FILE NO. S-224652
VANCOUVER REGISTRY

SUPREME COURT OF BRITISH COLUMBIA

BETWEEN

PETERNELLA HOOGERBRUG

PETITIONER

AND

PROVINCIAL HEALTH OFFICE OF BRITISH COLUMBIA

RESPONDENT

- AND -

FILE NO. S-224731
VANCOUVER REGISTRY

BETWEEN

YORK HSIANG, DAVID WILLIAM MORGAN AND HILARY VANDERGUGTEN

PETITIONERS

AND

PROVINCIAL HEALTH OFFICE OF BRITISH COLUMBIA

RESPONDENT

- AND –

FILE NO. S-222427
VANCOUVER REGISTRY

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

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I. INTRODUCTION

1. Since March 17, 2020, Dr. Bonnie Henry, as British Columbia's senior public health official, the Provincial Health Officer ("**PHO**"), has exercised her authority under the *Public Health Act*[1] ("***PHA***") to implement various public health measures to limit the risks of COVID-19. No sector of society was untouched by pandemic measures. The PHO's objectives included limiting serious illness, hospitalizations, and death, including amongst the most vulnerable members of society, and preserving the functioning and capacity of the health-care system, while minimizing social disruption.

2. On May 5, 2023, the World Health Organization ("**WHO**") issued a statement declaring an end to the COVID-19 public health emergency of international concern that had been in place since January 30, 2020. At that same time, the WHO's Director-General made clear that COVID-19 remained a deadly and evolving global health threat, and that all countries should carefully consider ongoing protective measures:[2]

> This virus is here to stay. It is still killing, and it's still changing. The risk remains of new variants emerging that cause new surges in cases and deaths. <u>The worst thing any country could do not is to use this news as a reason to let down its guard, to dismantle the systems it has built, or to send the message to its people that COVID-19 is nothing to worry about.</u>
>
> [Emphasis added]

3. The PHO was not the only official tasked with protecting health and lives in the face of COVID-19. Governments across the country have grappled with the tension between protecting the health and lives of citizens, and the impact of those protective measures. The Manitoba Court of Appeal described the dilemma, and particularly the concerns with health care system capacity:[3]

> Unquestionably, the COVID-19 pandemic challenged governments in Canada and around the world in their attempts to ensure the well-being, safety and lives of their citizens, including managing the capacity of their respective healthcare systems to provide services to the many people whose health was significantly impacted by the virus or to those who lost their lives to it.

4. As COVID-19 vaccinations became available in British Columbia, the PHO lifted several broader public health measures, such as her orders limiting gatherings and events and respecting food and liquor serving premises. At the same time, the heath care system has remained subject

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[1] *Public Health Act*, S.B.C. 2008, c. 28.
[2] Affidavit #1 of Haley Miller ("Miller #1"), Exhibit A, p. 3, Recital K. References in these submissions to page numbers for affidavits are to the cumulative page numbers of the exhibits.
[3] *Gateway Bible Baptist Church v. Manitoba*, 2023 MBCA 56 at para. 1.

to significant demands to address both COVID-19 and non-COVID-19 care needs. Outbreaks and emergency room closures continue to occur despite periods of remission.

5. The health-care system provides care for the entire population, and especially for populations at higher risk of illness including people over age 65, and those with chronic health conditions and compromised immune systems, who are more vulnerable to severe illness, hospitalization, intensive care unit admission and death from COVID-19 than younger, healthier individuals, even if they are vaccinated. It is in considering this current health-care system setting that the WHO's Director-General's words of caution are particularly important. The PHO has identified an urgent need for protective and precautionary public health measures in the health-care system to keep vulnerable populations safe and to preserve the health care system's ability and capacity to respond to all care needs.

6. This approach to COVID-19 is in line with the precautionary principle ("**Precautionary Principle**"): where there are threats of serious, irreversible damage, lack of full scientific certainty is not a reason to postpone harm reduction strategies; this is particularly the case when it comes to health-care worker safety.[4]

7. These petitions impugn PHO orders that formed one part of that precautionary approach to protecting health and lives, specifically by requiring health-care and residential care workers to be vaccinated to work within the British Columbia health care system. These orders (the **"Health-care Orders"**) were made by the PHO under the statutory authority conferred upon her by the *PHA.* These Health-care Orders were re-issued most recently on October 5, 2023.

8. The petitioners are the latest of a long list of unsuccessful litigants who have challenged government COVID-19 measures enacted across the country, measures that were enacted to ensure "well-being, safety and lives" and manage health-care system capacity. In an October 2023 decision, a unanimous Ontario Court of Appeal noted that Canadian courts have provided guidance on the constitutionality of government public health measures responding to the COVID-19 pandemic – in each case finding that public health restrictions either did not infringe *Charter* rights or were reasonable and proportionate limits or justified under s. 1 of the *Charter*.[5]

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[4] *Ontario (Attorney General)* v. *Trinity Bible Chapel*, 2023 ONCA 134 at paras 24, 105-115; *Ontario Nurses' Assn. v. Chief Medical Officer of Health (Ontario)*, 2021 ONSC 5999 ("*Ontario Nurses*") at para 12.

[5] *Harjee v. Ontario,* 2023 ONCA 716 at para 6 citing: *Canadian Constitution Foundation v. Attorney General of Canada*, 2021 ONSC 4744; *Costa, Love, Badowich and Mandekic v. Seneca College of Applied Arts and Technology*, 2022 ONSC 5111; *Banas v. HMTQ*, 2022 ONSC 999; *Sprague v. Her Majesty the Queen in right of Ontario*, 2020 ONSC 2335 (Div. Ct.); *Maddock v. British Columbia*, 2022 BCSC 1605, appeal dismissed as moot, 2023 BCCA 383; *Canadian Society for the Advancement of Science in Public Policy v. British Columbia*, 2022 BCSC 1606, appeal of individual applicant

9. Like the measures noted by the Ontario Court of Appeal, the respondents submit that that the Health-care Orders do not infringe *Charter* rights or alternatively are proportionate and justified measures. The PHO made the Health-care Orders to protect vulnerable members of society, reduce severe illness and prevent death, and to preserve the health-care system's ability to continue to deliver care for COVID-19-related and other care needs. The petitions ought to be dismissed in their entirety.

II. BACKGROUND

A. The public health system and the PHO

10. "Public health" is one component of B.C.'s health system and shares the same overall goals of other parts of the system: reducing premature death and preventing and minimizing the effects of disease, disability and injury. It is distinct because it focuses on the health of populations as a whole, rather than providing health care to individuals with health conditions.[6]

11. One of the goals of public health is to prevent and manage outbreaks of disease within the population. It is also responsible for developing and delivering province-wide vaccination programs, including oversight of and administering or ensuring administration of the various vaccinations now available for COVID-19.[7]

12. As noted above, one of the core principles of public health is the Precautionary Principle. This well-established health care principle maintains that the scientific method is the basis for action and should inform interventions and policies and programs to protect public health. The Precautionary Principle provides that in the face of scientific uncertainty, public health interventions are warranted when there is a risk of harm to the population even before all scientific data are obtained to confirm the risk.[8]

13. The PHO, Dr. Bonnie Henry, is the senior public health official for the province and is responsible for monitoring the health of the population and providing independent advice to ministers and public officials on health issues.[9]

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pending, 2023 BCCA 383; *Beaudoin v. British Columbia*, 2021 BCSC 512, appeal dismissed, 2022 BCCA 427; *Grandel v. Saskatchewan*, 2022 SKKB 209; *Gateway Bible Baptist Church et al. v. Manitoba et al.*, 2021 MBQB 219, appeal dismissed, 2023 MBCA 56; *Syndicat des métallos, section locale 2008 c. Procureur général du Canada*, 2022 QCCS 2455; *Taylor v. Newfoundland and Labrador*, 2020 NLSC 125 (appeal dismissed as moot, 2023 NLCA 22; *Spencer v. Canada (Minister of Health)*, 2021 FC 621, [2021] F.C.R. 581 appeal dismissed as moot, 2023 FCA 8.

[6] Affidavit #1 of Dr. Brian Emerson ("Emerson #1") at para 4.

[7] Emerson #1 at para. 5; *Beaudoin v. British Columbia (Attorney General)*, 2021 BCSC 512 ("*Beaudoin BCSC*") at para. 14, affirmed 2022 BCCA 427 ("*Beaudoin BCCA*").

[8] Emerson #1 at para 6

[9] Emerson #1 at para 7.

14. Dr. Henry is an expert in public health and preventive medicine. Her responsibilities are outlined in the *PHA*. She is informed by the public health component of B.C.'s health system, which includes the B.C. Centre for Disease Control (**"BCCDC"**) and regional medical health officials.[10]

15. British Columbia courts have already considered Dr. Henry's role as PHO in the context of COVID-19 public health orders. As explained by the courts, Dr. Henry bears the "formidable responsibility" of making the decisions that are intended to protect us from the COVID-19 pandemic. Against the serious risks associated with the pandemic, she is obliged to balance a wide variety of competing rights and interests of British Columbians and visitors to the province.[11]

16. Preventing and controlling transmission of communicable diseases is essential to maintaining the provincial health system's ability to deliver quality care and continue the safe delivery of essential health services. An epidemic or pandemic that gets out of control could overwhelm the provincial health system's ability to diagnose and treat patients for the myriad of health conditions experienced by the population.[12]

B. The ongoing COVID-19 pandemic

17. Proper context for the seriousness of the circumstances underlying the Health-care Orders can be found in the apt words of Justice Pomerance:

> The COVID-19 pandemic sent shockwaves across the globe. The virus has killed millions worldwide and has caused many others to experience chronic debilitating health conditions. While particularly dangerous for certain populations - those over the age of 60 and/or with underlying health conditions - COVID-19 does not discriminate based on age or infirmity. New variants of concern have increased mortality rates among young and healthy individuals. COVID-19 has threatened the viability of health care systems by consuming medical resources, leaving other illnesses untreated, and stretching hospitals and intensive care units ("ICUs") to their limits.[13]

18. On January 27, 2020, British Columbia diagnosed its first case of COVID-19 on January 27, 2020. On January 30, 2020, the Director General of the WHO determined that COVID-19 constituted a Public Health Emergency of International Concern. The WHO declared a pandemic

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[10] *Beaudoin BCCA* at para. 13; Emerson #1 at paras. 14-16.
[11] *Beaudoin BCCA* at para. 26; and see *Beaudoin BCSC* at paras. 19-25.
[12] Emerson #1 at para. 32.
[13] *Ontario (Attorney General) v. Trinity Bible Chapel,* 2022 ONSC 1344 ("*Trinity Bible ONSC*") at para. 1, affirmed 2023 ONCA 134 ("*Trinity Bible ONCA*").

on March 11, 2020, due to the extensive international spread of the infectious agent SARS-CoV-2 virus that causes COVID-19.[14]

19. By mid-March, British Columbia was in the first wave of the pandemic. Case counts were rapidly rising. It was understood at this time that an infected person could transmit the virus to others with whom they were in contact, and that gatherings of people in close contact would promote transmission, thereby increasing disease. There was no treatment or cure for COVID-19, and no vaccine to protect against SARS-CoV-2.[15]

20. COVID-19 quickly became the "worst global pandemic in over a century". By May 2021, little over a year after the state of emergency was declared, COVID-19 had infected over 120 million people; it killed more than 2.5 million worldwide. Most of the deaths occurred in persons over age 60 or in those with underlying health conditions. COVID-19 has also caused serious illness requiring hospitalization and admission to intensive care units across a wide spectrum of ages.[16]

21. On March 17, 2020, the PHO gave notice pursuant to s. 52(2) of the *PHA* that the spread of the infectious agent causing COVID-19 constituted a regional event as defined in s. 51. In her view, all of the criteria set out in s. 52(2) of the *PHA* were present. The designation of a regional event permitted the PHO to exercise emergency powers under Part 5 and 6 of the *PHA*, including the power to make oral and written public health orders in response to the COVID-19 pandemic. This was the first time the emergency powers under the *PHA* had been triggered in respect of a communicable disease in British Columbia.[17]

22. On March 18, 2020, the Minister of Public Safety and Solicitor General declared a state of emergency throughout the province pursuant to the *Emergency Program Act*,[18] which eventually expired on June 30, 2021.[19]

23. In March 2020, the PHO issued the first public health orders responding to the pandemic. Since that time, as noted by our Court of Appeal, Dr. Henry has regularly updated her orders to respond to local surveillance data, information about evolving situations, and national and international epidemiological information about the spread of COVID-19.[20]

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[14] *Beaudoin BCCA* at para. 54.
[15] *Beaudion,* 2022 BCCA 427 at para 55
[16] *Gateway Bible Baptist Church et al. v. Manitoba et al.,* 2021 MBQB 219 at para. 4.
[17] *Beaudoin BCCA* at paras. 56-58.
[18] *Emergency Program Act*, R.S.B.C. 1996, c. 111.
[19] *Kassian v. British Columbia*, 2022 BCSC 1603 at paras. 23-24.
[20] *Beaudoin BCCA* at para. 59.

24. With the onset of fall 2020, in light of the modelling projections available to her, the PHO correctly anticipated that British Columbians would experience a second wave of the pandemic. By mid-October 2020, the province began experiencing a surge in cases, hospitalizations, and admissions to intensive care units.[21]

25. By November 19, 2020, the PHO knew, *inter alia,* the following salient points, as set out by the Court of Appeal:[22]

a. Compared to influenza, COVID-19 has higher transmissibility, is transmissible prior to symptom onset, and has a higher infection fatality rate;

b. The surge of cases noted in mid-October was continuing, as were hospitalizations and the admission of COVID-19 patients to ICUs;

c. The transmission of the virus seemed to be highest in crowded settings or settings involving sustained interpersonal engagement (defined as 15 minutes or more) indoors or in enclosed spaces;

d. Transmission occurs through direct contact with respiratory droplets from an infected person, propelled when that person coughs, sneezes, sings, shouts or talks;

e. Higher community prevalence and transmission rates increase the risk that people attending a gathering or event will shed the virus and infect others;

f. SARS-CoV-2 was estimated to have a reproductive number of 2.87, meaning that each infected individual is likely to transmit the virus to another two to three people. Public health interventions were known to reduce the reproductive number;

g. Asymptomatic transmission was occurring;

h. Enhanced transmission of the virus was likely to occur in the winter months;

i. The risks associated with COVID-19 were greater for the vulnerable, including the elderly and people with underlying health conditions;

j. The capacity of the public health-care system to deliver essential services could be breached during the peak periods of COVID-19 activity;

k. The pandemic had led, not only in Canada but globally, to the extraordinary implementation of broad, restrictive community-based public health measures.

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[21] *Beaudoin BCCA* at para. 64.
[22] *Beaudoin BCCA* at para. 69

26. COVID-19 is highly infectious and has mutated since it emerged. Variants that are a greater threat to public health than the original Virus are called “variants of concern”. More than five variants of concern have emerged: Alpha, Beta, Gamma, Delta, Omicron and its sublineages such as XBB.[23]

27. The presence of the variants of concern in British Columbia, in particular Delta and Omicron, heightened the risk to the population generally and particularly to the frail, elderly, and persons living with underlying medical conditions.[24]

28. From August to December 2021, Delta was the most common variant of concern. Delta is estimated to be more than two times as contagious as previous variants. Data suggests Delta causes more severe illness than previous variants, particularly in unvaccinated people.[25]

29. Eventually, Omicron became the dominant variant, precisely because it was able to transmit better in the face of higher prevalence of immunity in the population. However, immunity from prior vaccination continued to be the primary factor in reducing the seriousness of the consequences from infection, especially hospitalization and death. Breakthrough infections tended to be less serious for those who had been vaccinated.[26]

30. By September 10, 2021, the Chief Public Health Officer of Canada confirmed there had been 27,134 deaths related to COVID-19, that daily reported cases had increased by 8% over the previous week, that national severity trends were increasing – particularly involving unvaccinated people, that an average of 1,600 people with COVID-19 were treated in Canadian hospitals day (an increase of 27% over the previous week) including an average of 597 in intensive care units (“**ICU**”), and an average of 18 deaths daily. Moreover, most reported cases, hospitalizations and deaths were occurring among unvaccinated people and virus-spread in areas with low vaccination coverage presented an ongoing risk for emergence of new variants of concern.[27]

31. At the same time that the public health system was under the strain of the COVID-19 pandemic, it was faced with a concurrent public health emergency in the overdose crisis. On August 31, 2021, Health Minister Dix reported that the first six months of 2021 saw 1,011 die due to poisoned drug supply, with 159 dying in June alone.[28]

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[23] Emerson #1 at paras. 26-29; Miller #1, Exhibit K at p. 118.
[24] Emerson #1 at para. 64.
[25] Emerson #1 at para. 29 and 152 and Exhibit 12 at p. 766
[26] Emerson #1 at para. 55.
[27] Emerson #1 at para. 50 and Exhibit 5 at pp. 31-32.
[28] Emerson #1, Exhibit 8 at p. 662.

32. These simultaneous public health emergencies impacted the province's health care system. Non-urgent surgeries were suspended in March and April 2020. Other surgeries were not even booked. By November 2021, most operating rooms were performing surgeries, albeit in reduced numbers. From September 5 to October 30, 2021 there were 2,389 surgical postponements. Health Minister Dix reported that the Province was still working towards its commitment to catch up to surgeries lost to COVID-19 and other surgeries in demand.[29]

33. Data reported by the BCCDC through the fall of 2021 and into 2022 showed that cases, hospitalizations, and deaths continued at an alarming rate. On January 14, 2022, the BCCDC reported that the prior week included 17,515 cases, 580 hospitalizations, and 32 deaths – bringing the total number of deaths to 2,462.[30]

34. In her related media briefing, the PHO noted that a challenge her office faced was to determine the impact on the health care system. In particular, the impact was twofold: the number of hospitalizations was increasing, but also health care workers were needing to recover from illness and consequently were taking time off from work in higher numbers than ever before in the pandemic.[31] The same media briefing described that there were significant increases in health workers not working due to illness during the first week of January, compared to the previous two years: 8,802 in 2020, 7,573 in 2021, and 14,591 in 2022. This led to an impact on services, including canceling non-urgent scheduled surgeries and home support services.[32]

35. COVID-19 continued to cause harm to British Columbians into 2022 and all the way to present day. On April 5, 2022, the PHO reported that over 3,000 people had died of COVID-19 in the course of the pandemic in the province.[33] It was only at the same time the province could report no surgical postponements due to COVID-19.[34]

36. In the week ending August 25, 2022, there were 192 hospitalizations, 29 critical care admissions, and 32 deaths.[35] In the week ending September 24, 2022, there were five new care facility outbreaks (two acute care and three long-term care).[36]

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[29] Emerson #1, Exhibit 10 at p. 717.
[30] Emerson #1, Exhibit 13 at p. 789.
[31] Emerson #1, Exhibit 14 at pp. 823-824.
[32] Emerson #1 at p. 831.
[33] Affidavit #2 of Dr. Brian Emerson ("Emerson #2") at p. 928.
[34] Emerson #2 at p. 936.
[35] Emerson #1 at para. 60.
[36] Emerson #2, Exhibit 1 at p. 46.

37. In the week ending November 26, 2022, the BCCDC reported that 46% of deaths in which SARS-CoV-2 was detected were determined to have COVID-19 as the underlying cause of death. The BCCDC also reported four new acute care facility outbreaks.

38. The pandemic continued into 2023. The province faced an uptick in RSV (respiratory syncytial virus) and the XBB.1.5 variant of COVID-19 was emerging.[37] The health care system remained stretched far beyond capacity. The number of those hospitalized in BC was 110% of base bed capacity.[38] Despite significant efforts to conduct surgeries at pre-pandemic levels, from January 1 to 7, 2023, there were 190 non-urgent postponed surgeries.[39] In January 2023, different regions faced overnight closure of emergency departments.[40]

39. As forecasted by the WHO statement, the pandemic is not over and continues to pose a risk to health and a burden on the health care system.

40. On June 9, 2023, the National Advisory Committee on Immunization ("**NACI**") reported that hospitalizations remained at a relatively high level since the widespread circulation of Omicron, with the highest hospitalization rates among older adults and that the trajectory of the COVID-19 pandemic remains unclear.[41] NACI also reported that the risk of hospitalizations and deaths were highest for adults 60 years and older, with risk increasing with age, and highest among "those 80 years and older and those who are unvaccinated".[42] In contrast, risk is lowest for those recently vaccinated and with hybrid immunity (i.e., vaccination and infection), although this varies by age group with older adults more likely to be protected by vaccination only.[43] In the same report, the NACI recommended that unvaccinated individuals receive a primary series of COVID-19 vaccines.[44]

41. On September 28, 2023, the province was still dealing with the impact of dual emergencies, in the pandemic and the overdose crisis, with 500 or 600 more people in hospital than usual in the previous summer.[45]

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[37] Emerson #3 at p. 2054.
[38] Emerson #3 at p. 2057.
[39] Emerson #3 at p. 2058.
[40] Emerson #3 at pp. 2070 and 2071.
[41] Miller #1 at p. 61
[42] Miller #1 at p. 62
[43] Miller #1 at pp 62-63.
[44] Miller #1 at p. 66.
[45] Miller#1 at p. 196.

42. On October 5, 2023, the BCCDC reported that SARS-CoV-2 levels were increasing at wastewater plants across the province, that COVID-19 cases were increasing particularly in the 60+ age group, and that patients hospitalized and in critical care with COVID-19 had increased.[46]

43. On October 26, 2023, the BCCDC reported a steady increase in deaths, with 44% of deaths with a positive COVID-19 lab test reported to have COVID-19 as the underlying cause of death, and 263 patients hospitalized in the prior week.[47]

C. The facts concerning transmission that are properly before the Court

44. As set out in the record of materials available to the PHO, the scientific community and public health officials have learned that the likelihood of transmission of COVID-19 is greater in certain settings, including indoors, when people are living in communal settings such as residential care or assisted living, and when people are unvaccinated or partially vaccinated.[48]

45. Likelihood of transmission also increases exponentially in a susceptible population when a number of people are simultaneously infected in a group setting, causing a chain reaction where those people infect their contacts, who infect their contacts, etc.[49]

46. Over the course of the pandemic, the scientific community and public health officials have learned that the likelihood of transmission of SARS-CoV-2 is greater:

a. when people are interacting in communal settings (e.g. gatherings, events, celebrations) than in transactional settings (e.g. at retail or fast food outlets)[50];

b. when people are living in communal settings (e.g. residential care, assisted living, or other congregate living situations);[51] and

c. when people are unvaccinated or partially vaccinated.[52]

47. The likelihood of transmission also increases exponentially in a susceptible population when a number of people are simultaneously infected in a group setting, and subsequently infect their contacts, who infect their contacts and so on. This can quickly result in a scenario where local public health resources can be overwhelmed. When this occurs, community spread can quickly become rampant, leading to increased case counts and, in time, has the potential to overwhelm our health-care system as hospitalizations increase.

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[46] Miller #1 at p. 57
[47] Miller #1 at p. 52.
[48] Emerson #1 at para. 33.
[49] Emerson #1 at para. 34
[50] Emerson #1, Exhibit 8 at pp. 666, 671, 672.
[51] Emerson #1, Exhibit 9 at p. 722.
[52] Emerson #1, Exhibit 5 at p. 32.

48. 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. The Province and the PHO have been actively trying to prevent and contain 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.[53]

49. Additional measures adopted in B.C. to date include: broad population measures such as PHO orders; environmental measures; surveillance and response measures i.e. contact tracing and isolation; physical distancing measures; domestic and international travel-related measures; and widespread vaccination.[54]

D. The facts concerning vaccination that are before the Court

50. As set out in the record before the PHO, vaccines play a crucial role in limiting spread of COVID-19 and minimizing severe disease. The current available scientific literature establishes that vaccination is the best way to protect against COVID-19 on both individual and community levels. High vaccination coverage will reduce spread of COVID-19, limit severe outcomes and help prevent new variants from emerging in our communities.[55]

51. B.C.'s immunization plan was developed by working closely with the federal government and through a collaborative effort of the Office of the PHO (the **"OPHO"**), Ministry of Health, BCCDC and regional health authorities. Expert leaders were hired to spearhead the initiative and special working groups established to oversee and implement this massive initiative.[56]

52. Health Canada has conducted a rigorous scientific review of the available medical evidence to assess the safety of the approved COVID-19 vaccines. To the date of this petition, six vaccines had been approved for use by Health Canada: the Pfizer-BioNTech vaccine; the Moderna vaccine; the AstraZeneca/SII COVISHIELD (AZ/SII) vaccine; and Janssen (the Johnson & Johnson vaccine, which is not administered in B.C.).[57] The Novavax and Medicago vaccines have also now been authorized for use by Health Canada.

53. Each of the vaccines approved by Health Canada have been shown to be safe and efficacious. In particular, the available vaccines are highly effective at preventing severe disease and death. However, and as expected, vaccines are not 100% effective, and some fully

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[53] Emerson #1 at paras. 35-36.
[54] Emerson #1 at para. 37.
[55] Emerson #1 at para. 42
[56] Emerson #1 at para. 44
[57] Emerson #1 at para. 46

vaccinated people will become infected (called a “breakthrough infection”) and experience illness. Nonetheless, even in the case of breakthrough infection, vaccination remains highly effective in preventing serious illness requiring critical of ICU care and, most importantly, death.[58] All people living or visiting British Columbia who are 5 years and older are currently eligible to get a vaccine.

54. As of January 21, 2022, 92.9% of all eligible adults in BC had received their first dose, 90.3% had received their second dose, and 40.5% had received a third dose.[59] Through B.C. immunization program, residents of long-term care and assisted living facilities (**“LTC Facilities”**) have been prioritized for vaccination. By late January 2022, approximately 96% of residents in long-term care and 93% of residents in assisted living completed their primary course (*i.e.,* two doses) of vaccine, with third or booster doses being prioritized for staff and residents in LTC Facilities as well.[60]

55. Vaccination is the most important tool that we have available to us to mitigate the effects of the SARS-CoV-2 pandemic.[61] Data available to the PHO, since vaccines became available in December 2020, shows that vaccines make a significant difference reducing hospitalizations and deaths.

56. During British Columbia’s Delta-driven fourth wave, most transmission and infection in British Columbia was occurring in and between unvaccinated people.[62] However, due to the highly transmissible nature of the Delta variant, and the not insubstantial number of people in British Columbia who remained unvaccinated at the time, vaccinated people continue to be exposed to the SARS-CoV-2 virus and some of those people were also contracting COVID-19. Vaccinated individuals who are elderly, and who often have underlying medical conditions, are more likely than other vaccinated individuals to contract COVID-19, get seriously ill, and die.

57. Unvaccinated people likewise are at significantly higher risk of becoming infected with Omicron, though the emerging scientific data suggests that Omicron is more capable of infecting vaccinated people than Delta. Omicron’s ability to infect vaccinated people decreases for people who have received a third dose of vaccine.

58. For both Delta and Omicron, the emerging consensus in the scientific literature is that vaccinated people who contract COVID-19 can still transmit the virus to others, but the risk of transmission is lower in vaccinated people than in unvaccinated people.[63] Put differently, a

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[58] Emerson #1 at para. 48
[59] Emerson #1 at para. 49
[60] Emerson #1 at paras. 49-50.
[61] Emerson # 1, Exhibit 34 at p. 1875, Exhibit 12 at p. 765.
[62] Emerson # 1, Exhibit 5 at p. 31.
[63] Emerson # 1, Exhibit 4 at p. 24.

vaccinated person with COVID-19 is less likely to transmit the virus at all or for as long a period as an unvaccinated person.

59. More importantly, the data consistently shows that a primary course of vaccination offers high levels of protection against serious illness, hospitalization and death for both Delta and Omicron, and that this protection is increased for persons who have received a third (booster) dose of vaccine. Unvaccinated people are at a higher risk than vaccinated people of being infected with SARS-CoV-2 and of having more severe illness leading to hospitalization and the need for critical care.[64]

60. Unvaccinated people are also at a much higher risk of serious complications of COVID-19, which can result in hospitalization, admission to intensive care units and death. In addition to serious impacts on the health of a person who contracts COVID-19, high numbers of seriously ill people can overtax the health care system to the extent that the health care system can be compromised in its ability to deliver health care to other seriously ill people, further endangering public health.

61. 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. However, with first Delta and now Omicron circulating in British Columbia, it is apparent that very high levels of primary vaccination coverage and third doses will be needed to combat the ongoing spread of the SARS-CoV-2 virus.[65]

62. During the Delta-driven fourth wave, people who had not completed their primary course of vaccine (two doses) consistently accounted for the majority of COVID-19 cases and hospitalizations.[66] Throughout the Delta-driven fourth wave of the pandemic, a significant majority of people in critical care due to COVID-19 were not fully vaccinated.

63. In the September to November 2021 time frame, the number of people in critical care due to COVID-19 fluctuated, with people who had not completed their primary course of vaccine consistently accounting for more than 75%. Between November and December 9, 2021, unvaccinated individual accounted for 68% of hospitalizations and 78% of critical care admissions. [67]

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[64] Emerson #1 at p. 142.
[65] Emerson #1, p. 713
[66] Emerson #1, Exhibit 11 at p. 738.
[67] Emerson #1, Exhibit 11 at p. 745 and see p. 738.

64. After adjusting for age differences, unvaccinated individuals are at much greater risk of infection, hospitalization, or death from COVID-19 than people who have completed their primary course of vaccination[68]. For example, as of October 28, 2021 when Delta was the dominant variant, unvaccinated people were 10 times more likely that people with two doses to be infected with COVID-19, were 50 times more likely to be hospitalized, and were 46 times more likely to die.[69]

65. In fall 2023, PHAC and NACI released guidance strongly recommending vaccination with an XBB.1.5 containing mRNA COVID-19 vaccine, given ongoing evidence of higher rates of hospitalization and death in Canada for those over age 65, and those who are unvaccinated.[70]

E. The facts concerning the impact of COVID-19 on LTC facilities, hospitals and community care settings that are before the Court

66. Since the onset of the pandemic in British Columbia, long-term care and assisted living residents and staff have experienced a disproportionate share of cases and deaths from COVID-19.[71] Residents of these facilities are typically elderly and usually have chronic health conditions and compromised immune systems which make them particularly vulnerable to severe illness and death from COVID-19, even if they are vaccinated.[72]

67. 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.[73]

68. Throughout the pandemic, long-term care and assisted living facilities have been a frequent site of outbreaks of COVID-19 across British Columbia. Outbreaks in these facilities are of particular concern due the susceptibility of the resident population to serious illness and death.[74]

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[68] Emerson #1, Exhibit 9 at p. 697.
[69] Emerson #1, Exhibit 9 at p. 699
[70] Miller #1, Exhibit I at p. 95 and Exhibit K at pp. 118-120.
[71] Emerson # 1, Exhibit 26 at p. 1663, Figure 1 showing Proportional Impact of COVID-19 in Long-Term Care and Assisted Living in BC.
[72] Emerson #1 at para. 63.
[73] Emerson #1 at para. 64.
[74] Emerson #1 at para. 65.

69. Beginning in January 2021, the BCCDC started publishing Weekly COVID-19 Outbreak Reports for Long-Term Care, Assisted Living & Independent Living Facilities on their website. These reports show the number of cases and deaths for both residents and staff of each facility with an outbreak of COVID-19.[75]

70. The contact tracing efforts by public health officials and data collected by the BCCDC indicated that staff in long-term care and assisted living facilities were generally the source of an initial infection with SARS-CoV-2, and the virus was then able to spread rapidly through some facilities, to both residents and other staff.[76]

71. In response to the threat that COVID-19 presented to residents and staff of long-term care and assisted living, the PHO has implemented several public health measures designed to decrease the transmission of SARS-CoV-2 in these settings over the course of the pandemic. These measures included restricting visitors to long-term care and assisted living, restricting staff working in these facilities to work at one site only, and prioritizing vaccination (once it became available in British Columbia) for staff and residents of long-term care and assisted living facilities.[77]

72. The BCCDC and Ministry of Health also provided extensive guidance on public health measures to prevent and control the transmission of COVID-19 in long-term care and assisted living settings.[78]

73. The large number of COVID-19 outbreaks and deaths, and the resulting public health measures, impacted the quality of life of residents of long-term care and assisted living facilities and their families. In particular, strict restrictions were required to deal with outbreaks in these facilities, which at times meant confining residents to their rooms and severely restricting visits from family and friends, even when a resident faced serious or fatal illness.[79]

74. On October 6, 2021, the British Columbia Seniors Advocate Isobel Mackenzie released the results of a province-wide review of COVID-19 outbreaks in long-term care and assisted living facilities during the first year of the pandemic ("**Seniors Advocate Review**"). The report relied on data from the BCCDC and consultation with Ministry of Health officials.[80]

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[75] Emerson #1 at para. 66.
[76] Emerson #1 at para. 70.
[77] Emerson #1 at para. 72.
[78] Emerson #1 at para. 73 and see examples at Exhibits 21, 22, 23, 24.
[79] Emerson #1 at para. 74.
[80] Emerson #1 at para. 75 and Exhibit 26 at p. 1654 and following.

75. The Seniors Advocate Review examined outbreaks of COVID-19 in long-term care and assisted living in British Columbia for the one-year period of March 2020 to February 2021. Based on data collected from the BCCDC, the report found that, as a proportion of the population, residents and staff of long-term care were 3.3 times more likely to contract COVID-19 and residents of long-term care were 32.6 times more likely to die from COVID-19 than members of the population at large. The Seniors Advocate Review also reported that in most outbreaks (76%), the first COVID-19 case was a staff member. In 22% of outbreaks, a resident was the first case, and in one outbreak the confirmed first case was a visitor.[81]

76. The information contained in Seniors Advocate Review, including in particular about the disproportionate impacts of the pandemic on long-term care and assisted living facilities and their residents, was available to and known by the PHO at the time she made the Health-care Orders. The Seniors Advocate Review provides a helpful summary of some of the underlying data from the BCCDC and risks associated with these facilities, and information that was known to the PHO upon which she relied in making the Health-care Orders.[82]

77. The Seniors Advocate Review made seven recommendations, including making vaccinations in long-term care and assisted living mandatory for staff. By the time the Seniors Advocate Review was published, this recommendation had been implemented through the Health-care Orders.[83]

78. The rise in SARS-CoV-2 cases in British Columbia during the fourth wave of the pandemic also impacted residents and staff in long-term care and assisted living facilities. By mid-August, there were 11 active, ongoing outbreaks in long-term care and assisted living facilities, one of which had resulted in the death of a resident patient. These outbreaks caused illness in both vaccinated and unvaccinated individuals, and caused significant disruption to the lives of staff, residents and their families.[84]

79. The increase in the number of outbreaks in LTC Facilities in August 2021 and throughout the fall was of concern to the PHO and public health officials, particularly as community transmission continued to rise, driven by the Delta variant and unvaccinated individuals.[85]

80. As was the case in LTC Facilities, unvaccinated people providing health care or services in hospitals or community settings put patients, residents and staff at risk of infection with SARS-

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[81] Emerson #1 at para. 76.
[82] Emerson #1 at para. 77.
[83] Emerson #1 at para. 78, and Exhibit 26 at p. 1692.
[84] Emerson #1 at para. 79.
[85] Emerson #1 at para. 81.

CoV-2. In light of this, the PHO determined that it was necessary in the interest of protecting public health to require staff working in hospital and community care settings to be vaccinated. As such the PHO directed the order to regional health authorities, other major health employers, and organizations contracted or funded by them to ensure broad coverage of the health care system.[86]

81. Vaccination of health professionals in hospitals and community care settings remains the most important measure that can be taken to protect patients, workers in these settings, their families and their coworkers from infection with SARS-CoV-2 and severe illness from COVID-19. Through this measure, the health care workforce can stay as healthy as possible to ensure that patients are protected and that the health care system can continue to function to provide COVID-19 and non-COVID-19 care (such as cancer and cardiac care, as examples).[87]

82. Vaccination of health care workers also is particularly important to protect the people they care for both in LTC Facilities and acute care, but also and in broader community settings (for example, where community care workers are visiting multiple different patients in their homes or other community settings) because these patients are often elderly, have comorbidities or are clinically extremely vulnerable, and are therefore at high risk of severe illness or death from COVID-19.[88]

83. Also, because vaccination significantly reduces the risk of severe illness, hospitalization, and admission to acute care, it is an important measure to help manage the burden on the health care system as a whole. This helps reduce the need to delay non-urgent elective surgeries, and also manage worker burnout and absenteeism which make it difficult for the health-care system to deliver health-care services across the spectrum.[89]

84. More recently, on October 2, 2023, the COVID-19 Immunity Task Force reported that a preprint study found that health-care workers had a higher incidence of SARS-CoV-2 infection compared to the general population.[90]

85. The COVID-19 Task Force also reported another preprint study that SARS-CoV-2 antibody levels increased with each vaccine dose, but waned over time.[91]

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[86] Emerson #1 at para. 85, Exhibit 28, and 87.
[87] Emerson #1 at para. 79, Exhibit 26, p. 1692, Miller #1, Exhibit V at pp. 176 and 177.
[88] Emerson #1 at Exhibit 26, p.1688 Summary of Findings.
[89] Emerson #1 at para. 86.
[90] Miller #1 at p. 178.
[91] Miller #1 at p. 180

F. Vaccination requirements in LTC Facilities, hospitals and community care settings

86. To reduce the rising number of outbreaks in long-term care and assisted living facilities and to try to minimize the disruptive impacts these outbreaks cause for staff, residents and their families, the PHO, in conjunction with other public health officials, decided new public health measures were required.

87. The PHO made a number of orders under the *PHA* in response to the COVID-19 regional event, including the Health-care Orders.[92] In making or amending orders, the PHO monitors the surveillance data of case reports in B.C. from the BCCDC and national and international surveillance data respecting the emergence and progression of the virus, and local, national and international epidemiological data respecting the virus and COVID-19. Situation reports summarizing the data are provided to the PHO and made available to the public on the BCCDC website.[93]

88. PHO orders and BCCDC guidance are regularly updated to respond to local surveillance data, information about evolving local situations from medical health officers ("**MHO**") and national and international epidemiological information about COVID-19. If the current state of scientific knowledge about COVID-19 or the incidence or prevalence of the disease in B.C. changes, PHO orders and guidance can be amended or revised in response to the current epidemiologic conditions in British Columbia.

89. The overriding concern is to ensure that public health orders and guidance protect the most vulnerable members of the society and protect the functioning of the health care system while minimizing social disruption. As such, changes to orders and guidance are undertaken where there is epidemiological evidence to support the change.

90. The vaccine requirements in LTC Facilities, hospitals and community care settings are public health measures put in place for the overarching purpose of protecting public health, the health of vulnerable populations, to help limit transmission in higher risk settings and to protect the functioning of the health care system.

91. The objectives of the Health-care Orders include:

a. reducing the risk and spread of 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

[92] Emerson #1 at para. 38.
[93] Emerson #1 at para. 39.

b. 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 number of health care and other professionals working in LTC Facilities, hospitals and community care setting who, if infected with COVID-19, experience severe illness and cannot work.

92. Generally speaking, the settings covered by the Health-care Orders are settings where vulnerable populations reside in communal environments and where people are receiving health care services. The PHO observed that transmission occurs 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 health-care system of clusters and outbreaks of disease, and of staff being absent due to illness from COVID-19.

93. Following the announcement, and the phased implementation, of the initial Health-care Orders, there was a significant increase in vaccination. While vaccination rates vary between health authorities, facilities, and categories of workers, generally speaking, as of November 4, 2021, almost 100% of workers in LTC Facilities were vaccinated and approximately 98% of workers in acute care had their first dose and 96% had two doses. At that point in time, in the majority of health authorities, there were only 1-2% of health care workers who were unvaccinated and on leave without pay. Subsequently, all health care workers have become vaccinated, except for those with medical deferral-based exemptions.

94. The Health-care Orders are an alternative to the significantly more restrictive public health measures that were imposed in LTC Facilities at earlier points in the pandemic, as noted in Dr. Emerson's affidavit, which measures had detrimental impacts, particularly on LTC Facility residents and their families, and which restrictions might otherwise need to be imposed in LTC Facilities, hospitals and in community care settings if the Orders were not in effect.

95. The PHO made the most recent iterations of the Health-care Orders on October 5, 2023. These orders are titled as follows: Hospital and Community (Health Care and Other Services)

COVID-19 Vaccination Status Information and Preventive Measures Order; and Residential Care COVID-19 Preventive Measures Order.

96. The new orders change the requirement for health-care workers to be considered vaccinated as the orders define it to include a single dose updated mRNA vaccine tailored to the XBB.1.5 variant, which is now recommended rather than a two dose primary series. The primary series vaccines will become unavailable once the XBB.1.5 vaccine is available.

97. Anyone seeking to work as a staff member must receive the XBB.1.5 formulation or obtain a medical deferral-based exemption. However, those health care workers who were defined as vaccinated under the previous orders will not be required to take the XBB.1.5 dose, though it is highly recommended. As noted below, this is because there is a high level of immunity amongst those already working within the health-care sector and there are "so many different permutations and combinations" of immunity that there is "no one single thing that you could do that would make it work for everybody".[94]

G. The evidence concerning the impact if the Health-care Orders are rescinded

98. Omicron (B.1.1.529) emerged globally in late November 2021 and was designated by the WHO as a new variant of concern on November 26, 2021.

99. Omicron was first detected in British Columbia in late November 2021. As of late December 2021, Omicron was the dominant variant of concern circulating in British Columbia.

100. The scientific, medical and public health communities worked to better understand different aspects of Omicron, including its transmissibility, whether it can evade immunity provided by our current vaccine regimes or immunity gained from prior COVID-19 infection, and the severity of disease, namely whether Omicron causes more severe disease when compared to other variants, including Delta.

101. Based on Dr. Emerson's review of the available scientific evidence, modelling, and other data regarding Omicron, it appears that:

a. Omicron is 2-4 times more transmissible than Delta;

b. Omicron rapidly spreads through populations due to being highly transmissible, including being transmitted before people develop symptoms, and having a shorter incubation period (about 3 days) which renders contact tracing and isolation less effective;

[94] Miller #1, Exhibit AA at p. 202.

c. Omicron has the ability to escape immunity from prior infection from another strain of SARS-CoV-2;

d. 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;

e. Omicron appears to cause less severe illness in vaccinated individuals than prior variants, including Delta; and

f. while Omicron may cause less severe illness in vaccinated people, it still has the potential to lead to severe illness in people who are unvaccinated and in vulnerable populations, for example in elderly people or people with pre-existing health conditions or who are immunocompromised, regardless of vaccination status.

102. Omicron's greater transmissibility alone, or in combination with reduced protection from prior infection or vaccine, drove an unprecedented fifth wave of COVID-19 in British Columbia, with case rates and hospitalizations far in excess of those seen at any prior stage of the pandemic, and which impacted all facets of the pandemic response, including testing capacity, contact tracing, and capacity within the health care system both in terms of the system's ability to provide health-care to patients across the spectrum and staffing within the system itself due to absenteeism because of COVID-19. [95]

103. On December 14, 2021, the PHO provided an updated modelling presentation regarding the current state of British Columbia's COVID-19 pandemic.

104. On January 14, 2022, the PHO provided further updated modelling regarding the current state of British Columbia's COVID-19 pandemic.

105. On January 21, 2021, the PHO provided further information about hospitalization risk during the current wave of the pandemic.

106. The data contained in the December 14, 2021 modelling presentation (in particular at pages 9, 13, 16-20 and 22) and the January 14, 2022 modelling presentation (in particular at pages 9-15), illustrates the importance of vaccination in terms of minimizing the risk of infection, hospitalization, critical care admission and death from COVID-19.[96]

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[95] Emerson #1 at paras. 140-144.
[96] Emerson #1 at paras. 145 and 146, Exhibit 62.

107. The data regarding Omicron suggested that similar dynamics were at work in terms of the effect of vaccination, in that people with two or three doses of vaccine are less likely to be infected and transmit virus than unvaccinated people. However, vaccinated people are more likely to be infected with Omicron than Delta, i.e. vaccination was more protective against infection with the Delta variant than the Omicron variant. Vaccination remains very effective against severe illness, hospitalization, acute care admission and death from Omicron.

108. As of September 28, 2023, the PHO referenced the XBB sublineage, which evolved from Omicron, that unvaccinated people remain at most risk for illness and hospitalization, the observation of again increasing COVID-19 rates, the fall respiratory virus season, and the need for vaccination of the health-care workforce to preserve it to provide care, including for the most vulnerable.[97]

109. The PHO and her team of advisors are continually analyzing the data and changing epidemiologic circumstances of British Columbia's COVID-19 pandemic and experiences from other jurisdictions with the goal of managing the ongoing pandemic in a manner that minimizes to the best extent possible the risk to individuals, to the health of the population and to our public health and health-care systems.

H. Variance of public health order reconsideration provisions

110. The PHO continually reviews the currently available and generally accepted scientific data to determine whether other measures, such as natural immunity, PCR testing or rapid antigen testing are as effective as vaccination in reducing the risk of transmission of SARS-CoV-2 and the severity of illness if infected. To date, the scientific data confirms that vaccination remains the most important tool we have to protect people from severe illness if infected with COVID-19, including the Delta and Omicron variants.

111. Over the course of the pandemic, the OPHO has received hundreds of requests under s. 43 of the *PHA.* In particular, the OPHO has received approximately 380 requests for reconsideration of the various orders implementing the vaccine mandate in health care settings, 360 requests related to the Gatherings and Events and Food and Liquor Serving Premises orders in respect of the vaccine card program and approximately 200 other requests for reconsideration relating to, among other things, limitations on gatherings and events and food and liquor premises from earlier in the pandemic.

[97] Miller #1, Exhibit AA at pp. 191-193.

112. Some of these requests are made based on a medical deferral or contraindication to vaccination, some are sought based on an individual or group's rights under the *Charter*, and many others seek reconsideration on other grounds or simply because they do not agree with the PHO's orders. In many cases, requests for reconsideration suggested alternative measures to those adopted by the PHO, such as rapid testing or reliance on natural immunity. Considering and determining each of these reconsideration requests occupies a significant amount of time and effort from multiple individuals within the OPHO and requires a decision of the PHO or her delegate. [98]

113. Given the amount of the OPHO and PHO'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, until the level of transmission, incidence of serious disease, and strain on the public health care system are significantly reduced.

114. Accordingly, on November 9, 2021, the PHO exercised her power under section 54(1)(h) of the *PHA* to issue a variance indicating she would 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. The variance has retroactive effect.

115. In the October 5, 2023 Health-care Orders, the PHO continued the variance and provided the following reasoning about the many complex considerations involved in her decision:

> After 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 anticipated onset of the respiratory virus season, the continuing reasonable probability of a resurgence of disease transmission with increases in serious outcomes, clusters and outbreaks of COVID-19 and resulting strain this would place upon the public health and health care systems, and the risk inherent in accommodating persons who are not vaccinated, it is my reasonable belief that it is necessary that I limit requests for reconsideration of this Order to those made by an individual on the basis

[98] Emerson #11 at paras. 123-125.

> that vaccination would so seriously jeopardize the individual's health that the risk to the individual's health posed by vaccination outweighs the benefit.[99]

III. ARGUMENT

A. Overview

116. In the respondents' submission, the PHO's exercise of her authority under the *PHA* and her decision implementing a vaccine requirement were eminently reasonable on the record and reflect the unprecedented and difficult public health situation that is the onset and evolution of COVID-19 in British Columbia. The petitioners have not proven engagement or infringement of ss. 2(a), 7 or 15 of the *Charter*, and in any event the vaccination requirement is a reasonable and proportionate limit on those rights if they have been limited. On these bases, the respondents submit that the petitions should be dismissed.

B. Preliminary Issue: The Scope of the Record on Judicial Review

117. The petitioners in all three proceedings improperly urge this Court to make factual findings and scientific determinations that are outside the scope of this judicial review. The petitioners rely on extra-record evidence, hearsay evidence for the truth of its contents, and so-called expert evidence.

118. Judicial review under the *Judicial Review Procedure Act*,[100] is a review "on the record". The court is reviewing the reasonableness of a decision of a statutory decision maker, based on the information before that decision maker. The court does not undertake a fresh examination of the substantive issues.[101] Evidence beyond the scope of the record is generally inadmissible.

119. Judicial review does not require, or permit, civil action processes for determining facts. The discretion to look beyond the record must be exercised sparingly and only in exceptional circumstances.[102] Despite this principle, the petitioners seek to introduce and rely upon inadmissible and extra-record evidence. Among other categories, this evidence includes the following:

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[99] Miller #1, Exhibit B at p. 43.
[100] *Judicial Review Procedure Act,* R.S.B.C. 1996, c. 241 ("*JRPA*").
[101] *Air Canada v. British Columbia (Workers' Compensation Appeal Tribunal),* 2018 BCCA 387 ("*Air Canada*") at para. 34; *Beaudoin BCCA* at para. 154.
[102] *Li v. Virk,* 2023 BCSC 83 at para 37

a. Affidavits that seek to adduce evidence of facts that could have been provided to the decision maker but were not.[103]

b. Opinion evidence as to what the decision maker ought to have done.[104]

c. Purported expert evidence that would allow the petitioners to bypass the PHO without affording deference to her findings on the record before her.[105]

d. Affidavits based on information and belief, rather than personal knowledge.[106]

120. This Court has already considered the scope of the record properly before it and determined the PHO's record was appropriate for judicial review: *Canadian Society for the Advancement of Science in Public Policy v British Columbia*, 2023 BCSC 284. In that application, the Hsiang, Hoogerbrug and CSASPP petitioners unsuccessfully applied to add broad categories of documents to the record.

121. The record of proceeding that was before this Court on the preliminary application included two affidavits from Dr. Emerson and two additional affidavits appending press conference information from Ms. Dragland. During the course of the hearing, although not conceding the petitioners' arguments, the respondents agreed for expediency to strike certain paragraphs from Affidavit #1 of Dr. Emerson.

122. Nearly a year has passed since the December 2022 hearing. Consequently, the respondents have had to update the record. The record of proceeding now includes the following affidavits:

a. Emerson Affidavit #1 made September 13, 2022, except for portions struck by agreement.[107]

b. Dragland Affidavit #1 made September 15, 2022

c. Dragland Affidavit #2 made October 6, 2022.

d. Emerson Affidavit #2 made October 27, 2022.

e. Emerson Affidavit #3 made September 27, 2023.

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[103] *Sobeys West Inc. v. College of Pharmacists of British Columbia*, 2016 BCCA 41 at para. 52, leave to appeal refused 2016 CanLII 41773 (SCC)
[104] *Cypress Provincial Park Society v. Minister of Environment, Lands and Parks,* 2000 BCSC 466 at para. 5.
[105] *Beaudoin* (BCSC) at paras 100, 118; *Le et al. v. British Columbia (Attorney General),* BCSC Docket No. S217361, February 16, 2022 (chambers) at para 18
[106] Supreme Court Civil Rules 16-1(2) and (3), 22-2(12) and (13)
[107] The struck-through version was filed as Exhibit "C" to Dragland Affidavit #3 made September 27, 2023.

f. Miller Affidavit #1 made November 1, 2023 [this update would otherwise have been Emerson Affidavit #4].

123. The non-record affidavits filed by the petitioners are only admissible in three circumstances: (1) the evidence provides the factual matrix for the alleged *Charter* breaches, (2) the evidence fits into one of the rare exceptions to the rule against extra-record evidence, or (3) the parties reached agreement that the materials were before the PHO.

124. On the final point, the respondents agree that there may be limited documents in petitioner affidavits that were before the PHO such that they form part of the record. However, this does not elevate the documents to expert evidence or escape hearsay concerns.

125. Indeed, in its preliminary decision, this Court already determined that petitioners' affidavits included inadmissible extra-record evidence. For example, portions of Dr. Nordine's affidavit evidence was improper medical evidence and argument, while portions of Dr. Pelech's affidavit evidence were improper advocacy and opinion.[108] This Court already noted the Court of Appeal's caution against relying on extra-record evidence inconsistent with "the supervisory jurisdiction of the court and [placing] it in the "untenable position of assessing matters afresh on an expanded record."[109]

126. The respondents reiterate that, despite the petitioners' urging to the contrary, in assessing the PHO's orders, this Court must consider the materials that were before the PHO at the relevant time, and should not engage in its own assessment of extra-record materials that do not form part of the record and are otherwise inadmissible on judicial review.

C. Review of legal principles

127. Section 2 of the *JRPA* applies to this judicial review. That section provides:

> 2(1) An application for judicial review must be brought by way of a petition proceeding.
>
> (2) On an application for judicial review, the court may grant any relief that the applicant would be entitled to in any one or more of the proceedings for:
>
> (a) relief in the nature of mandamus, prohibition or certiorari;
>
> (b) a declaration or injunction, or both, in relation to the exercise, refusal to exercise, or proposed or purported exercise, of a statutory power.

128. Relief in mandamus is not available in these circumstances, nor are *Charter* damages.[110]The relief sought should properly be in respect of the October 5, 2023 Orders,

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[108] *CSASPP v. BC*, 2023 BCSC 284 at paras 82-96.
[109] *CSASPP v. BC*, 2023 BCSC 284 at paras 82-96.
[110] *Rogers Communication Inc. v. British Columbia (Assessors of Areas #01, 08, 09, 11, 11, 14, 15, 20, 22, 23, 45, 50 and 53)*, 2022 BCSC 1688 ("*Rogers Communications*") at paras. 42-43.

because earlier iterations of the Orders no longer exist and so relief in respect of them is moot. These submissions address the relief sought in further detail below.

129. The petition is a challenge to the constitutionality of the Health-care Orders themselves, not the enabling provisions of the *PHA.* The parties agree that the standard of review is reasonableness.[111]

130. In *Beaudoin BCCA*, the Court of Appeal observed that reasonableness review should include "thoughtful deference that recognizes the complexity of the problem presented to public officials, and the challenges associated with crafting a solution". The Court of Appeal also wrote[112]:

> While a decision maker's expertise is no longer relevant in determining the standard of review, the specialized knowledge and experience possessed by a decision maker remains a relevant consideration in conducting reasonableness review—one that calls for an understanding of the institutional limitations of the court and a correspondingly respectful measure of judicial deference [citations omitted].
>
> In the public health context, courts have consistently acknowledged the specialized expertise of public health officials and the need to judicially review decisions made by them in emergent circumstances with a degree of judicial humility.

D. The PHO's powers under the *PHA* – Notice of Regional Event for COVID-19

131. The Hsiang and Hoogerbrug petitioners focus much of their argument on whether a public health emergency still exists in a general sense. They rely on both admissible evidence and extra-record inadmissible evidence to attempt to demonstrate that there is no longer an emergency.

132. However, the Court's task on this judicial review is not to determine whether there was or is an emergency. It is to determine the reasonableness and *Charter* compliance of the PHO's decisions.

133. The statutory context is the starting point. The Health-care Orders are enacted pursuant to section 52 of the *PHA,* which falls under Part 5 – Emergency Powers. Section 51 of Part 5 defines a "regional event" as an immediate and significant risk to public health throughout a region or the province.

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[110] *Yang v. Real Estate Council of British Columbia*, 2019 BCCA 43 ("*Yang*") at paras. 35-37.
[111] Petitioners' written submissions at paras. 90-91; *Beaudoin BCCA* at para. 142.
[112] *Beaudoin BCCA* at paras. 149-151.

134. Section 52 of Part 5 provides that to exercise her powers under Part 5 in respect of the regional event, the PHO must provide notice that she "reasonably believes" at least two of the following criteria are met:

a. the regional event could have a serious impact on public health;

b. the regional event is unusual or unexpected;

c. there is significant risk of the spread of an infectious agent or a hazardous agent;

d. there is a significant risk of travel or trade restrictions as a result of the regional event.

135. The petitioners misconstrue issues that are before the Court for determination. They effectively ask this Court to assess scientific evidence, including extra-record materials that post-date the October 5 orders,[113] to make a finding as to whether the criteria are satisfied. That is misguided and improper for three reasons.

136. First, this is a judicial review. The Court's task is to review the reasonableness of the PHO's orders. It would be an error of law for the Court to undertake its own analysis, devoid of the PHO's specialized medical and scientific expertise, of whether the criteria *in fact* exist.

137. Second, the Section 52 Notice of Regional Event is not under judicial review. The Court is not tasked with determining the reasonableness of the issuance of the notice. To the contrary, the existence of the notice of regional event is an underlying fact forming part of the context for the Health-care Orders. While the Court can consider the PHO's reasoning to see if it is rational and logical, it cannot go behind the underlying facts to make its own finding. The "fact" here is that the PHO's made an informed opinion that the section 52 threshold was met. The resulting Health-care Orders are what are challenged in the petitions.

138. Third, the statutory language itself plainly does not require that the criteria must *in fact* exist to engage the PHO's powers. Section 52 requires that the PHO have a "reasonable belief" that the criteria exist. Provided that the PHO formed that reasonable belief, it is not determinative whether the Court could find that any of the individual criteria are met on its own assessment. The question for the Court is whether the PHO's "reasonable belief" was reasonable.

139. The PHO's reasonable belief was reasonable, as explained in detail below in the respondent's reasonableness submission, but including:

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[113] For example, on page 26 of their written submissions, the petitioners rely on an October 30, 2023 paper (Harney #6, Exhibit M). On page 27, the petitioners rely on a graph from the November 2, 2023 COVID-19 Situation Report. This graph does not appear to be in the evidence.

a. SARS-CoV-2, the virus that causes COVID-19, is an infectious agent with a significant and proven risk of spread;

b. SARS-CoV-2 has and could continue to have an impact on public health:

   i. vulnerable populations and unvaccinated persons remaining at increased risk of illness, hospitalization and death, and

   ii. the impacts upon the health care system have occurred and continue with potential for more closures and system stresses, impacting the ability to provide care for all care needs.

140. For the foregoing reasons, it is unnecessary and inappropriate for the Court to consider the Hsiang petitioners' efforts at pages 16-43 of their submissions to embark on a *de novo* fact-finding mission. (There is also the obvious problem that the petitioners rely on inadmissible "expert" evidence and materials that post-date the October 5 orders).

E. The reasonableness of the Health-care Orders and their vaccination requirements

i. Reasonableness review

141. The petitioners bear the burden of establishing that the Health-care Orders are unreasonable. They must establish a failure of rationality internal to the reasoning process, or that the Health-care Orders cannot be justified in light of the factual or legal constraints.[114] Reasonableness review begins with the reasons of the decision maker and prioritizes the decision maker's justification for its decisions.

ii. Court should not exercise its discretion to review repealed orders

142. The Tatlock Petitioners continue to challenge, and focus their argument in large part on, prior versions of the Health-care Orders that have been repealed and replaced. This includes orders dating back to the fall of 2021.

143. As these orders are no longer in force, the Tatlock Petitioners' challenge to prior orders should be dismissed as moot. A court may decline to hear a case that raises only a hypothetical or abstract question, the determination of which will not resolve a tangible controversy affecting the parties' rights.[115]

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[114] *Vavilov* at paras. 101-107.

[115] *Independent Contractors and Businesses Association v. British Columbia (Attorney General)*, 2020 BCCA 245 at paras. 8, 17 and 21.

144. The two-step test for determining whether a proceeding ought to be dismissed as moot was set out by the Court in *Borowski v. Canada (Attorney General)*.[116] The first step involves an inquiry into whether the required tangible and concrete dispute has disappeared so as to make the issues academic. If there is no live controversy, the second step involves an inquiry into whether the Court should exercise its discretion to decide the merits of the case nonetheless.

145. The first step of the test is satisfied in the circumstances. The prior orders are no longer in force and, as a result, the issues regarding those orders are academic. As the Court of Appeal recently held, the question of whether a law that has long been rescinded was constitutional is "a moot one".[117]

146. Under the second step of the test, the Court should not exercise its discretion to decide the merits of the Tatlock Petitioners' challenge to the prior orders in any event. An assessment of the prior orders would serve no purpose, particularly in light of the petitioners' challenge to the October 5, 2023 orders which remain in place.

147. Importantly, consideration of the prior orders would be contrary to judicial economy. It would require the Court to assess *each* order, on numerous bases, in light of the particular reasons and the materials available to the PHO during *each* relevant time period.

148. As there are 12 prior orders at issue, and the Tatlock Petitioners challenge each of these orders as unreasonably limiting ss. 2(a), 7 and 15(1) of the *Charter*, on these grounds alone the Court would be required to engage in at least 36 separate analyses, even if there was only <u>one</u> petitioner raising the issues.

149. This review would ultimately serve no purpose. As a result, the Court ought to only consider the October 5, 2023 orders.

iii. Petitioners' Approach is Misguided

150. In assessing the reasonableness of the Health-care Orders, the petitioners, in essence, ask this Court to review technical and complex scientific materials to engage in its own assessment of the Orders.[118] This approach is misguided and inconsistent with the Court's role in carrying out reasonableness review.

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[116] *Borowski v. Canada (Attorney General)*, [1989] 1 SCR 342 at 353; *Peckford* v. *Canada (Attorney General),* 2023 FCA 219 (CanLII).
[117] *Kassian v. British Columbia*, 2023 BCCA 383 at para. 33.
[118] See, for example, the Hsiang/Hoogerbrug petitioners' heading: "science behind covid vaccinations and Omicron – what we have learned".

151. The existence of competing opinions on scientific or medical matters does not render the Health-care Orders unreasonable. The opinion evidence proffered by the petitioners is, at best, an alternate view of the risks that have been considered and weighed by the PHO in making the Health-care Orders.[119]

152. The petitioners' approach is similar to the failed effort in Ontario to argue that a directive requiring personal protective equipment due to COVID-19 was unreasonable because the understanding of COVID-19 was evolving.[120]

153. Moreover, the petitioners argue that there is "a higher burden of reasonableness where an administrative decision maker is exercising extraordinary powers that, in the case of a valid and ongoing emergency, authorize highly intrusive and extreme measures that can have a significant and harmful impact on the rights, liberties, and interests of members of the population".[121] In doing so, the petitioners focus solely on those subject to the order who "make the personal medical decision to not be vaccinated".

154. However, the Orders have broader implications. Most importantly, the Health-care Orders, as set out in more detail below, are intended to reduce risk for those most vulnerable to serious illness and death from infection with SARS-CoV-2. While the loss of employment within the public health and residential care systems may be significant for those who choose to remain unvaccinated, consideration must also be given to the significant interests of those requiring care.

iv. PHO is Entitled to Considerable Deference in Matters of Science and Medicine

155. Although a decision maker's expertise is no longer relevant in determining the standard of review, specialized knowledge and experience possessed by a decision maker remains a relevant consideration in conducting reasonableness review – one that, as noted by our Court of Appeal, calls for an understanding of the institutional limitations of the court and "a correspondingly respectful measure of judicial deference".[122]

156. The PHO is entitled to deference in the matters of science and medicine.[123] The situation does not call for blind or absolute deference from the courts, but "a thoughtful deference that

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[119] *Doré* at para. 56; *Beaudoin* at paras. 124-125
[120] *Ontario Nurses*.
[121] Hsiang/Hoogerbrug Written Submissions at para. 278.
[122] *Beaudoin BCCA* at para. 149 citing *Vavilov* at paras. 31, 75, 93 and *Air Canada* at para. 36.
[123] The PHO's curriculum vitae can be found at Emerson #1, Exhibit 2 at pp. 8-18.

recognizes the complexity of the problem presented to public officials, and the challenges associated with crafting a solution".[124]

157. Courts have consistently acknowledged the specialized expertise of public health officials and the need to judicially review decisions made by them in emergent circumstances "with a degree of judicial humility".[125] As recognized in *Trinity Bible* and affirmed by our Court of Appeal in *Beaudoin*, the court's role is "not that of an armchair epidemiologist"; it is not equipped to resolve scientific debates and controversy surrounding COVID-19.[126]

v. PHO's Authority Under the Public Health Act

158. As noted above, "public health" is one component of British Columbia's health system. It shares the same overall goals of other parts of the system including reducing premature death and minimizing the effects of disease, disability and injury. The focus of public health, however, is on the health of populations as a whole, rather than providing health care to individuals.[127] One goal in particular is to prevent and manage outbreaks of disease within the population.[128]

159. In Canada, public health programs share a common set of principles, values and ethics which public health officials are expected to follow in their decision-making.[129] As noted above, a core principle is the Precautionary Principle which provides that in the face of scientific uncertainty, public health interventions may be warranted when there is a risk of harm to the population even before all scientific data are obtained to confirm the risk.

160. The *PHA* provides the PHO with broad authority in relation to public health matters. Relevant to this proceeding, under s. 30(1), the PHO may issue an order under Division 4 of the *PHA* (orders respecting health hazards and contraventions) if she reasonably believes that a "health hazard" exists or "a condition, a thing or an activity presents a significant risk of causing a health hazard". A "health hazard" is defined in s. 1 as including a "condition, a thing or an activity" that:

> (i) endangers, or is likely to endanger, public health, or
>
> (ii) interferes, or is likely to interfere, with the suppression of infectious agents or hazardous agents.

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[124] *Beaudoin BCCA* at para. 151 citing *Trinity Bible (ONSC)* at para. 6.
[125] *Beaudoin BCCA* at para. 150.
[126] *Trinity Bible (ONSC)* at para. 6; *Beaudoin* at para. 156.
[127] Emerson #1 at para. 4.
[128] Emerson #1 at para. 5.
[129] Emerson #1 at para. 6.

161. Section 31 of the *PHA* sets out the PHO's general powers respecting health hazards and contraventions.[130] If the circumstances in s. 30 are satisfied, under s. 31(1) the PHO may order a person[131] to do anything that she reasonably believes is necessary to, among other things, prevent or stop a health hazard, or mitigate the harm or prevent further harm from a health hazard. Section 32 sets out a list of specific powers respecting health hazards and contraventions without limiting s. 31.

162. While s. 43 provides that a person affected by an order may request a reconsideration of the order in certain circumstances, s. 54 allows the PHO in an emergency to not reconsider an order under s. 43, not review an order under s. 44, or not reassess an order under s. 45.

vi. The October 5, 2023 Orders are Reasonable

163. The PHO's reasoning, as set out in the Health-care Orders and explained in her public briefings (collectively the "**Reasons**"), reveal a rational and coherent chain of analysis. The Health-care Orders are justified in light of the relevant factual and legal constraints. The petitioners' challenge on administrative law grounds must be dismissed.

164. Broadly speaking, the Health-care Orders are informed by the following considerations which will be addressed in more detail below:

a. epidemiology of COVID-19;

b. vaccination importance and effectiveness;

c. post-infection immunity and testing;

d. patient vulnerability, resource use and health care system capacity; and

e. the balancing of competing interests.

165. The PHO's findings and rationale for issuing the Health-care Orders are supported by the information available to her at the time the Health-care Orders were made, including without limitation the epidemiology in British Columbia, scientific literature, evidence of outbreaks in LTC Facilities both in British Columbia and other jurisdictions, the impact of prior restrictions on LTC Facilities, the risks associated with vulnerable populations contracting COVID-19, and the impact on the health care system of staff becoming infected with COVID-19.

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[130] The provisions refer to a "health officer"; however, s. 67 of the *PHA* provides that the PHO may exercise a power or perform a duty of a medical health officer in certain circumstances, including during an emergency under Part 5 of the *PHA*.

[131] Section 39(3) specifies that an order may be made in respect of a class of persons.

vii. Epidemiology of COVID-19

166. In making the Health-care Orders, the PHO considered the current epidemiology of COVID-19, including the ongoing unpredictability of SARS-CoV-2, the continuing emergence of variants, the need to protect those who are particularly vulnerable to infection with SARS-CoV-2, and the need to maintain capacity of the health-care system by reducing illness in the workforce. In particular, the PHO stated in the Recitals:

> C. People over 65 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;
>
> D. Adults and children who are particularly vulnerable to infection with SARS-CoV-2 depend upon the people with whom they come into contact to protect them from the risk of infection;
>
> …
>
> G. The emergence of the Omicron variants introduced uncertainty into the course of the pandemic. The suddenness of the arrival of the first Omicron variant and its swift and significant impact on the level of infection, hospitalization and ICU admission rates in British Columbia, and the greater level of transmissibly of subsequent Omicron variants, reflects the unpredictability of SARS-CoV2, and this uncertainty has led me to conclude that I must exercise caution when determining what measures continue to be necessary to mitigate the extent of the virus's transmission, and to reduce the severity of disease which it causes;
>
> H. Chief among these measures is vaccination, and I am of the opinion that any slippage in the level of vaccination in the health-care workforce could result in significant illness on the part of the health-care workforce which would undermine the capacity of the health-care system to respond to a significant resurgence of disease;
>
> I. There continues to be a reasonable probability of the emergence of virulent variants that could result in a significant resurgence of disease in the province;
>
> J. On May 5, 2023, the World Health Organization ("WHO") issued a statement that the WHO Director-General, relying on the advice offered in the Report of the fifteenth meeting of the International Health Regulations (2005) (IHR) Emergency Committee regarding the COVID-19 pandemic, declared an end to the public health emergency of international concern;
>
> K. At the same time, however, in his statement the WHO Director-General made it most clear that this change "does not mean COVID-19 is over as a global health threat" and stated that: "This virus is here to stay. It is still killing, and it's still changing. The risk remains of new variants emerging that cause new surges in cases and deaths. The worst thing any country could do now is to use this

> news as a reason to let down its guard, to dismantle the systems it has built, or to send the message to its people that COVID-19 is nothing to worry about.";
>
> [Emphasis added.]

167. The PHO's conclusions on the current epidemiology are grounded in the materials that were available to her. For example, in its report titled "Guidance on the use of COVID-19 vaccines in the fall of 2023" (the "Fall 2023 NACI Report"),[132] NACI states, based on the available scientific literature, that the evolutionary trajectory of SARS-CoV-2 remains uncertain, with recombinant XBB sub-lineages continuing to circulate in Canada and globally.[133],[134]

168. NACI notes that rates of hospitalization and deaths in Canada from COVID-19 continue to be highest for adults 65 years of age and older, with risk increasing with age and highest among those 80 years or older and those who are unvaccinated.[135] In addition to age, vaccination status and prior infection, NACI states that studies looking at risk factors continue to show that individuals with comorbidities are at highest risk for severe outcomes due to COVID-19 in adults.

169. Importantly, NACI also concludes that vaccination of individuals at lower risk for severe disease may provide additional benefit to those at higher risk through indirect protection, particularly shortly after vaccination and in the context of hybrid immunity when protection from infection is greater.[136]

viii. Vaccination Importance and Effectiveness

170. The PHO also considered the importance and effectiveness of vaccination including the reduction in transmission, severe illness and long-term effects of COVID-19 and the need to minimize disruption in the health-care sector caused by absenteeism. At Recitals M-U, the PHO stated:

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[132] Miller #1, Exhibit I at p. 91. NACI is a national advisory committee of experts in the fields of pediatrics, infectious diseases, immunology, pharmacy, nursing, epidemiology, Pharmacoeconomics, social sciences and public health that provides guidance on the use of vaccines in Canada to the Government of Canada. NACI's independent advice and recommendations are said to be based on the best current available scientific knowledge.

[133] Miller #1, Exhibit I at p. 95.

[134] The frequent evolution of the Omicron sublineages is also noted, among other places, in the Office of the Chief Science Officer's Omicron Scans of Evidence. For example, Scan of Evidence #25 covering March 2-9, 2022 notes the detection of the BA.1, BA1.1, BA.2, and BA. 3, while Scan of Evidence #32 covering April 20-27, 2022 cites additional lineages including BA.4, BA.5 and reports of "recombinant lineages" known as XD and XE. Scan of Evidence #32 also provides that several Omicron variants have been "flagged as having concerning growth over circulating Omicron variants (mainly BA.2)" (Emerson #2 at Exhibits EE-LL).

[135] Miller #1, Exhibit I at p. 95.

[136] Miller #1, Exhibit I at p. 101.

M. 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. …

N. 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. 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.

O. 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.

…

Q. 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;

…

T. 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;

> U. 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;
>
> [Emphasis added.]

171. Again, the PHO's conclusions regarding the importance and safety of vaccination are grounded in the record. In a literature review titled "Impacts of COVID-19 Vaccination on Health Care Worker SARS-CoV-2 Transmission" dated September 8, 2022,[137] Dr. Naomi Dove notes that numerous COVID-19 outbreaks have occurred in health care settings in the province, with health-care workers identified as a common source of transmission.

172. Dr. Dove further notes that health-care workers have experienced a "considerable burden of SARS-CoV-2 infections during the COVID-19 pandemic that appeared to decline with vaccination".[138] Dr. Dove states that available studies suggest that fully vaccinated persons are less likely to become infected and contribute to SARS-CoV-2 transmission, with attenuated but still beneficial impact during the Omicron wave.[139]

173. With respect to seroprevalence of COVID-19 antibodies, a publication by the COVID-19 Immunity Task Force indicates that infection-acquired seroprevalence in Canada increased significantly between November 1, 2023 and February 14, 2023 from approximately 6.4% to 77.0%.[140] Those over 60, however, are less likely to have infection-acquired seroprevalence compared to younger age groups, meaning that fewer possess hybrid immunity.

174. Importantly, the Fall 2023 NACI Report expressly provides that vaccination of health-care providers and others who provide essential community services is expected to be important in maintaining the health system capacity.[141] NACI states that to the extent vaccination presents infection, it also prevents "post-COVID-19 condition" (also known as "long COVID"), as those who do not become infected do not develop the condition. Further, there is evidence that those who are vaccinated with at least two doses of the monovalent original COVID-19 vaccine before

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[137] Emerson #1, Exhibit 65.
[138] Emerson #1, Exhibit 65 at p. 2476.
[139] Emerson #1, Exhibit 65 at p. 2466.
[140] Affidavit #3 of Dr. Brian Emerson ("Emerson #3"), Exhibit AAA at p. 1991.
[141] Miller #1, Exhibit I, p. 101.

becoming infected are less likely to develop post COVID-19 condition than those who are not vaccinated before infection.[142]

175. In addition to reduced risk of infection and severe outcomes, which undoubtedly reduces disruption in the system, the paper titled "Vaccination Helps Reduce Workplace Absenteeism Among Canadian Health-care Workers", as summarized in the COVID-19 Immunity Task Force's September 1, 2023 report, provides that Canadian health-care workers who had a positive SARS-CoV-2 test and were vaccinated against COVID-19 were less absent from work. Absenteeism from work declined with each vaccine dose.[143]

176. With respect to additional doses, in her September 28, 2023 media briefing, the PHO explained that data indicates that most health care workers have had at least one booster and that most health care workers have hybrid immunity. The PHO noted that, as a result, there are "so many different permutations and combinations" of immunity that there is "no one single thing that you could do that would make it work for everybody". She stated that "we want to have a period of time between boosters and infection and the updated vaccine. So there's just too many combinations".[144]

ix. Post-Infection Immunity and Testing

177. The PHO addressed both post-infection immunity and testing in the Orders. The PHO noted that the strength and duration of post-infection immunity varies and that there is no reliable means of assessing the level of immunity which a person may have to re-infection or serious illness. She also considered asymptomatic testing, stating that there is a potential for false negatives leading to a false sense of security that an individual is not infected with in fact they are. In particular, the PHO reasoned:

> X. I have considered and continue to consider, based on the currently available generally accepted scientific evidence, whether other measures such as post-infection immunity, polymerase chain reaction (PCR) testing or rapid antigen testing, are as effective as vaccination in reducing the risk of transmission of SARS-Co-2, or the severity of illness, if a person is infected;
>
> Y. While people who have contracted SARS-CoV-2 may develop some post-infection immunity for a period of time following infection, the strength and duration of that immunity varies depending on a multitude of factors, including age, co-occurring medical conditions, medications being taken, which variant they were infected with, severity of infection, and time since infection;

[142] Miller #1, Exhibit I, p. 97.
[143] Miller #1 at p. 176.
[144] Miller #1, Exhibit AA at p. 202.

> Z. 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;
>
> AA. 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 with SARS-CoV-2;
>
> BB. 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;
>
> …
>
> DD. Although the wearing of personal protective equipment 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;
>
> …
>
> FF. There are difficulties and risks in accommodating a person who is unvaccinated, since no other measures are nearly as effective as vaccination in reducing the risk of contracting or transmitting SARS-CoV-2, and the likelihood of severe illness and death;
>
> [Emphasis added.]

178. Again, the record supports her conclusion that post-infection immunity and testing cannot effectively replace vaccination. For example, as set out in the summary of the May 9, 2022 article titled “Antibody Seronegativity in COVID-19 RT-PCR-Positive Children”,[145] scientific research suggests that COVID-19 infection does not always induce an immune response. The summary notes that approximately one in eight individuals with COVID-19 in the study did not develop antibodies detectable in blood serum as a result of infection.

179. In her literature review, Dr. Dove notes that although both SARS-CoV-2 infection and vaccination can induce an immune response that protects against symptomatic COVID-19 illness for at least six months, vaccination leads to a more consistent and reliable antibody response.[146]

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[145] Emerson #1, Exhibit 64 at p. 2462.
[146] Emerson #1, Exhibit 65 at pp. 2469-2470.

She states that global vaccine effectiveness studies show that vaccines provide “substantial and consistent protection against severe disease and infection due to SARS-CoV-2 that is well-maintained to 8-month post vaccination”.

180. Dr. Dove concludes that vaccination is likely the most consistent way to assure than an individual has immune protection and is less likely to transmit COVID-19, particularly with consideration of booster doses and the contribution of recent antigenic exposure through infection.

x. Patient Vulnerability, Resource Use and Health-care System Capacity

181. In addition to the above, the PHO considered the particular vulnerabilities of those living in residential care and those receiving health care, the need to manage demands on resources, and the proper functioning of residential facilities and the health care system as a whole.

182. For example, in making the Residential Care Order, the PHO stated the following:

> HH. Residents of facilities are typically elderly and usually have chronic health conditions or compromised immune systems which makes them particularly vulnerable to severe illness and death from COVID-19, even if they are vaccinated, since despite the fact that vaccination is the single most effective protection against illness, vaccination is not completely protective, and protection may wane with time;
>
> II. Their high level of vulnerability to infection with SARS-CoV-2 and risk of resulting serious illness distinguishes the situation of residents of facilities from that of young people in the general population, who are generally in robust good health. Accordingly, and by way of example, although the risk of transmission of infection and attendant illness created by the presence of unvaccinated post-secondary students in post-secondary environments does not require comprehensive vaccination as a measure of mitigation, the situation is completely different when it comes to the risk of transmission of infection and attendant illness created by the presence of unvaccinated people working or providing services in the residential care sector;
>
> JJ. Further, since vaccinated workers 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 residential facility sector;
>
> …
>
> MM. To avoid the risk of undermining the ability of the residential care sector to function safely and to properly care for residents, it is necessary to keep the number of unvaccinated people in the residential care workforce as low as

> possible, including among the members of the workforce who may have little or no direct contact with residents or other workers on a regular basis;
>
> …
>
> OO. Consequently, despite the currently lower level of illness in the general population caused by the Omicron variants, and the removal of widespread measures to mitigate the risk of infection both in British Columbia and elsewhere, in my opinion, any step back from the comprehensive vaccination of people working or providing services in the residential care sector would undermine the level of safety which comprehensive vaccination of the workforce has brought to these environments;
>
> [Emphasis added.]

183. In making the Hospital and Community Care Order, the PHO addressed the impacts on the hospital and community care system:

> GG. Ensuring safe hospital and community care is critical to the wellbeing of the public, as is protecting the ability of the hospital and community care sectors to function safely and efficiently, and the best means to achieve this is by having a highly vaccinated health-care workforce;
>
> …
>
> II. Both the public health and the health-care systems have been required to devote significant amounts of their resources to preventing and responding to COVID-19 due to the transmission of SARS-CoV-2 across the province, and to providing care for those who have become ill with COVID-19, who can be quite ill, require high levels of care and be hospitalized for long periods of time, which situation is exacerbated by the care needs of unvaccinated people who are at greater risk of hospitalization and ICU admission;
>
> JJ. Both the public health and health-care systems have experienced severe stress and been stretched beyond capacity in their efforts to prevent and respond to illness resulting from the transmission of COVID-19 in the population;
>
> KK. Preserving the ability of the public health and health-care systems to protect and care for the health needs of the population, including providing care for health needs other than COVID-19, is critical;
>
> LL. A high incidence of transmission and illness in one or more regions has previously 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;
>
> MM. The inroads which have been made on the backlog of surgeries and surgical wait times can only be sustained if the demands on the health-care system arising from COVID-19 related illness continue to be mitigated. Similarly, the need to focus its efforts on responding to the pandemic has

created a backlog of work for the public health system, including in the areas of childhood vaccination, overdose response measures and restaurant and other environmental health services related inspections, which the public health system will only be able to address if the incidence of COVID-19 continues to be mitigated;

…

OO. People receiving health care, personal care or home support in hospital or community settings are often of an advanced age or have chronic health conditions or compromised immune systems which make them particularly vulnerable to severe illness and death from COVID-19 even if they are vaccinated, and the evidence demonstrates that they are at risk of being infected by health- care workers;

…

RR. 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;

SS. 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;

TT. 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 could cause significant absenteeism among the workforce, thereby putting increased stress on the hospital and community care sectors and the health-care system;

UU. Consequently, despite the currently lower level of serious illness in the general population caused by the Omicron variants, and the removal of widespread measures to mitigate the risk of infection both in British Columbia and elsewhere, in my opinion, any step back from the comprehensive vaccination of people in the health-care workforce would undermine the level of safety and workforce preparedness and resiliency which comprehensive vaccination of the workforce has brought to the hospital and community care environments;

VV. The public needs to have confidence in the safety and integrity of the hospital and community care systems, and the knowledge that the health-care workforce is vaccinated is critical to establishing and maintaining this

> confidence on the part of those served by these systems, the workforce and the public;
>
> [Emphasis added.]

184. The strain on the health-care system throughout the COVID-19 pandemic is well-documented in the record. Most recently, in a September 28, 2023 media briefing, Minister Dix explained that the demand on the health care system has been growing significantly. In addition to an increase in the age and size of the population, the COVID-19 pandemic and the ongoing overdose public health emergency have contributed significantly to the demand on the system.[147] Noting the current strains on the system, Minister Dix stated that "we have to, as you would expect under these circumstances, continue to prepare and enhance those services this winter".[148]

xi. Balancing of competing interests

185. Finally, in both of the Health-care Orders, the PHO expressly acknowledges the effect which the orders may have on people who are unvaccinated. With that in mind, the PHO states that she continually engages in reconsideration of these measures based upon the information and evidence available to her, including scientific journals reflecting divergent opinions and opinions expressing contrary views to her own submitted in support of challenges to her orders, with a view to balancing the interests of those working or volunteering in the health-care sector against the risk of harm posed by unvaccinated people working or volunteering in those settings.[149]

186. Further, the PHO recognizes her obligation to choose measures that limit the *Charter* rights and freedoms of British Columbians less intrusively, and to balance these rights and interests in a way that is consistent with the protection of public health. She concludes that the measures put in place by the Orders are proportionate, rational and tailored to address the risk.[150]

xii. Conclusion on reasonableness

187. While the petitioners may disagree with the PHO's approach, there is no basis to find that the Health-care Orders are unreasonable. The Health-care Orders are justified in light of the legal and factual constraints on the PHO and represent a reasonable exercise of her discretion under the authority granted to her by the *PHA*. Moreover, the PHO's Reasons exhibit all the hallmarks

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[147] Miller #1 at Exhibit AA, p. 196.
[148] Miller #1 at Exhibit AA, p. 197.
[149] Hospital and Community Care Order, Recital WW; Residential Care Order, Recital RR.
[150] Hospital and Community Care Order, Recital YY; Residential Care Order, Recital TT.

of reasonability espoused by the Supreme Court of Canada in *Vavilov.* The PHO provides considered and internally coherent reasoning that is both rational and logical.

F. The Tatlock petitioners "remote work" distinction

188. The Tatlock petitioners add a nuance to their argument in that they frame their petition in terms of whether exemptions should be available to *remote* workers specifically. The respondents submit that an exemption on that basis is not defensible and that the Tatlock petitioners' evidence is insufficient for their argument.

i. Remote work

189. The central rationale for requiring vaccination of health care workers is that it protects the health of patients who require care. Another key public health purpose is to promote the integrity of the health care system, including preserving its ability to respond to all care needs.

190. Those care needs include serving vulnerable populations including people over age 70, and those with underlying conditions that suppress their immune systems even with vaccination against COVID-19. Those vulnerable populations, and all other British Columbians, access their care through the BC health care system.

191. The vaccination requirement for all health care workers, whether they work remotely or in person, has several proven public health and health care system impacts:

192. As a statistical matter, a vaccinated health-care workforce is less likely to get sick and will likely have less severe sickness.[151]

193. Vaccination against COVID-19 continues to be demonstrated to reduce both the severity and duration of illness,[152] meaning a vaccinated health care workforce will lose less of its capacity to provide care for all care needs.

194. Since epidemics and pandemics, including the COVID-19 pandemic, put pressure on the capacity of the health-care system – and since this pressure is correlated with outbreaks of

[151] Miller #1, Exhibit I at p. 95, "An Advisory Committee Statement (ACS) National Advisory Committee on Immunization (NACI) – Guidance on the use of COVID-19 vaccines in the fall of 2023: based on scientific literature as of May 19, 2023: "Rates of hospitalization and deaths in Canada continue to be highest for adults 65 years of age and older, with risk increasing with age and highest among those over 80 years and those who are unvaccinated … Rates of infection and severe disease are lowest for those recently vaccinated and those with hybrid immunity…"

[152] Miller #1, Exhibit V, COVID-19 Immunity Task Force article "Vaccination helps reduce workplace absenteeism among Canadian health-care workers", a summary of a study reporting that among 1454 health-care workers in British Columbia, Alberta, Quebec and Ontario, days off work reduced as the number of vaccine doses increased, and time off work was unrelated to sex, age, marital status or having a child at home. Most cases of COVID-19 captured by the study were in 2022. Time off work was longer when symptoms were more severe.

COVID-19 – a vaccinated workforce is better able to provide health care for COVID and non-COVID-19 care needs for all British Columbians, including at times of extreme stress on the health care system.[153]

195. A vaccinated health-care workforce will be less likely to infect vulnerable patients and thereby more likely to keep them healthy and safe from preventable COVID-19 infection, severe outcomes and death.[154]

196. In the Health-care Orders, the PHO gave detailed reasons for requiring vaccination across the health care workforce. Most recently, in the October 5, 2023 Orders, the PHO explained:

a. 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.[155]

b. 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.[156]

c. 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).[157]

d. 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.[158]

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[153] Miller #1, Exhibit AA at p. 199, bottom four paragraphs highlighting the unique risks involved in the health-care setting.
[154] Emerson #1 at para. 54.
[155] Miller #1, Exhibit B at p. 24, Recitals C-G.
[156] Miller #1, Exhibit B at p. 24, Recital H.
[157] Miller #1, Exhibit B at pp. 24 and 25, Recital L.
[158] Miller #1, Exhibit B at pp. 25 and 26, Recitals M-T, and p. 27, Recitals GG-VV.

ii. Application To the Petitioners

197. Only the Tatlock petitioners argue that the Orders should have made provision to exempt health care workers who work remotely from the COVID-19 vaccination requirement. However, most of the Tatlock petitioners do not work in remote settings:

a. Phyllis Janet Tatlock – Not remote. Registered Nurse. Director of Operations, BC Cancer, Provincial Health Services Authority (PHSA).[159]

b. Laura Koop – Not remote. Primary care Nurse Practitioner at Creston Valley Hospital building.[160]

c. Scott Macdonald – Not remote. Registered Art Therapist at Vancouver's Dr. Peter Centre.[161]

d. Lynda June Hamley – Not remote. Residential support worker in a group home setting, at Kootenay Society of Community Living.[162]

e. Melina Joy Parenteau – Not remote. Registered Midwife who worked as a private contractor for Apple Tree Maternity in Nelson, BC.[163]

f. Dr. Joshua Nordine – Not remote. Family Physician who worked at Bridge Detox Centre in Kelowna.[164]

198. Only five petitioners provided evidence that they worked remotely at the time that they each decided not to be vaccinated against COVID-19:

a. Monika Bielecki was an Employee Health and Wellness Advisor with Interior Health Authority (IHA), who deposed that she worked entirely from home since 2016, but then referenced attending occasional *in person* team meetings until 2019.[165]

b. Ana Lucia Mateus was an Administrative Assistant for a Health Authority Medical Advisory Committee in Vancouver Coastal Health. Ms. Mateus worked from home from March 13, 2020 due to the COVID-19 pandemic and the public health protocols her employer implemented.[166]

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[159] Phyllis Janet Tatlock Affidavit #1 at paras. 1 and 2.
[160] Laura Koop Affidavit #1 at paras. 1 and 2.
[161] Scott Macdonald Affidavit #1 at paras. 1 and 2.
[162] Lynda June Hamley Affidavit #1 at para. 3.
[163] Melinda Joy Parenteau Affidavit #1 at para. 1.
[164] Joshua Nordine Affidavit #1 at paras. 2-5.
[165] Monika Bielecki Affidavit #1 at paras. 1, 5 and 7.
[166] Ana Lucia Mateus Affidavit #1 at paras. 2 and 5

c. Lori Jane Nelson was a Senior Director - Provider Engagement Lead, Clinical Informatics who worked remotely[167]. However, Ms. Nelson's Flexible Work Options Agreement shows 4 days a week, and that she may have to attend in a mixture of settings including BC Childrens and Womens Hospital or other PHSA sites, as required for her role.[168] Ms. Nelson has nursing and other training, and previously worked as a general duty nurse and clinical nurse coordinator.[169]

d. Ingeborg Keyser was a Communications Advisor for the IHA. Ms. Keyser worked entirely from home (permanent, half-day role), due to the COVID-19 pandemic, starting in February 2021. Prior to that she worked in an Interior Heath Authority office within a Community & Health Services Centre, in Kelowna. [170]

e. Darold Sturgeon was an Executive Director, Medical Affairs for the IHA in Kelowna. Mr. Sturgeon worked remotely for his last 2 years in that role.[171]

199. To the extent that these petitioners' evidence is internally inconsistent as to their remote work (i.e. where some did come into physical care settings from time to time), it underscores the PHO's observations about the difficulty in accommodating exemptions for anything other than medial deferral.

200. The evidence does not prove that the petitioners' work arrangements would have remained 100% remote, had they elected to become vaccinated. Rather the Flexible Work Options Agreements indicate they are renewable on mutual agreement of the employer and employee only, and subject to change.

201. All five remote worker petitioners are in roles that underpin the functioning of the health care system to provide care for vulnerable patients and all care needs, whether directly or by supporting the apparatus and infrastructure necessary for continuity in respect of health care workers with direct patient care roles. As such, their roles fall properly within the public health rationales for requiring vaccination, articulated by the PHO, to (a) protect the health of patients, including the vulnerable, and (b) preserve the health care system's integrity to provide care for all British Columbians.

202. The health care system is interconnected within and between health authorities across the Province. The health care system must be reliable and nimble as demand changes and to ensure

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[167] Lori Jane Nelson Affidavit #1 at para. 2.
[168] Lori Jane Nelson Affidavit #1 at para. 6 and Exhibit A, p. 2.
[169] Lori Jane Nelson Affidavit #1 at para. 5.
[170] Ingeborg Keyser Affidavit #1 at para. 5.
[171] Darold Sturgeon Affidavit #1 at paras. 5 and 6.

that safe patient care is provided. Given current evidence about COVID-19, the PHO's requirement for all health care workers to be vaccinated, except those with medical deferrals, is necessary and reasonable to (a) protect patients including vulnerable populations, (b) preserve health care system capacity and (c) the ability to provide safe care for all needs.

iv. CHARTER ISSUES

G. Section 2(a)

i. The evidentiary failings

203. The petitioners have not adduced a sufficient evidentiary foundation upon which the Court could determine the alleged *Charter* breaches. This is fatal to judicial review on *Charter* grounds as the court will not determine constitutional questions absent properly particularized pleadings and in an evidentiary vacuum.[172]

204. The petitioners' failure to properly plead or establish on the evidence any limitation of their *Charter* rights is dispositive of the relief sought in the petition.

205. The respondents deny that the petitioners' *Charter* rights were engaged or infringed by the Health-care Orders, as alleged or at all, and says that if any infringement of *Charter* rights occurred, the Health-care Orders properly balanced those rights in accordance with s. 1 of the *Charter*. As this Court recently held, the PHO's guidance, advice and policies are "firmly rooted in current scientific knowledge and best practices".[173]

ii. Governing principles

206. Section 2(a) of the *Charter* guarantees the fundamental freedom of freedom of conscience and religion. The purpose of the provision is to prevent interference with profoundly held personal beliefs that govern one's perception of oneself, humankind, nature, and, in some cases, a higher or different order of being.[174]

207. This provision guarantees freedom to hold religious or conscientious beliefs and freedom of religious practice, but it does <u>not</u> indemnify practitioners against all costs incidental to the

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[172] *AAA Action Movers (2008) Inc. v. Walker*, 2021 BCCA 400 ("*AAA Action Movers*") at paras. 32-33; *MacKay v. Manitoba*, [1989] 2 S.C.R. 357 at 361; *Danson v. Ontario (Attorney General)*, [1990] 2 S.C.R. 1086; *Cambie Surgeries Corporation v. British Columbia (Attorney General),* 2018 BCCA 385 at paras. 49-55.

[173] *Trest v. British Columbia (Minister of Health),* 2020 BCSC 1524, at para. 91.

[174] *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37 ("*Hutterian Brethren*") at para. 32.

practice of religion.[175] 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".[176]

208. To establish an infringement of s. 2(a), a claimant must demonstrate two things:[177]

a. First, the claimant must prove that they hold a sincere belief that has a nexus with religion.

b. Second, the claimant must show that the conduct at issue interferes with the claimant's ability to act in accordance with their practice or belief in a manner that is "more than trivial or insubstantial".

209. At the first stage of the analysis, the Court should avoid determining the content of a religious obligation; however, the evidence must show that the claimant sincerely believes that a certain belief or practice is required by their religion.[178]

210. At the second stage, while s. 2(a) does not expressly qualify the scope of the guarantee, the Supreme Court of Canada has held that not every limit on religion will run afoul of the *Charter*. There must be a functional and qualitative assessment of the extent to which religious freedom is *actually* threatened or constrained.[179]

211. A law that merely creates an inconvenience for or imposes a cost on religious adherents will not make out an infringement. As the Court explained in *Hutterian Brethren*, a law may impose costs on a religious practitioner in terms of "money, tradition or inconvenience". However, these costs may still leave the adherent with a meaningful choice concerning the religious practice at issue. The *Charter* guarantees freedom of religion; it does not indemnify practitioners against all costs incidental to the practice.[180]

212. Section 2(a) of the *Charter* guarantees the fundamental freedom of freedom of conscience and religion. The purpose of the provision is to prevent interference with profoundly held personal beliefs that govern one's perception of oneself, humankind, nature, and, in some cases, a higher or different order of being.[181] This provision guarantees freedom to hold religious or conscientious beliefs and freedom of religious practice, but it does not guarantee the object of beliefs.[182]

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[175] *Hutterian Brethren* at para. 95.
[176] R. v. Edwards Books and Art Ltd., 1986 CanLII 12 (SCC) at p. 759, per Dickson C.J.
[177] *Hutterian Brethren* at para. 32 citing *Syndicat Northcrest v. Amselen*, 2004 SCC 47 ("*Amselen*").
[178] *Servatius v. Alberni School District No. 70*, 2022 BCCA 421 ("*Servatius*") at para. 56.
[179] *Trinity Bible ONSC* at para. 90.
[180] See also *Harjee v. Ontario*, 2022 ONSC 7033 ("*Harjee ONSC*") appeal dismissed as moot 2023 ONCA 716.
[181] *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37 ("*Hutterian Brethren*") at para. 37.
[182] *Law Society of British Columbia v. Trinity Western University*, 2018 SCC 32 ("*Trinity Western*") at para. 63; *Ktunaxa Nation v. British Columbia (Forests, Lands and Natural Resource Operations)*, 2017 SCC 54

iii. No engagement with the petitioners' section 2(a) rights

213. *Hutterian Brethren* is dispositive in this case. It dealt with an Alberta regulation that required all persons who wish to drive a motor vehicle on a highway to have a licence bearing their photograph. The Hutterian object on religious grounds to having their photograph taken, and alleged that the regulation infringed their s. 2(a) rights.

214. The Supreme Court of Canada held that the impugned regulation did not engage the Hutterian claimant's religious freedom because they were free not to have their photographs taken.[183] The majority found that it was "impossible to conclude" on the record before the court that members had been deprived of a meaningful choice to follow or not follow the edicts of their religion.[184]

215. Although the Court acknowledged that the regulation "imposes a cost on those who choose not to have their photos taken: the cost of not being able to drive on the highway" that "cost does not rise to the level of depriving the Hutterian claimants of a meaningful choice as to their religious practice".[185] While the claimants were obliged to make alternative arrangements for highway transport, which imposes a financial costs and requires them to depart from their tradition of being self-sufficient in terms of transport, the Court found that these costs did not "rise to the level of seriously affecting the claimants' right to pursue their religion".[186] The Court elaborated:

> The Charter guarantees freedom of religion, but does not indemnify practitioners against all costs incident to the practice of religion. Many religious practices entail costs which society reasonably expects the adherents to bear. The inability to access conditional benefits or privileges conferred by law may be among such costs.[187]

216. As in *Hutterian Brethren*, the cost imposed by the impugned orders is of a secular nature. The cost of declining vaccination is extraneous to the asserted religious beliefs; the orders do not require the petitioners to become vaccinated contrary to their asserted beliefs. This is not a case where the orders interfere with the petitioners' religious freedom to engage in "the very activity that animates and defines its religious character".[188]

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[183] The constitutional analysis in *Hutterian* was conducted under s. 1 of the *Charter* because the courts below proceeded on the basis that the parties had concede an infringement of s. 2(a). Nonetheless, courts have found that the analysis readily transfers to the s. 2(a) framework. See for example *Trinity Bible ONSC* at para. 94.
[184] *Hutterian Brethren* at para. 98.
[185] *Hutterian Brethren* at para. 96.
[186] *Hutterian Brethren* at para. 99.
[187] *Hutterian Brethren* at para. 95 [emphasis added].
[188] *Trinity Bible ONSC* at para. 107 citing *Loyola*.

217. Put simply, the petitioners are not deprived of a meaningful choice as to their religious practices. The orders preclude the petitioners from engaging in certain employment in the public health sector while the orders remain in place. This is a cost "which society reasonably expects the adherents to bear".[189]

iv. The petitioners have not satisfied their evidentiary burden to establish the impugned conduct has a nexus with religious beliefs

218. Even if the orders engage the petitioners s. 2(a) rights, which is denied, the petitioners have failed to meet the necessary evidentiary burden of establishing that their religious beliefs mandate against vaccination.

219. The respondent does not dispute that the petitioner's beliefs are sincere. Instead, the question for the Court is whether the petitioners have satisfied their evidentiary burden that they sincerely believe "that a certain belief or practice [i.e., refusing vaccination] is required by their religion, or to put it another way, that their religion calls for a particular line of conduct."[190] The respondent submits that the petitioners have not met this evidentiary burden.

220. Further, the religious petitioners may have sincere *personal* beliefs about COVID-19 vaccination, but that does not make them sincere religious beliefs protected by s. 2(a). 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".

221. The petitioners have also not met their evidentiary burden with respect to conscience beliefs. 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.[191] The commitment must have a "profound moral dimension and be embedded in a larger belief system of right and wrong."[192]

222. A sincere, strongly held 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.

Peternella Hoogerbrug

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[189] *Hutterian Brethren* at para. 95.
[190] *Servatius* at para. 56.
[191] *R. v. Locke,* 2004 ABPC 152 at para. 25.
[192] *Affleck v. The Attorney General of Ontario*, 2021 ONSC 1108 ("*Affleck*") at paras. 41-46.

223. With respect to Ms. Hoogerbrug, while the sincerity of the petitioner's opposition to taking a vaccine against COVID-19 is not in dispute, she has not proven a nexus to religion nor that the belief is held "to connect with the divine":

a. There is no direct affidavit evidence from a Reformed Congregation in North America (RCNA) religious leader to prove that Ms. Hoogerbrug's belief regarding vaccination has a nexus to that religion.

b. The purported "Position Statement" of the RCNA at Exhibit "A" of Ms. Hoogerbrug's affidavit is unattributed, hearsay evidence in the same font as the covering letter in that same Exhibit authored by Ms. Hoogerbrug.

c. Ms. Hoogerbrug deposes that her religion opposes vaccination, but then deposes that it only opposes the use of vaccinations "too often" (para. 18, subpara. ii). This contradictory evidence does not found a religious belief that prohibits vaccination to connect with the divine.

d. Ms. Hoogerbrug has accepted vaccinations for travel in the past (between 2008 and 2012, para. 24), further suggesting either that it is a personal decision to decline COVID-19 vaccination, or that declining or accepting vaccination does not impact the connection with the divine based on RCNA doctrine, and so may not be more than a trivial interference with religion or conscience .

Phyllis Janet Tatlock

224. Ms. Tatlock says she is a Registered Nurse. She deposes that she is religious; specifically, that she is Catholic. She also deposes that she believes the vaccine is contrary to her anti-abortion views. However, her evidence does not show that refusing the vaccine itself is a religious belief. To the contrary, her evidence suggests her belief may be *sincere,* but is not *religious,* and is in fact counter to her own church's views.

225. Her evidence shows only that the Catholic church disagrees with Ms. Tatlock and that she believes she should be free to make her own choice.

226. Ms. Tatlock's evidence is that she is Catholic, but that she has developed "doctrinal differences" with the Roman Catholic church.[193] She notes that the Pope, as head of the

[193] Tatlock Affidavit #1 at para. 7.

worldwide Catholic Church, has advised parishioners that they can take the vaccine.[194] Ms. Tatlock says she left the Catholic church because of the Pope's endorsement of the vaccines.[195]

227. In her first affidavit, Ms. Tatlock deposes that she became "disenchanted" with the current Pope and then, after extensively reviewing an anti-abortion website, experienced an "awakening to the evil of abortion" which solidified her anti-abortion views. She believes she cannot take the vaccine because, according to Ms. Tatlock, the vaccine was developed with the use of fetal cell lines, which means she would benefit from an intentional termination of life.[196]

228. She deposes these views align with the "National Catholics Bioethics Center" (NCBC), but the hearsay evidence attached to her affidavits only reinforce that Ms. Tatlock's refusal is a personal, rather than a religious, decision. As Ms. Tatlock deposes, the NCBC says "there is no universal moral obligation to accept or refuse [the vaccine], and it should be a voluntary decision of the individual".[197] At best, Ms. Tatlock has shown that her own belief, reinforced by a Catholic-affiliated organization, is that she should be able to choose whether to be vaccinated. Her evidence does not show any religious practice at issue.

229. Moreover, Ms. Tatlock's evidence is somewhat ambiguous on her true concern with the COVID-19 vaccines. In both her first and third affidavits, she raises concerns with vaccine efficacy, safety-testing, and sufficiency of studies.[198]

Laura Koop (personal objection only)

230. Ms. Koop is a primary care Nurse Practitioner who has decided not to be vaccinated against COVID-19 due to her personal views.

231. Ms. Koop concedes she is not opposed to vaccines in general, has taken her recommended vaccines as a child, and supports and accepts vaccines that are proven safe and effective.[199]

232. Ms. Koop raises a wide range of "concerns" about the COVID-19 vaccines. However, she gives no evidence of a strongly held moral idea of right or wrong that is impacted by the required vaccination. Instead, her evidence is that she has various concerns that could conceivably arise for most people with most vaccines:

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[194] Tatlock Affidavit #1 at para. 9.
[195] Tatlock Affidavit #2 at para. 4.
[196] Tatlock Affidavit #1 at paras. 10-11.
[197] Tatlock Affidavit #2 at para. 6
[198] Tatlock Affidavit #1 at para. 16; Tatlock Affidavit #3 at para. 2.
[199] Koop Affidavit #1 at para. 15.

a. Ms. Koop's concerns range from safety to the mRNA technology, to "the lack of transparency from pharmaceutical corporations and all level of Canadian (and international) governments" (para 8);

b. Ms. Koop deposes that she is "concerned" about the "vaccine contents, "use of fetal tissue in development of the vaccines" and "unknown ingredients that the pharmaceutical companies are not disclosing." (para. 9);

c. Ms. Koop is "strongly opposed" to having health-care workers decide between being vaccinated against COVID-19 and their employment. (para. 10)

d. Ms. Koop offers non-expert, anecdotal evidence of observing three patients have reactions (grand mal seizures, lymph node swelling and hives), which she says developed post-injection with the COVID-19 vaccine (para. 11), and irrelevant, non-expert hearsay evidence about clinical trials not particularized and therapies (hydroxychloroquine and Ivermectin) not at issue here (paras. 12 & 13).

233. At most, the evidence suggests Ms. Koop mistrusts the government, her employer and pharmaceutical companies. However, that does not ground a *Charter*-protected vaccination refusal.

Monika Bielecki

234. Ms. Bielecki was the Employee Health and Wellness Advisor with Interior Health who worked remotely, but also attended in-office meetings.[200] She has no medical training.

235. Ms. Bielecki opposes having to take the vaccine for two reasons: she objects to the perceived state coercion and she has made her own scientific assessments of COVID-19 risks. In neither case does Ms. Koop raise a deeply-held moral objection that would attract Charter engagement.

236. Among other things, the evidence before the Court is that Ms. Bielecki believes that natural immunity protects her, that vaccination does not work, that she has not been sick despite having a child at school, that COVID-19 can cause vertigo and that other medications can be used as treatment.[201] These are not moral beliefs – they are unfounded speculation.

237. In her second affidavit, Ms. Bielecki says bluntly that she is "not willing to take a vaccination or any medical treatment as a condition of employment. I believe I would be giving up my human rights in doing so."[202] This sums up the flaw in her position. She has no *Charter*-

[200] Bielecki #1 at para 7.
[201] Bielecki #1 at para 12.
[202] Bielecki #2 at para 2.

protected conscience objection to taking the COVID-19 vaccine; instead, she has a general objection to any medical requirement of employment. That position is untenable for practical reasons, but also does not rise to the level required for *Charter* engagement.

Scott MacDonald

238. Mr. Macdonald is a registered art therapist with no scientific or medical training. His primary concern is that the vaccines were "rushed to market".[203] Despite having no training, he is "keeping up with the current science" which has led him to conclude the vaccines do not prevent infection or transmission.[204] He says that there is, without elaboration, a "mountain-sized pile of data, studies, released information from the pharmaceutical companies, and the government contradicting prior claims".[205]

239. It appears that Mr. Macdonald has concerns with the impact of the vaccine on his own medical condition and experience with the flu vaccine, but he provides no evidence to support those concerns and does not indicate he has sought a medical exemption.[206]

240. Rather than any deeply-rooted moral objection, Mr. Macdonald only deposes to general concerns ranging from "the invasive effects of a genetic experiment" (para 7) and the government "openly inciting hatred" against unvaccinated people (para 12), which has led him to conclude he "cannot stand idly by" knowing the traumatic effect of the mandate (para 13). Much of his affidavit addresses his concerns with the perceived segregation and other impacts on others who are not vaccinated.

241. Mr. Macdonald's evidence does not even suggest he has a sincerely held belief against vaccines generally or the COVID-19 vaccine specifically. Instead, Mr. Macdonald raises a myriad of concerns arising from his own unqualified assessment, his perception of injustice, and anecdotal evidence. None of his evidence supports a *Charter*-protected conscience-based objection.

Ana Lucia Mateus

242. Ms. Mateus is an administrative assistant with no scientific or medical training. She deposes that she is not opposed to vaccines and had childhood and adult vaccines.[207] She also deposes that she believes vaccines should only be taken if necessary and subject to stringent studies and trials.

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[203] Macdonald #1 at para 6.
[204] Macdonald #1 at para 8.
[205] Macdonald #1 at para 3.
[206] Macdonald #1 at paras. 10 and 16.
[207] Mateus #1 at para. 14.

243. However, Ms. Mateus believes there are “unanswered questions” about the COVID-19 vaccine and is troubled that the pharmaceutical companies “have no liability and no accountability” in relation to the vaccines.[208] She deposes to her unqualified view that her own immune system and herd immunity are sufficient.[209]

244. Ms. Mateus deposes to no sincere belief against vaccines or the COVID-19 vaccine. She raises only vague concerns and her belief in immunity. None of her evidence engages the *Charter.*

Darold Sturgeon

245. Darold Sturgeon rejects the vaccine based on his unqualified opinion and his claim that he has infection-based immunity. He says he is not opposed to vaccines.[210]

246. Mr. Sturgeon professes to have a religious objection. He deposes that he is Catholic.[211] However, his evidence is not that his Catholicism prohibits vaccines. Instead, his objection is grounded in his evidence that his Church supports his freedom “to do anything I want”.[212]

247. In his second affidavit, Mr. Sturgeon explains that he is pro-life and cannot admit an “abortion-tainted vaccine” into his body.[213] In his third affidavit, he explains he views the vaccine as immoral because any attempts to “coerce the will are infamies and are a supreme dishonour to God”.[214] However, he notes that the Catholic Church does not prohibit the vaccines, but rather supports choice.[215]

248. Mr. Sturgeon cites certain religious sources that reinforce his views, although he himself describes his views as “conscientiously-held beliefs”, rather than religious beliefs.

249. Mr. Sturgeon is a trained Chartered Professional Accountant and has held various senior executive roles in government.[216] He has provided no evidence regarding his ability to work as a CPA or senior executive in roles outside the health-care context that would not be impacted by vaccination requirements.

Lori Jane Nelson

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[208] Mateus #1 at para. 16.
[209] Mateus #1 at para. 16 and 17.
[210] Sturgeon #1 at para. 18.
[211] Sturgeon #1 at paras. 9-10.
[212] Sturgeon #1 at para. 11.
[213] Sturgeon #2 at paras. 3-4.
[214] Sturgeon #2 at para. 2
[215] Sturgeon #2 at paras. 6-7.
[216] Sturgeon #1 at para. 3.

250. Lori Jane Nelson deposes that she is Christian and that sincere religious beliefs prevent her from taking a COVID-19 vaccine.[217] However, her objection is not religious. Indeed, she acknowledges that congregants can make up their own minds about the vaccine.[218] Ms. Nelson attaches hearsay evidence to her second affidavit, but at most it shows that different churches/religious leaders have taken differing views on the subject.

251. Rather, she says that after "detailed analysis" she concluded that the vaccine posed a risk because of her allergies.[219] Indeed, she submitted a medical deferral request that was denied.[220] She also believes the vaccine requirement is more than what is needed, because she was "at zero risk to the public".[221]

252. Ms. Nelson's own assessment that the vaccine is unsafe or coercive does not engage the *Charter.* She has deposed to no religious belief that is impacted by the Health-care Orders at all.

Ingebrog Keyser

253. Ingebrog Keyser says she is opposed to taking a vaccine on the basis of conscience. She expresses her view that it is "illegal to force a person to receive an injection to keep his or her job" and that there is not enough data to confirm the safety and long-term effects of the vaccine.[222]

254. She also raises a myriad of other concerns and unqualified assessments: the vaccine is not a "one size fits all" solution, the vaccine was developed for those with underlying health concerns, she is against a vaccine card requirement, and she is pregnant.[223]

255. Ms. Keyser also claims the unqualified assessment that the vaccine has low efficacy, the vaccines have a "poor track record", the original vaccines "did not work", and there are "effective treatments" for COVID-19, including her own healthy lifestyle.[224]

256. Ms. Keyser provides no sincerely held moral belief that engages the *Charter.* Her evidence simply recites unsubstantiated concerns and unqualified opinions that have led her to doubt the utility and safety of the vaccine. There is no moral position that warrants *Charter* scrutiny.

Lynda June Hamley

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[217] Nelson #1 at para. 8.
[218] Nelson #1 at para. 4.
[219] Nelson #1 at para. 11.
[220] Nelson #1 at paras. 12 and 14.
[221] Nelson #1 at para. 17.
[222] Keyser #1 at para. 2.
[223] Keyser #1 at paras. 8-9.
[224] Keyser #2 at para. 2.

257. Ms. Hamley asserts a religious objection (para. 7) but does not depose that her religion prohibits vaccination. Rather, a quote she says was taken from the Seventh Day Adventists' website reads: "The decision to be immunized or not is the choice of each individual…" (Exhibit D, page 5)

258. 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 *Charte*r.

259. Her pastor, Doug Pond, urges a conscience objection to vaccination. However, Ms. Hamley's evidence does not establish a conscience objection attracting *Charter* protection (Exhibit D, page 6)

Melinda Joy Parenteau

260. Mrs. Parenteau asserts a conscience objection and rejects the vaccine because she considers the requirement to be coercive, to put her under duress, and to constitute a threat and because she has her own "medical/scientific objections" to them. She does not oppose vaccination generally. These concerns do not ground a *Charter*-protected right of conscience (Affidavit #1, paras. 4-7, and see Affidavit # 2, para. 2).

Dr. Joshua Nordine

261. Dr. Nordine deposes that he is "a Christian, and [has] sincerely held religious belief that prevent me from taking the Covid-19 vaccine." He appears to connect this with his objection to historical fetal cell lines. Without doubting the sincerity of his belief, there is no evidentiary basis for a nexus with religion.

262. At the same time, Dr. Nordine acknowledges the church does not have a formal doctrinal position on the issue, and raises his natural immunity, medical and vaccine-safety based objections. (affidavit # 1, para. 9, para. 10, para. 18, para. 23).

263. To establish a breach of s. 2(a) for freedom of religion, it does not suffice to provide evidence of a personal belief and hearsay evidence on the question of nexus to religion and contradictory evidence on the nexus and connection to the divine

264. Indeed, in a recent section 2(a) challenge concerning First Nations practices in school, the claimant introduced evidence from a pastor regarding the religious doctrine applicable to the claimant's beliefs.[225] No such evidence exists here.

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[225] *Servatius* at para. 178.

v. Section 2(a) requires a non-trivial or substantial interference

265. In order to establish infringement of freedom of religion, the courts require claimants to show that the state conduct at issue interferes with the claimants' ability to act in accordance with their practice or belief in a manner that is more than trivial or insubstantial. It is not enough for claimants to simply say that their rights have been infringed. Rather, the courts should determine this question by objectively considering the impact of the impugned conduct on the claimants.[226]

266. The courts have already held in the COVID-19 context that proof of vaccination mandates may have practical consequences for those unvaccinated due to religious beliefs—such a denied entry to businesses or organizations—but do not constitute interference with religious beliefs.[227] The claimants remain free to continue their religious belief or practice and remain free to be unvaccinated. There is no interference, whether trivial or non-trivial.

267. However, to the extent that the Court determines there is an interference, not all engagements with religious beliefs rise beyond the required threshold. Our Court of Appeal recently cited the example from Supreme Court of Canada jurisprudence, where a parent held a religious conviction that the state should not educate his children and that it would be a sin to ask for permission to home school. That parent was legally compelled to send his children to public school or ask permission from the state to home school, which the Court held was a trivial burden that did not infringe religious freedom, particularly given the compelling state interest in the education of young people.[228]

268. The respondents submit that, if the Court finds that the inability to obtain an exemption from the Health-care Orders on religious or conscience grounds does interfere with s. 2(a) of the *Charter,* which is denied, the lack of that exemption is a reasonable and proportionate limit in light of the statutory objectives of the *PHA*.

269. In any event, the question of whether an interference is sufficiently substantial is best assessed at the proportionality stage of the analysis, which is revisited below.

vi. The evidence does not support the freedom of conscience argument

270. The petitioners also have not proven a conscience-based belief at the level that attracts s. 2(a) protection. Rather, Ms. Hoogerbrug's affidavit evidence explains a personal objection to COVID-19 vaccination that may be strongly held, but which applies only in certain circumstances and time frames, unconnected to an overarching moral commitment. The other petitioners'

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[226] *Servatius* at para. 57
[227] *Harjee ONSC* at paras. 61-63.
[228] *Servatius* at para. 59

evidence, discussed above, has a similar failing. Ms. Hoogerbrug's evidence is that she has taken vaccines when her belief is that some good may come from the activities she can undertake if vaccinated.

271. In *Affleck*, the applicants were producers and consumers of raw milk who claimed that raw milk should be made available for purchase because it had substantiated health benefits compared to pasteurized milk.

272. The court held that the applicants' s. 2(a) freedom of conscience rights were not violated by federal regulations and provincial statutes prohibiting the sale of unpasteurized milk, because the belief in the health benefits of raw milk even when coupled with belief in their right to choose what to consume, did not "rise to a level of belief with profound moral dimensions", required for protection of freedom of conscience.[229]

273. The court also dismissed s. 15(1) and s. 2(a) freedom of religion *Charter* claims and found that in any event s. 1 would apply as a proportionate limit on any infringement because there was extensive evidence about safety concerns of consuming raw milk, particularly for vulnerable populations.

274. Notably, on freedom of religion, the court wrote the applicant Bryant's evidence that interwove his discussion of the divine with his broad subjective beliefs about the health benefits of raw milk such that "[i]t could be relied upon to justify almost any healthy lifestyle choice, which, as set out above, is not the sphere of personal belief the *Charter* is designed to protect. By interweaving his comments about his right to optimize his health with his comments about religion, Mr. Bryant has failed to demonstrate that the inaccessibility of raw milk specifically impacts his religious freedom in a manner that is more than trivial or insubstantial." Several of these petitioners also interweave their purported religious and personal objections in such way that it is difficult to determine their evidence in any definitive way.

275. Given that significant constitutional issues should not be decided in a factual vacuum, the court should dismiss the petition for failure to prove a breach of s. 2(a) on religious or conscience grounds.

vii. The absence of a religious exemption is reasonable

276. The petitioners raise an argument about whether the absence of a religious- or conscience-based exemption process was reasonable or engages s. 2(a) of the *Charter.*

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[229] *Affleck* at paras. 40-46.

277. The respondents' position is twofold: First, the petitioners' evidence is insufficient to allow this Court to undertake an analysis on the s. 2(a) issue and so the petition should be dismissed on that basis. Second, to the extent that the absence of an exemption process does engage s. 2(a), it is a reasonable and proportionate limit under s. 1 of the *Charter* and the petition should alternatively be dismissed on that basis.

278. In the event the Court finds any part of the Health-care Orders unjustifiably infringe the *Charter* or is unreasonable, the appropriate form of relief is to remit the Health-care Orders to the PHO for reconsideration in light of the Court's reasons.

279. *Charter* values may inform the interpretation of *Charte*r claims, including consideration of reasonableness and proportionate limits in a particular factual context.[230] but do not create independent grounds that replace the analysis of *Charter* engagement, infringement, proportionality and reasonableness.

H. Section 7

280. Section 7 of the *Charter* provides:

> 7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

281. The analytical framework for s. 7 requires considering both whether s. 7 is engaged *and* whether it is infringed. The two-stage section analysis is as follows:

a. the applicant must establish that the impugned governmental act imposes limits on a life, liberty or security of the person interest such that s. 7 is engaged; and

b. the applicant must establish that the deprivation is contrary to the principles of fundamental justice.[231]

282. Thus, an infringement of s. 7 may only be found where it is engaged and the government action is contrary to at least one of the principles of fundamental justice.

i. The petitioners' liberty and security of the person rights are not engaged

283. The petitioners concede that s. 7 is not engaged by the right to practice a particular profession or occupation.[232] Put differently, the s. 7 interest is not engaged in these petitions

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[230] To accord with jurisprudence suggesting that *Charter* values may be an interpretive aid in a purposive approach: *Law v. Canada (Minister of Employment and Immigration)*, [1999] S.C.J. No. 12.
[231] *Bedford v. Canada (Attorney General)*, 2013 SCC 72 ("*Bedford*") at para. 57.
[2] Para. 197 of the Hsiang/Hoogerbrug written submissions; para. 297 of the Tatlock written submissions.

because the interest at stake for the petitioners is employment in a particular sector, not life, liberty or security of the person.[233]

284. The right to life is engaged where the law of state action imposes death or an increased risk of death on a person, directly or indirectly.[234] This component of s. 7 is not at issue in these petitions.

285. Instead, the Tatlock petitioners focus on the liberty and security of the person rights of the type that are engaged in cases about the right to make fundamental personal choices such as those involved in medically assisted dying. These types of rights were discussed in *Carter v. Canada (Attorney General)*,[235] the Supreme Court of Canada discussed liberty and security of the person rights under s. 7:

> [64] Underlying both of these rights is a concern for the protection of individual autonomy and dignity. Liberty protects "the right to make fundamental personal choices free from state interference". Security of the person encompasses "a notion of personal autonomy involving . . . control over one's bodily integrity free from state interference" and it is engaged by state interference with an individual's physical or psychological integrity, including any state action that causes physical or serious psychological suffering. To the extent that the petitioners argue that the Health-care Orders interfere with their right to medical self-determination,[236] their position is contrary to jurisprudence. The petitioners' right to medical self-determination is unaffected. *Charter* s. 7 is not engaged.
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> [Citations omitted.]

286. In *Lewis* v. *Alberta Health Services*,[237] the Alberta Court of Appeal found that a pre-transplant requirement that Ms. Lewis be vaccinated against COVID-19 to receive a needed organ transplant neither engaged nor infringed her s. 7 *Charter* rights. (The Court of Appeal held that the impugned vaccine requirement did not engage the *Charter*; however, for the sake of

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[233] *Mussani v. College of Physicians and Surgeons of Ontario*, [2004] O.J. No. 5176 (ONCA) at paras. 4, 40-44. Dr. Mussani's certificate of registration was revoked, under his regulator's mandatory revocation scheme, for sexual relations with a patient. Dr. Mussani's s. 7 liberty and security of the person *Charter* claims were dismissed. There is no constitutional right to practice a profession unfettered by applicable rules that regulate it. See also *Tanase v. College of Dental Hygienists of Ontario,* 2021 ONCA 482, leave to appeal refused [2021] S.C.C.A. No. 350 and *Ouellette v. Law Society of Alberta*, 2019 ABQB 492 leave to appeal refused 2021 ABCA 99. Mr. Ouelette's s. 7 *Charter* claim, including his argument about security of the person, framed as economic security for himself and his son that was threatened by the revocation of his license to practice law, causing significant emotional distress, dismissed as not engaging section 7.

[234] *Trest v. British Columbia (Minister of Health),* 2020 BCSC 1524 at para 91.

[235] *Carter v. Canada (Attorney General)*, 2015 SCC 5 ("*Carter*").

[236] Third Amended Petition at Part 3, para 4; Tatlock petitioners' written submissions at para 195.

[237] *Lewis* v. *Alberta Health Services*, 2022 ABCA 359 ("*Lewis*").

completeness, it provided its opinion as to whether Ms. Lewis' *Charter* rights had been breached, assuming for the sake of argument that the *Charter* applied.)

287. Looking at the right to life, the Alberta Court of Appeal held that, while the transplantation program's requirement to receive an organize transplant was characterized by Ms. Lewis as a "death sentence", it was Ms. Lewis' choice was whether she would comply with the vaccination requirement. The COVID-19 vaccine requirement did not prohibit her access to medical treatment, but was part of her treatment as a necessary component of proper medical care for those seeking an organ transplant.

288. With regards to the liberty interest, Ms. Lewis was also held not to have been deprived of her right to refuse to be vaccinated against COVID-19. At para. 47 the Court wrote:

> The state has not deprived Ms Lewis from exercising her autonomous right to refuse to be vaccinated against COVID-19, which refusal is consistent with her right to refuse any medical treatment. However, the consequences that flow from her autonomous decision to refuse the COVID-19 vaccine were not caused by the respondents. As an aspect of medical self-determination, it is well understood that a patient's decisions can result in serious risks or consequences, including death: *Carter* at para 67.

289. Similarly, in these petitions, the Health-care Orders do not engage any s. 7 rights. The Health-care Orders are not coercive in the way described in the above-noted passage from *Carter* or the cases cited within it. As in *Lewis*, it was the petitioners' choice to forgo the COVID-19 vaccine. While their choice has implications for their employment in a particular sector, the petitioners' control over their bodies and their ability to makes choices that go to individual autonomy and dignity remains.

290. Section 7 also does not create any positive obligation on the government to ensure for example, either an organ transplant or a specific type of employment.[238]

291. While the security of the person component of s. 7 extends to serious state-imposed psychological stress, that stress must exceed the ordinary stresses of life and pose a genuine threat to the individual's psychological integrity.[239] Though stressful, many people make personal choices that require them to change employment. For instance, many people leave the paid workforce to care for young children. These petitioners made informed choices that limited their ability to remain employed in the health care setting. However, the stresses upon them were due

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[238] *Lewis* at para. 49.
[239] *Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44 at paras. 56-60.

their own choices, and in any event none of them provided medical evidence of their psychological integrity being threatened to the level required to engage s. 7.

ii. There is no breach of the principles of fundamental justice

60. Section 7 does not promise that the state will never interfere with a person's life, liberty and security of the person; but rather, that the state will not do so in a way that violates the principles of fundamental justice.[240] If the Court finds that the petitioners' s. 7 *Charter* rights are engaged by the Health-care Orders, which is denied, the petitioners must also demonstrate that the deprivation is not in accordance with the principles of fundamental justice.

iii. The Health-care Orders are not arbitrary

61. The deprivation of a right will be arbitrary and thus violate s. 7 only if it bears no real connection to the law's purpose.[241]

62. The petitioners claim the Health-care Orders are arbitrary because their effect is to worsen the petitioners' psychological health, contrary to their purpose of protecting public health. However, and to the contrary, the Health-care Orders are on their face aimed at protecting both the petitioners' health and the wider population's health.

63. *Annex I – Constitutionality of the Canadian Armed Forces COVID-19 vaccination policy,* relied on by the Tatlock petitioners, is not a court decision and so is not binding here. It failed to consider arbitrariness in the manner defined in *Bedford*. Further, the analysis differs here, in the public health and health-care system context, which itself provides patient care for British Columbians in evolving circumstances, by contrast to a policy in the armed forces context. There is a real connection between the purposes of the Health-care Orders and their application to these petitioners, being preservation of health care system capacity and ability to provide care for all needs.

64. The Tatlock petitioners argue that the fact that contractors were not subject to vaccination requirements makes the Health-care Orders arbitrary. While that may establish under- inclusion, it does not show arbitrariness. The vaccination requirement remains connected to the Health-care Orders' twin purposes of protecting patients and the health care system's integrity and capacity to provide for all care needs. All employees are subject to the same vaccination requirement: a mandatory requirement with medical deferrals only, and no other exemptions. All employees,

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[240] *Carter* at para. 71.
[241] *Bedford* at paras. 93-123.

whether holding religious or conscience beliefs or not, are subject to the same requirements. The Health-care Orders are not arbitrary.

iv. The Health-care Orders are not overbroad

65. The deprivation of a right will be overbroad if it goes too far and interferes with some conduct that bears no connection to its objective.[242]

66. Under the *PHA*, Dr. Henry is authorized to suspend reconsiderations for any purpose where she is satisfied that a regional event exists. While that regional event status exists, Dr. Henry can elect to apply the vaccination requirement broadly as it is required to maintain safe patient care and the health care system's integrity and capacity.

67. The Tatlock petitioners contend that application to remote or administrative workers makes the Health-care Orders overbroad. The administrative work petitioners would share physical settings and potentially meetings with front-line, patient-facing health-care workers, making a requirement that they be vaccinated reasonable.

68. As analyzed further elsewhere in the reasonableness section of this submission, only three petitioners provided internally consistent evidence that they worked remotely. Even that was time-specific evidence, with no guarantee that they could continue to fulfil their roles in the health-care system without attending in-person settings. Further, if any of them suffered a prolonged absence from those roles due to being unvaccinated and ill with COVID-19, it would impact the system's ability to provide for all care needs, regardless of whether their work was performed in person, and regardless of absolute numbers of absent health-care workers. That is, an absence of one or a few individuals can have grave impacts, particularly in small communities or those already suffering absences from outbreaks.[243] The petitioners were part of the health-care system's interconnected and interdependent infrastructure.

69. The Health-care Orders are indeed broad, by necessity, as they are aimed at mitigating the serious risks in the provision of health-care for British Columbians, but they are not overly

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[242] *Bedford* at paras. 93-123.

[243] See Emerson #2, p. 500 for closure of Delta Hospital emergency due to HCW absences; p. 9 for peaks and valleys of hospitalization, critical care and death due to COVID-19 over the period from January 2021-August 2022; see Miller #1, Exhibit V and Exhibit AA, at pp. 196, 198, 2000 for the stress on the public health and health-care systems as a result of COVID-19, the overdose public health emergency, increasing population and the need for continuous improvements in capacity, including bed and staff related capacity, care access and flow; p. 204 for rotating ER closures in Interior Health; and p. 205.

broad. Requiring health-care workers to be vaccinated to protect patients' health and ensure the resiliency of the public health system is a proportionate response to COVID-19 generally in the health-care system and its impacts on vulnerable populations.

v. The Health-care Orders are not grossly disproportionate

70. Finally, the deprivation of a right will be grossly disproportionate if the seriousness of the deprivation is so totally "out of sync" with the objective that it cannot be rationally supported.[244]

71. The vaccination requirement in the Health-care Orders was put in place to protect patients, vulnerable populations, and to preserve the health-care system's ability to provide for all care needs by preventing severe illness, hospitalization, and death. These are important public health purposes aimed protecting and preserving the health of British Columbians at a population level. If there has been a deprivation of these petitioners' s. 7 rights, which is denied, then it is not "out of sync" with these objectives.

72. The respondents submit that the petitioners have failed to demonstrate any deprivation of s. 7 rights, and in particular, any deprivation that is not in accordance with the principles of fundamental justice. The respondents ask the Court to dismiss the s. 7 *Charter* claims.

I. Section 15

292. The analysis for whether there is a breach of *Charter* s. 15(1) involves two questions:

a. First, does the challenged law, on its face or in its impact, draw a distinction based on an enumerated or analogous ground? If a law is facially neutral, it may draw a distinction indirectly where it has an adverse impact upon members of a protected group.

b. Second, if it does draw a distinction, does it impose burdens or deny a benefit in a manner that has the effect of reinforcing, perpetuating or exacerbating . . . disadvantage, including historical disadvantage?[245]

293. The distinction drawn by the Orders is between vaccinated and unvaccinated persons. Vaccination status is not an enumerated or analogous ground.[246] Given that, the petitioners must demonstrate that the Health-care Orders have an adverse impact upon members of a protected group *qua* group. Section 15 does not allow a government to disadvantage a group of persons

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[244] *Bedford* at paras. 93-123.
[245] *Ontario (Attorney General)* v. *G*, 2020 SCC 38 at para. 40.
[246] *Lewis* v. *Alberta Health Services*, 2022 ABCA 359 at paras. 68-69.

based on their religious beliefs, but it is not about neutrality among practices or beliefs, which is addressed by s. 2(a).

294. *Nova Scotia (Workers' Compensation Board) v. Martin* and *Vriend v. Alberta*,[247] cited by the Hsiang/Hoogerbrug Petitioners, are distinguishable because they each address exclusion of enumerated or analogous grounds (disability and sexual orientation, respectively) from schemes that confers benefits on others within those same groups.

295. With respect to s. 15, there is no evidence that the Health-care Orders specifically disadvantage a group of people *based on their religious beliefs*. The same activities are allowed and restricted for secular and religious people, distinguishing whether or not they can work as health care workers only based on vaccination status. Under the Health-care Orders, exemptions from the vaccination requirement are not available to anyone, religious or not, leaving aside only medical deferrals.

J. Any infringement of *Charter* rights is reasonable, proportionate and justified

296. Even if the petitioners demonstrate infringement of ss. 2(a) or 15, or that s. 7 is engaged and that a principle of fundamental justice is infringed, such infringements may be found to be reasonable limits under s. 1 if the impugned parts of the Health-care Orders are proportionate limits on the petitioners' rights. At the s. 1 stage of the analysis, the question is whether the impact of the Health-care Orders on the petitioners' rights reflects a proportionate balance between the *Charter* protections at play and the relevant statutory objectives of the decision maker, also known as the *Doré/Loyola* framework.[248]

297. One recent example of this "proportionality analysis" is in *Trinity Western*,[249] in which the Court upheld a decision to not approve a law school that imposed a mandatory religious covenant, when that covenant would have excluded and degraded LGBTQ students. The limit on freedom of religion was justified to uphold and protect the public interest in the administration of justice.

298. The proportionality analysis requires considering not only the individual complainant's rights, but broader values, and understanding that sometimes conflicts between the two are inevitable. The majority's reasoning in *Trinity Western* is apt for the present circumstances:

> [100] The limitation on religious freedom in this case must be understood in light of the reality that conflict between the pursuit of statutory objectives and

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[247] Petitioners' written submissions at para. 623 and 624 citing *Nova Scotia (Workers' Compensation Board) v. Martin*, 2003 SCC 54 and *Vriend v. Alberta*, [1998] 1 SCR 493.
[248] *Doré v. Barreau du Québec*, 2012 SCC 12 ("*Doré*"); *Loyola High School v. Québec (Attorney General)*, 2015 SCC 12 ("*Loyola*").
[249] *Trinity Western.*

> individual freedoms may be inevitable. ... minor limits on religious freedom are often an unavoidable reality of a decision-maker's pursuit of its statutory mandate in a multicultural and democratic society.
>
> [101] In saying this, we do not dispute that "[d]isagreement and discomfort with the views of others is unavoidable in a free and democratic society" (C.A. reasons, at para. 188), and that a secular state cannot interfere with religious freedom unless it conflicts with or harms overriding public interests (para. 131, citing *Loyola*, at para. 43). But more is at stake here than simply "disagreement and discomfort" with views that some will find offensive. This Court has held that religious freedom can be limited where an individual's religious beliefs or practices have the effect of "injur[ing] his or her neighbours or their parallel rights to hold and manifest beliefs and opinions of their own"
>
> [Emphasis added.]

299. Finally, not all administrative decision-making requires the same procedure, and any review of the decision must consider the context and nature of the decision-making.[250]

300. If the Court finds that the impugned Health-care Orders infringe the petitioners' rights under ss. 2(a), 7 or 15 of the *Charter,* which is denied, the Health-care Orders reflect a proportionate balancing of the *Charter* protections at play.

301. Under the *Doré* analysis, the issue is not whether the exercise of administrative discretion that limits a *Charter* right is correct (i.e., whether the court would come to the same result), but whether it is reasonable (i.e., whether it is within the range of acceptable alternatives once appropriate curial deference is given). An administrative decision will be reasonable if it reflects a proportionate balancing of the *Charter* right with the objective of the measures that limit the right.

K. The PHO proportionately balanced public health objectives with the right to life, liberty and security of the person

302. Rights and freedoms under the *Charter* are not absolute. Protecting the vulnerable from death or severe illness and protecting the health-care system from being overwhelmed by COVID-19 and its implications so that it can continue to provide for all care needs, are also clearly crucial public objectives.

303. As set out in the preambles to the Health-care Orders, they were issued with the objectives of protecting public health, preventing severe illness, hospitalization and death, and preserving the health care system's ability and capacity to provide care for all care needs.

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[250] *Servatius* at para. 97 citing *Trinity Western* at para. 53.

304. In *Beaudoin BCCA*, the Court of Appeal held that the *Doré* analysis is applicable and involves a reasonableness analysis. The respondents have presented a detailed reasonableness analysis of these Health-care Orders above, which they also rely upon here.

305. In overview, Dr. Henry is British Columbia's chief public health official and a public health physician with extensive training and unique experience that equips her to make informed decisions to combat the impacts of COVID-19. The Court of Appeal in *Beaudoin* noted that courts have afforded substantial deference to measures adopted by public health officials to combat COVID-19.

306. The PHO has made these decisions in real time, responding to the COVID-19 regional event under the *PHA*, to protect patients, vulnerable populations and the health care system, in a climate of evolving knowledge. As the Court of Appeal affirmed in *Beaudoin*, limitations on individual rights can be proportionate where there is a "…need to take precautions to stop preventable deaths from occurring and the need to protect the capacity of the health-care system".[251]

307. The Health-care Orders explain the PHO's reasoning and provide specific justification for the vaccine mandate for health care workers anchored in the epidemiological data and generally accepted scientific knowledge regarding SARS-CoV-2 and COVID-19. The PHO proportionately balanced the pressing public health objectives of the Health-care Orders against their impact on individual liberties.

308. The preambles to the Health-care Orders expressly acknowledge the PHO's consideration of the *Charter* rights and freedoms of those who may be subject to them and note that the limitations chosen are aligned with public health principles, proportionate, precautionary and evidence-based and intended to prevent loss of life, serious illness and disruption of the health system and society.

309. A proportionality analysis asks whether the deleterious effects of the Health-care Orders, in their impact on the rights of these petitioners, outweigh the salutary benefits to be gained from them. Among other things, the evidence proves that a requirement for vaccination among health-care workers allowed the health-care system to provide care for those whose surgeries were postponed during the earlier waves of COVID-19 by preserving the health-care workforce, and has allowed other parts of our society, outside the health-care system, to return to previously restricted interactions and activities. The vaccination requirement has remained in place to ensure that the health-care system can provide care for all care needs, and to protect vulnerable

[251] *Beaudoin BCCA* at para. 267.

populations. These significant salutary public health and health care system effects and outcomes are not outweighed by the situation of these comparatively few petitioners who were able to exercise choice about vaccination.

310. As the Court of Appeal articulated in *Beaudoin BCCA*, the COVID-19 pandemic has highlighted the interdependence of our community and, by extension, our health-care system:

> [306] A free society is a pluralistic one in which individuals are entitled to pursue, within reasonable limits, their individual beliefs. But to live in community is also to acknowledge our interdependence. We share limited collective resources upon which all of us depend, including our health-care system. We share the environment, the air we breathe, and our susceptibility to transmissible diseases, the burden of which falls disproportionately on the most vulnerable among us.
>
> [307] The COVID-19 pandemic highlighted our interdependence as a community. It forced us to confront the reality that the pursuit of some activities, including the exercise of some constitutionally protected rights, would increase the risk of exponential spread of the disease and the loss of human life. In the exercise of her responsibility to safeguard public health and access to our health-care system, the PHO made time-limited and setting-specific orders restricting activities she considered to be most likely to foster widespread transmission of the virus. She was uniquely qualified to make these decisions and the exercise of her judgment must be afforded deference.

311. Several Tatlock petitioners provided recent affidavits suggesting they are willing to wear masks or other personal protective equipment ("**PPE**") in lieu of vaccination. Setting aside the debatable efficacy of that approach, the PHO would no doubt have been faced with a similar challenge that the PPE directive was unreasonable or disproportionate. Indeed, in *Ontario Nurses'* the applicants advanced a challenge to a PPE health-care directive. The reality is that any type of regulation or rule to deal with COVID-19 is likely to meet with opposition. The petitioners' belated attempt to propose PPE alternatives is of little utility, particular given the evidence that vaccination is the most effective preventive measure available for the health-care system.

312. The Health-care Orders represent a reasonable and proportionate balance. They are carefully considered, periodically updated requirements put in place the specific setting of the British Columbia health care system, to protect our most vulnerable, to act against preventable severe illness, hospitalization and death and to preserve that very health care system's ability to provide care for everyone at a time of significant and growing demand. If the Court finds that any *Charter* rights are engaged or infringed, then respondent submits that any such infringement is justified under s. 1 of the *Charter*.

L. Other arguments - The Health-care Orders are *intra vires* the PHO and *Public Health Act* / *Charter* values

313. The petitioners make brief references to assertions that the Health-care Orders are *ultra vires,* but do not develop those arguments. They do not challenge the jurisdiction of the legislature to enact the *PHA*, or any provision of the *PHA* itself.

314. In any event, the Health-care Orders are not *ultra vires* the PHO. They were made pursuant to the PHO's powers under ss. 30, 31, 32, 39(3), 54, 56, 67(2) and 69 of the *PHA*.

315. The notice of regional event issued March 17, 2020 provided the statutory authority for the PHO to exercise her emergency powers under the *PHA*, including the power to issue orders respecting health hazards under Part 4 of the *PHA*.

316. On March 17, 2020, Dr. Henry provided notice that the transmission of the infectious agent SARS-CoV-2, which has caused cases and outbreaks of COVID-19 among the population of BC, constitutes a regional event as defined under s. 51 of the *PHA.* In her notice, Dr. Henry advised that she reasonably believed that all four criteria of s. 52(2) existed.[252] This enabled the PHO to exercise her emergency powers under the *PHA,* including the power to make oral and written public health orders in response to the COVID-19 pandemic.

317. The Health-care Orders set out that Dr. Henry had reason to believe and did believe that: the risk of an outbreak of COVID-19 among the public constitutes a health hazard under the *PHA*; there is an immediate and urgent need for focused action to reduce the rate of the transmission of COVID-19 which extends beyond the authority of one or more MHOs; coordinated action is needed to protect the public from the transmission of COVID-19; and that it was in the public interest for Dr. Henry to exercise the powers in sections 30, 31, 32 and 39 (3) of the *PHA.*

318. As noted above, s. 32 of the *PHA* permits the PHO in an emergency to make orders in respect of "a place", including that a person not enter a place, and s. 39(3) permits an order to be made in respect of classes of persons.

319. There is no basis for this Court to set aside the Health-care Orders as *ultra vires* the *PHA*.

320. The petitioners also make brief reference to *Charter* values, although do not develop their arguments. *Charter* values may inform the interpretation of *Charte*r claims, including consideration of reasonableness and proportionate limits in a particular factual context[253], but do not create independent grounds that replace the analysis of *Charter* engagement, infringement,

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[252] Emerson #1, Ex. K.

[253] To accord with jurisprudence suggesting that *Charter* values may be an interpretive aid in a purposive approach: *Law v. Canada (Minister of Employment and Immigration)*, [1999] S.C.J. No. 12, [1999] 1 S.C.R. 497 (S.C.C.).

proportionality and reasonableness. The parties have engaged with the *Charter* issues in their submissions. Recourse to *Charter* values does not change the appropriate outcome, which the respondents submit is to dismiss the petition.

IV. CONCLUSION AND ORDERS SOUGHT

A. Petitions Should Be Dismissed

321. The petitions ought to be dismissed in their entirety.

322. The petitioners have failed to establish any infringement of their *Charter* rights, let alone that any such infringement is unreasonable per the *Doré*/*Loyola* framework. Similarly, the petitioners have failed to demonstrate that the Health-care Orders and, in the case of the Hsiang Petitioners, the PHO's use of her emergency powers under the *PHA*, are unreasonable.

323. However, if this Court finds the petitioners are successful on any of the asserted grounds, the appropriate remedy is to remit the matter to the PHO to have her reconsider the decision with the benefit of the Court's reasons.[254] This Court should not quash or set aside the Health-care Orders.

324. Determining what public health measures are necessary and appropriate at any given time is a matter that ought to be left to the PHO and the Court should not intervene or substitute its own views. If, for example, the Court finds that a particular *Charter* right was not reasonably balanced with the protection of public health, the practical impact will vary significantly depending on the particular right at issue. Complex public health decisions ought to be left to the PHO and her team of expert advisors.

B. Mandamus is Not Available

325. An order in the nature of *mandamus* is not available in the circumstances. *Mandamus* is an "extraordinary remedy" used to secure the performance of a public duty. A party seeking the remedy must establish very clearly the right that it sought to protect, and that an order should not be granted in doubtful cases. Where the duty sought to be imposed is discretionary, *mandamus* is only available when the decision maker's discretion is "spent", meaning the applicant has a vested right to the performance of the duty.[255]

326. The PHO's authority under the *PHA* to issue the Orders is discretionary. Section 30(1) provides that a health officer *may* issue an order in certain circumstances. Similarly, in an emergency, under s. 54(1) a health officer *may* not reconsider an order under s. 43, not review

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[254] *Vavilov* at para. 141.
[255] *Rogers Communication* at paras. 42-43.

an order under s. 44, or not reassess an order under s. 45. The petitioners have no "vested right" to the performance of any duty.

C. Damages are Not Available

327. It is trite law that damages are not an available remedy on judicial review. This includes damages pursuant to s. 24(1) of the *Charter*, as sought by the Tatlock Petitioners.[256] As a result, even if this Court finds that the Orders unreasonably infringe any of the petitioners' *Charter* rights, the petitioners are not entitled to any award of damages.

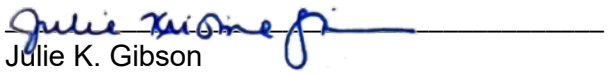
D. Guidelines are Not Subject to Judicial Review

328. The Tatlock Petitioners also seek a declaration that the "Guidelines for Request for Reconsideration (Exemption) Process for Health Care Workers affected by the Provincial Health Officer Orders" are of no force or effect. However, the Guidelines are not on their own an exercise of statutory authority and therefore are not subject to judicial review.

E. No Award of Costs

329. Subject to limited exceptions, statutory decision makers do not receive costs or have them awarded against them on judicial review.[257] There is no basis for depart from the general rule in this case.

ALL OF WHICH IS RESPECTFULLY SUBMITTED this 15th day of November 2023.



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[256] *Yang* at paras. 35-37.
[257] *Lang v. British Columbia (Superintendent of Motor Vehicles)*, 2005 BCCA 244 at paras. 46-48.