Court File No. 223/31

ONTARIO
SUPERIOR COURT OF JUSTICE
(Divisional Court)

BETWEEN:

DAVID DANESHVAR

Applicant

- and -

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO AS REPRESENTED BY THE MINISTER OF HEALTH, and the HONOURABLE CHRISTINE ELLIOTT, MINISTER OF HEALTH for the PROVINCE OF ONTARIO

Respondents

FACTUM OF THE APPLICANT

Dated: April 12, 2021

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I. INTRODUCTION

1. In the face of a deadly global pandemic, the Ontario government controls a monopoly over vaccines which are as life sustaining as water to drink and air to breathe. The decisions the Respondents are statutorily empowered to make in creating and implementing its COVID-19 vaccination plan will determine who will live and who will remain at risk of dying.
2. There are barriers to accessing the vaccine, these were predictable and predicted. These barriers include:
    a) Technology and language barriers to booking vaccine appointments;
    b) Vaccine hesitancy and misinformation barriers; and
    c) Physical barriers to attending a vaccination site.
3. In making decisions regarding the vaccination program, the Respondents must be guided by their duty to act in accordance with the principle of health equity, section 7 of the *Charter of Rights and Freedoms* and the equality obligations contained in section 1 of the *Human Rights Code of Ontario* and section 15 of the *Charter of Rights and Freedoms*. They have ignored these obligations.
4. The Respondents appointed a Task Force to provide it with guidance in making these unprecedented decisions. The Task Force has been headed by a retired General who has no health equity expertise. The Respondents have also received advice from the Science Advisory Table composed of preeminent experts in health equity. There is no evidence that the equity advice provided by the Science Advisory Table was heeded by the Task Force, let alone the Respondents.
5. Until recently the Respondents disregarded the heath equity science provided to it by ignoring the vaccine barriers. The Respondents purported to contract and delegate out of

their section 7 and 15 *Charter* obligations. Recent catastrophic rates of hospitalization and deaths because of COVID-19 in poor, racialized districts of Toronto, have forced the Respondents to reassume responsibility for equitable stewardship of vaccines. The Respondents have belatedly implemented the heath equity advice received from the Science Advisory Table by prioritizing these neighbourhoods for vaccination. These hospitalizations and deaths were both foreseeable and avoidable.

6. This Court is requested to review the decisions of the Respondents, including those by which they purported to abdicate their equity obligations. The Applicant seeks a remedy which will confirm that future decisions regarding the vaccine program are made in conformity with health equity obligations—this includes listening to, and acting upon, evidence-based accommodation advice regarding the vaccine barriers.

II. SUMMARY OF FACTS

Health Equity is the Respondents' Responsibility

7. Since early 2020, the world has been struggling amidst a global pandemic arising from the spread of coronavirus (COVID-19). It was clear from early on that a large-scale vaccination program would be required quell the spread, save lives, and allow society to return to "normal".

8. Ontario marshalled expertise through the creation of the COVID-19 Vaccine Distribution Task Force and related sub-tables including the Science Advisory Table. These bodies were tasked with advising the Respondents on the creation and execution of an equitable, mass-scale vaccination program.

> Affidavit of Dr. Rachlis, Application Record, Tab 5, at para 19, Exhibit 5, pp. 248, 398.
> Affidavit of J. Melnychuk, Application Record, Tab 6, at para 10, p. 721.

9. The Respondents have the statutory authority under the *Health Protection and Promotion Act*, *Ministry of Health and Long-Term Care Act*, *Health Insurance Act*, and *Emergency Management and Civil Protection Act*, to make decisions regarding its vaccination program. Notwithstanding the broad discretion the Respondents have in making decisions regarding its COVID-19 vaccine program, they are still bound by the *Charter*, human rights and health equity obligations, and may not contract out, delegate or download its obligations. Any entities involved in the delivery of the vaccine program must be subject to the same obligations as the Respondents as they are engaged in delivering a governmental program.

> *Health Protection and Promotion Act*, RSO 1990, c H.7.
> *Ministry of Health and Long-Term Care Act*, RSO 1990, c M.26, s.3(3).
> *Emergency Management and Civil Protection Act*, RSO 1990, c E.9.
> *Judicial Review Procedure Act,* RSO 1990, c J.1, ss. 1, 2.

10. By means of the Respondents' "Ethical Framework", offered as guidance for vaccine delivering entities, and the operation of Schedule 1 to *Supporting Ontario's Recovery Act, 2020*, the province purports to grant itself, and other bodies through which it contractually agrees to administer vaccines, immunity from liability. Provided both demonstrate "good faith" conduct in the operations of statutory obligations including the Health Equity Guidelines, *Human Rights Code* as well as constitutional obligations pursuant to the *Charter of Rights and Freedoms*, liability can allegedly be avoided.

> Affidavit of J. Melnychuk, Application Record, Tab 6, at Exhibit 33, p. 1046.
> *Supporting Ontario's Recovery Act, 2020*, SO 2020, c 26, Sched. 1.

11. Health equity "means that all people can reach their full health potential without disadvantage due to social position or other socially determined circumstances, such as ability, age, culture, ethnicity, family status, gender, language, race, religion, sex, social

class and socioeconomic status" (Health Equity Guideline). An equitable vaccination program would need to address barriers to vaccination including 1) those unable to book an appointment through a technology-based booking system; 2) vaccine hesitancy and misinformation; and 3) those unable to attend mass-vaccination sites or in other words, homebound individuals.

> Affidavit of Dr. Rachlis, Application Record, Tab 5, at paras 46-47 (access to vaccination sites), Exhibit 4 (Health Equity Guidelines), pp. 254, 377-396.
> Affidavit of Dr. Treviranus, Application Record, Tab 4, at paras 12 (misinformation), 16-17 (technology-based booking systems), pp.177, 179.
> Affidavit of Dr. Siddiqi, Application Record at Tab 3, at paras 26-27 (technology-based booking systems), 17, 22-28 (vaccine hesitancy and misinformation), pp. 51, 48-49, 50-52.
> Transcript of J. Melnychuk, Application Record, Tab 8, q. 68, Exhibit 5, pp. 1256, 1428-1436.

12. The Applicant, Mr. Daneshvar, meets almost all of the listed socially determined circumstances which could inhibit his ability to reach his full health potential (e.g. receive a vaccine) if unaccommodated. He is disadvantaged due to his disabilities, culture, ethnicity, language, social class and socioeconomic status. Mr. Daneshvar suffers from a number of diagnoses which impact his physical and mental health including: Helicobacter Plyori, vision deficiencies, chronic pain, post-traumatic stress disorder, anxiety, depression, and vertigo, among other impairments. As a result, Mr. Daneshvar must take numerous prescription medications and requires significant assistance in the activities of daily living and personal care. He receives social assistance through the Ontario Disability Support Program.

> Affidavit of D. Daneshvar, Application Record, Tab 2, at paras 2-8, pp.26-28.
> Transcript of D. Daneshvar, Application Record, Tab 7, at qs. 157-58, 162-71, pp. 1221-1222, 1223-1226.

13. The Applicant is a refugee, is Jewish, his first language is not English, he struggles to use a computer, and cannot stand or be outside for any length of time. The Applicant cannot attend a mass-vaccination site nor make a booking without significant assistance. The Respondents have not provided, nor directed those with which it contracts, to provide such assistance. Instead, the Respondents' vaccination program relies on the "good will" of others to assist persons like the Applicant to overcome these vaccine barriers.

Affidavit of D. Daneshvar, at paras 17-26, pp. 30-32.

The Respondents Decided to Ignore Health Equity in the Vaccination Program

14. The Respondents decided to contract with vaccine delivery entities including hospitals, pharmacies and primary care providers to administer vaccines. The Respondents decide how many vaccines are provided to these entities. The Respondents decide which groups are most in need of the vaccine. Ms. Melnychuk alleges that public health units ("PHUs") are responsible for the vaccination program. She gives the example that public health units determine which groups receive the vaccines and when. However, the Respondents can and do maintain overall control of the flow of vaccines. The Respondents recently reallocated vaccines to address hotspot areas in Toronto neighbourhoods where hospitalizations and death rates are high and vaccination rates are low. The Respondents retain a monopoly over the vaccines and retain control over the vaccination program.

Affidavit of J. Melnychuk, Application Record, Tab 6, at paras 21 (pharmacy contracts), 14 (control over vaccine distribution) 16 (control over prioritization), 19, 24 (alleged PHU control), pp. 724-725, 722, 723, 723-24, 725.

15. The Respondents' vaccination program is allegedly arranged to ensure that those most at risk of contracting or experiencing complications arising from COVID-19, are vaccinated first. However, the vaccination program does not address vaccine barriers and in that way,

it fails to accomplish its stated goal of vaccinating those most at risk. For example, persons can be in the highest priority group for vaccination such as "recipient of chronic home care", but never receive vaccination because they are home bound and unable to attend a mass vaccination site. No vaccine is available privately in Ontario, nor are people currently free to travel if able, to other jurisdictions where vaccine can be purchased privately.

Affidavit of J. Melnychuk, Application Record, Tab 6, at para 17, p. 723.
Transcript of J. Melnychuk, Application Record, Tab 8, Exhibit 2, pp. 1409-1418.

16. Early on, the Respondents' expert advisors identified barriers, which would preclude an equitable vaccination program if not addressed and accommodated. This advice came from individuals such as the Applicant's experts including:

    a) Dr. Arjumand Siddiqi, health equity expert and member of the Ontario Science Advisory Table tasked with advising the Respondents on relevant scientific advice regarding COVID-19; and

    b) Dr. Jutta Treviranus, expert in "assessing equity in technology-based programs and implementing solutions to address the shortcomings of such programs, who worked with the Ontario Digital Service in the creation of the online portal to book a COVID-19 vaccination appointment.

    Affidavit of Dr. Siddiqi, Application Record, Tab 3, at paras 8-9, p. 47.
    Affidavit of Dr. Treviranus, Application Record, Tab 4, at paras 8, 10, p. 177.

17. While not an advisor to the Respondents, the Applicant also relies on the expertise of public health expert, Dr. Michael Rachlis. None of these experts were cross-examined and therefore their evidence remains unchallenged.

    Affidavit of Dr. Rachlis, Application Record, Tab 5, pp. 244-258.

18. The Respondents were made aware that vaccine barriers would not impact everyone in the same way—individuals from enumerated categories would be more prone to experiencing vaccine barriers. Experts advised the Respondents that persons with disabilities, older adults and persons whose first language is something other than English or French would struggle to use the technology-based appointment booking system. Experts advised the Respondents that racialized minorities would be more prone to vaccine hesitancy because of historical oppression. Experts advised the Respondents that accommodations would need to be made for those who are homebound and unable to attend a mass clinic. Vaccination plans and rates to date, demonstrate that this advice was ignored.

> Affidavit of Dr. Treviranus, Application Record, Tab 4, at paras 12 (misinformation), 16-17 (technology-based booking systems), pp. 177-178, 179.
> Affidavit of Dr. Rachlis, Application Record, Tab 5, at paras 46-47 (access to vaccination sites), p.254.
> Affidavit of Dr. Siddiqi, Application Record at Tab 3, at paras 26-27 (technology-based booking systems), 17, 22-28 (vaccine hesitancy and misinformation), Exhibit 4, pp. 51, 48-49, 50-52, 102-117.
> Transcript of J. Melnychuk, Application Record, Tab 8, Exhibits 2, 5, pp. 1409-1418, 1428-1436.

Evidence of an Inequitable Program

19. The Respondents decided not to incorporate health equity into its vaccination program. Moreover, they did not require any of the entities with which they contract to assume this responsibility. The Respondents' sole witness, Ms. Jodi Melnychuk, Director of Vaccine Planning and Engagement, acknowledged that health equity is focused on effects or the outcomes of health care programs. Vaccine equity both can and must be measured in order to verify its existence. If everyone is impacted by vaccine hesitancy in the same way, can book online, and attend a mass vaccination site, vaccination rates across any given prioritized group should be equal. There would be no difference in vaccination rates

between wealthy neighbourhoods and poorer ones, racialized individuals and non-racialized individuals, able-bodied persons and persons with disabilities. Health equity is measured by outcome; if equity exists, vaccination rates should be comparable across these categories of persons.

Transcript of J. Melnychuk, Application Record, Tab 8, q. 68, p. 1256.

20. The Respondents were informed through the Science Advisory Table, that coupling vaccine distribution by age and neighbourhoods, would assist in ensuring an equitable rollout. The Science Advisory Table warned that an inequitable, age-based strategy alone would result in "higher vaccination rates in wealthier neighbourhoods, as currently observed in the United States" (Dr. Siddiqi, Exhibit 4, p. 2). This advice was ignored. As anticipated, the outcome is that wealthy neighbourhoods with low COVID-19 rates, have the highest levels of vaccination compared to the areas with the highest transmission rates. Reasons abound but to cite only one, if there are no pharmacies in the Jane-Finch areas administering vaccines, vaccination rates will inevitably be lower in that area. As Dr. Siddiqi and her colleagues on the Science Advisory Table foretold, massive health inequities result when comparing wealthier and lower income neighbourhoods because accommodations to vaccines barriers were not made. Equity was left out of the planning.

Affidavit of Dr. Siddiqi, Application Record at Tab 3, at paras 25, 26, Exhibit 4 at p.2, pp. 51, 103.
Transcript of J. Melnychuk, Application Record, Tab 8, Exhibits 5, 7, pp. 1428-1436, 1442-1460.

21. Individuals 80 and older were eligible to receive the vaccine as part of Phase 1. As of March 19, 2021, slightly over 50% of this age group had received a vaccine. In light of this, the Respondents expanded access to those 75 and older. However, as of April 1, 2021, only 50% of individuals in this age bracket "in the neighbourhoods with the highest rates of

COVID-19" have been vaccinated "compared to 70 per cent in neighbourhoods with the lowest rates of infection" (Transcript, Exhibit 2). Those in neighbourhoods with low transmission rates, have high vaccination rates. If broken down by risk, those at the highest risk remained unvaccinated when the Respondents expanded vaccine eligibility. This is just one example where the Respondents own experts advised inequities would result, but no steps were taken.

> Affidavit of J. Melnychuk, Application Record, Tab 6, at para 60, p. 737.
> Transcript of J. Melnychuk, Application Record, Tab 8, Exhibits 2, 7 at p. 15, pp. 1409-1418, 1456.

22. Barriers exist in the booking process as well. For example, on or about March 7, 2021, in York Region, when additional supply was available to vaccinate those 80 and older, vaccine appointments went to those who created a profile and then booked online – walk in appointments were not available. The spots were snatched up quickly – those unable to book online were recommended to "seek out a support person … who can assist in the booking" (Dr. Rachlis, Exhibit 16). No accommodation was offered to those who faced barriers associated with the online booking system, and there was no attempt to focus or reserve supply for those facing barriers to either the booking process or the vaccination site. A similar issue occurred with a pre-registration process through hospitals.

> Affidavit of Dr. Rachlis, Application Record, at Tab 5, at para 42, Exhibit 16 (York Region), pp. 253, 524-525.
> Affidavit of Dr. Siddiqi, Application Record at Tab 3, at para 27, Exhibits 8, 9 (pre-registration), pp. 51, 136, 138-141.

23. On March 15th, the Respondents launched the provincial online reservation portal and accompanying phone line. The Respondents were advised on how to make these services accessible but failed to follow this advice. As a result, those lacking adequate technology (e.g. phone, internet, computer), skills, physical coordination and speed to access the

booking system and lack of literacy, struggle to use the system. This disproportionately impacts "seniors, racialized groups, low income groups, and people with disabilities who have been at higher risk of getting COVID-19, [they] are exactly the same groups who are less likely to have computers, broadband, and be 'digitally savvy'" (Kwame McKenzie as quoted in Dr. Rachlis' Affidavit, Exhibit 17). Rather than address a known vaccine barrier, the Respondents decided to use its resources to create a province-wide barrier.

> Affidavit of Dr. Treviranus, Application Record, Tab 4, at paras 10-12, p. 177.
> Affidavit of Dr. Rachlis, Application Record, at Tab 5, Exhibit 17, pp. 527-535.
> Affidavit of Dr. Siddiqi, Application Record at Tab 3, at para 27, p. 51.
> Affidavit of J. Melnychuk, Application Record, Tab 6, at para 56, p. 736.

24. Physical attendance at a vaccination site was also a predictable, and therefore avoidable, barrier. In January 2020, the head of the Registered Nurses Association of Ontario and home care-agencies wrote to the Respondents and sought to "enlist the thousands of home-care nurses who are already delivering care to also vaccinate persons who are homebound" (Transcript, J. Melnychuk, Exhibit 2). The Respondents decided not to address this barrier by enlisting homecare nurses to participate in the vaccination program.

> Transcript of J. Melnychuk, Application Record, Tab 8, Exhibit, 4, see also Response to Undertakings, Application Record, Tab 9, Response to Undertaking 10, pp. 1426, 1614-1616.

25. The Respondents have contracted with pharmacies to administer vaccines. However, pharmacies are only permitted to deliver vaccines in their retail locations. Those facing technology barriers will be unable to book an appointment. Those facing mobility barriers will be unable to attend the pharmacy in order receive the vaccine. Pharmacies are not required to undertake any initiatives to combat vaccine hesitancy. Rather than address

known barriers, the Respondents decided to add a route of vaccination which is explicitly prohibited from accommodating at-risk individuals such as homebound persons.

> Transcript of J. Melnychuk, Application Record, Tab 8, q. 295, p. 1321.
> Response to Undertakings, Application Record, Tab 9, Response to Undertaking 8, pp. 1586-1612.

26. The Respondents decided to ignore their own experts in accommodating vaccine barriers. This has resulted in an inequitable vaccination program. Whether the Respondents chose to ignore the advice or simply did not understand the importance of it, the Respondents were recently confronted with an issue in hotspot areas where the inequalities of the vaccination program were too great to ignore. In order to respond to this, the Respondents revised their prioritization framework to address the hot spots thereby demonstrating the significant control they maintain over the vaccination program.

The Respondents Decisions are the Source of the Inequitable Outcomes

27. Despite knowing that a large-scale vaccination program would be required, the Respondents decided to wait until January 9, 2021 to meet with public health units (PHUs) to discuss their role in vaccine delivery and even later to engage with other entities such as pharmacies and primary care providers. This was "far too late and with far too little direction and resources with which to achieve equity" (Dr. Siddiqi).

> Affidavit of J. Melnychuk, Application Record, Tab 6, at paras 21, 36, Exhibit 15, pp. 724-725, 728-729, 841-843.
> Affidavit of Dr. Siddiqi, Application Record, Tab 3, at para 23, p. 50.

28. PHUs were given a Checklist, a Playbook created by Councils of Medical Officers of Health, and the Ethical Framework. None of these documents were mandatory to include in their plans. Plans were reviewed or at least had the opportunity to be reviewed by the

Respondents. Opportunity for feedback and changes were available to the Respondents. The Respondents are unaware if plans have changed or what the current plans encompass.

> Affidavit of J. Melnychuk, Application Record, Tab 6, at paras 36 (resources), Exhibit 30 (Checklist), Exhibit 35 (Playbook) and Exhibit 32 (Ethical Framework), para 47 (equity not mandated), Exhibit 28 (NB: indicates no individual feedback would be provided), Exhibit 30 (NB: indicates review and feedback would be forthcoming); para 53 (content of current plans unknown), pp. 728-729, 1015-1019, 1081-1129, 1025-1044, 732, 1008-1010, 1015-1018, 735.

29. The Respondent's are required to fund 75% of the mandatory programs delivered by PHUs. The Respondents review reports from public health units and monitor how the program is rolling out across the province, but are providing no direction regarding vaccine equity. The Respondents expect PHU's to monitor themselves, but the Respondents are unaware if any are collecting data which would identify equitable outcomes. The Respondents decided to not collect mandatory socio-economic data, which is considered essential to assessing the achievement of vaccine equity. Even where dire predictions proved correct, the Respondents have decided not to monitor the roll out from an equity perspective which would enable them to identify the equity failures. Doing so would enable the Respondents and its sub-contractors to implement the requisite changes before hotspots arise.

> Affidavit of Dr. Rachlis, Application Record, Tab 5, at para 10.
> Transcript of J. Melnychuk, Application Record, Tab 8, q. 386, q. 462, p. 45, q. 223, pp. 1360, 1387, 1302.

30. The Premier indicated that he was "kind of shocked" that vaccine appointments were going unfilled. But the vaccine program has failed to address barriers to vaccination such as vaccine hesitancy and those who are homebound or on the wrong side of the digital divide. The barriers and corresponding vaccination rates are not "shocking", there were predictable, predicted, and disregarded.

Transcript of J. Melnychuk, Application Record, Tab 8, Exhibit "B" for Identification, pp. 1475-1476.

31. The Respondents are aware of these barriers and have been for months. Their experts warned them of these issues. The Respondents have the resources to monitor the vaccine program and authority to require changes as necessary to ensure equity in the program. The Respondents' failure to ensure equity in the vaccine program has resulted in persons like the Applicant, David Daneshvar being at risk of being left behind.

III. ISSUES AND STATEMENT OF ARGUMENT

ISSUES:

i. Does the failure to accommodate vaccine barriers violate section 7 of the *Charter*?

ii. Does the failure to accommodate vaccines barriers violate section 15 of the *Charter*?

iii. Can the *Charter* violations be saved by section 1?

iv. Did the Respondents fail to fulfill or otherwise delegate their accommodation obligations?

v. What is the appropriate remedy?

ISSUE i. Does the failure to accommodate vaccine barriers violate section 7 of the *Charter?*

32. Section 7 of the *Charter* protects the right to life, liberty and security of the person in accordance with the principles of fundamental justice. As outlined above, the Respondents have a monopoly over the COVID-19 vaccine. They therefore, have a duty to ensure that access to the vaccine is not delayed or prevented altogether, thereby jeopardizing the lives and security of Ontarians. However, by deciding to ignore equity in the vaccination program, barriers to vaccine access are going unaccommodated. Mr. Daneshvar, and others who are otherwise prioritized for access, face delays in receiving the COVID-19 vaccine.

The delay violates section 7 in that it endangers the right to life and security of the persons in an arbitrary and inequitable manner.

> *Canadian Charter of Rights and Freedoms*, s.15, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

33. It is trite to say that vaccines are part of health care. Delay in access to the COVID-19 vaccine is a delay in access to health care. A delay in access to health care has been identified by the Supreme Court of Canada as being as source of a section 7 violation both in terms of right to life and security of the person.

> *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35 at paras 43, 118.

34. The Supreme Court has held that "where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*" (*Chaoulli*). Moreover, "when the province assumes a monopoly power over the provision of medical services it is under a constitutional duty to ensure that the service is provided in a timely fashion" (*Cambie Surgeries*). Mr. Daneshvar, like others in equity seeking groups, are being deprived of timely access to COVID-19 vaccines for reasons unrelated to the availability of vaccines, or the Respondents' prioritization of eligible recipients. Individuals such as Mr. Daneshvar, have been identified as being most at risk but accommodations have not been put in place to ensure their timely access.

> *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35, at para 104.
> *Cambie Surgeries Corporation v British Columbia (Attorney General)*, 2020 BCSC 1310, at para 1330.
> *Health Services and Support - Facilities Subsector Bargaining Assn. v. British Columbia*, 2007 SCC 27.

35. As outlined above, in the present case, the Respondents have a monopoly over the provision of COVID-19 vaccines. They decide which entities can administer vaccines, the

conditions placed upon those entities and which individuals can receive the vaccines and when. Barriers to vaccination exists. Any accommodations provided, are at the discretion (and ability) of vaccine delivering entities to offer. In some instances, e.g. pharmacies, the Respondents have specifically precluded these entities from accommodating individuals such as those who are homebound. Without a clear mandate to remove these barriers, the Respondents have created a vaccine program which is discriminatory and places the lives and the security of Ontarians at risk. This in turn prevents some individuals from being able to access the COVID-19 vaccines when it is their turn, or in other words, deprives them of access to timely health care.

36. A "sufficient causal connection" between the effect of the Respondents' conduct and the harm suffered by the Applicant is present. The deprivation, which endangers the lives and security of the person, can be directly linked to the conduct of the Respondent. Causation is not negated by third parties (e.g. the entities contracted to administer vaccines).

Canada (Attorney General) v Bedford, 2013 SCC 72, at paras 75-76, 79-82.

37. The Applicant, like those 80 and older in high risk neighbourhoods, those on the wrong side of the digital divide, homebound individuals and those prone to vaccine hesitancy, face barriers to receiving the COVID-19 vaccine. Such barriers are not required to be, and are not being addressed in the Respondents' vaccination program. Those who do not face such barriers are able to access the vaccine in a timely manner as they become eligible. The failure to address these barriers means that individuals like the Applicant, will face delays in accessing the vaccine. In this way, they are deprived of timely access to health care and their lives and security of their persons are at stake.

Chaoulli v Quebec (Attorney General), 2005 SCC 35, at paras 43, 104, 118.

38. The Respondents have created a program which neglects the needs of those requiring accommodations to vaccine barriers. The vaccination program is created and controlled by the Respondent. Despite contracting with various entities, the Respondents have not required any entity to assume its constitutional obligations. As such, the barriers to vaccination are going unaccommodated thereby delaying access to those facing the barriers. This is the source of the infringement as it makes lives more dangerous.

Canada (Attorney General) v Bedford, 2013 SCC 72, at para 87.

39. The danger is amplified by the *Supporting Ontario's Recovery Act, 2020*, S.O. 2020, c. 26, Sched. 1. Through this statute, the Respondents and those with which they contract, can allege they have made "good faith" efforts in the vaccination program. While it will be asserted, this should not alleviate the Respondents or their sub-contractors from their quasi-constitutional obligations under the *Human Rights Code* or their constitutional obligations.

Supporting Ontario's Recovery Act, 2020, S.O. 2020, c. 26, Sched. 1
Human Rights Code, RSO 1990, c H.19.

40. The above deprivations are not in accordance with the principles of fundamental justice in that they are arbitrary and inequitable. The above effects experienced by persons like the Applicant are contrary to the objectives of the vaccination program and are therefore arbitrary. The program is intended to provide a vaccine to those most at-risk if such a vaccine is desired. Those like the Applicant would like to receive a vaccine. However, they will be unable to do so in a timely manner because of a lack of accommodations. Moreover, as outlined below, the deprivations are inequitable in that they disproportionately impact persons in enumerated categories. Something which is inequitable cannot be said to be in accordance with the principles of fundamental justice.

Affidavit of J. Melnychuk, Application Record, Tab 6, at para 16, p. 723.

Council of Canadians with Disabilities v. VIA Rail Canada Inc., 2007 SCC 15.

ISSUE ii. Does the failure to accommodate vaccines barriers violate section 15 of the *Charter*?

41. The above section 7 violation disproportionately impacts persons protected by the *Human Rights Code* and section 15 of the *Charter*.

42. The *Human Rights Code* requires accommodations for protected categories of individuals up to the point of undue hardship. Accommodations need to be as inclusive as possible.

Human Rights Code, RSO 1990, c H.19, at ss. 1, 11, 16.
Council of Canadians with Disabilities v VIA Rail Canada Inc., 2007 SCC 15.

43. Section 15 of the *Charter* provides the right to equality for groups which have been historically marginalized. Section 15 of the *Charter* focuses on substantive equality.

Withler v Canada (Attorney General), 2011 SCC 12 at paras 2, 31.

44. To demonstrate a section 15 violation, the Applicant must establish that the law 1) creates a distinction based on enumerated grounds and 2) that the distinction results in a disadvantage by "perpetuating prejudice or stereotyping" (*Withler*). The focus is on the impact of the impugned law (*Andrews*). Once the government provides a service, it is obliged to do so in a non-discriminatory manner (*Eldridge*).

Withler v Canada (Attorney General), 2011 SCC 12, at paras 40, 62-63.
Andrews v Law Society of British Columbia [1989], 1 SCR 143, at p. 165.
Eldridge v. British Columbia (Attorney General), [1997] 3 SCR 624, [1997] SCJ No. 86, at paras 60-66, 73, 74, 77, 78 [*Eldridge*].

45. In the present case, the Respondents' failure to adequately address vaccine barriers has resulted in a distinction. Of those prioritized for access and deemed to be most at-risk, those in enumerated categories such as those from racialized communities, persons with

disabilities and older adults, are less likely to be vaccinated in a timely manner. Those in enumerated categories are those who are most likely to be deprived of timely access to health care, in the form of a COVID-19 vaccine. In this way, those in protected categories are the ones whose lives and security of the person are jeopardized arbitrarily by the Respondents' failure to require accommodations in the vaccination program.

46. These distinctions in vaccine access have the effect of perpetuating disadvantage as it means these marginalized individuals face increased risk of COVID-19 transmission and therefore death. This risk is disproportionately borne by those in enumerated and therefore protected categories. The intersectionality of these enumerated grounds compound to further work against timely access to vaccination.

Affidavit of Dr. Siddiqi, Application Record, Tab 3, at para 23, p. 50.

ISSUE iii. Can the *Charter* violations be saved by section 1?

47. Section 7 and 15 rights are subject to the limitations set out in section 1 of the *Charter*. The Respondents bear the onus of justifying their conduct. In *Oakes*, the Supreme Court of Canada articulated the cumulative test for justification pursuant to section 1:

i. The limit is prescribed by law;
ii. The limit has a pressing and substantial objective; and
iii. The limit is proportional, that is, there is:
    a) A rational connection between the limit and the right being violated;
    b) Minimal impairment of the right infringed; and
    c) The salutary and deleterious effects are proportionate.

The test is not met in the present case.

R v Oakes, [1986] 1 SCR 103, at paras 69-71 [*Oakes*].

i. The limit is prescribed by law

48. To be prescribed by law, a limit may be found in government policies or programs. Provinces bear the obligation to deliver health care services, of which immunizations are a

part. The limitations on the Applicant's rights are prescribed by statutes authorizing the Respondents' creation of an inequitable COVID-19 vaccination program.

> *Greater Vancouver Transportation Authority v Canadian Federation of Students British Columbia Component*, [2009] 2 SCR 295 at para 50.
> *The Constitution Act, 1867* (UK), 30 & 31 Victoria, c 3, at ss. 91, 92.
> *Health Protection and Promotion Act*, RSO 1990, c H.7.
> *Ministry of Health and Long-Term Care Act*, RSO 1990, c M.26, s.3(3).
> *Health Insurance Act*, RSO 1990, c H.6, at s. 2(2).
> *Emergency Management and Civil Protection Act*, RSO 1990, c E.9.

ii. *The limit does not have a pressing and substantial objective*

49. The Applicant accepts that, generally, the COVID-19 Vaccination Program has a pressing and substantial objective, namely: to provide the life-saving vaccine to protect against the COVID-19 virus. However, the infringing measures in this case is the Respondents' decisions which have created a vaccination program which excludes those it is meant to protect—those most at risk by ignoring vaccine barriers. Accommodations are to be as inclusive as possible and provided up to the point of undue hardship. Given that the Respondents knew about the barriers in advance and were asked to address the same, their decision not to do so cannot be said to be pressing.

> *Figueroa v Canada (Attorney General)*, 2003 SCC 37 at para 59.
> *RJR-MacDonald v Canada*, [1995] 3 SCR 199, at para 144.
> *Human Rights Code*, RSO 1990, c H.19, ss. 1, 11, 16.
> *Council of Canadians with Disabilities v VIA Rail Canada Inc.*, 2007 SCC 15.

50. The Respondent's sole witness alleges that requiring accommodation to vaccine barriers would interfere with PHU discretion. However, as outlined above, accommodations for the vaccine barriers identified are consistent across the province. Mandating accommodations would not interfere with PHUs' knowledge. Notably, the Respondents have not committed to funding such accommodations. By failing to either delegate or alternatively, assume the

accommodation obligations themselves, those identified as most in need of the vaccine fall between the gaps arising from the undefined accommodation obligations. The lack of accommodation mandates in the program and the failure to ensure delivery of the same, cannot be said to have a pressing and substantial purpose.

> Affidavit of J. Melnychuk, Application Record, Tab 6, at paras 47 (PHU discretion), 28-29, Exhibit 25 (funding is not mandatory), pp. 732, 726-727, 969-970.

iii. *The limit is not proportionate*

a) *There is no rational connection between the limit and the Charter violations*

51. The impugned program must be carefully designed and not "arbitrary, unfair or based on irrational considerations" (*Oakes*). In this case, there is no rational connection. A vaccination program which ignores known vaccine barriers to be experienced by those most at risk is not rationally connected to the goal of administering a vaccination program where those most-at risk are vaccinated first. The limits arising from the failure to accommodate are irrational in that they work against the stated objective of the program.

> *Oakes*, *supra* para 138 at para 70.

b) *The limit is not minimally impairing*

52. To be minimally impairing, the limit must impair the right "as little as possible" (*Oakes*). The government must demonstrate that, among a range of reasonable alternatives, there is no other less-impairing means of achieving the objective.

> *Oakes*, *supra* para 138 at para 70.
> *Alberta v Hutterian Brethren of Wilson Colony*, 2009 SCC 37 at para 55.

53. The lack of accommodation results in vulnerable individuals being missed in the vaccination program. Lack of access to a vaccine can be deadly. Ms. Melnychuk provides an unqualified opinion that at-risk individuals receive benefit from an efficient rollout. Ms.

Melnychuk has no medical expertise and is not qualified to opine on this point. She has no idea of what level of protection is offered to at-risk individuals by having others vaccinated rather than receiving the vaccine directly. The Respondents' own decision to prioritize such individuals for a vaccination contradicts Ms. Melnychuk's statement.

Affidavit of J. Melnychuk, Application Record, Tab 6, at para 63, p. 738.

54. If the Respondents are going to offer a service to a select group of people, e.g. those over 80, then it must do so in a non-discriminatory manner. Saying that tech-savvy 80-year olds can receive the vaccine and those less tech-savvy individuals will still get a benefit from others having been vaccinated is the antithesis of equity. The impairment of not having equitable and timely access to the vaccine negatively impacts the lives and security of the person in a way that is not minimally impairing.

Eldridge v. British Columbia (Attorney General), [1997] 3 SCR 624, [1997] SCJ No. 86.

c) The salutary and deleterious effects are not proportionate

55. The salutary effects of the limit are not proportionate to its negative impact. As a result of the violations, at-risk individuals are going unvaccinated. Their eligibility is directly linked to the Respondents' recognition that these individuals are high risk of getting COVID or suffering complications arising therefrom. The vaccination program is failing to accommodate and therefore vaccinate these individuals, thereby increasing their risk of death, jeopardizing their security of the person and is violating their right to equality. Lives are at stake -- the deleterious impacts are immense.

Alberta v Hutterian Brethren of Wilson Colony, 2009 SCC 37 at para 55.

56. The salutary effect of the impugned vaccination program is that the Respondents are able to administer a large number of vaccines in a logistically simplistic manner—one

structured around mass distribution. The Applicant concedes that efficiency of vaccine delivery is important. However, speed of delivery at the expense of missing those most in need of a vaccine cannot be said to be beneficial and works against the Respondents' stated intention behind the vaccine program.

57. The *Charter* violations cannot be saved by section 1.

ISSUE iv. Did the Respondents fail to fulfill or otherwise delegate their accommodation obligations?

58. As set out above, the Respondents' vaccine program violates the *Human Rights Code* and the *Charter* at section 7 and 15. The Respondents purported to exercise their statutory authority to delegate components of the vaccination program e.g. vaccination administration, to other entities. In that attempted delegation, they failed to meet their *Charter* obligations. In the alterative, the delegation was incomplete insofar as they failed to explicitly delegate their *Charter* obligations. The Applicant seeks a review of this failure.

> *Human Rights Code*, RSO 1990, c H.19.
> *Judicial Review Procedure Act*, RSO 1990, c J.1, at, ss, 1, 2, 6.

59. The Respondents have statutory and *Charter* obligations to accommodate individuals in the delivery of health care services, of which vaccines are a part. Human rights must be protected—even in a pandemic. The Respondents have violated their statutory and *Charter* obligations to ensure that its COVID-19 vaccination program is administered equitably.

> *Human Rights Code*, RSO 1990, c H.19.
> *JL v. Empower Simcoe*, 2021 HRTO 222, at para 150.

60. The Minister of Health has broad powers of delegation under section 3(3) of the *Ministry of Health and Long-Term Care Act*, R.S.O. 1990, c. M.26. The Minister may enter into arrangements to provide health care services including public health units.

Health Insurance Act, RSO 1990, c H.6, at s. 2(2).
Health Protection and Promotion Act, RSO 1990, c H.7, at s.2.

61. The Respondents purported to exercise their statutory authority to contract with various entities –both private and public, such as hospitals, public health units, pharmacies and others, to deliver vaccines to residents. However, at no point did the Respondents explicitly delegate their human rights and *Charter* obligations to accommodate those who will face barriers to the vaccination program. In this way, the delegation was incomplete or in the alternative, inappropriate.

Judicial Review Procedure Act, RSO 1990, c J.1, at, ss, 1, 2.
Affidavit of J. Melnychuk, Application Record, Tab 6, at paras 47, p. 732.

62. The Supreme Court of Canada has held that "governments … should not be allowed to evade their constitutional responsibilities by delegating the implementation of their policies and programs to private entities" (*Eldridge*). Notwithstanding any discretion those entities may have to accommodate individuals, the government remains responsible (*Eldridge*, at para 51). Notably, "it is the government, and not [vaccine administrators], that is responsible for defining both the content of the service to be delivered and the persons entitled to receive it." (*Eldridge*, at para 49). Ultimately, the obligation to accommodate lies with the Respondents. It has failed to fulfill this duty or otherwise delegate it to those with which it contracts.

Eldridge v. British Columbia (Attorney General), [1997] 3 S.C.R. 624, [1997] S.C.J. No. 86., at paras 42, 49, 51.

63. The relevant factors outlined in *Eldridge* are present in this case:

a. **The Respondents have contracted with entities to deliver a governmental program** namely, the COVID-19 vaccination program (*Eldridge*, at para 40). The Respondents have contracted with multiple entities to administer vaccines; however, they have failed

to mandate that these entities provide accommodations to the known barriers to vaccination. To the contrary, with respect to pharmacies, the province has stipulated that these entities are only permitted to administer vaccines on site. In other words, those who are homebound or unable to travel to the pharmacy, will be unable to receive their vaccination there. While there are other vaccine administering entities, the Respondents have not mandated that other entities focus on addressing the needs of those individuals which will be unmet by pharmacies.

> Affidavit of J. Melnychuk, Application Record, Tab 6, at para 47 (no mandatory standards), p. 732.
> Transcript of J. Melnychuk, Application Record, Tab 8, q. 506, p. 1400.
> *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, [1997] S.C.J. No. 86., at para 40.

b. **The Respondents maintain significant control over the entities involved** (*Eldridge* at para 44). The Respondents have a monopoly over the COVID-19 vaccination program. The Respondents are responsible for determining which entities can distribute the vaccine, allocating vaccines to those entities, the parameters these entities are to work within, and identifying who is eligible for the vaccine and when. In addition, the Respondents also host the data collection site: COVAXon, and stipulates what information vaccine administering entities must collect. Clearly, the Respondents maintain a significant level of control over the direction, and implementation of the vaccination program.; and

> Transcript of J. Melnychuk, Application Record, Tab 8, q. 232, p. 1304.
> Affidavit of J. Melnychuk, Application Record, Tab 6, at paras 21 (pharmacy contracts), 14 (control over vaccine distribution) 16 (control over prioritization), pp. 724-725, 722, 723.
> *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, [1997] S.C.J. No. 86., at para 44.
> *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, at ss. 2, 7, 82.

c. **There is a direct connection between a government program and the impugned conduct** (*Eldridge*, at para 51). By analogy, and to paraphrase the Supreme Court of Canada, failure to provide accommodation to vaccine barriers is intimately connected to the vaccine program created by the Respondents. The provision of such accommodation is not simply a matter of vaccine administrating entities' conduct, it is an expression of a government program including the parameters of the contracts between these entities and the Respondents. Thus, while the vaccine administering entities may be autonomous in their day-to-day operations, they act as agents for the Respondent in providing specific services, namely: COVID-19 vaccines to specific populations at specific times. The Respondents, upon defining its objective as providing vaccines to those most at risk first, cannot evades its obligations under the *Charter* by appointing other entities to carry out that objective.

> *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, [1997] S.C.J. No. 86., at para 51.

64. While the impugned vaccination program gives the vaccine delivering entities the discretion to accommodate, the Respondents have been clear that the focus is on volume. The purported delegation was incomplete insofar as the Respondents failed to explicitly require vaccine administering entities to accommodate known vaccine barriers.

65. The Respondents have an obligation to monitor and oversee delivery of health care services across the province. The Minister of Health is entitled to "publish public health standards for the provision of mandatory health programs and services and every board of health shall comply with them." (*HPPA*, s.7(1)). The Minister has decided not to publish any such standards regarding COVID-19.

> Affidavit of J. Melnychuk, Application Record, Tab 6, at para 47, p. 732.

Health Protection and Promotion Act, R.S.O. 1990, c. H.7, at s. 7(1).

66. "The Minister may appoint assessors" to oversee the delivery of health care programs administered by public health units (*HPPA*, s.82(1)). The Minister has decided not to appoint any assessors to monitor the vaccine program.

Health Protection and Promotion Act, R.S.O. 1990, c. H.7, at s. 82(1).
Affidavit of J. Melnychuk, Application Record, Tab 6, at para 48, p. 733.

67. The Respondents' vaccine program is the creation of multiple instances of purported delegation of its equity obligations through contractual relationships with public and private entities which administer vaccines. But such delegation never occurred. In the alternative, if it did, the delegation was incomplete. This is evidenced by the fact that the vaccine program to date, is inequitable.

Affidavit of J. Melnychuk, Application Record, Tab 6, at para 60, p. 737.
Transcript of J. Melnychuk, Application Record, Tab 8, Exhibits 2, 6, 7 at pg. 15, pp. 1409-1418, 1438-1440, 1456.

68. The vaccination program is broader than just making appointments and administering vaccines. It also includes public education, communication, combatting misinformation and addressing vaccine hesitancy. Accommodations arise throughout each of those elements. Those administering the vaccines are not providing the accommodations required. The Respondents are not fulfilling the accommodations obligations directly. This is clear from the data which demonstrates those in high-risk areas are going unvaccinated at a greater rate than those in affluent and low-risk neighbourhoods; health equity is not being provided.

69. Notably, the accommodations required to address these predictable equity gaps are consistent across the province. Those without computers, internet or phones required to book an appointment will require the same accommodations regardless of what catchment

area they reside. Those with mobility issues will exist across the province and require some form of on-site vaccination delivery or transportation to a vaccination site. Those in racialized groups or other groups with high levels of vaccine hesitancy will require accommodations in order to address the hesitancy and ensure questions are answered in order to enable them to receive a vaccine. In this way, the barriers to the vaccination program are both predictable and relatively consistent across the province.

70. The Respondents attempt to rely on the delay of vaccines as a justification for current vaccination rates. However, some of the largest barriers could have been addressed in advance of the delivery of vaccines to the province. For example, public education an initiative aimed at addressing vaccine hesitancy take time. Delays in vaccine delivery could have seen resources focused on these elements of the vaccine program. That did not occur.

Affidavit of Dr. Siddiqi, Application Record at Tab 3, at para 23, p. 50.

71. The Applicant notes that his evidence was filed exactly one month before the hearing, on March 16, 2021. The facts surrounding this Application are can change quickly. The Applicant requests that as necessary, judicial notice be taken of facts that would be "accepted by reasonable people who have taken the trouble to inform themselves on the topic as not being the subject of reasonable dispute for the particular purpose for which it is to be used" (*Spence*). This would include facts as set out as exhibits to Ms. Melnychuk's cross-examination. As these exhibits demonstrate, the vaccine program is inequitable.

R v Spence, 2005 SCC 71, at para 65.
Fraser v Canada (Attorney General), 2020 SCC 28, at para 57.

72. Even if the Respondents, at this late stage attempt to argue that it did delegate its accommodation obligations, and did so completely, it has failed to monitor (*HPPA*, s. 82), enforce (*HPPA*, ss. 83-84) and redirect resources to provide accommodations where it is

clear that accommodations are not being provided. This alone is a failure in the Respondents' statutory obligations.

> *Health Protection and Promotion Act*, R.S.O. 1990, c. H.7, at ss. 82-84 [*HPPA*].

ISSUE v. The appropriate remedy is a declaration that equity is essential in the vaccination program

73. The appropriate remedy in the matter is to:

i. Overturn the Respondents' decision to rely on the Ethical Framework rather than the Health Equity Guidelines, s. 1 of the *Human Rights Code* and s. 7 and 15 of *Charter Rights and Freedoms* as the guiding standard for the vaccination program;

ii. Declare that vaccine equity based on science remains an obligation, and to the extent that the Respondents decide to contract with any other entities, they must impose upon them mandatory public health standards by referencing the Health Equity Guideline pursuant to s. 7(5) of the *Health Protection and Promotion Act*, R.S.O. c. H7 [*HPPA*];

iii. Overturn the Respondents' decision to not collect mandatory socio-economic data and its declination to appoint assessors pursuant to s. 82(3)(a) of the *HPPA* to monitor the outcomes of the vaccination program to ensure health equity is achieved; and

iv. Declare the Respondents remain ultimately responsible for ensuring equity in the vaccine program.

74. Courts must ensure that *Charter* remedies are meaningful and effective. A declaration is appropriate where there are multiple ways available to address the *Charter* violations.

> *Doucet-Boudreau v Nova Scotia (Minister of Education)*, 2003 SCC 62 at paras 25, 55-59.
> *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, [1997] S.C.J. No. 86., at para 96.
> *Charter*, at s.24.

75. In the present case the Respondents decided to rely on the Ethical Framework as an optional public health document to guide itself and entities it contracts with, in the vaccine program. As outlined above, this has led to disastrous consequences and infringed the human and *Charter* rights of the Applicant and many others similarly situated. The Applicant requests this Court overturn the Respondents' decision to rely on the Ethical Framework instead of the Health Equity Guidelines and human and *Charter* obligations in its vaccine program. The Applicant further seeks a declaration that equity is mandatory in the vaccine program. This will require that existing contracts and vaccination delivery plans be modified to ensure the vaccine program addresses barriers to vaccination.

Health Protection and Promotion Act, R.S.O. 1990, c. H7, s. 7(5).

76. The current inequitable rollout of the vaccination program could have been prevented had the Respondents decided to collect mandatory, relevant socio-economic data and closely monitor the rollout. The Applicant seeks to have this Court overturn the Respondents' decision to not collect this data and to not appoint assessors to review vaccine delivery for equitable outcomes. The Applicant further seeks a declaration that the Respondents remain ultimately responsible for equity in the vaccine program.

Health Protection and Promotion Act, R.S.O. 1990, c. H7, s. 82(3)(a), 83(1)(a).
Transcript of J. Melnychuk, Application Record, Tab 8, q. 386, q. 435, q. 462, q. 223, pp. 1360, 1376, 1387, 1302.

IV. ORDERS REQUESTED

77. The Applicant requests:

i. An order quashing the Respondents' Ethical Framework and confirming the Health Equity Guideline, s. 1 of the *Human Rights Code* and s. 7 and 15 of *Charter Rights and Freedoms* continue to define the vaccine equity rights of Ontarians;

ii. A Declaration that vaccine equity based on science remains an obligation, and to the extent that it decides to contract with any other entities, it must impose upon them mandatory public health standards by referencing the Health Equity Guideline pursuant to s. 7(5) of the *Health Protection and Promotion Act*, R.S.O. c. H7 [*HPPA*] and requiring the relevant amendments of vaccination plans and contracts;

iii. A declaration that the Respondents monitor, by means that include mandatorily collecting and publicly disclosing timely vaccine equity data, both its own vaccine equity program and that of its sub-contractors and further that it appoints assessors pursuant to s. 82(3)(a) of the *HPPA* and provide necessary direction pursuant to s. 83(1)(a) of the *HPPA*;

iv. Declare the Respondents remain ultimately responsible for ensuring the provision of vaccine equity;

v. An award to the Applicant of special costs or in the alternative, costs on a substantial indemnity basis; and

vi. Such further orders as this Honourable Court deems just.

vii.

ALL OF WHICH IS RESPECTFULLY SUBMITTED this 12th day of April, 2021

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V. LAWYER'S CERTIFICATE

I CERTIFY that I estimate that oral argument on behalf of the Applicant, not including reply, will take 1hour and 50 minutes.

April 12, 2021

Signature of Lawyer

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SCHEDULE A

1. *Alberta v Hutterian Brethren of Wilson Colony*, 2009 SCC 37
2. *Andrews v Law Society of British Columbia,* [1989] 1 SCR 143
3. *Cambie Surgeries Corporation v British Columbia (Attorney General)*, 2020 BCSC 1310
4. *Canada (Attorney General) v Bedford*, 2013 SCC 72
5. *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35
6. *Council of Canadians with Disabilities v. VIA Rail Canada Inc.*, 2007 SCC 15
7. *Doucet-Boudreau v Nova Scotia (Minister of Education)*, 2003 SCC 62
8. *Eldridge v. British Columbia (Attorney General)*, [1997] 3 SCR 624
9. *Figueroa v Canada (Attorney General)*, 2003 SCC 37
10. *Fraser v Canada (Attorney General)*, 2020 SCC 28
11. *Greater Vancouver Transportation Authority v Canadian Federation of Students British Columbia Component*, [2009] 2 SCR 295
12. *Health Services and Support - Facilities Subsector Bargaining Assn. v. British Columbia*, 2007 SCC 27
13. *JL v. Empower Simcoe*, 2021 HRTO 222
14. *R v Oakes*, [1986] 1 SCR 103
15. *R v Spence*, 2005 SCC 71
16. *RJR-MacDonald v Canada*, [1995] 3 SCR 199
17. *Withler v Canada (Attorney General)*, 2011 SCC 12

SCHEDULE B

***Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act* 1982 (UK), 1982, c. 11**

Consolidated as of January 1, 2013

1 The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

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

15 Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

24 (1) Anyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances.

(2) Where, in proceedings under subsection (1), a court concludes that evidence was obtained in a manner that infringed or denied any rights or freedoms guaranteed by this Charter, the evidence shall be excluded if it is established that, having regard to all the circumstances, the admission of it in the proceedings would bring the administration of justice into disrepute.

***Constitution Act*, 1867 (UK), 30 & 31 Victoria, c 3**
Consolidated as of January 1, 2013

91 It shall be lawful for the Queen, by and with the Advice and Consent of the Senate and House of Commons, to make Laws for the Peace, Order, and good Government of Canada, in relation to all Matters not coming within the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces; and for greater Certainty, but not so as to restrict the Generality of the foregoing Terms of this Section, it is hereby declared that (notwithstanding anything in this Act) the exclusive Legislative Authority of the Parliament of Canada extends to all Matters coming within the Classes of Subjects next hereinafter enumerated; that is to say,

1. Repealed.
1A. The Public Debt and Property.End note(45)
2. The Regulation of Trade and Commerce.
2A. Unemployment insurance.End note(46)
3. The raising of Money by any Mode or System of Taxation.

4. The borrowing of Money on the Public Credit.
5. Postal Service.
6. The Census and Statistics.
7. Militia, Military and Naval Service, and Defence.
8. The fixing of and providing for the Salaries and Allowances of Civil and other Officers of the Government of Canada.
9. Beacons, Buoys, Lighthouses, and Sable Island.
10. Navigation and Shipping.
11. Quarantine and the Establishment and Maintenance of Marine Hospitals.
12. Sea Coast and Inland Fisheries.
13. Ferries between a Province and any British or Foreign Country or between Two Provinces.
14. Currency and Coinage.
15. Banking, Incorporation of Banks, and the Issue of Paper Money.
16. Savings Banks.
17. Weights and Measures.
18. Bills of Exchange and Promissory Notes.
19. Interest.
20. Legal Tender.
21. Bankruptcy and Insolvency.
22. Patents of Invention and Discovery.
23. Copyrights.
24. Indians, and Lands reserved for the Indians.
25. Naturalization and Aliens.
26. Marriage and Divorce.
27. The Criminal Law, except the Constitution of Courts of Criminal Jurisdiction, but including the Procedure in Criminal Matters.
28. The Establishment, Maintenance, and Management of Penitentiaries.
29. Such Classes of Subjects as are expressly excepted in the Enumeration of the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces.

And any Matter coming within any of the Classes of Subjects enumerated in this Section shall not be deemed to come within the Class of Matters of a local or private Nature comprised in the Enumeration of the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces.

92 In each Province the Legislature may exclusively make Laws in relation to Matters coming within the Classes of Subjects next hereinafter enumerated; that is to say,

1. Repealed.
2. Direct Taxation within the Province in order to the raising of a Revenue for Provincial Purposes.
3. The borrowing of Money on the sole Credit of the Province.
4. The Establishment and Tenure of Provincial Offices and the Appointment and Payment of Provincial Officers.
5. The Management and Sale of the Public Lands belonging to the Province and of the Timber and Wood thereon.

6. The Establishment, Maintenance, and Management of Public and Reformatory Prisons in and for the Province.
7. The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals.
8. Municipal Institutions in the Province.
9. Shop, Saloon, Tavern, Auctioneer, and other Licences in order to the raising of a Revenue for Provincial, Local, or Municipal Purposes.
10. Local Works and Undertakings other than such as are of the following Classes:

(a) Lines of Steam or other Ships, Railways, Canals, Telegraphs, and other Works and Undertakings connecting the Province with any other or others of the Provinces, or extending beyond the Limits of the Province:

(b) Lines of Steam Ships between the Province and any British or Foreign Country:

(c) Such Works as, although wholly situate within the Province, are before or after their Execution declared by the Parliament of Canada to be for the general Advantage of Canada or for the Advantage of Two or more of the Provinces.

11. The Incorporation of Companies with Provincial Objects.
12. The Solemnization of Marriage in the Province.
13. Property and Civil Rights in the Province.
14. The Administration of Justice in the Province, including the Constitution, Maintenance, and Organization of Provincial Courts, both of Civil and of Criminal Jurisdiction, and including Procedure in Civil Matters in those Courts.
15. The Imposition of Punishment by Fine, Penalty, or Imprisonment for enforcing any Law of the Province made in relation to any Matter coming within any of the Classes of Subjects enumerated in this Section.
16. Generally all Matters of a merely local or private Nature in the Province.

***Emergency Management and Civil Protection Act*, R.S.O. 1990, c. E.9.**
Last amendment: 2019, c. 7, Sched. 17, s. 64
Passim

***Health Insurance Act*, R.S.O. 1990, c. H.6**
Last amendment: 2019, c. 15, Sched. 15, s. 1-35.

2 (2) The Minister may,

(a) enter into arrangements for the payment of remuneration to physicians, practitioners and health facilities rendering insured services to insured persons on a basis other than fee for service;

(b) enter into agreements with persons, organizations and government agencies outside Ontario for the provision of insured services to insured persons.

(c), (d), (e) Repealed: 2009, c. 33, Sched. 18, s. 11 (2).
R.S.O. 1990, c. H.6, s. 2 (2); 2009, c. 33, Sched. 18, s. 11 (2); 2017, c. 11, Sched. 3, s. 11.

***Health Protection and Promotion Act*, R.S.O. 1990, c. H.7**

Last amendment: 2020, c. 13, Sched. 3, s. 4.

2 The purpose of this Act is to provide for the organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario. R.S.O. 1990, c. H.7, s. 2.

7 (1) The Minister may publish public health standards for the provision of mandatory health programs and services and every board of health shall comply with them. 2017, c. 25, Sched. 3, s. 4 (1).

(2) Public health standards shall be transmitted to each board of health and shall be available for public inspection at the Ministry. R.S.O. 1990, c. H.7, s. 7 (2); 2017, c. 25, Sched. 3, s. 1 (2), 4 (2).

(3) A public health standard is not a regulation within the meaning of Part III (Regulations) of the Legislation Act, 2006. R.S.O. 1990, c. H.7, s. 7 (3); 2006, c. 21, Sched. F, s. 136 (1); 2017, c. 25, Sched. 3, s. 1 (1).

(4) In the event of conflict between a regulation and a public health standard, the regulation prevails. R.S.O. 1990, c. H.7, s. 7 (4); 2017, c. 25, Sched. 3, s. 1 (1).

(5) A public health standard may adopt by reference, in whole or in part, with such changes as are specified in the public health standard, any code, formula, protocol or procedure and may require compliance with the code, formula, protocol or

procedure so adopted. 2007, c. 10, Sched. D, s. 1 (4); 2017, c. 25, Sched. 3, s. 1 (1).

(6) If a public health standard under subsection (5) so provides, a code, formula, protocol or procedure adopted by reference shall be a reference to it as amended from time to time and whether the amendment was made before or after the public health standard was made. 2007, c. 10, Sched. D, s. 1 (4); 2017, c. 25, Sched. 3, s. 1 (1).

(7) The adoption of an amendment to a code, formula, protocol or procedure that has been adopted by reference comes into effect upon the Ministry publishing notice of the amendment and transmitting the notice to each board of health. 2007, c. 10, Sched. D, s. 1 (4).

82 (1) The Minister may appoint assessors for the purposes of this Act. 1997, c. 30, Sched. D, s. 11; 2017, c. 25, Sched. 3, s. 13.

(2) An appointment under subsection (1) shall be in writing. 1997, c. 30, Sched. D, s. 11.

(3) An assessor may carry out an assessment of a board of health for the purpose of,

(a) ascertaining whether the board of health is providing or ensuring the provision of health programs and services in accordance with sections 5, 6 and 7, the regulations and the public health standards;

(b) ascertaining whether the board of health is complying in all other respects with this Act and the regulations; or

(c) assessing the quality of the management or administration of the affairs of the board of health. 1997, c. 30, Sched. D, s. 11; 2017, c. 25, Sched. 3, s. 1 (2).

(4) In carrying out an assessment of a board of health, an assessor may, without a warrant, enter and inspect,

(a) any premises occupied by the board of health;

(b) any premises where health programs or services that are required to be provided or ensured by the board of health under this Act are provided; and

(c) any premises where the board of health performs any function required under this or any other Act. 1997, c. 30, Sched. D, s. 11.

(5) The power in subsection (4) to enter and inspect premises without a warrant may be exercised only during regular business hours. 1997, c. 30, Sched. D, s. 11.

(6) Subsection (4) does not authorize an assessor to enter a private residence without the consent of the occupier. 1997, c. 30, Sched. D, s. 11.

(7) An assessor is not entitled to use force to enter and inspect premises. 1997, c. 30, Sched. D, s. 11.

(8) An assessor who enters premises under this section shall produce, on request, evidence of his or her appointment. 1997, c. 30, Sched. D, s. 11.

(9) Upon entering premises under this section, an assessor,

(a) may examine any record or document that is relevant to the assessment, including financial and book-keeping records and minutes and by-laws of the board of health;

(b) may demand the production for examination of any record or document described in clause (a);

(c) may make copies of any record or document described in clause (a) and may, on providing a receipt, remove any such record or document from the premises in order to copy it; and

(d) may question any person on matters relevant to the assessment. 1997, c. 30, Sched. D, s. 11.

(10) An assessor who removes a record or document from the premises shall return it to the premises within a reasonable time. 1997, c. 30, Sched. D, s. 11.

(11) A copy made under clause (9) (c) that purports to be certified by an assessor as being a true copy of the original is admissible in evidence in any proceeding as proof, in the absence of evidence to the contrary, of the original. 1997, c. 30, Sched. D, s. 11.

(12) An assessor may at any time request a board of health to send him or her, at the time specified by the assessor, any information, including copies of any record or document, that is relevant to an assessment under this section. 1997, c. 30, Sched. D, s. 11.

(13) If an assessor demands the production for examination of a record or document under clause (9) (b), the person having custody of the record or document shall comply with the demand. 1997, c. 30, Sched. D, s. 11.

(14) If an assessor questions a person under clause (9) (d), the person shall answer the assessor's questions. 1997, c. 30, Sched. D, s. 11.

(15) If an assessor requests a board of health to send information under subsection (12), the board of health shall comply with the request. 1997, c. 30, Sched. D, s. 11.

(16) At the request of an assessor, a board of health shall provide, in respect of the records and documents that the assessor is entitled to examine under clause (9) (a) and in respect of the information that the assessor requests the board of health to send under subsection (12), such assistance and explanations as are reasonably necessary to enable the assessor to carry out his or her assessment of the board of health. 1997, c. 30, Sched. D, s. 11.

(17) No person shall hinder or obstruct an assessor conducting an assessment of a board of health. 1997, c. 30, Sched. D, s. 11.

83 (1) The Minister may give a board of health a written direction described in subsection (2) if he or she is of the opinion, based on an assessment under section 82, that the board of health has,

(a) failed to provide or ensure the provision of a health program or service in accordance with section 5, 6 or 7, the regulations or the public health standards;

(b) failed to comply in any other respect with this Act or the regulations; or

(c) failed to ensure the adequacy of the quality of the administration or management of its affairs. 1997, c. 30, Sched. D, s. 11; 2017, c. 25, Sched. 3, s. 1 (2).

(2) In a direction under this section, the Minister may require a board of health,

(a) to do anything that the Minister considers necessary or advisable to correct the failure identified in the direction; or

(b) to cease to do anything that the Minister believes may have caused or contributed to the failure identified in the direction. 1997, c. 30, Sched. D, s. 11.

(3) A board of health that is given a direction under this section shall comply with the direction,

(a) within the period of time specified in the direction; or

(b) if no period of time is specified in the direction, within 30 days from the day the direction is given. 1997, c. 30, Sched. D, s. 11.

84 (1) If, in the opinion of the Minister, a board of health has failed to comply with a direction under section 83 within the period of time required under subsection 83 (3), the Minister may do whatever is necessary to ensure that the direction is carried out, including but not limited to,

(a) providing or ensuring the provision of any health program or service in accordance with sections 5, 6 and 7, the regulations and the public health standards;

(b) exercising any of the powers of the board of health or the medical officer of health of the board of health;

(c) appointing a person to act as the medical officer of health of the board of health in the place of the medical officer of health appointed by the board;

(d) providing advice and guidance to the board of health, the medical officer of health of the board of health, and any person whose services are engaged by the board of health;

(e) approving, revoking or amending any decision of the board of health, the medical officer of health of the board of health, or any person whose services are engaged by the board of health; and

(f) accessing any record or document that is in the custody or under the control of the board of health, the medical officer of health of the board of health, or any person whose services are engaged by the board of health. 1997, c. 30, Sched. D, s. 11; 2017, c. 25, Sched. 3, s. 1 (2).

(2) No person shall hinder or obstruct the Minister in the exercise of his or her powers under subsection (1). 1997, c. 30, Sched. D, s. 11.

(3) The Minister may exercise his or her powers under subsection (1) even though a hearing by the Board in respect of the direction has been required or is proceeding under section 85. 1997, c. 30, Sched. D, s. 11.

(4) If the Board determines, after a hearing under section 85, that the board of health has complied with the direction, the Minister shall not thereafter exercise his or her powers under subsection (1) and shall cease to exercise any of such powers that he or she had already begun to exercise before the Board rendered its decision. 1997, c. 30, Sched. D, s. 11.

***Human Rights Code*, R.S.O. 1990, c. H.19.**
Last amendment: 2020, c. 11, Sched. 17, s. 6.

1 Every person has a right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, gender identity, gender expression, age, marital status, family status or disability. R.S.O. 1990, c. H.19, s. 1; 1999, c. 6, s. 28 (1); 2001, c. 32, s. 27 (1); 2005, c. 5, s. 32 (1); 2012, c. 7, s. 1.

11 (1) A right of a person under Part I is infringed where a requirement, qualification or factor exists that is not discrimination on a prohibited ground but that results in the exclusion, restriction or preference of a group of persons who are identified by a prohibited ground of discrimination and of whom the person is a member, except where,

(a) the requirement, qualification or factor is reasonable and bona fide in the circumstances; or

(b) it is declared in this Act, other than in section 17, that to discriminate because of such ground is not an infringement of a right. R.S.O. 1990, c. H.19, s. 11 (1).

(2) The Tribunal or a court shall not find that a requirement, qualification or factor is reasonable and bona fide in the circumstances unless it is satisfied that the needs of the group of which the person is a member cannot be accommodated without undue hardship on the person responsible for accommodating those needs, considering the cost, outside sources of funding, if any, and health and safety requirements, if any. R.S.O. 1990, c. H.19, s. 11 (2); 1994, c. 27, s. 65 (1); 2002, c. 18, Sched. C, s. 2 (1); 2009, c. 33, Sched. 2, s. 35 (1).

(3) The Tribunal or a court shall consider any standards prescribed by the regulations for assessing what is undue hardship. R.S.O. 1990, c. H.19, s. 11 (3);

1994, c. 27, s. 65 (2); 2002, c. 18, Sched. C, s. 2 (2); 2009, c. 33, Sched. 2, s. 35 (2).

16 (1) A right under Part I to non-discrimination because of citizenship is not infringed where Canadian citizenship is a requirement, qualification or consideration imposed or authorized by law. R.S.O. 1990, c. H.19, s. 16 (1).

(2) A right under Part I to non-discrimination because of citizenship is not infringed where Canadian citizenship or lawful admission to Canada for permanent residence is a requirement, qualification or consideration adopted for the purpose of fostering and developing participation in cultural, educational, trade union or athletic activities by Canadian citizens or persons lawfully admitted to Canada for permanent residence. R.S.O. 1990, c. H.19, s. 16 (2).

(3) A right under Part I to non-discrimination because of citizenship is not infringed where Canadian citizenship or domicile in Canada with the intention to obtain Canadian citizenship is a requirement, qualification or consideration adopted by an organization or enterprise for the holder of chief or senior executive positions. R.S.O. 1990, c. H.19, s. 16 (3).

Judicial Review Procedure Act, R.S.O. 1990, c. J.1

Last amendment: 2020, c. 11, Sched. 10.

1 In this Act,

"application for judicial review" means an application under subsection 2 (1); ("requête en révision judiciaire")

"court" means the Superior Court of Justice; ("Cour")

"licence" includes any permit, certificate, approval, registration or similar form of permission required by law; ("autorisation")

"municipality" has the same meaning as in the Municipal Affairs Act; ("municipalité")

"party" includes a municipality, association of employers, a trade union or council of trade unions which may be a party to any of the proceedings mentioned in subsection 2 (1); ("partie")

"statutory power" means a power or right conferred by or under a statute,

(a) to make any regulation, rule, by-law or order, or to give any other direction having force as subordinate legislation,

(b) to exercise a statutory power of decision,

(c) to require any person or party to do or to refrain from doing any act or thing that, but for such requirement, such person or party would not be required by law to do or to refrain from doing,

(d) to do any act or thing that would, but for such power or right, be a breach of the legal rights of any person or party; ("compétence légale")

"statutory power of decision" means a power or right conferred by or under a statute to make a decision deciding or prescribing,

(a) the legal rights, powers, privileges, immunities, duties or liabilities of any person or party, or

(b) the eligibility of any person or party to receive, or to the continuation of, a benefit or licence, whether the person or party is legally entitled thereto or not,

and includes the powers of an inferior court. ("compétence légale de décision") R.S.O. 1990, c. J.1, s. 1; 2002, c. 17, Sched. F, Table; 2006, c. 19, Sched. C, s. 1 (1).

2 (1) On an application by way of originating notice, which may be styled "Notice of Application for Judicial Review", the court may, despite any right of appeal, by order grant any relief that the applicant would be entitled to in any one or more of the following:

1. Proceedings by way of application for an order in the nature of mandamus, prohibition or certiorari.

2. Proceedings by way of an action for a declaration or for an injunction, or both, in relation to the exercise, refusal to exercise or proposed or purported exercise of a statutory power. R.S.O. 1990, c. J.1, s. 2 (1).

6 (1) Subject to subsection (2), an application for judicial review shall be made to the Divisional Court. R.S.O. 1990, c. J.1, s. 6 (1).

(2) An application for judicial review may be made to the Superior Court of Justice with leave of a judge thereof, which may be granted at the hearing of the application, where it is made to appear to the judge that the case is one of urgency and that the delay required for an application to the Divisional Court is likely to involve a failure of justice. R.S.O. 1990, c. J.1, s. 6 (2); 2006, c. 19, Sched. C, s. 1 (1).

(3) Where a judge refuses leave for an application under subsection (2), he or she may order that the application be transferred to the Divisional Court. R.S.O. 1990, c. J.1, s. 6 (3).

(4) An appeal lies to the Court of Appeal, with leave of the Court of Appeal, from a final order of the Superior Court of Justice disposing of an application for judicial review pursuant to leave granted under subsection (2). R.S.O. 1990, c. J.1, s. 6 (4); 2006, c. 19, Sched. C, s. 1 (1).

***Ministry of Health and Long-Term Care Act*, R.S.O. 1990, c. M.26**

Last amendment: 2020, c. 13, Sched. 2.

3 (3) The Minister may delegate, in writing, any of his or her powers or duties under this or any other Act or otherwise at law to any of the following persons and may impose conditions and restrictions with respect to the delegation:

1. The Deputy Minister.
2. An associate deputy minister or assistant deputy minister of the Ministry.
3. A public servant employed under Part III of the Public Service of Ontario Act, 2006.
4. Any officer or member of the board of an agency or other entity for which the Minister has been assigned responsibility by the Lieutenant Governor in Council, or any employee of such an agency or other entity.
5. A person or member of a class of person prescribed in the regulations. 2006, c. 35, Sched. C, s. 75 (2).

***Supporting Ontario's Recovery Act*, 2020, S.O. 2020, c. 26, Sched. 1**
No amendments
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DANESHVAR Applicant	and	HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO AS REPRESENTED BY THE MINISTER OF HEALTH, et al. Respondents	Court File No: 223/21

ONTARIO
SUPERIOR COURT OF JUSTICE
(DIVISIONAL COURT)

FACUM OF THE APPLICANT

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