rapid testing and mask wearing.

56. For those with less proximity to persons residing in LTC Facilities, the Residential Care Order imposed less stringent requirements, including complying with preventative measures such as physical distancing and mask wearing.

57. In the Residential Care Order, Dr. Henry exercised her discretion pursuant to s. 54(1)(h) of the *Public Health Act* to not consider requests for reconsideration of the order, except for the purpose of a medical deferral for COVID-19 vaccination.

58. On October 21, 2021, Dr. Henry issued the *Hospital and Community (Health Care and Other Services) COVID-19 Vaccination Status Information and Preventative Measures* order (the "Hospital and Community Order" and, together with the Residential Care Order and the Vaccination Status Order, the "Orders"). Recital V to the Hospital and Community Order read as follows in material part:

> I have reason to believe and do believe that
>
> a. a lack of information on the part of employers about the vaccination status of staff interferes with the suppression of SARS-CoV-2 in hospital and community settings, and constitutes a health hazard under the *Public Health Act*;
>
> b. an unvaccinated person who provides health care or services in a hospital or community setting, puts patients, residents, clients, staff and other persons who provide health care or services at risk of infection with SARS-CoV-2, and constitutes a health hazard under the *Public Health Act*;
>
> c. an unvaccinated staff member of an organization which provides health care or services puts staff who provide health care or services, and patients, residents or clients, at risk of infection with SARS-CoV-2, and constitutes a health hazard under the *Public Health Act*;

59. The Hospital and Community Order required that persons employed, contracted, funded or otherwise affiliated with hospital and community settings provide proof of vaccination for COVID-19 for input, by those who had access, into the Workplace Health Indicator Tracking and Evaluation database by October 26, 2021.

60. Persons who had not received a full dosage prior to October 26, 2021 could, pending full vaccination, continue to attend hospital and community settings if they complied with certain preventative measures, including mask wearing.

61. For those with less proximity to persons residing in hospital and community care settings, the Hospital and Community Order imposed less stringent requirements, including complying with preventative measures such as social distancing and mask wearing.

62. The Hospital and Community Order was repealed and replaced on November 9 and November 18, 2021. In both subsequent orders, Dr. Henry exercised her discretion pursuant to s. 54(1)(h) of the *Public Health Act* to refuse any further requests for reconsideration of the order, except for the purpose of a medical exemption COVID-19 vaccination.

63. The Orders were made for the overarching purpose of, *inter alia*:

d. Reducing the risk and spread of SARS-CoV-2 infection in populations who are more likely to suffer severe illness and require hospitalization, critical care admission and potentially suffer serious outcomes of COVID-19 including death if infected; and

e. Protecting the ability of the health care system to continue to provide care to all British Columbians by reducing the risk of clusters and outbreaks of COVID-19 in health care settings, which is extremely disruptive to the services they deliver, and by reducing the risk of transmission and severe illness within the healthcare workforce who, if infected with COVID-19, experience illness and are unable to provide care while they are ill.

Requests for Reconsideration of the Orders

64. Under s. 43 of the *Public Health Act*, a request for reconsideration may be made by a person affected by an order. On October 7, 2021, Dr. Henry issued *Guidelines for Request for Reconsideration (Exemption) Process for Health Care Workers affected by the Provincial Health Officer Orders.*

65. Dr. Henry weighed the interests of persons receiving health care and related services in LTC Facilities, hospitals and community care settings against the interests of persons who provide care in those settings who were unvaccinated for reasons other than medical deferral, and exercised her discretion pursuant to s. 54(1)(h) of the *Public Health Act* to not consider any requests for reconsideration of the Orders except for the purpose of a medical exemption. In the Hospital and Community Order, Dr. Henry reasoned in material part as follows:[1]

[1] See for example, Hospital and Community Order dated November 18, 2021.

> After weighing the interests of persons who receive health care and related services in hospital or community settings, against the interests of persons who provide care and services in those settings who are not vaccinated for reasons other than medical deferral to a vaccination, and taking into account the importance of maintaining a healthy workforce in hospitals and community care locations, 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 burden which responding to more clusters and outbreaks of COVID-19 would put on the public health system, the burden which responding to more patients with serious illness would place upon an already overburdened health care system, and the risk inherent in accommodating persons who are not vaccinated […]
>
> […] it is my reasonable belief that it is necessary, in the interest of the public health, that I not accept requests for a reconsideration of this Order, except from an individual on the basis of a medical deferral to a vaccination […].

66. The Orders permitted affected individuals to submit a request for reconsideration from the requirement to be vaccinated, or to provide proof of vaccination, on the basis that their health would be "seriously jeopardized" were they to comply with the Orders.

67. The Petitioners have not sought reconsideration on the basis of medical deferral to vaccination, but instead on the basis of alleged religious or conscience grounds. These are not available.

September 2022 Orders

68. In September 2022, Dr. Henry repealed and replaced the Hospital and Community Preventive Measures Order and the Residential Care Preventive Measures Order. A number of recitals to the updated Orders specifically address the argument that infection-induced immunity or rapid testing could be an adequate substitute for vaccine-induced immunity in accomplishing the public health objectives of the Orders. An infection-induced or testing-based approach were rejected with the following reasons:

f. While people who have contracted SARS-CoV-2 may develop some infection-induced immunity for a period of time following infection, the strength and duration of that immunity varies depending on a multitude of factors;

g. 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 to protect against reinfection by providing a more consistent and reliable immune response than immunity arising from infection alone;

h. There is no reliable means of assessing the level of immunity which a person may have to re-infection or serious illness in consequence of infection with SARS-CoV-2;

i. Routine COVID-19 testing of asymptomatic people is not recommended in British Columbia, and PCR testing capacity is reserved for people who may be ill with COVID-19 to enable initiation of treatment. Asymptomatic testing can result in false negative testing, leading to a false sense of security that someone is not infected when in fact they are, and increases the likelihood of generating false positive tests, which can be misleading and lead to imposition of unnecessary requirements on people who are not infected;

j. Rapid antigen testing is not a substitute for vaccination and is most useful when used for symptomatic people in specific settings in which additional layers of protection are needed to protect people at higher risk of serious outcomes of COVID-19, and then followed up with confirmatory PCR testing for positive tests, and when used in remote communities where obtaining results of PCR testing may be delayed;

k. Although the wearing of personal protective equipment (PPE) provides a measure of protection, it does not provide the level of protection afforded by vaccination, particularly in an environment where there are people who are highly vulnerable to infection and serious illness.

69. The September 2022 Orders no longer base the decision not to consider exemptions for non-medical reasons on capacity to address those exemption requests. Rather accommodating persons who are unvaccinated is 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 reasoning is based on the compelling concern that the health-care system is stretched and absences as a result of COVID-19 would tend to correlate to outbreaks in the community, which would put increase demands on the system at the same time, particularly given the annual fall/winter respiratory virus season.

70. The September 2022 Health Care Order states:

> A high incidence of transmission and illness in one or more regions has already created, and could again create, spill-over effects on health-care delivery across the Province, including in critical care and surgical services, resulting in a substantial backlog of surgeries and an increase in surgical wait times;

71. The September 2022 HCW Order continues to recognize the need to balance interests of unvaccinated individuals, including those guaranteed by the *Canadian Charter of Rights and Freedoms* with the needs of public health and maintenance of the healthcare system to respond to care needs for all British Columbians.

April 2023 Orders

72. On April 6, 2023, Dr. Henry repealed and replaced the Hospital and Community Preventive Measures Order. The Order includes Dr. Henry's assessment that the criteria described in s. 52(2) of the *Public Health Act* continue to be met due to:

(a) the history of mutation of SARS-CoV-2, uncertainty about its future behaviour, and the reasonable risk of a serious impact on public health;

(b) reasonable risk of an unexpected occurrence of a new variant which could cause serious disease among the population; and

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

73. The Order, in the Recitals, explains that people over 70 and those 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.

74. The Order also notes that slippage in the level of vaccination in the health-care workforce could result in significant illness on the part of the health-care workforce

(Recital I) which would undermine the health care-system's capacity to respond to significant resurgence of disease.

75. The Order also contains an explanation of Dr. Henry's consideration, based on currently available generally accepted scientific evidence, of whether other measures are as effective as vaccination; and that 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, and that there is no reliable means of assessing the level of immunity which a person may have to re-infection or serious illness in consequence of infection.

76. The Order describes that routine testing is not recommended due to the risks of false negative or false positive testing, that rapid antigen testing is not a substitute for vaccination, and that personal protective equipment does not provide the level of protection afforded by vaccination.

77. The Order outlines the impacts of the pandemic on the hospital and community care systems, and emphasizes that ensuring safe hospital and community care is critical to the wellbeing of the public and that the public health and health-care systems have experienced severe stress and been stretched beyond capacity. The Order specifically balances the competing interests, including *Charter* interests, of the public on the one hand and people who are unvaccinated on the other.

October 5, 2023 Orders

78. On October 5, 2023, Dr. Henry repealed and replaced the Hospital and Community Preventive Measures Order. The Order states Dr. Henry's view that s. 52(2) of the *Public Health Act* continue to be met. The Order notes that the WHO declared an end to the public health emergency, but that at the same time, the WHO Director-General made it clear that the change does not mean COVID-19 is over as a global health threat; and stated that the virus "is still killing, and it's still changing."

79. The Order notes that since the end of July 2023, COVID-19 indicators in the province has stopped declining and have instead continued to increase, and that an earlier onset of annual respiratory viruses is anticipated.

80. The Order reiterates that vaccination is safe and highly effective. The Order notes that Health Canada has authorized that vaccination with the mRNA based updated vaccines, rather than the vaccines previously recommended, is adequate to provide protection, and that the NACI has advised to no longer provide the previous vaccines once the updated vaccines are available. The Order also notes that most people who have been already 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 such that an updated vaccination is not necessary.

81. The Order also notes that Dr. Henry has considered, based on currently available generally accepted scientific evidence, whether other measures are as effective as vaccination; and has concluded that 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, and further, there is no reliable means of assessing the level of immunity which a person may have to re-infection or serious illness in consequence of infection.

82. The Order describes that routine testing is not recommended because of the risks of false negative or false positive testing, that rapid antigen testing is not a substitute for vaccination, and that personal protective equipment does not provide the level of protection afforded by vaccination.

83. The Order outlines the impacts on the hospital and community care systems, including that ensuring safe hospital and community care is critical to the wellbeing of the public and that the public health and health-care systems have experienced severe stress and been stretched beyond capacity.

84. The Order specifically balances the competing interests of the public and people who are unvaccinated.

85. The Order concludes with the following:

(a) An unvaccinated workforce in hospital and community care settings poses a risk to patients, residents and clients, to other workers and to the functioning of the health-care system, and constitutes a health hazard under the Public Health Act;

(b) The provision of care or services by an unvaccinated person in a hospital or community care setting puts patients, residents, clients and other workers at risk of infection with SARS-CoV-2, and constitutes a health hazard under the Public Health Act;

(c) It is essential to maintain the high level of vaccination currently in place in the hospital and community care workforce since this is the best means available by which to mitigate the risk to the health of patients, residents, clients and workers and to ensure the preparedness and resiliency of the health care system, both at present and in the event of a resurgence of COVID19 disease in the province;

(d) Expanding the grounds upon which a person may request an exemption to the requirement to be vaccinated beyond those based upon a risk to the health of the person would undermine the high level of vaccination which is currently in place among the hospital and community care workforce, introduce an unacceptable level of risk to the health of patients, residents, clients and workers, weaken the preparedness and resiliency of the health-care system, and undermine the confidence of the health-care workforce in the safety of their working environment and the confidence of the public in the safety of the health-care system;

(e) A lack of information on the part of employers and operators about the vaccination status of workers interferes with the suppression of SARS-CoV-2

in hospital and community care settings, and constitutes a health hazard under the Public Health Act;

(f) Medical health officers need to know the vaccination status of workers in order to most effectively respond to clusters or outbreaks of COVID-19 among patients, residents, clients or workers;

(g) In order to mitigate the risk in hospital and community care settings and to the health-care system arising from an unvaccinated workforce, and to ensure the preparedness and resilience of the health-care system, it is necessary for me to exercise the powers in sections 30, 31, 32, 39, 53, 54, 56, 57, 67 (2) and 69 of the Public Health Act TO ORDER as follows:

Part 5: LEGAL BASIS

86. The petitioners seek judicial review of the Orders on the basis that they are unjustified infringements of sections 7, 2(a) and 15 of the *Charter* and are unreasonable in an administrative law sense. None of these grounds of review are the basis for overturning the Health Care Orders.

87. Section 7 is not engaged because the interest at stake for the petitioners is *employment,* not life, liberty or security of the person. If that is incorrect, then the Orders are not arbitrary, overbroad or grossly disproportionate.

88. While the petitioners have not established that the Orders breach their *Charter* rights, it is conceded that the lack of a mechanism for accommodation of religious or conscientious belief is a *prima facie* limit on s. 2(a) of the *Charter*. That limit is, however, justified under s. 1 of the *Charter* as a proportionate balance between freedom of religion and conscience and public health objectives.

89. The petitioners have not established that the Orders make a distinction based on an enumerated or analogous ground or that such a distinction amounts to disadvantage. Section 15 of the *Charter* is therefore not engaged.

90. The Orders do not demonstrate either a lack of internal rationality or a failure to address a legal or factual constraint. They are therefore reasonable exercises of statutory authority.

A. Section 7 Is Not Engaged

91. To establish a breach of section 7 of the *Charter,* a claimant must establish that:

l. the impugned government law or action interferes with, or deprives them of, their life, liberty or security of the person; and

m. the deprivation is not in accordance with the principles of fundamental justice.[2]

92. The Orders complained of here are not laws requiring anyone to undergo medical treatment. Rather, they require those subject to them to choose between performing their job duties and undergoing medical treatment. The interest of an employee in a job is not, itself, protected by section 7 of the *Charter* and therefore the claim fails at the first stage.[3]

93. Even if the Orders interfere with a protected interest under s. 7, they are not arbitrary, overbroad or grossly disproportionate to the statutory objectives of the *Public Health Act.* An arbitrary law is one that is not capable of fulfilling its objectives, such that it exacts a constitutional price in terms of protected interests, without furthering the public good that is said to be the object of the law.[4] An overbroad law is one that is arbitrary "in part" (i.e. in some range of its application).[5] A law is grossly disproportionate if the seriousness of the deprivation of life, liberty and security of the person is totally out of sync with the objective of the measure, such that its draconian impact is entirely outside norms accepted in a free and democratic society. Gross disproportionality is illustrated by a sentence of life imprisonment for spitting on the sidewalk – which might have a deterrent effect on an unhygienic practice, but at an obviously unacceptable price.[6]

94. The objects here are protection of the health of the health-care workforce and its patients and clients and to protect the preparedness and resiliency of the health-care system, and by doing so to protect against preventable death, severe illness and hospitalization

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[2] *Bedford v. Canada (Attorney General)*, 2013 SCC 72 at para. 57.
[3] *B.C. Teachers' Federation v. School District No. 39,* 2003 BCCA 100.
[4] *Carter* at para. 83.
[5] *Bedford* at para. 112.
[6] *Bedford* at para. 120.

95. The Orders, as originally enacted and updated, were clearly rationally connected to these objects in light of the protection vaccination gave against the Delta variant and subsequent variants of the Virus. It was not practical to address the situation of individual workers on a case-by-case basis and thus the law was not overbroad. While vaccine mandates are no doubt controversial in many quarters, it is not plausible that the impact of having to find a different job is outside the norms of a free and democratic society, comparable to life imprisonment for a trivial infraction.

96. The rise of the Omicron variant and subsequent XBB lineages has changed some elements of the calculation, but not the ultimate result. The healthcare system's patients, clients and residents are still among the most vulnerable British Columbians. The health-care system is still stretched, still subject to annual seasonal respiratory virus variation, and an outbreak within it could still have devastating consequences. Individualized assessment of past infection remains impracticable. It is still the case that vaccination is the most important preventive measure an individual can take to minimize the effects of COVID-19, including to reduce the risk of serious outcomes, hospitalization and death Vaccination-based immunity and infection-based immunity are complementary. A highly vaccinated workforce continues to be the best defence against outbreaks and the consequences of a health-care system that is overwhelmed, locally or province-wide.

97. If some of these considerations cannot be taken into account under s. 7 of the *Charter*, because they are insufficiently individualized, then they can still be the basis for a justified limitation under s. 1 of the *Charter.*

B. Section 2(a) [Freedom of Religion and Conscience]

98. Section 2(a) of the *Charter* guarantees the fundamental freedom of freedom of conscience and religion. This provision guarantees freedom to *hold* religious or conscientious beliefs and freedom of religious *practice,* but it does not guarantee the object of beliefs.[7]

99. The religious petitioners may have sincere beliefs, but that does not make them sincere *religious* beliefs. The conscientious petitioners may have concerns with the vaccines (or governments, or pharmaceutical companies, etc.) but that

[7] *Law Society of British Columbia v. Trinity Western University*, 2018 SCC 32 at para. 63; *Ktunaxa Nation v. British Columbia (Forests, Lands and Natural Resource Operations)*, 2017 SCC 54

does not make the concerns *Charter*-protected conscience rights. A belief only has a nexus with religion if the individual demonstrates it is held "in order to connect with the divine or as a function of spiritual faith". A belief only has a nexus with conscience if the individual demonstrates it is held as an overarching moral commitment, analogous to ethical vegetarianism or pacifism.[8] A sincere belief about the risks and benefits of a medical treatment is not itself a religious or conscientious belief just because the individual holding it is religious or has moral commitments.

100. While the sincerity of the petitioners' opposition to taking a vaccine against the Virus is not in dispute, none of them have demonstrated a nexus to religion or conscience:

n. Ms. Tatlock deposes that she is religious, and that she has a sincerely held belief that the vaccine is contrary to her anti-abortion views. However, that is not a *religious belief* simply because she is religious. Indeed, her evidence instead suggests her belief is counter to her own Church's views.

o. Ms. Koop rejects the vaccine because she has concerns ranging from safety, to mRNA technology, to "the lack of transparency from pharmaceutical corporations and all level of Canadian (and international) governments". These concerns do not ground a *Charter*-protected *Charter* right of conscience.

p. Ms. Bielecki rejects the vaccine because of her objection to perceived state coercion. This does not ground a *Charter*-protected Charter right of conscience. Ms. Bilecki is not being asked to participate in state coercion that she has a moral objection to: rather she is asking for vindication of the *object* of her belief.

q. Mr. MacDonald rejects the vaccine largely due to his own assessment of medical risk, and also cites the "rush to market" of the vaccines. These concerns do not ground a *Charter*-protected *Charter* right of conscience.

r. Mr. Mateus rejects the vaccine because of the "unanswered questions "regarding the vaccine" and because the pharmaceutical companies

[8] *R. v. Locke,* 2004 ABPC 152 at para. 25.

"have no liability" in relation to the vaccines. These concerns do not ground a *Charter*-protected *Charter* right of conscience.

s. Mr. Sturgeon rejects the vaccine based on his unqualified medical opinion and a diagnosis from August 2021 purportedly giving him "natural" (infection-based) immunity. These concerns do not ground a *Charter*-protected *Charter* right of conscience. Mr. Sturgeon also professes to have a religious objection, but his objection is not that his Catholicism prohibits vaccines—instead his objection is that his church teaches freedom to make moral decisions and he finds the "coercion" to be immoral. Respectfully, that is insufficient to engage Mr. Sturgeon's religious rights in the sense of the *Charter.*

t. Ms. Nelson and Ms. Keyser reject the vaccine because their own assessment that the vaccine is unsafe and coercive. That does not engage the *Charter.*

u. Ms. Koh asserts a religious objection but does not depose that her religion prohibits vaccination. Ms. Koh also makes her own assessment that infection-related immunity is "superior" to that obtained through vaccination. Her assertion on that point does not engage the *Charter*.

v. Ms. Hamley asserts a religious objection, but does not depose that her religion prohibits vaccination. Instead, Ms. Hamley deposes that God only sanctions just mandates, and that in her view the vaccine mandate is unethical and therefore unjust. With respect, that is insufficient to engage Ms. Hamley's religious rights in the sense of the *Charter.*

w. Mrs. Parenteau rejects the vaccine because she considers the requirement to be coercive, to put her under duress, and to constitute a threat. She does not oppose vaccination. These concerns do not ground a *Charter*-protected *Charter* right of conscience.

x. Dr. Nordine deposes only that he is "a Christian, and [has] sincerely held religious belief that prevent me from taking the Covid-19 vaccine." Without doubting the sincerity of his belief, there is no evidentiary basis on which it could be concluded that his belief is itself religious.

101. The Respondents concede that there is no *process* in the Orders for religious or conscientious objection and that this could be contrary to s. 2(a) of the

Charter. However, if this is a proportionate limit on the protected right in light of the statutory objectives of the *Public Health Act,* it is a justified limitation under s. 1 of the *Charter*.[9] Both in the Fall of 2021 and again in September 2022 and in fall 2023, Dr. Henry turned her mind specifically to this issue and explained why it would be impracticable to have such an individualized process.

(iii) Section 15 – Discrimination

102. To establish a *prima facie* breach of s. 15(1) of the *Charter*, the petitioners must demonstrate that the impugned law or state action:

a. on its face or in its impact, creates a distinction based on enumerated or analogous grounds; and

b. imposes burdens or denies a benefit in a manner that has the effect of reinforcing, perpetuating, or exacerbating disadvantage.[10]

103. A personal choice to refuse vaccination is not an enumerated or analogous ground.

104. The Orders do not impose a burden or deny a benefit that have the effect of reinforcing, perpetuating, or exacerbating disadvantage to the petitioners.

(iv) Section 1: The Orders Proportionately Balanced Charter *Rights*

105. Alternatively, if the Orders do infringe the petitioners' rights under ss. 2(a), 7 or 15 of the *Charter*, all of which is denied, the Orders are reasonable and reflect a proportionate balancing of the *Charter* rights at play with the objectives of the Orders.[11]

106. In making the Health Care Orders, Dr. Henry was guided by the principles applicable to public health decision making, and in particular, that public health interventions be proportionate to the threat faced and that measures should not exceed those necessary to address the actual risk.

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[9] *Beaudoin v British Columbia,* 2021 BCSC 512 affirmed at 2022 BCCA 427, application for leave to appeal to the Supreme Court of Canada dismissed August 10, 2023.
[10] *Fraser v. Canada (Attorney General)*, 2020 SCC 28 at para. 27
[11] *Doré v. Barreau du Québec,* 2012 SCC 12, para. 57; *Beaudoin* at paras. 206-223.

107. The Orders are continually revised and reassessed to respond to current scientific evidence and epidemiological conditions in British Columbia.

108. In making the Orders, Dr. Henry specifically recognized and considered constitutionally-protected interests including rights and freedoms guaranteed by the *Charter.*

B. No Basis to Quash the Orders as Unreasonable

109. The Orders are administrative law decisions made through the delegation of discretionary decision-making authority under the *Public Health Act*. The standard of review with respect to the Orders is reasonableness.[12]

110. The petitioners bear the burden of establishing that the Orders are unreasonable. They must establish a failure of rationality internal to the reasoning process, or that the Orders cannot be justified in light of a factual or legal constraint.[13]

111. Dr. Henry is entitled to curial deference, in particular in respect of the factual bases of the management of a pandemic by public health officials. These are matters of science and medicine that this Court is not well-suited to second guess.[14]

112. The Orders are internally rational, and consistent with the constraints imposed by the legal and factual context within which they were made.

113. There can be no doubt that protecting the capacity of the health-care system in a pandemic and protecting residents and patients from infection from healthcare workers are both rational public health goals. Dr. Henry has laid out in her Reasons why those goals are best promoted by vaccine mandates and why religious and conscientious objection processes are unworkable.

114. The existence of differing opinions on scientific or medical matters – including as to whether vaccine mandates are necessary and proportionate - does not render the Orders unreasonable.[15]

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[12] *Beaudoin* at paras. 119-125, 218
[13] *Vavilov* at paras. 101-107.
[14] *Beaudoin* at para. 124; *Vavilov* at paras. 75, 125
[15] *Doré* at para. 56; *Beaudoin* at paras. 124-125; Vavilov at para. 83

115. Dr. Henry made the Orders in the face of scientific uncertainty and relied on specialized medical and scientific expertise. Dr. Henry was guided by the principles applicable to public health decision making, including the precautionary principle, and adhered to the principle that public health interventions be proportionate to the threat faced and that measures should not exceed those necessary to address the actual risk.

116. The Orders are reasonable. There is no basis for this Court to interfere on judicial review.

C. Other Grounds in the Petition

~~45. The existence of self-regulation by a profession does not mean that profession is exempted from public regulation. The Petitioners' claim that self-regulated professions are entitled to immunity from orders under the *Public Health Act* is without merit.~~

117. It is not an abuse of discretion or fettering for Dr. Henry to restrict the ambit of reconsideration under s. 43 of the *Public Health Act.* The PHO's authority to do so in an emergency is specifically affirmed by s. 54(1)(h) of the *Act* and Dr. Henry exercised this authority appropriately.

~~46. The orders in no way affect the right of an adult not to consent to health care under s. 6 of the *Health Care (Consent) and Care Facility Act.* Vaccination must be consented to. Similarly, personal and medical information transferred under the Orders must be consented to and the Orders provide statutory authority.~~

~~47. To the extent that the Amended Petition references the *Freedom of Information and Protection of Privacy Act*, RSBC 1996, c.165 ("FIPPA"), FIPPA complaints fall under the jurisdiction of the Information and Privacy Commissioner.~~[16]

~~48. The assertion that s. 1 of the *Privacy Act* RSBC 1996 c. 373 is engaged is without merit. Section 1(1) of the *Privacy Act* sets out a tort, which can only be pursued in a civil action. A cause of action under the *Privacy Act* cannot be adjudicated in a judicial review proceeding.~~

[16] It is a collateral attack to go directly to court rather than to seek review from the Information and Privacy Commissioner: *Varzeliotis v. The Queen et al*, 2007 BCSC 620.

~~49. A complaint under section 13(1) of the *Human Rights Code*, RSBC 1996, c. 210 must be made to the Human Rights Tribunal.~~

III. REMEDY

118. The respondent seeks an order dismissing the petition.

119. Damages are not an available remedy on judicial review.[17]

120. If the Petitioners succeed on their application for judicial review, the appropriate remedy is to set the decision aside and remit the matter to the PHO for reconsideration. There is no remedy in mandamus available in these circumstances.

JRPA, ss. 5-7; *Testa v. W.B.C. (B.C.)* (1989), 36 B.C.L.R. (2d) 129 (C.A.) at paras. 53-55; *Vavilov* at paras. 140-142

Rogers Communication Inc. v *British Columbia* (Assessors of Areas #01, 08, 09, 10, 11, 14,15, 20, 22, 23, 45, 50 and 53), 2022 BCSC 1688

Part 6: MATERIAL TO BE RELIED ON

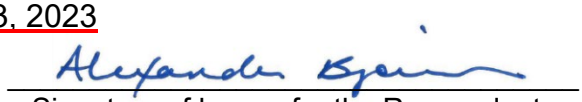
1. Affidavit #1 of Dr. Brian Emerson dated September 13, 2022.
2. Affidavit #1 of A. Dragland dated September 15, 2022.
3. Affidavit #2 of Dr. Brian Emerson dated October 27, 2022.
4. Affidavit #3 of Dr. Brian Emerson dated September 27, 2023.
5. Affidavit #2 of A. Dragland dated October 6, 2022.
6. Affidavit #3 of A. Dragland dated November 30, 2022.
7. Affidavit #1 of Haley Miller made November 1, 2023.
8. The pleadings and proceedings herein; and
9. Such further and other material as counsel may advise and

[17] *Madadi* v. *British Columbia*, 2014 BCSC 1062 at para. 50.

the Court permit.

The petition respondent estimates that the application will take ten days.

Date: ~~September 15, 2022~~ November 3, 2023



Signature of lawyer for the Respondents
~~Gareth Morley~~, Julie K. Gibson, Alexander Bjornson, Christine Bant

Petition Respondents' address for service:

Ministry of Attorney General
Legal Services Branch
[redacted]