IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *Hoogerbrug v. British Columbia,* 2024 BCSC 794

Date: 20240510
Docket: S224652
Registry: Vancouver

Between:

Peternella Hoogerbrug

Petitioner

And

Provincial Health Officer of British Columbia

Respondent

- and -

Docket: S224731
Registry: Vancouver

Between:

York Hsiang, David William Morgan and Hilary Vandergugten

Petitioners

And

Provincial Health Officer of British Columbia

Respondent

- and -

Docket: S222427
Registry: Vancouver

Between:

Phyllis Janet Tatlock, Laura Koop, Monika Bielecki, Scott Macdonald, Ana Lucia Mateus, Darold Sturgeon, Lori Jane Nelson, Ingeborg Keyser, Lynda June Hamley, Melinda Joy Parenteau and Dr. Joshua Nordine

Petitioners

And

Attorney General for the Province of British Columbia and
Dr. Bonnie Henry in her capacity as Provincial Health Officer
for the Province of British Columbia

Respondents

Before: The Honourable Mr. Justice Coval

Reasons for Judgment

Counsel for the Petitioners in S224652 and S224731:	P.A. Gall, K.C. M. Nohra S. Gyawali P. Thind, Articling Student
Counsel for the Petitioners in S222427	K.A. Bastow C.E. Le Beau
Counsel for the Respondents:	J. Gibson A.C. Bjornson C. Bant
Place and Dates of Hearing:	Vancouver, B.C. November 20-24, 28-30 December 1 and 18-21, 2023
Place and Date of Judgment:	Vancouver, B.C. May 10, 2024

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Introduction

[1] The petitioners are healthcare workers who have lost their jobs in the British Columbia healthcare system due to being unvaccinated against COVID-19. The respondent is Dr. Bonnie Henry, the Provincial Health Officer of British Columbia ("PHO").

[2] In these proceedings, the petitioners challenge the PHO's two orders of October 5, 2023 ("Orders"), which continued the vaccination requirement for the healthcare workforce in British Columbia which had been in place since October 2021.

[3] The petitioners argue that this continuation of the Orders was an unreasonable exercise of the PHO's statutory powers under the *Public Health Act*, S.B.C. 2008, c. 28 [*PHA*], causing ongoing hardship and harm to the unvaccinated healthcare workers who had lost their jobs, and to the healthcare system itself from the absence of these highly qualified personnel.

[4] The petitioners challenge the reasonableness of the Orders on four main grounds. First, they say that, by October 2023, COVID-19 was no longer "an immediate and significant risk" to public health in British Columbia, and therefore the statutory preconditions for the continued use of the PHO's emergency powers no longer applied.

[5] Second, they say the scientific record no longer indicated that unvaccinated healthcare workers posed any greater risk to vulnerable patients, or the healthcare system generally, than vaccinated workers.

[6] Third, those petitioners who worked remotely or held purely administrative positions argue that their inclusion in the orders was unreasonable, given their lack of contact with vulnerable patients or the frontline healthcare workers who care for them.

[7] Fourth, some petitioners challenge the Orders on constitutional grounds under the *Canadian Charter of Rights and Freedoms*. They argue that, by forcing them to choose between adherence to their fundamental religious and personal beliefs about vaccination, or keeping their jobs in their chosen professions, the Orders infringed their s. 2(a) right to freedom of conscience and religion, and their s. 7 right to liberty and security of the person.

[8] In response, the PHO submits that the Orders were reasonable measures to reduce the risk of transmission of COVID-19 to vulnerable patients and healthcare workers in hospitals and other care settings, and to protect the overall functioning and capacity of these crucial facilities.

[9] The PHO argues that, at the time of the Orders, the medical and scientific information continued to support the effectiveness of vaccination against COVID-19's most serious outcomes and its transmission to others. There was also a rising trend in British Columbia of COVID-19 severe cases and deaths, just as the worst of the respiratory illness season was fast approaching.

[10] The PHO submits that, in those circumstances, continued use of the *PHA* emergency powers was justified to protect the health of British Columbians, particularly the most vulnerable, and to safeguard the capacity of our healthcare system to provide essential services to those suffering from COVID-19 and other illnesses or conditions requiring acute care.

[11] Finally, the PHO says that the Orders did not infringe the petitioners' *Charter* rights. The petitioners remained free to follow their religious and conscientious beliefs by refusing to take the vaccines, which their evidence indicates they all chose to do, and the rights of liberty and security of the person do not extend to the ability to practice the profession of one's choice without complying with the rules and regulations that apply to it.

Summary of Decision

[12] The summary of this decision is as follows.

[13] The key findings regarding the medical and scientific record available to the PHO, as of October 5, 2023, are found in paragraphs 109-177 below. Based on those findings, in my view there was ample evidence in the record to support as reasonable the PHO's conclusions that:

a) Transmission of the virus continued to pose an immediate and significant risk to public health throughout the province, justifying the ongoing use of the emergency powers in the *PHA (*paragraphs 179-198);

b) An unvaccinated healthcare workforce continued to pose a risk to patients, residents, clients and healthcare workers in hospitals and other care settings, and to the functioning of the healthcare system, and to constitute a "health hazard" as defined in the *PHA* (paragraphs 199-209); and

c) It was essential to maintain the high level of workforce vaccination already in place in these settings, as the best means to mitigate these risks and safeguard the public health system in the province (paragraphs 199-209).

[14] Therefore, with one limited exception, the Orders were reasonable in light of the information available to the PHO at the time.

[15] The limited exception is that, in my view, there was a lack of justification in the record or Orders to support as reasonable the decision not to consider requests, under s. 43 of the *PHA*, for reconsideration of the vaccination requirement from healthcare workers able to perform their roles remotely, or in-person but without contact with patients, residents, clients, or the frontline healthcare workers who care for them (paragraphs 210-227).

[16] Regarding the *Charter* challenges, I find that the Orders infringed the s. 2(a) *Charter* rights of those petitioners who refused the vaccines on religious grounds. However, this infringement was reasonable in the circumstances because, on the record available to the PHO, it did not exceed what was necessary to achieve the essential public health objectives of protecting vulnerable patients, residents and clients from serious illness and death, and safeguarding the functioning of the province's healthcare system (paragraphs 223-261, 301-314).

[17] I find that the Orders did not infringe the s. 2(a) *Charter* rights of those petitioners who refused vaccination based on their personal concerns and convictions. On the evidence, these personal perspectives did not rise to the level of constitutionally-protected matters of conscience (paragraphs 239-245, 253-254, 262-263).

[18] Finally, regarding the petitioners' s. 7 *Charter* rights, I find that the Orders did not engage their rights to liberty or security of the person. The Orders did not compel them to accept unwanted medical treatment, and so did not interfere with their bodily integrity or medical self-determination. Further, under the case law, s. 7 protects neither the right to work in any specific employment or particular profession, nor the right to avoid the stress and hardship of being denied employment in a profession due to non-compliance with its governing rules and regulations (paragraphs 264-300).

[19] The petitions are therefore dismissed with the exception that, under s. 5(1) of the *Judicial Review Procedure Act*, R.S.B.C. 1996, c. 241, I remit to the PHO for reconsideration, in light of this decision, whether to consider s. 43 *PHA* requests for reconsideration of the vaccination requirement from healthcare workers able to perform their roles remotely, or in-person but without contact with patients, residents, clients, or the frontline healthcare workers who care for them.

The Petitioners

[20] In this hearing, three petitions were heard together.

[21] The first petition was filed on March 16, 2022, by eleven petitioners, made up of nurses, managers, administrators, therapists and one doctor ("Tatlock Petition"). Having worked across the province in hospitals, care and community living centres, and health service offices, they lost their jobs between October and December 2021 for being unvaccinated. Many among this group described themselves as solely administrative or remote workers whose roles did not require contact with patients or frontline healthcare workers. Their individual circumstances are summarized in paragraphs 221 and 254 below.

[22] The second petition was filed on June 8, 2022, by Ms. Peternella Hoogerbrug ("Hoogerbrug Petition"). Ms. Hoogerbrug is a nurse practitioner, previously employed in an urgent care centre within the Fraser Health Authority. She was terminated from her job in May 2022, having refused the vaccine for religious reasons.
Ms. Hoogerbrug is a member of the Reformed Congregation in North America. Her faith is an integral and deeply rooted part of her life and identity. Her Church opposes vaccination on the basis that it "interferes with the providence of God". Its teachings include that placing one's trust in the vaccine, rather than God, can lead to idolatry. In October 2021, she applied for a vaccination exemption which was denied. She deposed to being devastated by losing her job due to adherence to her faith, and that providing healthcare services has been a core aspect of her identity. The majority of alternative job postings she has seen for nurse practitioners are for settings subject to the Orders or in private clinics that have instituted similar requirements.

[23] The third petition was filed on June 10, 2022, by three petitioners ("Hsiang Petition"). Two are doctors, Dr. York Hsiang, a surgeon from Vancouver General Hospital, and Dr. David Morgan, a psychiatrist from Prince George Youth Forensic Clinic. The third, Ms. Hilary Vandergugten, is a registered nurse who was the clinical coordinator at Langley Memorial Hospital. All three refused vaccination based on their personal convictions and risk-benefit analyses.

[24] Dr. Hsiang is a vascular surgeon. In 2015, he ceased performing surgery and instead provided consultation services and referrals to other surgeons. He was also a professor at the University of British Columbia. He chose to retire in November 2021, at the age of 67, rather than face termination of his consultation and teaching roles. He chose not to receive the vaccine based on his own "medically-informed risk-benefit analysis in relation to my health and personal circumstances, and the risks posed by the virus and from vaccination to [him] personally", and his strong belief that such matters should be his choice to make. He deposed that providing healthcare services to the public has long been a core aspect of his identity and a

source of pride, and being forced to retire in this way caused him to suffer personal, professional and financial harm.

[25] Dr. Morgan was terminated from his role at the Prince George Youth Forensic Clinic in December 2021, where he assessed and treated youths in the criminal justice system. He was also the regional clinical director for northern British Columbia, where he participated in establishing goals for the Ministry's Youth Forensic Psychiatrist Services. He decided not to accept the vaccine based on his assessment of the risks and benefits given his personal circumstances, particularly that he was in good health and had likely already contacted and recovered from the virus. He has maintained a full-time private psychiatry practice and his role as a clinical assistant professor in UBC's Faculty of Forensic Psychiatry.

[26] Ms. Vandergugten was terminated in February 2022 from her position as patient care coordinator in the Emergency Department of the Langley Memorial Hospital, where she worked for 27 years. She decided against the vaccine based on her own "medically-informed risk-benefit analysis in relation to my health and personal circumstances", including that she was in good health and had already contracted and recovered from the virus. She described the loss of her job as impacting her financially and emotionally. She deposed that "it is very isolating losing my career due to my vaccination status. I loved my job. I loved learning, teaching, and helping people who were often at their most vulnerable". At the time of her affidavit, she was working part-time conducting COVID-19 testing in the film industry.

[27] The petitioners' reasons for vaccination refusal divided roughly evenly between religious beliefs and personal convictions. In their affidavit evidence, they took strong exception to being forced to choose between what they saw as an invasive, unwanted vaccine and keeping their healthcare jobs. Nearly all viewed vaccination as a personal health decision that should be a matter of choice.

[28] Most who refused on religious grounds referred to the conflict between their Christian beliefs and the use of fetal cells in the vaccines' development. Some described accepting the vaccine as contravening their obligation to trust in God's will

and providential care, protect their body from contaminants, or make their own moral decisions without coercion. A senior director of two hospitals described the vaccine as containing contaminants that offended the teaching that the body is “the temple of the Lord”.

[29] Those who refused for secular reasons expressed doubts about the safety and efficacy of the vaccines, citing studies and personal experiences of exaggerated benefits, negative side effects, and lack of rigorous testing. Some emphasized concerns about government transparency and access to reliable information. Many pointed to their personal risk/benefit assessments, focussing on their youth, good health, and natural immunity from prior COVID-19 infections. They recounted witnessing serious vaccine reactions, such as vertigo and bladder control issues, and seeing the vaccinated fall ill with COVID-19. Many described the vaccines as “rushed to market”, and some perceived the vaccines to be a “genetic experiment”.

[30] Their medical reasons for refusal included previous allergic reactions to flu shots, pregnancies or planned pregnancies, and compromised immune systems from blood or inflammatory conditions. Some had made unsuccessful medical exemption requests under s. 43 of the *PHA*.

[31] Many petitioners described severe consequences from losing their jobs for vaccine refusal. Most were placed on unpaid leave in the fall of 2021 and then terminated by their employers a few weeks later. Generally, they were terminated “for cause”, and so were ineligible for severance or employment insurance benefits. They lost jobs that included pension and insurance plans. A nurse who worked with mental health patients alleged losing over 1,000 hours of accrued sick time without compensation. Some deposed to abrupt terminations without time to prepare transitional care plans or explain their departures to colleagues or patients. Some described fighting for a better outcome, or voicing grievances to their employers and government decision-makers, all to no avail.

[32] With limited opportunity to practise their professions in British Columbia outside of the public health and long-term care settings, most petitioners described

remaining unemployed or underemployed. Some contemplated relocating to work elsewhere in Canada or the United States. Some described serious financial hardship, including limited means to pay for food and housing for themselves and their children. Many described stress, anxiety, depression, and feelings of being stigmatized and pariahs for losing their healthcare jobs in this fashion.

The PHO and Public Health

[33] Dr. Henry is a medical doctor with a master's degree in public health (epidemiology). As PHO during the pandemic, she had the formidable responsibility of making the public health decisions required to manage and prevent illness and death from this terrible disease, while at the same time reasonably balancing individual rights.

[34] As PHO, Dr. Henry is the senior public health official for British Columbia. In that role, she is responsible for monitoring the health of the population and providing independent advice to ministers and public officials on public health issues (*PHA*, ss. 64, 66). Dr. Henry has extensive experience in public health and preventative medicine. She has been a member of the Faculty of Medicine at the University of British Columbia and the University of Toronto. In 2000, she was the senior Canadian assigned to a World Health Organization ("WHO") mission to assist with the large-scale outbreak of Ebola in Uganda. While Associate Medical Officer of Health for the City of Toronto, she was the operational lead for the SARS outbreak in 2003. She was also formerly the Provincial Executive Medical Director for the BC Centre for Disease Control ("BCCDC"), the scientific and operational arm of the Public Health Office.

[35] Public health is one component of the Province's healthcare system. From the perspective of caring for the population as a whole, it aims to reduce premature death, and minimize the effects of disease, disability, and injury.

[36] When transmissible viruses like COVID-19 are present, public health initiatives seek to prevent and manage outbreaks, reduce the risk of infections, serious illnesses, and premature deaths, and protect the healthcare system's ability

to service the diverse medical needs of the population as a whole. The public health system is also responsible for developing and delivering province-wide vaccination programs.

The Public Health Act

[37] The PHO made the October 2023 Orders under the statutory authority conferred by the *PHA,* specifically ss. 30, 31, 32, 39, 53, 54, 56, 57, 67(2) and 69.

[38] The legislative framework of these parts of the *PHA* was summarized by the Court of Appeal in *Beaudoin v. British Columbia (Attorney General)*, 2022 BCCA 427, leave to appeal ref'd [2023] S.C.C.A. No. 78, as follows:

> [30] Section 30(1)(a) of the *PHA* provides that a health officer may issue an order if they reasonably believe that a health hazard exists. "Health hazard" is defined under s. 1 to mean "(a) a condition [or] a thing … that (i) endangers, or is likely to endanger public health" or "(b) a prescribed condition [or] thing … that (i) is associated with injury or illness…".
>
> [31] Section 31(1)(b) of the *PHA* provides that a health officer (or the PHO in an emergency) "may order a person to do anything that the health officer reasonably believes is necessary for any of the following purposes: … (b) to prevent or stop a health hazard, or mitigate the harm or prevent further harm from a health hazard."
>
> [32] Section 32(2) of the *PHA* provides that without limiting s. 31, a health officer (or the PHO in an emergency) may make one or more of the broad-ranging orders enumerated therein.
>
> [33] Section 39(1) of the *PHA* provides that orders made under Part 4 – Division 4 of the *PHA* (including ss. 30–32) must be made in writing and describe, among other things, who must comply with the order, what must be done or not done pursuant to the terms of the order, the date on which, or the circumstances under which, the order is to expire (if the date or circumstances are known) and how a person affected by the order may have the order reconsidered. Pursuant to s. 39(3), an order may be made in respect of a class of persons. Section 42(1) provides that a person named or described in an order must comply with the order.
>
> [34] The circumstances in which a person affected by an order may request reconsideration of the order are set out in s. 43 of the *PHA*….[T]he relevant provisions of s. 43 are set out below:
>
> > 43 (1) A person affected by an order, or the variance of an order, may request the health officer who issued the order or made the variance to reconsider the order or variance if the person

> (a) has additional relevant information that was not reasonably available to the health officer when the order was issued or varied,
>
> (b) has a proposal that was not presented to the health officer when the order was issued or varied but, if implemented, would
>
> (i) meet the objective of the order, and
>
> (ii) be suitable as the basis of a written agreement under section 38 [*may make written agreements*], or
>
> (c) requires more time to comply with the order.
>
> (2) A request for reconsideration must be made in the form required by the health officer.
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> (3) After considering a request for reconsideration, a health officer may do one or more of the following:
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> (a) reject the request on the basis that the information submitted in support of the request
>
> (i) is not relevant, or
>
> (ii) was reasonably available at the time the order was issued;
>
> (b) delay the date the order is to take effect or suspend the order, if satisfied that doing so would not be detrimental to public health;
>
> (c) confirm, rescind or vary the order.
>
> (4) A health officer must provide written reasons for a decision to reject the request under subsection (3)(a) or to confirm or vary the order under subsection (3)(c).
>
> (5) Following a decision made under subsection (3)(a) or (c), no further request for reconsideration may be made.
>
> (6) An order is not suspended during the period of reconsideration unless the health officer agrees, in writing, to suspend it.
>
> …

[35] Section 44 provides that a person affected by an order may request a review of the order, but only after the order has been reconsidered pursuant to s. 43.

[36] Section 45 provides that, subject to the regulations, a person affected by an order may request the health officer who issued the order to reassess the circumstances relevant to the making of the order to determine whether it should be terminated or varied.

> [37] Part 5 of the *PHA* provides for enumerated emergency powers. For present purposes, an "emergency" is defined in s. 51 to mean a regional event that meets the conditions set out in s. 52(2). A "regional event" means "an immediate and significant risk to public health throughout the region or the province".
>
> [38] Pursuant to s. 52(2) of the *PHA*, emergency powers must not be exercised in respect of a regional event unless the PHO provides notice that they reasonably believe at least two of the following criteria exist:
>
> > (a) the regional event could have a serious impact on public health;
> >
> > (b) the regional event is unusual or unexpected;
> >
> > (c) there is a significant risk of the spread of an infectious agent or hazardous agent;
> >
> > (d) there is a significant risk of travel or trade restrictions as a result of the regional event.
>
> [39] In an emergency, a health officer (including the PHO) may, pursuant to ss. 54(c) of the *PHA*, do orally what must otherwise be done in writing. In addition, pursuant to s. 54(1)(h), a health officer (including the PHO) has the authority not to reconsider an order under s. 43, not to review an order under s. 44, and not to reassess an order under s. 45.
>
> [40] Sections 70–72 of the *PHA* provide for the appointment of medical health officers who exercise powers within the geographic area of British Columbia to which they are designated …

[39] Under s. 56, the PHO may order persons to take vaccinations as a preventative measure in an emergency. In a non-emergency, persons can refuse such preventative measures if they believe them harmful to their health or object for reasons of conscience (s. 16). In an emergency under Part 5 of the *PHA*, however, the PHO may order that compliance is required except for persons with written notice from a medical practitioner that compliance would seriously jeopardize their health (s. 56(2)).

[40] Under s. 59(b), the authority to act under emergency powers for a regional event such as COVID-19 ends when the PHO provides notice that the emergency has passed.

The COVID-19 Pandemic

[41] The PHO relied on the following description of the exceptional nature of the COVID-19 pandemic, from *Ontario v. Trinity Bible Chapel et al,* 2022 ONSC 1344, aff'd 2023 ONCA 134, leave to appeal ref'd [2023] S.C.C.A. No. 168:

> [1] 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.

[42] British Columbia diagnosed its first case of COVID-19 on January 27, 2020. On January 30, 2020, the WHO declared a public health emergency of international concern. On March 11, 2020, it declared a pandemic, due to the extensive international spread of the infectious agent SARS-CoV-2 that causes COVID-19.

[43] By mid-March 2020, British Columbia was in the first wave of the pandemic. Case counts rapidly rose and it became clear that an infected person could transmit the virus to others in close quarters. There was no treatment or cure, and no vaccine to protect against transmission.

[44] On March 17, 2020, the PHO gave notice, under *PHA* s. 52(2)*,* that the spread of SARS-CoV-2 constituted a "regional event" as defined in s. 51. As explained above, this permitted the PHO to exercise the emergency powers under Part 5, including oral and written public health orders. Never before in British Columbia had these powers been implemented in response to a communicable disease. On March 18, 2023, the Minister of Public Safety and Solicitor General declared a state of emergency throughout the province pursuant to the *Emergency Program Act*, R.S.B.C. 1996, c. 111.

[45] Later in March, the PHO began issuing the public health orders responding to the pandemic. Since that time, she 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.

[46] SARS-CoV-2 has proven highly infectious and has come in waves of different dominant variants. In mid-October 2020, the province began experiencing its second wave, causing a surge of hospitalizations and admissions to intensive care units. Further waves occurred in March and July 2021. Surgeries were suspended and reduced throughout much of 2020 and 2021.

[47] Vaccines were introduced near the end of 2020, while the Delta variant was still dominant. British Columbia's immunization plan for the two-dose primary series was developed through collaboration between the PHO, the provincial and federal governments, the BCCDC, and regional health authorities. Expert leaders were retained to spearhead the initiative, and special working groups were established to oversee and implement this massive initiative. Health Canada conducted a rigorous scientific review of the available medical evidence to assess the safety of the approved COVID-19 vaccines.

[48] By the fall of 2021, Omicron was developing into the dominant variant of concern, and so its severity, contagiousness and response to the vaccines were being studied and assessed. Its sub-variants remained dominant in British Columbia at the time of the 2023 Orders.

[49] By early January 2022, Omicron's greater transmissibility brought a fifth wave of COVID-19 to British Columbia, with case rates and hospitalizations in excess of any prior stage of the pandemic. BCCDC data for the fall of 2021 and into 2022 showed cases, hospitalizations and deaths surging, and over 8,000 surgical postponements.

[50] By this time, as described by the PHO in an April 5, 2022 media briefing, over 90% of eligible adults in British Columbia had received the two-dose primary series, and 60% had received a third booster dose. In other briefings, the PHO advised that hospitalizations were increasing at the same time that healthcare workers were ill

and absent from work more than ever before. On April 5, 2022, the PHO reported that over 3,000 people in British Columbia had died of COVID-19 during the pandemic.

[51] Throughout 2022–2023, the PHO, BCCDC and others continued to monitor COVID-19 care-facility outbreaks, hospitalizations, critical care admissions, and deaths. At times, the healthcare system was stretched beyond capacity. In January 2023, the number of those hospitalized in British Columbia was 110% of base-bed capacity (or 87% of total beds plus surge-bed capacity). Non-urgent surgeries continued to be postponed and some regions faced overnight closure of emergency departments.

[52] On September 12, 2023, Health Canada approved an updated mRNA vaccine tailored to the newly-dominant sub-variant known as “XBB 1.5”, which is a sub-lineage of Omicron. The original two-dose primary series was phased out and National Advisory Committee on Immunization (“NACI”)[1] strongly recommended that individuals six months of age or older receive this XBB 1.5-specific vaccine.

[53] In a media briefing on September 28, 2023, the PHO discussed XBB 1.5 and emphasized that unvaccinated people remained most at risk for illness and hospitalization. She noted increasing COVID-19 rates, the fall respiratory virus season, and the need for vaccination of the healthcare workforce to preserve its ability to provide care, including for the most vulnerable.

The October 5, 2023 Orders

[54] The Orders are entitled “Hospital and Community (Health Care and Other Services) COVID-19 Vaccination Status Information and Preventive Measures Order” and “Residential Care COVID-19 Vaccination Status Information and Preventive Measures Order”.

1 NACI is a national advisory committee of experts in multiple fields that provides guidance on the use of vaccines to the Government of Canada.

[55] The two Orders are similar, except the former is addressed to hospital and community care settings, and the latter to long-term care facilities, private hospitals and assisted living residences. They are lengthy and complex. When referring to specific paragraphs, I will use the Hospital and Community Care Order.

[56] The Orders continued the vaccine mandate for healthcare workers that had commenced in October 2021, and was repealed and replaced by subsequent orders in November 2021, September 2022, and April 2023. As with the prior orders, the October 2023 Orders contained no expiration date.

[57] The prior orders required all healthcare workers across the province's hospitals, community health facilities, and residential and long-term care settings to have received at least the original two-dose, primary series of the vaccine introduced in British Columbia in December 2020. During the hearing, counsel advised that: (i) at the time of the Orders, all healthcare workers in the designated facilities had received the primary series, apart from approximately 35–40 workers who had obtained medical-deferral exemptions under *PHA* ss. 43 and 56(2); and (ii) approximately 1,800 healthcare workers had lost their jobs due to being unvaccinated contrary to these mandates.

[58] The Orders did not alter the mandate for healthcare workers already vaccinated with the primary series. They were not required to receive the new XBB.1.5 dose, though it was highly recommended. The Orders explained this was because of the high level of immunity amongst those already working within the healthcare sector, due to multiple factors such as the primary series of vaccines, boosters, and natural immunity from infections.

[59] The Orders did require the XBB.1.5 vaccine, however, for unvaccinated workers seeking new employment. This reflected Health Canada's approval of this updated mRNA vaccine tailored to XBB.1.5 and the associated phasing out of the primary series.

[60] They also reaffirmed the PHO's decision not to accept s. 43 requests for reconsideration of the Orders, other than for a medical deferral under s. 56(2). This continued the PHO's order, first made on November 9, 2021, exercising her power under s. 54(1)(h) to halt s. 43 reconsideration requests except for the limited medical deferrals mandated by s. 56(2).

[61] Focussing on the Hospital and Community Order, it includes 54 paragraphs of recitals, describing the context and reasoning underlying the vaccination mandate. The recitals address: the epidemiology of COVID-19; the importance and effectiveness of vaccines; post-infection immunity; impacts on the hospital and community healthcare systems; and, the balancing of the competing interests of the unvaccinated.

[62] After the Recitals come the PHO's key conclusions about the importance of workforce vaccination in medical and care settings ("Conclusions'). In the Hospital and Community Order, the Conclusions say this:

> **Therefore, I have reason to believe and do believe that**
>
> (a) An unvaccinated workforce in hospital and community care[2] settings poses a risk to patients, residents and clients, to other workers and to the functioning of the health-care system, and constitutes a health hazard under the *Public Health Act*;
>
> (b) The provision of care or services by an unvaccinated person in a hospital or community care setting puts patients, residents, clients and other workers at risk of infection with SARS-CoV-2, and constitutes a health hazard under the *Public Health Act*[3];
>
> (c) It is essential to maintain the high level of vaccination currently in place in the hospital and community care workforce since this is the best means available by which to mitigate the risk to the health of patients, residents, clients and workers and to ensure the preparedness and resiliency of the health care system, both at present and in the event of a resurgence of COVID- 19 disease in the province;

2 "Community care" and "care location" are defined in the Orders. Care locations include hospitals, community health centres, assisted living residences, and other provincial health facilities and agencies. They include, among other things, home nursing and support, mental health, drug and alcohol care, counselling, and health care provided in an office or clinic.
3 "Health hazard" is defined in s. 1 of the *PHA* to include a thing 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.

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

(e) A lack of information on the part of employers and operators about the vaccination status of workers interferes with the suppression of SARS-CoV-2 in hospital and community care settings, and constitutes a health hazard under the *Public Health Act*;

(f) Medical health officers need to know the vaccination status of workers in order to most effectively respond to clusters or outbreaks of COVID-I9 among patients, residents, clients or workers;

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

[63] The Orders then set out, in just under 20 pages for the Hospital and Community Order, their terms, including specifying which public healthcare and community care employers are captured, details of the vaccination requirements, and status information and records-of-proof required of employees.

[64] Pursuant to *PHA* s. 54(1)(h) and 56, the Orders continue to suspend the ability of an individual to apply for a s. 43 reconsideration, except for a medical deferral on the basis that "vaccination would so seriously jeopardize the individual's health that the risk to the individual's health posed by vaccination outweighs the benefit" (see Article F, "Variance and Reconsideration").

Reasonableness Review

[65] The parties agree that this judicial review of the Orders is to apply the reasonableness standard, not correctness. Under *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65, reasonableness is the presumptive standard where the legislature has created a decision-maker such as the PHO to

administer a statutory scheme. None of the established exceptions that would alter that standard apply in this case.

[66] Thus, the essential question of this judicial review is whether the Orders were reasonable in light of the information available to the PHO at the time.

[67] The aim of a reasonableness review is to balance: (a) deference for the legislative intent to leave certain decisions to the administrative body, with, (b) the constitutional role of judicial review to ensure that exercises of state power are subject to the rule of law (*Vavilov,* para. 82).

[68] In this way, the goal is to maintain the rule of law and safeguard the legality, rationality, and fairness of the administrative process while according appropriate deference to the statutory delegate's decision (*Vavilov,* para 13).

[69] A reviewing court must take a "reasons first" approach, which evaluates the administrative decision-maker's justification for its decision rather than the conclusion the court itself would have reached in the decision-maker's place. Reasons must be read "in light of the record and with due sensitivity to the administrative regime in which they were given" (*Vavilov*, para. 103). Absent exceptional circumstances, a reviewing court will defer to an administrative decision-maker's factual findings (*Mason v. Canada (Citizenship and Immigration)*, 2023 SCC 21, para. 73).

[70] The decision-maker's specialized knowledge and experience are relevant considerations, calling for an understanding of the institutional limitations of the court and a correspondingly respectful measure of judicial deference (*Vavilov,* paras. 31, 75, 93).

[71] As stated by our Court of Appeal in *Beaudoin* (at para. 150), 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.

[72] In *Beaudoin*, the Court of Appeal characterized the PHO's actions to safeguard public health in response to COVID-19's unprecedented threats, "a textbook recipe for deferential review" (para. 152). Justice Fitch said:

> [150] 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 …

[73] The Court went on to adopt (para. 150) the following from Chief Justice Joyal in *Gateway Bible Baptist Church et al. v. Manitoba et al*., 2021 MBQB 219, para. 292:

> … Although courts are frequently asked to adjudicate disputes involving aspects of medicine and science, humility and the reliance on credible experts are in such cases, usually required. In other words, where a sufficient evidentiary foundation has been provided in a case like the present, the determination of whether any limits on rights are constitutionally defensible is a determination that should be guided not only by the rigours of the existing legal tests, but as well, by a requisite judicial humility that comes from acknowledging that courts do not have the specialized expertise to casually second guess the decisions of public health officials, which decisions are otherwise supported in the evidence.

[74] At the same time, however, a reasonableness review must not be a mere "rubber-stamping" process that shelters administrative decision-makers from accountability. It must remain a "robust form of review" that highlights "the need to develop and strengthen a culture of justification in administrative decision making" (*Beaudoin,* para. 143; *Mason,* para. 63).

[75] This balancing is described as "a thoughtful deference that recognizes the complexity of the problem presented to public officials, and the challenges associated with crafting a solution" (*Beaudoin,* para. 151).

[76] *Vavilov* identified two types of "fundamental flaws" indicating the unreasonableness of an administrative decision: a failure of rationality internal to the reasoning process; and, a failure of justification given the legal and factual constraints bearing on the decision (*Vavilov,* para. 101; *Mason,* para. 64). A reviewing court need not categorize unreasonableness as falling into one category or another. They are simply a helpful way of describing how a decision may be

unreasonable. In each case, “the key question is whether the omitted aspect of the analysis causes the reviewing court to lose confidence in the outcome reached by the decision maker” (*Mason*, para. 69).

[77] Particularly important in a case such as this, where the decisions under review imposed serious consequences on the petitioners, is what *Vavilov* called the principle of “responsive justification” (para. 133). Because the *PHA* entrusts the PHO with an extraordinary degree of power over the lives of ordinary people, particularly in an emergency, there is a “heightened responsibility” to ensure that the reasons “reflect those stakes” by demonstrating consideration of “the consequences of a decision and that those consequences are justified in light of the facts and law” (*Vavilov*, paras.133–135; *Mason,* para. 76; *Beaudoin*, para. 148).

The Record

[78] The parties agree that, apart from general background, the evidence in this judicial review is confined to the record before the PHO when she made the Orders. This is because of the limitations on the court’s supervisory role described above.

[79] The “record of proceeding” is defined in s. 1 of the *JRPA* to include documents produced in evidence before the tribunal and the tribunal's decision and reasons given by it.

[80] In a non-adjudicative situation such as this, the record must be constructed. It potentially involves vast amounts of public health information and scientific evidence accumulated over the past three and a half years of the pandemic. The PHO’s orders have been regularly updated to respond to local surveillance data, information about evolving situations from other PHOs, the BCCDC, the Public Health Agency of Canada (“PHAC”), NACI, the WHO, and other national and international epidemiological information about the spread of COVID-19. (See the prior decision in these proceedings concerning the record, indexed at 2023 BCSC 284.)

[81] Recital WW of the Hospital and Community Order provides a summary of the types of information the PHO considered in arriving at the Orders:

> WW. I … continually engage in the reconsideration of these measures, based upon the information and evidence available to me, including case rates, sources of transmission, the presence of clusters and outbreaks, the number of people in hospital and in intensive care, deaths, the emergence of and risks posed by virus variants of concern, vaccine availability, immunization rates, the vulnerability of particular populations, reports from the rest of Canada and other jurisdictions, scientific journal articles reflecting divergent opinions, and opinions expressing contrary views to my own submitted in support of challenges to my orders …;
>
> [Emphasis added.]

[82] The record constructed for court purposes included three affidavits from Dr. Emerson, the Deputy Provincial Health Officer, plus additional affidavits appending numerous COVID-19 publications and medical briefings.

[83] Throughout the COVID-19 pandemic, Dr. Emerson has been the Deputy PHO with the Ministry of Health. Working closely with the PHO on many aspects of the COVID-19 response, he was the lead public health official involved in drafting and amending PHO orders under the *PHA*, including the orders under consideration in these proceedings.

[84] His affidavits provided background information about the COVID-19 pandemic and described the responses taken by the PHO and her team. Such evidence is admissible in judicial review cases such as this, involving procedural and factual complexity and a voluminous, evolving record. Such evidence may, “in a neutral and uncontroversial way”, review the steps taken and evidence considered by the administrative decision-maker (*Beaudoin*, para. 51).

[85] The record contains over 6,000 pages of material documents said to have been before the PHO when she made the Orders. This includes: dozens of BCCDC Situation Reports; NACI reports, recommendations and summaries; PHAC Monitoring Reports and Scans of Evidence; other federal government COVID-19 Immunity Task Force research newsletters and reviews; PHO media and public

briefings and modelling presentations; and many other reports and studies. It also includes Dr. Emerson's affidavits in other proceedings, and numerous medical reports and affidavits provided by the petitioners primarily in 2022.

Issues and Remedies

[86] In terms of the reasonableness challenges, in my view the key issues for decision are whether, on the record as of October 5, 2023, it was reasonable for the PHO to conclude that:

a) COVID-19 continued to pose an immediate and significant risk to public health, satisfying at least two of the four conditions in *PHA* s. 52(2);

b) the primary series of vaccination continued to materially reduce the risk of transmission; and

c) remote and administrative workers should be included within the Orders, without a right of reconsideration under s. 43.

[87] In terms of the *Charter* challenges, I see the key issues as:

a) Whether the Orders limited *Charter* ss. 2(a) or 7 rights or values?

b) If so, did they reflect a proportionate balancing of those rights or values with the public health objectives in issue?

[88] In terms of remedy, the Hoogerbrug and Hsiang petitioners assert that the Orders should be quashed because of the unreasonableness of the PHO's position that an emergency, as defined in the *PHA*, continued to exist. As a result, they argue, the Orders should not survive judicial review because they were adopted on a flawed understanding of the PHO's statutory authority (*Vavilov,* para. 86; *Mason*, para. 101).

[89] In the alternative, they seek directions, under *JRPA* s. 5(1), for the PHO to reconsider and determine whether to maintain the Orders, in light of the findings they seek about the absence of an immediate and significant risk to public health from either COVID-19 or unvaccinated healthcare workers.

[90] Regarding Ms. Hoogerbrug's s. 2(a) challenge, she seeks a finding that the omission of a reconsideration process for individuals with sincere religious-based opposition to vaccination, similar to the medical exemption process under s. 56, was unreasonable and disproportionately limited her s. 2(a) rights.

[91] Turning to the Tatlock petitioners, during the hearing they expressly confined their relief to seeking, under *JRPA* s. 5(1), directions to the PHO to provide a meaningful s. 43 reconsideration process for remote and administrative workers and for those whose ss. 2(a) and 7 rights had been infringed.

[92] They ask that such directions indicate why it was unreasonable, and not a proper balancing of the applicable *Charter* rights, to: (a) include remote and administrative workers; and (b) terminate the reconsideration process for those with religious or conscientious reasons for vaccination refusal, or who refused vaccination on s. 7 grounds.

[93] The Tatlock petitioners also sought "an expanded basis" for s. 43 medical exemptions, but in my view they provided neither a factual foundation for such relief, nor specifics of what they were seeking.

Analysis

Reasonableness Challenges

[94] As described above, the petitioners' core argument is that, by October 2023, the medical and scientific record no longer provided a reasonable basis to support the conclusions that: (i) COVID-19 posed an immediate and significant risk to public health, or (ii) unvaccinated healthcare workers posed any greater risk to vulnerable patients, residents or clients in the healthcare and community care settings in questions (whom I will now refer to simply as "patients"), or the healthcare system generally, than vaccinated workers who received the initial two-dose series first offered in December 2020.

[95] On argument (i), the petitioners submitted that, while at one time COVID-19 did present a public health emergency justifying the use of emergency powers, by

October 2023 that had passed due to greater scientific certainty, less severe variants, vaccinations, and natural immunity.

[96] They argued that, by continuing the vaccine mandate in October 2023, the *PHA*'s emergency powers were being used as a quasi-permanent precautionary measure for a virus which, by that time, the PHO herself described as no more serious than the common cold or flu. In this way, the Orders unreasonably strayed beyond the boundaries of the statutory scheme and failed to comply with its overall rationale and purview (*Mason*, para. 67).

[97] The petitioners pointed to the following PHO statements—in November 2022, January 2023, and April 2023, respectively—describing COVID-19 as no more severe than other respiratory infections, even for the vulnerable and immuno-compromised, and indicating the end of the emergency phase of the pandemic:

> What we do know is that right now it's really important for people to get that booster dose to protect us all from infection and help dampen down the transmission of COVID-19. And we know that the combinations we've seen mean that most people in BC are no longer at risk of severe illness and hospitalization -- even in long-term care, even people who are immunocompromised. And that is really important.
>
> …
>
> We do have the best protection that we have through vaccination; that level of immunity in our communities is that buffer. That means COVID is not causing any more severe illness than other respiratory infections, so to try and incrementally reduce transmission above that, we would have to take additional measures that would impact people's ability to do important things in their lives …So the most important thing that we can do as a community – and people in BC have done this – is to get vaccinated… [COVID is] another virus that we have to deal with. We are in a very different situation.
>
> I think we've been coming out of the emergency phase… I think in the next few months we're likely to be able to say we're no longer in a pandemic. We're sort of in a bit more of a steady state now, but we still don't know yet about the periodicity or the seasonality of the virus. We have some ideas that its worse in the winter when other things are worse and a little bit easier in the summer and were sort of seeing that, but we'll have to watch that.

[98] The petitioners also pointed to the WHO declaration, in May 2023, that "it is time for countries to transition from emergency mode to managing COVID-19 alongside other infectious diseases."

[99] The petitioners also relied on the fact that, by October 2023, the PHO had terminated all other emergency mandates—such as masking, capacity limits in restaurants, bars and gyms, vaccine passports, and so forth—except for these Orders for healthcare workers. Moreover, by this time, no other province had retained similar healthcare worker orders, although certain hospitals in Ontario and Nova Scotia had similar mandates in their working conditions.

[100] Finally, the petitioners argued that the wording of the Orders themselves revealed the lack of immediate and significant risk to public health. They pointed to the reference in Recital A, to a "reasonable risk" that SARS-CoV-2 "could have a serious impact on public health" or "an unusual or unexpected occurrence of a new variant … could cause serious disease". This, they said, was implicit acknowledgement of only a possible future threat to public health, not the "immediate and significant risk" required under the *PHA*.

[101] On argument (ii), the petitioners strenuously asserted there was nothing in the record to suggest, by October 2023, any difference in risk of infection or transmission between the unvaccinated and those vaccinated with the primary series. They also referred to reports and evidence in the record from their own medical experts, taking the position that no such difference existed. They placed little weight on this latter point, however, recognizing that, for judicial review purposes, the existence of competing views about the risks that were considered and weighed by the PHO was insufficient to establish that her views, or the factual considerations underlying them, were unreasonable based on the entire record.

[102] Regarding absenteeism, they argued that the healthcare system was highly attuned to dealing with absenteeism, and made the point that the system's capacity would be enhanced by return of the approximately 1,800 healthcare workers in British Columbia who had lost their jobs because of the vaccination mandate.

[103] The Tatlock petitioners made the additional argument that extending the Orders to include remote and administrative workers was particularly unreasonable because they posed no risk to vulnerable patients, or frontline healthcare workers.

They argued the unreasonableness was accentuated by the fact that the Orders permitted unvaccinated patients, visitors, and construction workers within these same settings.

[104] In response, the PHO drew a fundamental distinction between the circumstances inside, versus outside, healthcare and community care settings. By October 2023, outside such settings, the PHO had terminated most, if not all, public emergency measures. This, the PHO submitted, demonstrated her commitment to eliminating emergency measures once changes in the medical data and trends made it reasonable to do so.

[105] Inside healthcare settings, on the other hand, there were unique public health concerns. First, the consequences of infection were more serious because healthcare facilities are charged with caring for the medically vulnerable, including those at increased risk due to age or compromised immunity.

[106] Second was the broader issue of maintaining public healthcare capacity across the Province. The PHO pointed to the prior strains on the system when COVID-19 spiked, resulting in postponement of essential surgeries and other care while resources were redirected to the COVID-19 waves of increased serious illness, hospitalizations, and death.

[107] Third, the PHO pointed to the evidence, in the summer and fall of 2023, that key COVID-19 negative indicators were trending upwards, including serious illness and deaths. At the same time, flu and other respiratory illnesses were expected to arrive imminently.

[108] The PHO argued that, when the circumstances in October 2023 were understood and assessed from that perspective, her decision to extend the emergency Orders to protect the healthcare system, and the most vulnerable patients within it, could not be assessed as unreasonable.

Findings Regarding the Record

[109] Before turning to the issues for determination, I will address the key factual disputes about the medical and scientific evidence available to the PHO as of October 5, 2023.

[110] The essential time period for this assessment begins in around November 2021. By then, Omicron was designated the new variant of concern by the WHO, and its severity, contagiousness, and response to the vaccines were being studied and assessed. When the Orders were made in October 2023, sub-variants of Omicron remained dominant in British Columbia.

[111] In my view, the summaries below indicate there was ample evidence in the record, as of October 2023, to support the PHO's Conclusions (quoted in paragraph 62 above) regarding the risks of an unvaccinated workforce and the importance of maintaining its high level of vaccination.

Dr. Dove's Evidence Review

[112] I begin with the September 8, 2022 report by Dr. Naomi Dove, a member of the PHO's public health team. The PHO's oral submissions relied extensively on Dr. Dove's conclusions about healthcare worker COVID-19 infection and transmission, depending on vaccination status. I agree this report is a key aspect of the record for purposes of this judicial review.

[113] Dr. Dove's report is entitled "Impacts of COVID-19 Vaccination on Health Care Worker SARS-CoV-2 Transmission". Its goal was to assess "evidence of health care worker (HCW) transmission of SARS-CoV-2 according to vaccination status during the COVID-19 pandemic."

[114] To accomplish this, Dr. Dove identified, assessed, and summarized studies and reviews, including by other public health organizations, up to August 2022, evaluating the impact of vaccination on immunity and transmission during the

pandemic, and incorporating the "emerging evidence specific to the currently dominant Omicron variant wave".[4]

[115] In reaching her conclusions, Dr. Dove reviewed an extensive array of materials, from British Columbia and around the world, evaluating the impact of vaccination on immunity and transmission. She "prioritized studies higher in the evidence hierarchy, expert syntheses as well as BC data, representing the best quality aggregate evidence". As counsel for the PHO submitted, such prioritization is entitled to significant deference because of the specialized expertise and experience brought to bear.

[116] Dr. Dove's conclusions included the following regarding the role of vaccination in reducing healthcare worker infection and transmission:

> **Conclusion**
>
> …
>
> Studies of household transmission - including among households of health care workers - suggest that fully vaccinated persons [i.e. having received the primary series] are less likely to become infected and contribute to SARS-CoV-2 transmission. …
>
> … Thus a history of vaccination is often the most practical way to assure that an individual has sufficient immune protection and is less likely to transmit SARS-CoV-2.
>
> … [D]uring the Omicron wave individuals who had combined immunity from prior vaccination and an Omicron SARS-CoV-2 infection showed more robust protection against infection compared to those who are unvaccinated …
>
> Lastly, while data is limited, health care workers appear to be a high-risk group for acquiring and transmitting SARS-CoV-2. Since the onset of the COVID-19 pandemic, HCW have experienced a considerable burden of SARS-CoV-2 infections that declined with the onset of mass vaccination, with prior evidence suggesting an elevated incidence among HCW who remain unvaccinated. Throughout the COVID-19 pandemic, numerous outbreaks have occurred in health care settings, including in BC, with data suggesting that HCW are a common contributor to transmission, particularly to colleagues.
>
> … Hybrid immunity appears to provide the most robust protection against infection, particularly observed during the Omicron wave. Ultimately, evidence accumulated throughout the pandemic largely supports the role of vaccination in promoting the dual pandemic goals of protecting patients from

4 The petitioners did not contest the PHO's submission that Dr. Dove's references to "vaccination" were to the primary series unless otherwise indicated.

> SARS-CoV-2 infection and preserving health system capacity, particularly when considering the role of hybrid immunity and booster doses to strengthen the prevention of SARS-CoV-2 transmission moving forward.

[117] The four questions Dr. Dove addressed, and key excerpts from her summary of findings for each, were as follows:

> [**Question 1**]
>
> **What is the evidence regarding the transmission of the SARS-CoV-2 virus by unvaccinated people compared to vaccinated people? What is the evidence regarding SARS-CoV-2 transmission to patients from vaccinated health professionals compared to unvaccinated health professionals?**
>
> Summary: 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. This includes data from household transmission studies in the general population, as well as specifically for households of health care workers (HCW)…
>
> [**Question 2**]
>
> **How does vaccination induced immunity compare to infection induced immunity in terms of transmission risk?**
>
> Summary: Based on immunology and vaccine efficacy data, both SARS-CoV-2 infection and vaccination can induce an immune response that protects against symptomatic COVID-19 illness for at least 6 months, however vaccination leads to a more consistent and reliable antibody response.
>
> …
>
> Overall, studies suggest that the combination of vaccination and infection induced immunity may provide the strongest protection against future infection…
>
> Thus, vaccination is likely the most consistent way to assure that an individual has immune protection and is less likely to transmit COVID-19 illness, particularly with consideration of booster doses and the contribution of recent antigenic exposure through infection…
>
> [**Question 3**]
>
> **What is the risk that health care workers… will transmit SARS-CoV-2 to patients?**
>
> Summary: Data collated during the COVID-19 pandemic has consistently shown a considerable burden of SARS-CoV-2 infections among HCW. … Throughout the COVID-19 pandemic, numerous outbreaks have occurred in health care settings in BC, with HCW identified as a common source of transmission. Evidence directly tracing HCW transmission in health settings is limited, however available data suggests the transmission often originates from infected coworkers in shared workspaces, including outpatient settings.

> Goals of vaccination policies for HCW include protecting patients against SARS-CoV-2 transmission and reducing lost work time…
>
> [**Question 4**]
>
> **What evidence exists regarding the effectiveness of 2-doses vs. 3-doses of COVID-19 vaccine in protecting against SARS-CoV-2 infection?**
>
> Summary: Available clinical and epidemiology studies suggests that a 3rd dose of COVID-19 vaccine boosts antibody titres and restores protection against SARS-CoV-2 infection, largely counteracting the decline in VE observed during the Omicron dominant wave however the duration of boosted protection is uncertain …

[118] The petitioners highlighted certain statements in the Dove Report indicating the primary series to be more effective against Delta than Omicron. The main examples were: “emerging studies of Omicron infection suggest comparable viral loads and duration of viral shedding between vaccinated and unvaccinated individuals”; and, “two-dose protection ... has been substantial up to and including the Delta wave but has declined during the Omicron wave”. However, those statements must be read in the context of the overall summaries and conclusions quoted above.

[119] They also argued for the limited relevance of Dr. Dove’s conclusions because her review was performed only around eight months into Omicron’s dominance, and more than a year before the Orders. In my view, however, it would be an error for me to make such an assessment because: (a) the report repeatedly referred to incorporating the emerging Omicron evidence; (b) the subject matter is extremely technical in nature; and, (c) the petitioners did not demonstrate that the record supported discounting or dismissing the report on such a basis.

[120] In a judicial review such as this, my role is not to assess the competing scientific evidence in the record and decide which to prefer. That is for the PHO and her team. My role is to assess whether her Orders were reasonable in the context of the record before her. As the Hsiang petitioners put it in their Outline/Overview of Argument, the court must not “purport to resolve areas of scientific controversy – but rather .. look at the evidence of whether there is any credible evidence in support of what the PHO is saying.”

[121] I turn next to assessing the evidence in the record regarding the key factual disputes raised between the parties.

Vaccination and protection against serious illness, hospitalization, and death

[122] The Recitals assert that vaccination was the single most important preventative measure against COVID-19 infection, severe illness, hospitalization and possible death (see Recitals M, R, S, U, Z, FF, HH).

[123] The petitioners acknowledged evidence in the record from which the PHO could reasonably conclude that the primary series is safe and effective in reducing the seriousness of illness and hospitalizations from infection with Omicron. However, they downplayed its effectiveness, particularly compared with natural immunity.

[124] I find that, as of October 2023, there was ample evidence in the record to support the statements in the Recitals regarding the continued effectiveness and importance of the primary series, particularly when combined with hybrid immunity and boosters. As counsel for the PHO pointed out, it is important to bear in mind that such combinations of protections were only available to those who had received the primary series.

[125] Some key examples in the record were as follows.

[126] Starting with the Dove Report, as shown above, its conclusions included that the evidence supported vaccination to protect against infection and preserve health system capacity, even more so when considering the role of hybrid immunity and booster doses to strengthen the prevention of SARS-CoV-2 transmission moving forward. Media briefings in the record indicated that, as of September/October 2023, 80% of adults under 80 years old had some degree of natural immunity from prior infection, and most healthcare workers had the primary series plus at least one booster and hybrid immunity.

[127] The Dove Report also stated that, during the Omicron wave, vaccine effectiveness “remained substantial against serious illness”, and that when

combined with boosters, its efficacy reached the high levels previously achieved against Delta:

> During the Omicron dominant wave in BC, two dose VE estimates declined [compared to the Delta wave] but remained substantial against serious illness (65-75% vs. hospitalization, 40-50% ER visits), with a notable decline in protection against SARS-CoV-2 infection (to 10-15%).
>
> However, a 3rd booster dose significantly increased protection up to 90% for Delta associated hospitalization and infection, while a booster dose in the Omicron wave increased protection against hospitalization (>90%) and bumped up protection against any SARS-CoV-2 infection (to [approx.] 50-60%).
>
> Similar vaccine immune profiles have been found among HCW … A cohort study of over 11,000 HCW in India found that almost a fifth were infected during the Omicron wave and exhibited predominantly milder disease in hospital settings …
>
> … [D]uring the Omicron wave … individuals who had combined immunity from prior vaccination and an Omicron SARS-CoV-2 infection showed more robust protection against infection compared to those who are unvaccinated …

[128] The Dove Report also stated that "similar vaccine immune profiles" have been found among healthcare workers, and that the combination of vaccination and prior infection "appears to provide the most robust protection against infection, particularly observed during the Omicron wave."

[129] The PHO's December 14, 2021 presentation on Omicron modelling said:

> 86% of people who are hospitalized are people from that very small group who have not yet been vaccinated and 78% of people in our ICUs and critical care are people who have not been vaccinated. If we break that down further … it really shows [the] picture that age and not being vaccinated are what put you at risk of being hospitalized, [and] will put you at risk of requiring ICU, intubation, critical care and put you at risk of dying.

[130] PHAC's Omicron Monitoring Report, January 11, 2022, said this in its "Summary of Key Epidemiology Information":

> Transmissibility: Higher for Omicron than other variants…
>
> Symptoms and severity:
>
> … Despite being less severe, Omicron is causing significant burden on the health care system because it is very transmissible and resulting in large

> numbers of cases. The impact on the health care system is compounded by Omicron causing illness among health care workers …
>
> Vaccine effectiveness:
>
> … Severe disease with two COVID-19 vaccine doses: A study from England and a study from South Africa note good vaccine effectiveness against hospitalizations after the second dose …
>
> Severe disease with mRNA booster: A study from England noted 88% vaccinated effectiveness against hospitalization from third dose. Another study from the UK in those 65 years of age and over showed the booster was 94% effective against hospitalization within 2 to 9 weeks and 89% effective at 10 more weeks.

[131] On January 21, 2022, the PHO's "Hospital Risk – Preliminary Analysis of Risk" report for cases from mid-December showed that persons with the two-dose primary series were 4.2 times less likely to be hospitalized (controlling for other factors) and those with three doses were 9 times less likely to be hospitalized.

[132] The March 8, 2022 BCCDC report on "Measuring Vaccination Impact and Coverage," stated that: "For Omicron: Two doses provided good protection against severe outcomes." It went on to say that "Two doses prevented about 65-75% of hospitalizations (reducing the risk of COVID-19 hospitalizations by about two-thirds to three-quarters compared to unvaccinated people)."

[133] A September 9, 2022 study by numerous authors of vaccine and infection induced immunity in children and adults in British Columbia, from March 2020–August 2022 stated that "Multiple … studies have reinforced the improved protection afforded by hybrid (vaccine + infection) immunity over that induced by exposure alone."

[134] On December 9, 2022, NACI published a report titled "Updated recommendations on the use of COVID-19 vaccine booster doses in children 5 to 11 years of age and concurrent vaccine administration". Addressing the Omicron variant, it said that NACI "continues to recommend a primary series with an original mRNA vaccine in all authorized age groups." It also said that for young children:

> Hybrid immunity (ie. protection conferred from both vaccination and infection) is more robust than immunity due to either infection or vaccination alone …

> Omicron infection in a previously-vaccinated individual confers a significant protection from reinfection with Omicron …

[135] The March 3, 2023 NACI report "Guidance on additional COVID-19 booster dose in the spring of 2023 for individuals at high risk of severe illness due to COVID-19" reported on the benefits of vaccination as against severe outcome. Under "Vaccine effectiveness and duration of vaccine protection of mRNA COVID-19 vaccine booster doses", it said:

> Vaccine protection against infection and symptomatic disease with original monovalent COVID-19 vaccines has been shown to wane over time; however protection against severe outcome persists longer that protection against symptomatic disease… [Vaccine Effectiveness] against severe disease from booster doses is generally higher and more sustained than against infection.
>
> [Emphasis added.]

[136] In July 2023, NACI advisories stated that:

> Rates of hospitalizations 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 >80 years and those who are unvaccinated... Rates of infection and severe disease are lowest for those recently vaccinated and those with hybrid immunity …

[137] The June 27, 2023 report from the COVID-19 Immunity Task Force stated that

> People vaccinated against COVID-19 are more likely to neutralize Omicron than unvaccinated individuals. A CITF-funded study published in *Microbiology Spectrum* found that vaccinated [blood] donors, regardless of infection status, were more likely than unvaccinated donors to neutralize Omicron …

[138] The July 11, 2023 NACI Advisory Statement stated that:

> In addition to age, vaccination status and prior history of SARS-CoV-2 infection, studies looking at risk factors continue to show individuals with comorbidities are at higher risk for severe outcomes due to COVID-19 in adults.

[139] The September 1, 2023 COVID-19 Immunity Task Force Report concluded that "vaccination helps reduce workplace absenteeism among Canadian healthcare workers." The report summarized a Canadian study that included British Columbia

healthcare workers and found that “absenteeism from work declined with each vaccine dose.”

[140] The record also included evidence to support the statement in Recital N that

> 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. …

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

Vaccination and protection against transmission

[142] The Orders assert that vaccination continued to provide protection against transmission of the virus to others, and therefore the unvaccinated posed a greater risk of transmission than the vaccinated. (See the Conclusions and Recitals E, T, U, FF, HH.)

[143] Regarding healthcare workers in particular, they assert that worker vaccination reduces transmission to others, and so protects the healthcare workforce, reduces absenteeism, and protects the capacity of the healthcare system. (See Conclusions and Recitals H, M, QQ, RR, SS.)

[144] The petitioners strenuously denied there was evidence in the record to support these conclusions, arguing that there was “no evidence in the record that the primary series vaccination makes it any less likely that a person will transmit Omicron to others.” They also referred to the expert evidence they themselves had submitted to the PHO on these issues in 2022, from experts such as Dr. Richard Schabas, a former public health officer in Ontario, and Dr. Shirin Kalyan, an immunologist specializing in immune dysfunction and an Adjunct Professor at the University of British Columbia, Department of Medicine.

[145] I find there was evidence in the record to support the PHO's assertions in the Orders regarding the continued effectiveness of the primary series of vaccination, including that it continued to be an important preventative measure against transmission of the virus, by the healthcare workforce, to both vulnerable patients and other workers.

[146] Regarding healthcare workers in particular, Dr. Dove's report concluded that healthcare workers "are commonly implicated in COVID-19 outbreaks and clusters in health settings … particularly between colleagues". The report referred to numerous studies showing healthcare workers as a common source of transmission to colleagues and patients. On October 2, 2023, the COVID-19 Immunity Task Force reported that a pre-print study found that healthcare workers had a higher incidence of SARS-CoV-2 infection compared to the general population.

[147] The petitioners pointed to statements in the Dove Report appearing to suggest that vaccination status may not affect contagiousness. For example, they emphasized the statement that "Studies during the Omicron wave show similar viral loads and duration of viral shedding between vaccinated and unvaccinated individuals". They referred to similar statements from the Chief Medical Health Officer of Vancouver Coastal Health.

[148] However, as quoted above, Dr. Dove's conclusions were replete with statements about studies finding that vaccinated persons, and vaccinated healthcare workers specifically, were "less likely to …contribute to SARS-CoV2 transmission", and that:

> Studies of household transmission - including among households of health care workers - suggest that fully vaccinated persons [i.e. having received the primary series] are less likely to become infected and contribute to SARS-CoV-2 transmission. …
>
> Thus a history of vaccination is often the most practical way to assure that an individual has sufficient immune protection and is less likely to transmit SARS-CoV-2.
>
> ... Hybrid immunity appears to provide the most robust protection against infection, particularly observed during the Omicron wave. Ultimately, evidence accumulated throughout the pandemic largely supports the role of

> vaccination in promoting the dual pandemic goals of protecting patients from SARS-CoV-2 infection and preserving health system capacity, particularly when considering the role of hybrid immunity and booster doses to strengthen the prevention of SARS-CoV-2 transmission moving forward.

[149] The Dove Report contained further statements to the same effect:

> Available studies suggests 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. This includes data from household transmission studies in the general population, as well as specifically for households of health care workers (HCW)…
>
> Thus, vaccination is likely the most consistent way to assure that an individual has immune protection and is less likely to transmit COVID-19 illness, particularly with consideration of booster doses and the contribution of recent antigenic exposure through infection.

[150] The Dove Report also referred to various studies of the Omicron variant wave, between December 2021 and January 2022, that found the vaccinated had reduced "susceptibility and transmissibility compared to unvaccinated individuals". One such study found vaccination reduced risk of transmission to close contacts by 24%, and by 41% when combined with prior infection.

Protection of vulnerable patients and residents

[151] The Orders assert that those particularly vulnerable to serious outcomes from COVID-19—due to advanced age, health conditions, or compromised immune systems—were at risk of infection from healthcare workers. (See Recitals C, D, LL, MM, OO.)

[152] I find there was evidence in the record to reasonably support the PHO's view that such groups were particularly vulnerable to serious outcomes, and so were both the most in need of protection from COVID-19, and most likely to find themselves in hospitals and long-term care facilities by necessity rather than choice. There was also evidence that their own vaccination provided them with less protection than healthier members of the community compared to others.

[153] As shown above, the Dove Report found that evidence accumulated throughout the pandemic "largely supports" vaccination of healthcare workers to

protect patients from infection, because such workers were less likely to become infected and contribute to transmission.

[154] The Dove Report also said:

> Throughout the COVID-19 pandemic, numerous outbreaks have occurred in health care settings in BC, with HCW identified as a common source of transmission … Goals of vaccination policies for HCW include protecting patients against SARS-CoV-2 transmission and reducing lost work time.

It also said:

> Numerous outbreaks have occurred in acute care and residential care facilities in BC stemming from the early days of the COVID-19 pandemic.

[155] Modelling presentations from the PHO for the BC Ministry of Health in 2020 and 2022 showed that 36% of COVID-19 cases were associated with other chronic conditions (cancer, diabetes, cardiac disease, etc.), which made severe illness more likely. A NACI study, referred to in the PHO's September 6, 2022 Technical Briefing, indicating various medical pre-conditions that "increase the risk of poor outcomes from COVID-19".

[156] A study in March 2023 by the Federal Government's COVID-19 Immunity Task Force indicated that waning of vaccine immunity "seems to occur faster" for people with compromised immune systems from severe health conditions or auto-immune disease. A further NACI study published in July 2023 found that, in addition to age, vaccination status, and prior history of infection, risk factors for serious outcomes included co-morbidities.

Strain on the healthcare system

[157] The Orders asserted that the public health and healthcare systems have at times been stressed beyond capacity by COVID-19, and that preserving the capacity of these systems is critical (Conclusion (c) and Recitals JJ to MM).

[158] I find there was evidence in the record to support the reasonableness of these assertions, including evidence of: (i) Omicron waves causing severe spikes in cases,

hospitalizations, and deaths; (ii) public health and healthcare systems at times being severely stressed, sometimes beyond capacity, by COVID-19.

[159] In *Beaudoin* (para. 69), the Court found that the record as of November 19, 2020, established that the PHO knew the "capacity of the public healthcare system to deliver essential services could be breached during the peak periods of COVID-19 activity".

[160] As shown above, the Dove Report referred to the numerous outbreaks in BC healthcare settings. It stated that "Evidence suggests that HCW are commonly implicated in COVID-19 outbreaks and clusters in health settings", and concluded that vaccination promoted "preserving health system capacity".

[161] In the PHO's December 14, 2021 presentation on Omicron modelling, after referring to the elevated risks for hospitalization and critical care for those over 60, it said:

> It is unvaccinated people, as we get older, who are more and more likely to end up in hospital. This means that in many cases people had to be flown out of their home communities, our hospital system was stretched to care for people and the challenge we now have is that these types of hospitalizations—even with the Delta variant, with the Omicron variant that we're seeing now, we need to protect ourselves.

[162] The COVID-19 briefings indicated various stages in which the pandemic contributed to surgical cancellations and postponements. For example, In March–May 2020, non-urgent surgeries were cancelled. Non-elective surgeries were cancelled throughout the spring of 2020. From September to October 2021, the Provincial Health Services Authority postponed 2,140 surgeries. In the March 10, 2022 modelling presentation to the media with the PHO, the Minister of Health said "[a]ccumulatively from September 5, 2021 to March 5, 2022, regional surges of COVID-19 and [other] factors had caused 8,098 surgical postponements."

[163] In a media briefing on January 14, 2022, the PHO advised that Omicron infecting healthcare workers "has led to staff being off ill in higher numbers than ever before in the pandemic." In the briefing, she referred to 14,591 healthcare workers

off due to illness from January 3–9, 2022, compared with 8,802 for the same time in 2020 which was a “higher influenza and respiratory illness year”.

[164] The January 26, 2022 PHAC Monitoring Report said:

> Despite being less severe, Omicron is causing significant burden on the health care system because it is very transmissible and resulting in large numbers of cases. The impact on the health care system is compounded by Omicron causing illness among health care workers.

The record referred to situations, during some of the early waves, where people had to be flown from their home communities to locations with Intensive Care Units that could treat them.

[165] On June 9, 2023, NACI reported that hospitalizations remained at a relatively high level since the arrival of Omicron. NACI’s July 11, 2023 “Guidance on the use of COVID-19 vaccines in the fall of 2023” said that:

> Transition to long-term management of the COVID-19 pandemic is now needed, but there continue to be uncertainties such as the ongoing epidemiology of COVID-19, duration of protection from current COVID-19 booster doses and previous infection, and vaccine effectiveness (VE) of future vaccines.

Risks in October 2023

[166] The Orders asserted that, since the end of July 2023, COVID-19 indicators of severe outcomes in British Columbia had increased. Compounding this concern was the imminent arrival of seasonal respiratory viruses and infections. According to the Orders, this led the PHO to be “particularly concerned” that unvaccinated healthcare workers could “ravage” vulnerable populations and cause significant absenteeism among the workforce, thereby stressing healthcare facilities and the system. (See Recitals L and TT.)

[167] I find there was evidence in the record as of October 5, 2023 to support this view. Key indicators of COVID-19 pointed to severe outcomes and deaths increasing, while the annual onset of flu and other respiratory illnesses was also imminent.

[168] On March 25, 2022, the PHAC published "Public Health Response Plan for Ongoing Management of COVID-19", which warned that new variants of concern "may be more transmissible, severe and/or immune-evasive". It further said that "uncertainty will continue to factor into risk assessments going forward… [and] will not be known until it is observed over a number of months to years."

[169] On June 9, 2023, NACI reported that "[t]he evolutionary trajectory or SARS-CoV-2, including the emergence of novel variants of concern… remains uncertain". Also, "[r]ates of hospitalizations and deaths in Canada continue to be highest for adults 60 years of age and older, with risk increasing with age and highest among those 80 years of age and older and those who are unvaccinated, and lowest for those recently vaccinated and those with hybrid immunity, particularly if the previous infection was with an Omicron strain." In the same report, NACI recommended that "unvaccinated individuals receive a primary series of COVID-19 vaccines".

[170] On September 12, 2023, NACI published the "Addendum to Guidance on the Use of COVID-19 Vaccines in the Fall of 2023", strongly recommending immunization for "[p]eople who provide essential community services", and identifying those at increased risk to include adults 65 or over, residents of long-term care and assisted living settings, and those with underlying medical conditions.

[171] Its report also said that, based on the available scientific literature, the evolutionary trajectory of SARS-CoV-2 remained uncertain with recombinant XBB sub-lineages continuing to circulate in Canada and globally, and that vaccination of healthcare providers "is expected to be important in maintaining the health system capacity".

[172] In the media briefing of September 28, 2023, the PHO commented on the upcoming trajectory for COVID-19 and the arrival of other respiratory diseases:

> The southern hemisphere can give us some indications of what we might expect this year and what they saw again was, variable COVID over the period of their respiratory virus season. They also saw influenza HINI and Influenza 8, and we're starting to see that that may be what we would see here. Again, those are viruses that particularly affect children. So that's

> something we will be looking out for. And they also saw a variable RSV season.

[173] On October 5, 2023, the BCCDC reported "[i]ncreased COVID-19 activity across the Province". The Centre reported increases in: a) SARS-CoV-2 levels at all wastewater plants across the province; b) COVID-19 cases, particularly for those over 60; and c) COVID-19 cases of patients hospitalized and in critical care.

[174] The parties agreed that three further reports, prepared after October 5, 2023, were also properly part of the record because their information was available to the PHO at the time of the Orders.

[175] The BCCDC's "COVID-19 Situation Report" of October 27, 2023, with British Columbia-specific information, referred to an increase in COVID-19 activity since late August, with indications of decreasing positive tests and hospitalizations in October while "deaths have steadily increased". This report showed 1,282 COVID-19 deaths from April–October 2023 and another 296 with underlying cause of death pending.

[176] On November 2, 2023, the BCCDC "COVID-19 Situation Report" showed that, as of September 2023, the seven-day rolling average of severe outcomes (hospitalizations, critical care admissions, and deaths) had been on the rise since July 2023 and had reached similar levels to the fall of 2021.

[177] Regarding the petitioners' submission that COVID-19 had become no more dangerous than the flu, the PHO pointed to the BCCDC "Respiratory Season Surveillance Report", for August 2022–April 2023, which showed 110 COVID-19 outbreaks declared—47 in long-term care and 63 in acute care facilities, compared with 43 influenza outbreaks.

The Three Reasonableness Challenges

[178] Having found ample support in the record for these fundamental aspects of the Orders, I turn to the petitioners' three reasonableness challenges.

Challenge 1: No Immediate and Significant Risk to Public Health

[179] Under s. 52 of the *PHA*, for the PHO to use the emergency powers in response to a "regional event", there must be "an immediate and significant risk to public health throughout a region or the province", which the PHO "reasonably believes" satisfies two of the four criteria in s. 52(2).

[180] The "regional event" declared by the PHO on March 17, 2020 was "the transmission of the infectious agent SARS-CoV-2".

[181] The four criteria in s. 52(2) are:

> (a) the regional event could have a serious impact on public health;
>
> (b) the regional event is unusual or unexpected;
>
> (c) there is a significant risk of the spread of an infectious agent or a hazardous agent; and
>
> (d) there is a significant risk of travel or trade restrictions as a result of the regional event.

[182] Recital A of the Orders says the PHO believed the s. 52(2) criteria continued to be met for the following reasons:

> (a) In view of the history and ongoing mutation of SARS-CoV-2, and the uncertainty which exists about its future behaviour, there continues to be a reasonable risk that it could have a serious impact on public health;
>
> (b) There is a continued reasonable risk of an unusual or unexpected occurrence of a new variant of SARS-CoV-2 which could cause serious disease among the population; [and]
>
> (c) The infectious agent, SARS-CoV-2 continues to mutate and new variants continue to spread in British Columbia, Canada and around the world.

[183] In my view, the summaries above demonstrate abundant support in the record for the PHO to reasonably conclude that COVID-19 continued to represent a regional event that satisfied ss. 52(2)(a), (b), and (c).

[184] As the Supreme Court of Canada said in *Vavilov* and *Mason*, the governing statutory scheme can play an important part of a reasonableness review. Whether

an interpretation of the governing statutory scheme is justified will "depend on the context, including the language chosen by the legislature in describing the limits and contours of the decision maker's authority" (*Vavilov,* para. 110; *Mason,* para. 67).

[185] In this case, the broad powers and open-ended, highly qualitative concepts throughout ss. 51–52 suggest greater flexibility for the PHO in the implementation of the emergency powers (*Vavilov,* paras. 68, 110; *Mason*, para. 67). This is further exemplified in s. 59(b), which says that the authority to act under the emergency powers ends "when the provincial health officer provides notice that the emergency has passed."

[186] Another important consideration for this assessment is the "precautionary principle," which the petitioners acknowledged applied to the PHO's COVID-19 decision-making. The principle being that, in the face of serious threats, scientific uncertainty must be resolved in favour of protection of the healthcare system. It would be a dereliction of duty for the PHO to await the actual grips of another severe COVID-19 wave before taking steps to protect the healthcare system. As the point is sometimes put in the cases, to wait for certainty about the risks is to wait too long.

[187] Approaching this question with the appropriate deference, in recognition of the specialized expertise of the PHO, the flexibility afforded her by the statutory language in issue, and the precautionary principle, in my view one cannot say the PHO was unreasonable in deciding to extend the use of the *PHA* emergency powers.

[188] As summarized above, the circumstances evident in the record included: (i) the three-year COVID-19 experience of an unprecedented and unpredictable virus, with the ability to create new variants, and to attack in waves causing widespread serious illness, death, and harm to the functioning of the healthcare system which stressed it beyond capacity to protect and care for the health needs of the population; (ii) the extreme contagiousness of Omicron and its variants, including within healthcare settings; (iii) the particular vulnerability of patients within the healthcare and long-term care settings; and (iv) the key negative indicators, leading

up to October 2023, of rising COVID-19 severe outcomes and deaths, back to levels seen in the fall of 2021, as the annual onset of flu and other respiratory illnesses was about to arrive.

[189] Turning to the s. 52(2) pre-conditions to the exercise of emergency powers, and beginning with s. 52(2)(a), for the reasons summarized in the previous paragraph, there was ample support in the record for the reasonableness of the PHO's conclusion that the transmission of SARS-CoV-2 continued to pose a significant and immediate risk that "could have a serious impact on public health", including the health of vulnerable patients and the capacity of our healthcare system to continue providing essential care for those afflicted by the virus or other serious illnesses or conditions.

[190] Regarding s. 52(2)(b), I agree with counsel for the PHO that, despite the pandemic having commenced more than three and a half years earlier, in October 2023 COVID-19 continued to be an "unusual and unexpected" immediate and significant risk to public health. As counsel submitted, the overdose drug crisis is another example of an unusual and unexpected event giving rise to an extended emergency.

[191] British Columbia had not previously faced the type of health crisis posed by this highly communicable, dangerous, global disease. The negative indicators, reasonable risk of new variants, previous waves of infections causing serious illness and harm to the public health system, and applicability of the precautionary principle all contributed to the reasonableness of continuing to characterize COVID-19 in this way.

[192] Finally, regarding s. 52(2)(c), the petitioners acknowledged that at the time of the Orders, there continued to be a significant risk of the spread of SARS-CoV-2, and therefore s. 52(2)(c) was satisfied. I agree that is uncontroversial.

[193] Regarding the evidence that other jurisdictions had terminated this type of mandate, the case law repeatedly states that judicial review is highly context-

sensitive. In October 2023, circumstances in some of those jurisdictions may have been different than here. More fundamentally, there is more than one reasonable way to approach the complex medical, scientific, and social issues addressed in the Orders. At the time, there could be no certainty about what will be most effective or strike the right balance. Rather, these are judgment calls on which reasonable public health experts may disagree.

[194] Regarding the PHO's statements in the spring of 2023, downplaying the risks of COVID-19 and comparing it to other respiratory illnesses, I agree with counsel for the PHO that many of these statements were aspirational regarding the direction it appeared things were headed at that time, and before the key negative indicators began to rise in the summer and fall of 2023.

[195] These statements can also be reconciled with the Orders by reference to the distinction between inside and outside the healthcare contexts. As stated in Recital PP:

> This high level of vulnerability to infection … and risk of resulting serious illness, distinguishes the situation of people receiving health care, personal care or home support in hospital or community settings …

[196] Outside of healthcare, the PHO saw it as safe to transition away from much of the former emergency regime, such as public masking, distancing, vaccine passports, and restrictions on gatherings and travel. As the record indicates, in large part this was due to the high percentage of the population that was vaccinated. At the same time, the record indicated good reason for continued vigilance within the healthcare system itself for the reasons that I have summarized above.

[197] An important aspect of the within-healthcare context is that, as the record repeatedly indicated, hospital patients and long-term care residents are more vulnerable than the general population to COVID-19. This is due to pre-existing conditions, suppressed immune systems, and less protection from their own vaccination due to reduced antibody production. The petitioners did not contest this. It must also be borne in mind that, generally speaking, such patients do not choose to be in these healthcare settings. If there were no vaccine mandate, they could not

simply choose to avoid receiving treatment from unvaccinated healthcare workers. This differentiates their situation from outside-healthcare settings, such as restaurants, gyms, etc., which the vulnerable can choose to avoid if the staff are unvaccinated.

[198] In sum, in light of the record as of October 5, 2023 and applying the appropriate legal deference, in my view the record supported the reasonableness of the PHO's decision to continue to exercise the emergency powers in the *PHA,* to protect public health, and in particular the functioning of the healthcare system and the health of those most vulnerable to COVID-19.

Challenge 2: Unvaccinated healthcare workers posed no greater risk

[199] The petitioners' second challenge is that the Orders were unreasonable because, by October 2023, the record no longer indicated that the primary series of vaccination reduced a healthcare worker's contagiousness, i.e. the risk of transmission of the virus to patients and other healthcare workers.

[200] In my view, the record, as summarized above, clearly refuted this submission. It also contained abundant evidence to support as reasonable the PHO's Conclusions that: (i) unvaccinated healthcare workers continued to pose a "health hazard" as defined in s. 1 of the *PHA*, because of their greater risk of becoming infected, being sicker for longer, and transmitting their infection to vulnerable patients and other healthcare workers; and, (ii) it was therefore essential to maintain the high level of vaccination in the healthcare settings, as the best means to mitigate these risks and safeguard the preparedness and resiliency of the healthcare system.

[201] The petitioners argued that, if one accepted that continuation of a vaccine mandate was indeed justified, the only reasonable approach would be requiring all healthcare workers to obtain the new vaccine, tailored to the dominant XBB 1.5 sub-variant of Omicron.

[202] The orders addressed this in Recital 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.

[203] Given the support in the record for the continued, significant benefits of the primary series of vaccination for healthcare workers, including when combined with previous boosters and hybrid immunity, in my view this does not manifest any internal inconsistency. The balancing of these complex considerations falls squarely within the expertise of the PHO. I can see no basis to find unreasonable the PHO's decision not to require the new vaccine for healthcare workers who had already received at least the primary series.

[204] The petitioners also argued that the vaccine mandate was unreasonable in circumstances where, as an alternative, vaccinated workers could be required to mask and test, just as many other categories of unvaccinated people were permitted to do in these healthcare facilities, such as patients, family members, visitors, and some construction workers.

[205] The Orders state that, while these other methods of protection are useful, they do not provide the level of protection afforded by vaccination, particularly in an environment of people highly vulnerable to infection and serious illness, or promote the same level of preparedness and resiliency in the healthcare system (see Recitals BB, CC, DD, YY). This too falls squarely within the expertise of the PHO, and is supported by the Dove Report and other evidence in the record regarding the limitations on masking and testing, including false negative and positive results, and the review of COVID-19 outbreaks in care homes which described rapid tests as having "lower sensitivity to detecting the virus".

[206] Regarding the categories of other persons allowed in these settings without proof of vaccination, the Dove Report highlighted the particular concerns regarding transmission by healthcare workers. I also accept the submission of counsel for the PHO about the unique role of healthcare workers in the public healthcare system, given the crucial role they play and their close contact with vulnerable patients, who generally speaking have no choice but to accept that contact.

[207] Drawing the lines in this way is therefore rationally connected to protecting the most vulnerable patients, and the capacity of these key members of the healthcare system, while at the same time reducing other aspects of the coercive regime implemented during the worst of the pandemic.

[208] Finally, the petitioners argued that the Orders were unreasonable for having no expiration date. In my view, such an approach is not unreasonable in circumstances where the record demonstrates the PHO is consistently reassessing and revising the emergency orders in light of current evidence and conditions.

[209] In sum, I find the PHO's decisions about the risks of unvaccinated healthcare workers to be reasonable. The record provided ample support for the reasonableness of her Conclusions (quoted in paragraph 62 above) that, at the time of the Orders: unvaccinated healthcare workers continued to pose unacceptable risks to vulnerable patients and other healthcare workers; and, it was therefore essential to maintain the high level of vaccination in place in the hospital, community care and residential care workforce, to mitigate the risks to patients and other healthcare workers, and to safeguard the functioning of the healthcare system.

Challenge 3: Was it reasonable to include remote and administrative workers without a s. 43 reconsideration process?

[210] The Tatlock petitioners argued that it was unreasonable for the Orders to exclude s. 43 requests for reconsideration by remote and administrative healthcare workers who posed no risk to vulnerable patients or the frontline healthcare workers who cared for them.

[211] They argued that the unreasonableness was accentuated by the fact that the Orders permitted unvaccinated patients, visitors, and construction workers access to the settings in question. Moreover, prior versions of the Orders allowed the same for some vendors, suppliers and technical specialists.

[212] Recital SS indicates that the PHO was alive to this issue, which had been squarely raised by the Tatlock petitioners' pleadings, evidence and arguments since at least March 2022.

[213] Recital SS says it is necessary to keep the number of unvaccinated workers as low as possible, even amongst this group of workers with limited contact with patients:

> 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;
>
> [Emphasis added.]

[214] Article F, "Variance and Reconsideration" says that, after taking into account all the circumstances, the PHO believed it necessary to limit requests for reconsideration to solely medical exemptions where vaccination would seriously jeopardize a person's health.

[215] Such statements from the PHO about the functioning of the healthcare system must receive significant judicial deference. Nevertheless, in my view, there remains a question of failure of justification regarding this issue. In other words, there is a question whether the Orders and record meet the "heightened responsibility" of demonstrating why the significant consequences of the Orders are justified for unvaccinated remote and purely administrative workers.

[216] As stated by the Supreme Court of Canada in *Mason* (citing *Vavilov*):

> [74] An administrative decision maker's reasons must "meaningfully account for the central issues and concerns raised by the parties" (para. 127). Reasons must be "responsive" to the parties' submissions, because reasons

> are the "primary mechanism by which decision makers demonstrate that they have actually *listened* to the parties" (para. 127 (emphasis in original)). Although an administrative decision does not have to "respond to every argument or line of possible analysis" raised by the parties, "a decision maker's failure to meaningfully grapple with key issues or central arguments raised by the parties may call into question whether the decision maker was actually alert and sensitive to the matter before it" (para. 128).

[217] A first point to note, in my view, is that Recital SS expresses concerns about workers who have "little or no direct contact with patients, residents, clients or other workers on a regular basis". According to the evidence of the Tatlock petitioners, however, many of their roles involved no such contact at all.

[218] Second, there is a lack of connection between vaccination of these types of workers and the central rationale for the Orders, which is to protect vulnerable patients and the healthcare workers who care for them. This lack of connection can be seen in the following excerpt from the PHO's submissions, which in my view does not apply to purely remote and administrative workers:

> 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.

[219] Third, there is an absence of evidence in the record considering this specific issue of vaccination and healthcare workers who are able to perform their roles remotely or without direct contact with vulnerable patients or the healthcare workers who care for them. For example, while there was evidence in the record, including as described in the Dove Report, about vaccination status and transmission of the virus within care settings, there was not such evidence regarding remote and administrative workers.

[220] The PHO's first point in response on this issue was that none of the Tatlock petitioners who self-described as remote or administrative workers provided clear evidence that their prior jobs truly involved no contact with patients or frontline healthcare workers, and therefore their relief sought was not supported by the evidence.

[221] In my view, while some of the evidence is ambiguous in this way, overall it does establish that some petitioners were able to perform their jobs without any such contact. For example:

> Ms. Phyllis Tatlock, a registered nurse, described her former role as director of operations for BC Cancer, as "solely administrative" and deposed that she did not interact with patients. Ms. Tatlock was terminated on November 15, 2021. Her evidence described significant emotional upset and anxiety from her job loss. Ms. Tatlock is a life-long Christian whose beliefs align with the National Catholic Bioethics Centre, which views as ethically problematic the use of fetal cell lines in the vaccine development. Her request for a religious exemption was denied.
>
> Ms. Monika Bielecki, a former Employee Health and Wellness advisor with BC Interior Health, described her work as remote since early 2016, apart from the occasional team meeting in the office which could be attended by telephone if necessary. She had no workspace with Interior Health and worked entirely from home. In 2019, she signed a flexible work location agreement, prepared by her manager. She refused vaccination based on her own risk-benefit analysis, and was terminated in November 2021.
>
> Ms. Ingeborg Keyser, formerly a communications advisor for Interior Health, deposed to working at corporate offices in Kelowna and then remotely during the pandemic. She deposed to viewing vaccination as a personal choice, and that it is "illegal to force a person to receive an injection to keep his or her job". She believes there are other effective treatments for COVID-19, including her own healthy lifestyle. She expressed concerns about vaccine safety and efficacy, particularly during her pregnancy. She was terminated in November 2021, and deposed to resulting economic hardship for her and her children.
>
> Ms. Ana Mateus, formerly an administrative assistant with Vancouver Coastal Health, deposed to working remotely during the pandemic. She was terminated in November 2021. Ms. Mateus deposed to seeing vaccination as a personal choice, and the vaccines as rushed to market with too many unanswered questions about safety and effectiveness. She believes her own immune system and natural immunity are sufficient protections. Placed on

> unpaid leave in October 2021, she deposed to anxiety and emotional upheaval from the vaccine mandate and lack of exemption process. She stated she would comply with reasonable accommodations in patient-care areas.
>
> Mr. Darold Sturgeon, former executive director of Medical Affairs for Interior Health in Kelowna, was terminated from his job in November 2021. He deposed that his role did not involve the provision of healthcare services and that he worked entirely remotely for the past few years, including before the pandemic. A lifelong Catholic, he refused vaccination based on his religious views about the use of fetal cells in their development.
>
> Ms. Lori Jane Nelson, former senior director for BC Children's Hospital and BC Women's Hospital & Health Care deposed to working remotely, with a "work from home agreement", although it was unclear if that was only during the pandemic. Having been a person of religious faith throughout her life, she could not accept the vaccine because of the fetal cell line issue. She also deposed to severe allergies and prior anaphylactic reactions. On the evidence, it appears her request for a medical exemption was denied because she did not provide all requisite information.
>
> Dr. David Morgan, one of the Hsiang Petitioners described in para. 24 above, lost his position treating youths in the criminal justice system. He deposed to providing "100% of the assessment, management, and treatment of my patients virtually which eliminated any risk of transmission of the virus … When I questioned the basis for [my termination], I was informed that … I might be asked to see a patient in-person in the future, despite the fact that I had not done so for an extended period of time, and that it is simply not necessary in my practice."
>
> Jennifer Koh, a witness for the Tatlock petitioners, was Organization Development and Change management consultant for the Interior Health Authority. From July 2020 to November 2021 she worked 100% remotely, and had no contact with patients and only rarely with co-workers. She refused the vaccine for reasons of her Catholic beliefs and her personal views about its safety.

[222] Counsel for the PHO pointed to the statements in the Orders about the enhanced risk of absenteeism and associated slippage in the system. They gave the example of a surgery booking clerk, and submitted that, while such a role might be performed remotely, any increased absenteeism from lack of vaccination could create problems for surgical scheduling. In my view, such a single example does not justify the total elimination of a reconsideration process for all remote and administrative workers.

[223] Counsel for the PHO also referred to the evidence in the record of the inordinate time and resources required to deal with s. 43 reconsideration requests before they were suspended on November 9, 2021. However, all of this evidence referred back to when such requests related to the broad range of orders applicable to the general public, regarding gatherings, events, restaurants, gyms, bars, etc. Further, the bases for such requests were much broader, and included claims based on competing medical evidence and pure personal disagreement. To my understanding, there is nothing in the record to suggest such difficulties would arise in a reconsideration process limited to remote and administrative workers.

[224] The PHO also argued for the impracticality of requiring her team to make the individual determinations required of a such reconsideration process, because they lacked the requisite specifics about the personnel and roles in question. I was shown nothing in the record, however, to suggest this was a significant obstacle, and in my view there would appear to be reasonable ways of addressing the issue if it arises. For example, a remote worker requesting such reconsideration might provide evidence—such as a supporting letter from the employer—that their role can be fully performed remotely and that absenteeism is generally manageable due to back-up personnel and systems. As the petitioners pointed out, the record indicates that hundreds, if not thousands, of healthcare workers are absent every day across the province, for a host of reasons, which the system is able to manage. For purely administrative workers, who unlike remote workers present the additional consideration of potential spread of illness to colleagues, there might be evidence of the option for remote work when feeling ill.

[225] In sum, for the reasons expressed in this section, I find the Tatlock Petitioners have demonstrated that there remains a lack of justification for not including a reconsideration process for remote and purely administrative workers, as a less drastic means of achieving the PHO's objectives, particularly given the heightened burden of justification because what is at stake is the loss of a person's job as a healthcare professional.

[226] In terms of remedy, I am guided by the legislature having entrusted decisions about these matters to the PHO, not the court, and by the deference owed to the PHO on these complex public health decisions. I cannot say this is a case where any decision refusing the s. 43 reconsideration process would be unreasonable, and no particular outcome on this issue is "overwhelmingly" favoured or "inevitable". Thus, the issue should be remitted to the PHO for reconsideration with the benefit of these reasons (*Vavilov,* paras. 124, 140, 141; *Mason,* para. 120).

[227] Thus, under *JRPA* s. 5(1), I remit to the PHO for reconsideration whether to consider s. 43 requests for reconsideration of the vaccination requirement from healthcare workers who are able to perform their roles remotely, or in-person but without contact with patients or the frontline workers who care for them.

Charter **Challenges**

[228] Ms. Hoogerbrug and the Tatlock petitioners argue that the Orders infringed their *Charter* rights by forcing them to choose between accepting an unwanted vaccine or losing their jobs in healthcare.

[229] Those who refused the vaccine for reasons of religion or personal conviction argue that the Orders infringed their rights to freedom of conscience and religion under s. 2(a). The Tatlock petitioners, but not Ms. Hoogerbrug, also argue that the imposition of this choice, between vaccination and keeping their jobs, infringed their s. 7 rights to life, liberty and security of the person.

[230] As part of the *Constitution Act*, 1982, Schedule B to the *Canada Act* 1982 (UK), 1982, c 11, the *Charter* guarantees everyone certain fundamental rights and freedoms to be protected from infringement by the state. These protections are not absolute. Under s. 1, they are subject to "such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society". Thus, the government may limit an individual's *Charter* rights when it can demonstrate that the limit is reasonable and justified under s. 1.

[231] Based on the Court of Appeal's decision in *Beaudoin* (paras. 255–258), the parties agreed that the framework applicable to reviewing these *Charter* challenges is that established in *Doré v. Barreau du Québec*, 2012 SCC 12. This is because the Orders are administrative decisions made through a delegation of discretionary decision-making authority under the *PHA*. The petitioners' constitutional case did not challenge any provision of the *PHA* or the legislative authority of the PHO to make the Orders, in which case the approach from *R. v. Oakes*, [1986] 1 S.C.R. 103, 1986 CanLII 46, would have applied.

[232] Applying the *Doré* framework to these *Charter* challenges, two questions arise (*Loyola High School v. Quebec (Attorney General)*, 2015 SCC 12 at para. 39; *Doré* at paras. 7, 57):

1. Do the Orders limit *Charter* protections – rights and values?
2. If so, do they reflect a proportionate balancing of those *Charter* protections with the public health and safety objectives underlying the Orders?

Section 2(a)

[233] First, then, is whether the Orders limit the s 2(a) *Charter* protections of Ms. Hoogerbrug and the Tatlock petitioners.

[234] Section 2(a) says: "Everyone has the… freedom of conscience and religion". Its purpose is to ensure the state does not interfere with profoundly held personal beliefs that govern a person's conception of themselves, humankind, nature, and, in some cases, a higher or different order of being. Canada's pluralistic, multicultural society depends on respect for a broad range of such beliefs and their associated practices (*R. v. Edwards Books and Art Ltd.*, [1986] 2 S.C.R. 713, 1986 CanLII 12, at paras. 97, 215).

[235] The parties agree that, to establish an infringement of s. 2(a) religious freedom, one must meet the two-part test established in *Syndicat Northcrest v. Amselem*, 2004 SCC 47, at para. 65, and reaffirmed in subsequent cases including *Alberta v. Hutterian Brethren of Wilson Colony*, 2009 SCC 37 at para. 32, by

showing*:* sincere commitment to a belief or practice that has a nexus with religion; and, that the Orders interfered, in a non-trivial way, with the ability to act in accordance with that belief or practice.

[236] To satisfy (i), the belief or practice must have spiritual significance for the person as an individual. It may be entirely personal and not part of a more widely held belief system. It need not be obligatory, required by official religious dogma or in conformity with the position of religious officials, but only personally and sincerely held and linked to their spiritual faith or connection to the divine, so long as the practice has a nexus with religion (*Amselem*, paras. 46-56, 69).

[237] To satisfy (ii), the non-trivial, state-imposed cost or burden can be "direct or indirect, intentional or unintentional, foreseeable or unforeseeable" (*Edwards Books*, para. 96).

[238] Ms. Hoogerbrug and these Tatlock petitioners submit that the Orders imposed such a burden by forcing them to choose between the lesser of two evils: violating their deeply held religious or personal convictions, or losing their employment in the healthcare system. By placing them on the horns of this dilemma, they say the Orders substantially interfered with their freedom to follow their religious or conscience-based beliefs, and so infringed their s. 2(a) rights, particularly due to cancellation of any s. 43 religious reconsideration process.

[239] Turning to freedom of conscience, this aspect of s. 2(a) has received less judicial attention than freedom of religion. In my view, the following principles emerge from the cases:

a) freedom of religion may be viewed as a subset of freedom of conscience, in that religious belief and practice are "paradigmatic of conscientiously-held beliefs" (*R. v. Big M Drug Mart Ltd.,* [1985] 1 S.C.R. 295, 1985 CanLII 69, at para. 123);

b) freedom of conscience is aimed at protecting serious matters of conscience based on strongly held moral ideas of right and wrong (*Roach v. Canada (Minister of State for Multiculturalism and Citizenship)*, [1994] 2 F.C. 406, 1994 CanLII 3453 (C.A.));

c) freedom of conscience is not the mere decision to act or not act in a certain way. To warrant constitutional protection, the behaviour or practice must be based upon "a set of beliefs by which one feels bound to conduct most, if not all, of one's voluntary actions" (*R. v. Videoflicks Ltd*., 48 O.R. (2d) 395, 1984 CanLII 44 (C.A.) at 40, rev'd in part on other grounds in *Edwards Books*); and

d) the commitment must have a "profound moral dimension" and be embedded in a "larger belief system of right and wrong" The *Amselem* test for infringement of religious freedom might be adapted and applied to an alleged infringement of freedom of conscience by substituting "nexus with conscience" for "nexus with religion" in the first branch of the test (*Affleck v. The Attorney General of Ontario,* 2021 ONSC 1108 at paras. 40-46, 51-52).

[240] While not conceding the point, counsel for the PHO acknowledged that the religious petitioners likely satisfied the first branch of the *Amselem* test. Counsel took a stronger line however against the petitioners who had purely conscience-based objections to the vaccine.

[241] In opposing the petitioners who relied on freedom of conscience, the PHO relied on cases such as *R. v. Locke*, 2004 ABPC 152 and *Affleck*. In *Locke*, the Provincial Court of Alberta found that Mr. Locke's refusal to wear a seatbelt—because he believed it caused more harm than good—did not engage s. 2(a). The trial judge found that Mr. Locke's beliefs about seatbelts were not part of a "comprehensive value system" but merely strong views about a particular issue.

[242] In *Affleck*, the applicants argued for a right to purchase raw milk based on their sincere beliefs about its health benefits. The Court found their beliefs more akin to a lifestyle choice than a fundamental ethical belief system about right and wrong. Thus, they did not "rise to the level of a belief with profound moral dimensions" required for s.2(a) matters of conscience (paras. 4, 51).

[243] The PHO also relied on prior judicial rejection of freedom of conscience claims in the context of COVID-19 vaccination disputes. In *Costa, Love, Badowich and Mandekic v. Seneca College of Applied Arts and Technology*, 2022 ONSC 5111 ("*Costa*"), leave to appeal to the Ontario Superior Court of Justice ref'd in 2023 ONSC 443, two students opposing vaccination applied for an interlocutory injunction

to restrain the College from requiring vaccination as a condition of being on campus. The students opposed the mandate as a violation of their s. 2(a) freedom of conscience based on their own assessment of the benefits and risks.

[244] In denying their injunction, the Court found no "strong case" for s. 2(a) protection because their objections were not part of a "comprehensive moral code or value system yielding a foundational belief that requiring vaccinations is 'wrong'" (paras. 52, 62-63). Instead, they were better characterized as "individual concerns about potential dangers of the vaccine, and the fact that they perceive, by virtue of not being able to complete their programs, that they are being treated unfairly" (para. 61).

[245] Similarly, in *Lewis v. Alberta Health Services*, 2022 ABCA 359, (paras. 38-39), leave to appeal ref'd [2023] S.C.C.A. No. 6, the Court found Ms. Lewis' belief that the vaccine was experimental, lacking in long-term safety data, and forced upon her did not attract protection under s. 2(a). This was because it was "not grounded in morality but concerns over vaccine safety".

[246] On the second branch of *Amselem*, the PHO submits that the petitioners fall short because the Orders did not compel vaccination. The petitioners were left free to follow their personal or religious beliefs and decline the vaccine, which on the evidence they in fact all did.

[247] On this point, the PHO relies primarily on *Hutterian Brethren*, which challenged amendments to Alberta regulations terminating an exemption process for those who, for religious reasons, objected to having their photos taken and shown on their driver's licences. Before the amendment, members of the Hutterian Brethren of Wilson Colony were exempted from the photographic requirement because of their belief that the Bible's Second Commandment forbade the making of photographic images. Under the amended regulations, they were required to be photographed to have a licence issued.

[248] In upholding the amendment, Chief Justice McLachlin for the majority found that the Colony members were neither compelled to take a photo, nor deprived of a meaningful choice about whether to follow their fundamental beliefs. The photo requirement did not "negate the choice that lies at the heart of freedom of religion" (paras. 98–99).

The Religious Reasons for Refusal

[249] Ms. Hoogerbrug and five of the Tatlock petitioners—Phyllis Tatlock, Darold Sturgeon, Lori Nelson, Lynda Hamley, and Joshua Nordine—deposed to being Christians of different denominations who believe in their religious obligation to avoid the COVID-19 vaccine. Each described, in personal terms, why the vaccination was contrary to their fundamental religious beliefs. As described above, for most this included the use of fetal cell lines in the vaccines' development, contrary to their religious views about treatment of unborn human life.

[250] The personal circumstances of Ms. Hoogerbrug, Ms. Tatlock, Mr. Sturgeon and Ms. Nelson are described above.

[251] Ms. Hamley, a single mother, was a residential support worker with the Kootenay Society for Community Living, which provides group home care to persons with developmental challenges. She deposed to believing that it is contrary to God's will to force a person to accept a novel medical intervention. She deposed that, after her request for a religious exemption was denied, she was placed on unpaid leave in December 2021, and returned to a previous job as a classroom support worker. She described stress and anxiety from the financial pressures caused by losing her job, and expressed willingness to mask and rapid-test before contact with patients.

[252] Dr. Joshua Nordine was a clinical physician with the Bridge Detox Centre in Kelowna. In November 2021, he was terminated by the Centre and lost his hospital privileges. He is a member of the Kelowna Right to Life Society, and objects to receiving the vaccine on religious and medical grounds. He deposed to having observed patients suffer adverse consequences from the vaccines. He deposed that

his exemption request was denied and he has continued his family practice in a private clinic in Kelowna, and is willing to mask and rapid-test in patient-care areas.

The Conscience Reasons for Refusal

[253] The remaining Tatlock petitioners offered secular reasons for their vaccine refusal. Their affidavits described strongly-held beliefs about: (a) the vaccines being rushed, experimental, ineffective and possibly unsafe; and (b) decisions about vaccination being a matter of personal self-determination, particularly for those not at high risk for serious consequences from COVID-19 due to their youth, good health, and/or natural immunity from prior infection.

[254] More specifically, I would summarize the concerns expressed in their respective affidavits as follows:

> Ms. Laura Koop is a primary care nurse practitioner, specializing in high-risk situations such as drug and alcohol abuse. She lost her position in Creston, with the Interior Health Authority, in November 2021. Ms. Koop deposed to concerns about safety and lack of information from pharmaceutical companies and the government, and lack of freedom of choice. Her affidavit described financial difficulties from the loss of her job and associated benefits, as she was the primary wage-earner for her family. She also deposed to stress and anxiety from the loss of her career and inability to assist her former patients.
>
> Ms. Monika Bielecki (previously mentioned above) is a health and wellness adviser and certified vocational rehabilitation professional, residing in Kelowna. She lost her position with Interior Health in November 2021. She deposed to believing vaccination should be a matter of free choice and not a condition of employment. She also expressed confidence in her natural immunity and lifestyle, and doubts about the safety and efficacy of the vaccines. She would be willing to mask and rapid-test before entering patient-care areas.
>
> Mr. Scott MacDonald was a registered art therapist at the Dr. Peter Centre in Vancouver. He was placed on unpaid medical leave in October 2021. He deposed to believing vaccination should be a matter of personal choice and expressed concerns about the vaccines being rushed to market, ineffective and unsafe. He believed COVID-19 posed a low risk to him personally and had experienced adverse reactions to other vaccines in the past. He deposed to being willing to consider reasonable accommodations in patient areas.

> Ms. Ana Mateus (previously mentioned above), formerly employed by Coastal Health, deposed to working remotely during the pandemic. She was terminated in November 2021. Ms. Mateus deposed to seeing vaccination as a personal choice, and these vaccines as rushed to market with too many unanswered questions about safety and effectiveness. She believed her own immune system and natural immunity were sufficient protections. Placed on unpaid leave in October 2021, she deposed to anxiety and emotional upheaval from the vaccine mandate and lack of exemption process. She stated she would comply with reasonable accommodations in patient-care areas
>
> Ms. Ingeborg Keyser (previously mentioned above) was a communications adviser for Interior Health in Kelowna. She deposed to the view that vaccination was a personal choice and it was "illegal to force a person to receive an injection to keep his or her job". She believed there are other effective treatments for COVID-19 including her own healthy lifestyle. She expressed concerns about vaccine safety and efficacy, particularly during her pregnancy. She was terminated in November 2021, and deposed to resulting economic hardship for her and her children.
>
> Ms. Melinda Parenteau is a registered midwife, who lost her hospital privileges in Nelson in October 2021. She deposed to belief in the right of informed medical choice without coercion. She viewed the vaccines as experimental, and had concerns about their safety and long-term effects, and doubts about their efficacy particularly compared with natural immunity. She described being unable to practice midwifery without hospital privileges, and financial hardship and stress for her spouse and their two young children, as well as personal distress over the loss of her chosen career.

Were the Petitioners' s. 2(a) rights infringed?

[255] In my view, the religious petitioners have shown a limitation of their s. 2(a) rights, but the petitioners relying on freedom of conscience have not.

[256] On the first branch of the *Amselem* test, the religious petitioners' uncontested evidence demonstrates sincere religious beliefs which conflict with accepting the vaccine. They each explained, in concrete terms, why being true to their religious faith required them to refuse. On the evidence, their reasons for refusal reflected sincerely held aspects of their religious faith.

[257] On the second branch of the test, the Orders imposed far more than a trivial or insubstantial burden on their freedom to act in accordance with their religious

beliefs, by forcing them to choose between accepting vaccination, contrary to their sincere religious beliefs, or losing their jobs.

[258] In my view, this conclusion that the Orders limited the religious petitioners' s. 2(a) rights is supported by previous s. 2(a) COVID-19 decisions. In *Beaudoin*, the Court of Appeal upheld Chief Justice Hinkson's findings that orders restricting the size of religious gatherings limited s. 2(a) rights, although the limits were justified under both the analysis in *Doré* and the analysis in *Oakes*. The Ontario Court of Appeal upheld similar findings in *Trinity Bible Chapel*, as did the Manitoba Court of Appeal in *Gateway Bible Baptist Church et al v Manitoba et al,* 2023 MBCA 56, aff'g 2021 MBQB 219, leave to appeal ref'd [2023] S.C.C.A. No. 369.

[259] It is also supported by *Multani v. Commission Scolaire Marguerite-Bourgeoys*, 2006 SCC 6, where the majority held that forcing a Sikh student to choose between wearing a kirpan and attending public school amounted to an infringement of his freedom of religion. This was so despite the student being able to follow his religious convictions by moving to a private school (para. 40).

[260] I do not accept the PHO's argument that s. 2(a) was not infringed because the Orders leave the religious petitioners free to refuse the vaccine. In my view, this is contrary to *Multani* and the principle from *Edwards Books* that interference can include indirect burdens or costs placed upon one's religious practices. By making the religious petitioners choose between vaccination and losing their jobs, the Orders clearly imposed a substantial burden and cost on following their religious beliefs.

[261] I also do not accept the PHO's argument that this conclusion runs contrary to Chief Justice McLachlin's analysis in *Hutterian Brethren.* In that case, the s. 2(a) infringement was conceded by Alberta (*Hutterian Brethren*, paras. 33-34). The Chief Justice's conclusion that the law did not rise to the level of seriously affecting the claimants' right to pursue their religion was part of the s. 1 analysis of whether the infringement was justified.

[262] Regarding those Tatlock petitioners who rely on reasons of conscience, while accepting the uncontradicted evidence of their specific objections and concerns, I find their s. 2(a) freedom of conscience rights were not limited by the Orders. This is because their objections and concerns, summarized above, do not reflect an overarching moral belief system, but rather personal convictions and assessments regarding the vaccine and vaccination mandates. On the evidence, these convictions and assessments, primarily about safety, the approval process and freedom of choice regarding vaccination, do not rise to the level of profound and overarching moral belief systems about themselves and how to live their lives that receive constitutional protection under freedom of conscience. Cases such as *Videoflicks*, *Affleck, Costa,* and *Lewis* suggest this is insufficient. In my view, the petitioners provided no applicable cases to the contrary.

[263] In sum, I find that the Orders limited the s. 2(a) rights of the religious petitioners, all of whom demonstrated that the Orders presented an objectively significant interference with following their religious beliefs. I find the Orders did not, however, infringe the s. 2(a) freedom of conscience rights of those petitioners who refused vaccination due to their personal concerns and convictions.

Section 7

[264] Section 7 says that:

> 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.

[265] To establish a limitation on s. 7 rights, a claimant must show that a law or state action has: (i) interfered with, or deprived them of, their life, liberty or security of the person, and (ii) done so in a manner inconsistent with the principles of fundamental justice. Such inconsistency may be proven by showing the law or government measure is arbitrary, overbroad, or grossly disproportionate (*Carter v. Canada (Attorney General)*, 2015 SCC 5, paras. 55, 72).

[266] The Tatlock petitioners argue that the Orders infringed their right to liberty by interfering with medical self-determination (relying on *Carter,* and *A.C. v. Manitoba (Director of Child and Family Services),* 2009 SCC 30), and their right to security of the person by causing serious psychological stress and harm (relying on *United Steelworkers, Local 2008 v. Attorney General of Canada*, 2022 QCCS 2455 [*United Steelworkers*]).

[267] As the Supreme Court of Canada said in *Carter* (para. 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. 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.

[268] The effects of state interference on security of the person must be assessed objectively, with a view to the impact on the psychological integrity of a person of reasonable sensibility. It need not rise to the level of nervous shock or psychiatric illness, but must have a serious and profound effect on a person's psychological integrity, that is greater than ordinary stress or anxiety (*New Brunswick (Minister of Health and Community Services) v. G. (J.)*, 3 S.C.R. 46, 1999 CanLII 653 [*J.G.*], paras. 56–60).

[269] In *Cambie Surgeries Corporation v. British Columbia (Attorney General)*, 2022 BCCA 245 [*Cambie Surgeries*], leave to appeal ref'd [2022] S.C.C.A. No. 354, Justice Harris for the majority said this about the scope of these rights in the medical context:

> [234] The right to liberty is a right to make fundamental personal decisions without interference from the state. In the medical context, this has been interpreted as limited to the right to consent to or withhold consent from certain medical interventions: see e.g., *Carter* at para. 67; *A.C. v. Manitoba (Director of Child and Family Services)*, 2009 SCC 30 at para. 100.
>
> [235] Importantly, the Supreme Court of Canada has said, "[t]he right to life, liberty and security of the person encompasses fundamental life choices, not

> pure economic interests": *Siemens v. Manitoba (Attorney General)*, 2003 SCC 3 at para. 45.
>
> [Emphasis added in original.]

[270] The Tatlock petitioners argued that requiring vaccination as a condition of employment infringed their s. 7 liberty right to make fundamental personal decisions without state interference, and the stress and anxiety caused by their job losses were interference with their psychological integrity infringing security of the person.

[271] While acknowledging that s. 7 challenges to the COVID-19 mandates have generally been unsuccessful, the Tatlock petitioners relied primarily on *United Steelworkers.*

[272] In *United Steelworkers*, s. 7 rights were found to be engaged by orders of the federal Minister of Transport, requiring COVID-19 vaccination in the federally regulated marine, air and rail transport sectors. The Court agreed with the claimants—who were unions and some individual workers—that the rights to liberty and security of the person were engaged because of the significant constraint on important life choices and the severe psychological stress and pressure of accepting the vaccine or losing one's job (paras. 171–176).

[273] This case was a double-edged sword for the Tatlock petitioners, however, because the Court found the orders complied with the principles of fundamental justice and so s. 7 rights were not breached. Having accepted that the objective of the vaccine mandate was to protect workers from severe illness, reduce absenteeism, and foster key supply chains, Justice Phillips found the orders: not arbitrary, as there was evidence to suggest that unvaccinated people were at higher risk to develop more severe forms of the disease, with consequences on the rate of absenteeism (paras. 195–198); not overbroad, as the petitioners had not shown that the measure caused effects unrelated to its objective (paras. 199–202); and proportionate to the important goal of avoiding the potentially dramatic consequences of absenteeism and disruptions in the Canadian transport system (paras. 203–211).

[274] The PHO argues, first, that the Orders do not constitute state interference with “fundamentally important and personal medical decision-making”, because the petitioners remained free to choose whether to accept or decline vaccination for COVID-19. This distinguishes the situation from *Carter* which dealt with the right to medical self-determination in the context of physician-assisted dying, and from *A.C.* which dealt with coercive medical treatment.

[275] Second, the PHO argues that s. 7 is not engaged by a law or state action that threatens a claimant’s right to practice their particular profession or occupation, even if this causes significant emotional distress (*Mussani v. College of Physicians and Surgeons of Ontario*, [2004] O.J. No. 5176, 2004 CanLII 48653 (C.A.); *Tanase v. College of Dental Hygienists of Ontario,* 2021 ONCA 482, leave to appeal ref’d [2021] S.C.C.A. No. 350; *Ouellette v. Law Society of Alberta*, 2019 ABQB 492, leave to appeal ref’d 2021 ABCA 99; *Siemens v. Manitoba (Attorney General),* 2003 SCC 3; and *Banas v. HMTQ*, 2022 ONSC 999).

Did the Orders limit s. 7 rights?

[276] On the evidence, the Orders compelled none of the Tatlock petitioners to accept unwanted medical treatment. Thus, unlike *Carter*, their s. 7 rights associated with bodily integrity and medical self-determination were not engaged.

[277] Instead, they lost their jobs because they chose not to accept vaccination against a highly contagious virus which posed the risk of serious illness and death to vulnerable patients and other healthcare workers. In my view, this loss did not engage their s. 7 right to liberty because of the well-established principle that s. 7 does not protect the right to work in any specific employment or particular profession, particularly when the job-loss arises from non-compliance with its governing rules and regulations. This is not a constitutionally-protected fundamental life choice.

[278] In my view, their s. 7 security of the person rights were also not engaged. The fact that they experienced serious consequences, including stress and hardship, from choosing to follow their personal convictions about vaccination does not make

the Orders a state interference with their physical or psychological integrity. In effect, their position amounts to security of the person being engaged unless vaccination were a matter of free choice without any serious state-imposed consequences for refusal. As stated in by Chief Justice Lamer in *J.G.* at para. 59*:*

> … It is clear that the right to security of the person does not protect the individual from the ordinary stresses and anxieties that a person of reasonable sensibility would suffer as a result of government action. If the right were interpreted with such broad sweep, countless government initiatives could be challenged on the ground that they infringe the right to security of the person, massively expanding the scope of judicial review, and, in the process, trivializing what it means for a right to be constitutionally protected …
>
> [Emphasis added.]

[279] In arriving at these conclusions, it is important to bear in mind that, to the extent the petitioners' reasons for refusal reflected religious beliefs or matters of conscience, they are protected under s. 2(a). Also important is the fact that the petitioners are not seeking a finding that the vaccines were objectively unsafe.

[280] In my view, a number of cases support this conclusion that s. 7 is not infringed by the Orders, and persuade me not to follow *United Steelworkers* on that issue.

[281] In *B.C. Teachers' Federation v. School District No. 39 (Vancouver)*, 2003 BCCA 100 [*BCTF*], leave to appeal ref'd [2003] S.C.C.A. No. 156, the majority found the s. 7 right to liberty not engaged in the context of a teacher who lost her job for refusing to submit to a psychiatric examination. After a thorough review of *Blencoe v. British Columbia (Human Rights Commission),* 2000 SCC 44 and other decisions, Justice Hall for the majority concluded that s. 7 rights did not extend to matters concerning an individual's employment, including citing with approval the propositions that s. 7 is not engaged by "a right to any specific employment" or "the right to exercise their chosen profession" (paras. 201–210).

[282] Importantly, it was the dissenting judgment of Justice Prowse that would have supported the petitioners in this case. Justice Prowse saw the teacher's s. 7 liberty

interest as implicated because of the basis upon which her employment was terminated. She held that "the teacher's liberty interest was infringed by the state mandating that she forego her right to personal and psychological integrity or forfeit her means of livelihood" (paras. 142, 148).

[283] These same points were forcefully made in the recent decision of *Tanase.* Mr. Tanase lost his licence as a dental hygienist after a discipline committee found he engaged in a sexual relationship with a patient whom he eventually married. He argued the revocation was an "absurdity" because their relationship did not engage the concerns the scheme was meant to address, such as the exploitation of power dynamics and inducement of consent.

[284] Mr. Tanase asked a five-member panel of the Ontario Court of Appeal to overturn its prior decision of *Mussani,* and find that his s. 7 rights were infringed. Like Mr. Tanase, Dr. Mussani's licence had been revoked pursuant to mandatory provisions in Ontario's *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act*, 1991, S.O. 1991, c. 18. Dr. Mussani argued unsuccessfully that the mandatory revocation policy violated his s. 7 liberty and security of the person interests. He pointed, in particular, to the stigma and stress he had suffered as a result of being disciplined.

[285] The Court In *Tanase* declined to overturn *Mussani*, which they summarized this way:

> [35] In *Mussani* this court held that there is no constitutional right to practice a profession and that the penalty of mandatory revocation of a health professional's certificate of registration affects an economic interest that is not protected by ss. 7 or 12 of the *Charter*. Security of the person was not engaged by the revocation of registration regardless of the stress, anxiety, and stigma to which disciplinary proceedings inevitably give rise in the context of sexual abuse allegations, nor was a liberty right engaged …

[286] The Court in *Tanase* also found no common law, proprietary or constitutional right to practice as a regulated health professional, and so revocation of Mr. Tanase's registration, for violating the *Health Professions Procedural Code,*

"engages neither the right to liberty nor the right to security of the person" (paras. 41–42).

[287] Importantly for present purposes, Mr. Tanase had characterized the issue to be decided in a similar way to the petitioners in this case. That is, it was characterized:

> [38] … not as whether s. 7 protects a positive right to practice a profession unfettered by standards and regulations, but instead, as whether it encompasses the negative right not to be deprived of a state-granted privilege to practice a profession except in accordance with the principles of fundamental justice. The appellant argues that psychological stress flows directly and automatically from the revocation of registration, and that this stress should be considered analogous to the possibility of the removal of a child, which was held to have engaged security of the person in *New Brunswick (Minister of Health and Community Services) v. G.(J.)*, 1999 CanLII 653 (SCC), [1999] 3 S.C.R. 46.

[288] In rejecting this argument, the Court found "an unbroken line of authority from the Supreme Court of Canada confirming that s. 7 of the *Charter* does not protect the right to practice a profession or occupation, an example of what that court has described as "pure economic interests'" (para. 40). They held that Mr. Tanase's argument for his negative right not to be deprived of his state-granted privilege to practice his profession did not engage security of the person because there was no "interference with bodily integrity and autonomy or serious state-imposed psychological stress" (para. 43).

[289] In rejecting his argument that publication of the revocation of his registration under the characterization of "sexual abuse" amounted to severe psychological stress and anguish, the Court said the following, which in my view also applies in this case:

> [44] … Professional discipline is stressful, to be sure, but it does not give rise to constitutional protection on that account. In *Blencoe v. British Columbia (Human Rights Commission)*, 2000 SCC 44, [2000] 2 S.C.R. 307, and in *G.(J.),* the Supreme Court articulated the need for a "serious and profound effect" on a person's psychological integrity before security of the person is engaged: *Blencoe*, at para. 81; *G.(J.)*, at para. 60. The threshold was crossed in *G.(J.)* because a mother was facing the possibility that the state would sever her relationship with her child. This is a profound

> interference with family autonomy and decisions taken in the context of regulating health care practitioners pale alongside it.
>
> [45] In saying this, I do not mean to minimize the significance of professional discipline. But s. 7 does not apply simply because legislation gives rise to serious consequences. Psychological integrity is a narrow and limited concept, and the right to security of the person is engaged only if there is a serious and profound effect on psychological integrity. The matter is to be judged on an objective basis, having regard to persons of ordinary sensibilities. It is irrelevant whether state action causes upset, stress, or worse. There must be a serious and profound impact on psychological integrity before the protection of s. 7 is engaged. Nothing in this case suggests that this threshold has been crossed, nor has the appellant proffered any basis for this court to revisit that threshold.

[290] Apart from *United Steelworkers*, the COVID-19 cases also do not favour the Tatlock petitioners regarding s. 7. In *Maddock v. British Columbia*, 2022 BCSC 1605 (appeal dismissed as moot, 2023 BCCA 383), Chief Justice Hinkson found s. 7 not engaged by the PHO's orders requiring restaurant patrons to provide proof of vaccination or proof of exemption. Mr. Maddock, a paralegal, argued the orders interfered with his s. 7 right to liberty because he could not carry on his business by meeting clients in restaurants. He argued that he faced coercive pressure to accept an unwanted medical treatment.

[291] Mr. Maddock's situation was different from that of the Tatlock petitioners because his vaccination refusal deprived him, not of his job, but merely access to privately owned establishments open to the public. Nevertheless, some of the Chief Justice's reasoning regarding s. 7 and COVID-19 vaccination applies:

> [78] However, the Suspension Order does not compel or prohibit subjection to any form of medical treatment. The Suspension Order may make the decision of whether or not to accept medical treatment in the form of vaccination more difficult, but it does not impose a decision on the petitioner. Each of the cases cited by the petitioner dealt with laws that left affected individuals with no reasonable choice but to accept, or effectively accept, non-consensual treatment …

[292] In *Costa,* as described above, the court rejected the students' application for an injunction restraining the vaccination mandate at their college. In doing so, it adopted the following comments from an arbitrator regarding s. 7 not being engaged:

> [57] Section 7 of the Charter protects an individual's right to decide: whether or not to be vaccinated. The Policy does not require mandatory vaccination. The Policy does not violate anyone's life, liberty or security of the person. It does not mandate a medical procedure or seek to impose one without consent… The Policy had an impact on TDSB employees who decided not to attest and/or get vaccinated, but there is no basis to conclude that life, liberty or security of the person is in any manner impaired by the Policy and by the choices individuals make. Employees are not prevented in any way from making a fundamental life choice …

[293] In *Lewis*, Ms. Lewis risked dying if she did not receive an organ transplant. She was ineligible for the transplant program, however, because she was unvaccinated against COVID-19. She argued that this ineligibility violated her s. 7 rights to life and security of the person. The Alberta Court of Appeal held that the anguish of her situation was not state-imposed. Rather, her serious psychological stress was caused by her personal views about vaccination, and the consequences of the decisions she made as a result:

> [60] … The consequences of Ms Lewis' refusal have caused her anguish but s 7 of the *Charter* only protects against serious psychological stress which is "state-imposed": *Blencoe* at para 57, citing *Morgentaler* at 56. We are not persuaded the COVID-19 vaccine requirement, deemed medically necessary to protect Ms Lewis and others in the transplant context, amounts to serious state-imposed psychological stress.

[294] Based on the analysis above, I respectfully depart from the finding in *United Steelworkers* that the vaccine mandate engaged the petitioners' s. 7 rights. The stress and difficulties they have endured from following their personal convictions about the vaccine do not engage s. 7 rights of liberty or security of the person.

Principles of Fundamental Justice

[295] Given that the rights protected by s. 7 are not engaged by the Orders, it is unnecessary to determine whether the petitioners' loss of their jobs was contrary to the principles of fundamental justice. However, for completeness, I would say that in my view there are strong reasons why, even if s. 7 rights were engaged, the Orders would not be contrary to the principles of fundamental justice.

[296] The relevant principles of fundamental justice in this case are arbitrariness, overbreadth, and gross disproportionality (*Carter*, para. 72).

[297] In my view, the Orders cannot be said to be arbitrary because of the clear connection in the Orders, supported by the record, between vaccination and protection of vulnerable patients and the healthcare system.

[298] The Orders are not overbroad because they do not go too far and interfere with some conduct that bears no connection to their objectives (*Cambie Surgeries* , para. 310). The vaccination of healthcare workers is directly related to the objectives of protecting vulnerable patients and residents and other healthcare workers, and safeguarding the capacity of the healthcare system (*Canada (Attorney General) v. Bedford*, 2013 SCC 72, at paras.101, 112).

[299] Finally, gross disproportionality occurs when the impugned decision infringes on the right in a way that is grossly disproportionate to its object. This standard is not easily met. The law's effects can be incommensurate with its object without being grossly disproportionate (*Cambie Surgeries,* para. 321 citing *Carter* at para. 89). Rather, the impact must be "totally out of sync with the objective of the measure"; "so severe that it violates our fundamental norms"; or, "too high a cost to life liberty or security of individuals" (*Cambie Surgeries,* para. 320).

[300] While the consequences of refusing the vaccine have been significant for the petitioners, in my view the Orders are not in violation of our fundamental norms or out of sync with their objectives. This is because the objectives are the critical public healthcare goals of protecting the public against a highly contagious disease, which that over the past few years has caused much death, serious illness, and harm to the functioning of the healthcare system.

Were the Orders reasonable under Doré?

[301] Having found that the Orders limited the s. 2(a) rights of the religious petitioners, I must assess whether they were nevertheless reasonable under the *Doré* framework.

[302] Under *Doré*, the reasonableness of the Orders is determined based on whether they reflect a proportionate balancing of the public health objectives of the

PHA and the petitioners' *Charter*-protected freedom of religion (*Beaudoin*, para. 257). The public health intervention must be proportionate to the threats faced and the measures should not exceed what is reasonably necessary to address the actual risks.

[303] There is no doubt that containing the spread of the virus and the protection of public health is a legitimate objective which can support limits on religious freedoms (*Beaudoin*, para. 267). In *Beaudoin (*para. 258), the Court of Appeal described the proper approach to the assessment of proportionate balancing by quoting extensively from Justice Abella's majority reasons in *Law Society of British Columbia v. Trinity Western University*, 2018 SCC 32 (cites omitted; reproduced in part):

> [79] … *Doré*'s approach recognizes that an administrative decision-maker, exercising a discretionary power under his or her home statute, typically brings expertise to the balancing of a *Charter* protection with the statutory objectives at stake. Consequently, the decision-maker is generally in the best position to weigh the *Charter* protections with his or her statutory mandate in light of the specific facts of the case. It follows that deference is warranted when a reviewing court is determining whether the decision reflects a proportionate balance …
>
> [80] … For a decision to be proportionate, it is not enough for the decision-maker to simply balance the statutory objectives with the *Charter* protection in making its decision. Rather, the reviewing court must be satisfied that the decision *proportionately* balances these factors, that is, that it "gives effect, as fully as possible to the *Charter* protections at stake given the particular statutory mandate" (*Loyola*, at para. 39). The *Charter* protection must be "affected ….as little as reasonably possible" in light of the applicable statutory objectives (*Loyola*, at para. 40). When a decision engages the *Charter*, reasonableness and proportionality become synonymous. Simply put, a decision that has a disproportionate impact on *Charter* rights is not reasonable.
>
> [81] … The question for the reviewing court is always whether the decision falls within a range of reasonable outcomes. However, if there was an option or avenue *reasonably* open to the decision-maker that would reduce the impact on the protected right while still permitting him or her to sufficiently further the relevant statutory objectives, the decision would not fall within a range of reasonable outcomes. This is a highly contextual inquiry.
>
> [82] … In working "the same justificatory muscles" as the *Oakes* test (*Doré*, at para. 5), the *Doré* analysis ensures that the pursuit of objectives is proportionate. In the context of a challenge to an administrative decision where the constitutionality of the statutory mandate itself is not at issue, the proper inquiry is whether the decision-maker has furthered his or her statutory mandate in a manner that is proportionate to the resulting limitation on the *Charter* right.

[304] The Orders are clear that the PHO fully recognized both the stakes for the individual rights of those whose beliefs clashed with accepting the vaccine, and the proportionality principle, meaning that the terms and effects of the Orders must be proportionate to the nature of the apprehended harm and not unnecessarily limit constitutional rights.

[305] The final section of the Recitals included this:

> Balancing Competing Interests
>
> WW. I recognize the effect which the measures I am putting in place to protect the health of patients, residents, clients and workers in hospital and community care settings may have on people who are unvaccinated and, with this in mind, continually engage in the reconsideration of these measures, based upon the information and evidence available to me, including case rates, sources of transmission, the presence of clusters and outbreaks, the number of people in hospital and in intensive care, deaths, the emergence of and risks posed by virus variants of concern, vaccine availability, immunization rates, the vulnerability of particular populations, reports from the rest of Canada and other jurisdictions, scientific journal articles reflecting divergent opinions, and opinions expressing contrary views to my own submitted in support of challenges to my orders, with a view to balancing the interests of the people working or volunteering in the hospital and community care sectors, including constitutionally protected interests, against the risk of harm posed by unvaccinated people working or volunteering in the hospital or community care sectors;
>
> XX. I further recognize that constitutionally protected interests include the rights and freedoms guaranteed by the Canadian Charter of Rights and Freedoms, including specifically freedom of religion and conscience, freedom of thought, belief, opinion and expression, and the right not to be deprived of life, liberty or security of the person, other than in accordance with the principles of fundamental justice. However, these rights and freedoms are not absolute and are subject to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society, which includes proportionate, precautionary and evidence-based measures to prevent loss of life, serious illness and disruption of our hospital and community care systems;
>
> YY. When exercising my powers to protect the health of the public from the risks posed by COVID19, I am aware of my 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. I have concluded that the measures which I am putting in place in this Order are proportionate, rational, and tailored to address the risk, and are consistent with principles of fundamental justice. The measures are neither arbitrary, overbroad, nor grossly disproportionate in light of the need to protect public health at this time. In my view, any limits on constitutionally protected rights and freedoms

> arising from this Order are proportionate and reasonable in the interests of protecting public health, and there are no other reasonable alternatives that would provide the same level of protection to patients, residents, clients and workers in hospital and community care settings and would promote the preparedness and resiliency of the health-care system;

[306] In my view, the following two Recitals capture the PHO's conclusions about the proportionate balancing from a public health perspective:

> H. … [A]ny 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; [and] …
>
> 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 …

[307] It is difficult to imagine more important and pressing public health concerns and objectives than reducing serious illness and loss of life, and safeguarding the functioning of the healthcare system.

[308] As the Court said in *Beaudoin* (paras. 267, 307), limits 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 healthcare system". It is the PHO who is uniquely qualified to make these decisions and her judgment must be afforded deference (*Beaudoin*, para. 278; *Doré,* paras. 54–57).

[309] In this context, the precautionary principle applies, because human life and safety are at stake and there is scientific uncertainty as to the nature and magnitude of the risks (*Trinity Bible Chapel,* paras. 112–115).

[310] Having found a sufficient evidentiary foundation in the record for the PHO's Conclusions regarding the risks posed by an unvaccinated healthcare workforce, and recognizing that deference is owed regarding these complex medical and scientific issues, I find the Orders reasonably balanced the risks posed by unvaccinated healthcare workers and the s. 2(a) rights of those who eschewed the vaccine for religious reasons.

[311] I find the Orders were not overbroad in precluding the unvaccinated religious petitioners from working in the designated healthcare settings while the Orders remain in place. Conclusion (c) explains that, from a public health perspective, the Orders are broad by necessity, because it is essential to maintain the high level of vaccination currently in place in the hospital and community care workforce. I have found this Conclusion reasonably supported by the evidence in the record.

[312] The Tatlock petitioners argue that the Orders are disproportionate in specific ways. First, they do not allow for alternatives to vaccination such as masking or rapid testing. In my view, on this issue the Court must defer to the PHO's medical conclusions that such alternatives are not as effective against transmission as vaccination (see Recitals BB-DD and the Dove Report.).

[313] Second, other unvaccinated persons are now permitted in these settings, namely, patients, visitors, healthcare workers with medical exemptions, and some construction workers (subject to distancing rules). In my view, that does not render the Orders arbitrary or disproportionate. Healthcare workers are in a special situation given the crucial role they play in the system and their near-constant, close contact with the most vulnerable patients, who generally speaking have no choice but to be treated by them. Drawing the lines in this way is connected to protecting the most vulnerable and the capacity of the healthcare system, while at the same time dismantling as much as possible the regime implemented during the worst of the pandemic. In my view, it cannot be said that this approach falls outside the range of reasonable outcomes.

[314] In sum, I find that the Orders, as supported by the record, represent a proportionate balancing of the public health objectives of the *PHA* and the petitioners' *Charter*-protected freedom of religion.

Conclusion

[315] The petitions are dismissed, with the exception that, under *JRPA* s. 5(1), I remit to the PHO for reconsideration, in light of this decision, whether to consider requests under s. 43 of the *PHA*, for reconsideration of the vaccination requirement

from healthcare workers able to perform their roles remotely, or in-person but without contact with patients, residents, clients or the frontline workers who care for them.

"Coval J."