CITATION: Ontario Nurses Association v. Eatonville/Henley Place, 2020 ONSC 2467
COURT FILE NOs: CV-20-639606-0000 and CV-20-639605-0000
DATE: 20200423

SUPERIOR COURT OF JUSTICE – ONTARIO

RE: ONTARIO NURSES' ASSOCIATION, VICKI MCKENNA, RN and BEVERLY MATHERS, RN, Applicants

– and –

EATONVILLE CARE CENTRE FACILITY INC., ANSON PLACE CARE CENTRE FACILITY INC., HAWTHORNE PLACE CARE CENTRE FACILITY INC., RYKKA CARE CENTRES GP INC., RYKKA CARE CENTRES II GP INC., RESPONSIVE MANAGEMENT INC. and RESPONSIVE GROUP INC., Respondents

– and –

ATTORNEY GENERAL OF ONTARIO, Intervener

AND RE: ONTARIO NURSES' ASSOCIATION, VICKI MCKENNA, RN and BEVERLY MATHERS, RN, Applicants

– and –

HENLEY PLACE LIMITED AND PRIMACARE LIVING SOLUTIONS INC., Respondents

– and –

ATTORNEY GENERAL OF ONTARIO, Intervener

BEFORE: E.M. Morgan J.

COUNSEL: *Kate Hughes, Philip Abbink, Janet Borowy, Danielle Bisnar, Tyler Boggs, Marcia Barry, Nicole Butt*, for the Applicants
Ian Dick, Sean Sells, and Mitchell Smith, for the Respondents
Daniel Gutman, Andrea Bolieiro, and Kristen Smith, for the Intervener

HEARD: April 22, 2020

APPLICATION FOR INJUNCTIVE RELIEF

I. Nursing staff and long-term care homes

[1] The Applicants represent Registered Nurses employed by the long-term care ("LTC") homes named as Respondents in these two companion Applications. They seek, on an urgent basis, mandatory Orders addressing what they describe as serious health and safety problems at these facilities.

[2] The Applicants ask this court for an injunction requiring the Respondents to refrain from ongoing breaches of Directives issued by the Chief Medical Officer of Health for Ontario ("CMOH") on March 30 and April 2, 2020. The Directives pertain to practices and procedures in LTC facilities and to the supply of personal protective equipment ("PPE") – including the most protective N95 respirator masks – in those facilities, during the current COVID-19 pandemic.

[3] All of the LTC homes named here have experienced outbreaks of COVID-19. As of the date of this hearing, in these four facilities over 110 residents have contracted COVID-19, at least 54 residents have died from COVID-19, and at least 7 nurses have contracted COVID-19, with one serious enough to be hospitalized and one more starting to show symptoms in the past week. These numbers have been rising steadily, thus creating the need for an urgent hearing.

[4] In a nutshell, the Applicants ask that the Respondents take any and all reasonable precautionary measures to ensure that nursing staff receive health and safety protections as directed by the CMOH in Directives #3 and #5 issued pursuant to the *Health Protection and Promotion Act*, RSO 1999, c H7 ("*HPPA*"). In particular, they ask that the Respondents provide them with appropriate access to the PPE that they need to protect themselves and the residents of the facilities and to implement the required administrative controls for LTC facilities. This includes allowing nurses to make PPE decisions on an ongoing basis at the point of care, as well as isolating and cohorting residents and the staff attending to them so that those who are infectious are kept separate from and treated by different nurses than those who are not.

[5] Counsel for the Applicants base the legal argument on a number of grounds. They submit that the lack of necessary PPE and appropriate infection control procedures at these LTC facilities is: a) a violation of the collective agreements between the Ontario Nurses' Association and the Respondents; b) a breach of the public health Directives that specifically apply to COVID-19; c) a violation of the *Occupational Health and Safety Act*, RSO 1990, c O1 ("OHSA"); and d) an infringement of the Applicants' rights under section 7 of the *Charter of Rights and Freedoms* ("life, liberty and security of the person"). Applicants' counsel further submit that the test for an interlocutory injunction has been made out, and that a mandatory Order restraining these various breaches must apply pending labour arbitrations that have been commenced by the Ontario Nurses' Association ("ONA") against the four LTC homes.

[6] The Respondents have filed material in which they say that they have, in fact, complied with Directives #3 and #5. Respondents' counsel submit that these companion Applications are

not really about compliance with the Directives or any health and safety measures implemented in the LTC home. Rather, they say that these proceedings challenge the allocation of scarce but essential medical resources – i.e. PPE and, in particular, N95 masks – and seek control by the ONA and its members over that allocation.

[7] Counsel for the Respondents argue that in denying that this is about allocation of resources and claiming that this is about continuous point-of-care safety, the Applicants portray an ideal world in which there is no scarcity. Unfortunately, they say, that ideal world does not exist.

[8] It is the Respondents' position that Directive #5 requires PPE decisions to take into account not only what the nurse determines to be necessary at the point of care, but what the LTC facility considers to be appropriate or reasonable under the circumstances. They contend that this must be done with a view to conserving supplies for all of the facility's health workers as well as for the future need for those supplies.

[9] The Attorney General of Ontario was served with the motion materials and with a Notice of Constitutional Question. Given the *Charter* issue raised by the Applicants, counsel at the Ministry of the Attorney General, together with counsel from the Ministry of Health (Ontario), have filed materials and appeared as Intervener in these Applications as of right pursuant to section 109(4) of the *Courts of Justice Act*, RSO 1990, c C43.

[10] Counsel for the Attorney General correctly points out that although they have served a Notice of Constitutional Question and make some cursory arguments about the *Charter*, the Applicants make no argument that the CMOH's Directives are unconstitutional. The Attorney General sees the Applicants' Notice and argument in these proceedings as focused entirely on the particular conduct of the four LTC homes in carrying out (or in not carrying out) the Directives.

[11] To the extent that the Applicants contend that private entities, albeit heavily regulated private entities such as LTC homes, are subject to the *Charter* at all requires at the very least some argument, and the Applicants have not addressed that issue. Counsel for the Attorney General also submit that the Directives constitute an exercise of the CMOH's statutory power under s. 77.7 of the *HPPA*, and that this power falls within the meaning of s. 2(1) of the *Judicial Review Procedure Act*, RSO 1990, c J1. They argue that the upshot of that is that a constitutional challenge to the Directives can only be brought to a full panel of the Divisional Court rather than to a single judge of the Superior Court of Justice. That, too, would take some argument, but is under the circumstances a moot point. The fact is that there is no real *Charter* challenge brought here.

[12] As Intervener, the Attorney General does not take a definitive position on whether an injunction or other court Order should be issued in the circumstances of the four LTC facilities in issue. Instead, it has focused its intervention on providing the policy context for interpreting and applying the CMOH's Directives and the principles embodied therein to the present COVID-19 situation. The Attorney General agrees, of course, that the CMOH's Directives are applicable to LTC homes across the province and must be adhered to. That said, the Attorney General views

the Applicants as overreaching to the extent that the relief that they seek requires LTC facilities to provide them, on demand, with whatever PPE they in their sole discretion deem necessary.

II. The four long-term care homes

[13] At issue are four Ontario LTC facilities: Eatonville Care Centre ("Eatonville") in Toronto, Anson Place ("Anson") in Hagersville, Hawthorne Place ("Hawthorne") in North York, and, by separate Application, Henley Place ("Henley") in London. The legal issues are similar with respect to the nurses' claim against each of these, but the situation on the ground varies from facility to facility.

a) Eatonville Care Centre

[14] On March 16, 2020, an outbreak of illness with symptoms resembling COVID-19 broke out in three units at Eatonville. Regina Borkovskaia, a nurse working at Eatonville, deposes that residents in a fourth Eatonville unit also showed COVID-19 symptoms, but were permitted to move about the residence freely.

[15] Ms. Borkovskaia relates that the facility early-on declared that the only staff who would be provided the most protective type of masks were those attending to residents with confirmed cases of COVID-19, not those attending to residents who were symptomatic but as yet unconfirmed. Accordingly, Ms. Borkovskaia states that Eatonville provided the nurses with ordinary surgical masks rather than with "N95 filtering, fit-tested face piece respirators", as described by Dr. Lisa Brosseau, a retired Professor from the University of Illinois Chicago School of Public Health whose field of research is respiratory protection and infectious diseases in her Report dated March 24, 2020 and submitted by the Applicants.

[16] According to Ms. Borkovskaia's affidavit, even after confirmation of a COVID-19 diagnosis for patients at Eatonville, the nursing staff continued to be denied the fully protective masks. She deposes that staff were advised that there were not enough N95s to go around, and that in any case they were unnecessary. In Dr. Brosseau's view, this was a medically indefensible position. She writes: "I believe that the decision to downgrade PPE arises not from the perspective of protecting healthcare workers (and patients), but rather for reasons of short-term economic expediency that put healthcare workers at significant risk of exposure, infection and disease."

[17] On April 14, 2020, Eatonville Care had 25 publicly confirmed deaths and 49 confirmed cases of COVID-19. It is unclear how accurate that information was at the time. Joe Buote, a labour relations officer with the Ontario Nurses' Association ("ONA"), has deposed that the Applicants believe that the number of deaths as of that date was actually in the range of 43 rather than 25. He also states that the Coroner's Office will no longer enter the building to access dead bodies; his evidence is that staff members are required to bring dead bodies outside to officials from the Coroner's Office and are instructed to avoid media and families when doing so. This has had some impact on publicizing accurate data from Eatonville.

[18] On April 2, 2020, ONA filed a grievance under its collective agreement with Eatonville alleging that the LTC home had failed to adequately ensure the safety of its nursing staff and that it failed to provide adequate PPE. The grievance also alleged that Eatonville failed to take reasonable precautions under the circumstances of the COVID-19 pandemic. As one of the remedies in its grievance, ONA sought access to N95 masks for its members. The ONA has to date not been able to expedite the hearing of this grievance.

b) Anson Place

[19] Nancy Oliviera, a nurse employed by Anson Place, has deposed that a COVID-19 outbreak was declared at Anson Place on March 27, 2020, but in fact the infections certainly started before that date. She states that as of April 14, 2020, 49 of the 58 residents of the long-term care unit on the second floor of Anson Place have tested positive for the virus, and that all of the other long-term care residents are presumed positive. Another 20-some residents of the retirement home on the first floor of Anson Place have tested positive as well.

[20] On March 30, 2020, the first nurse at Anson Place tested positive. According to Ms. Oliviera, that nurse had been working extensive shifts during most of March.

[21] The Applicants' evidence is that Anson Place has provided only sporadic access to N95 respirators, and has prohibited nurses from donning N95s on the basis of a point-of-care risk assessment. Ms. Oliviera deposes that up until April 6, 2020, nurses were advised that N95s were unnecessary and would only be provided when a nurse was swabbing a patient for COVID-19. In fact, she relates a number of instances where nurses wearing N95 masks as a result of their assessment that the patients under their care were actively contagious and posed a serious risk were told to remove them and wear lesser protective surgical masks instead.

[22] Ms. Oliviera describes that the management at Anson Place kept a small supply of N95 masks available at the nursing station for limited use while swabbing a patient, and that the rest of the LTC home's supply of N95s were removed from ordinary storage and placed under lock and key in the Executive Director's office. Ms. Oliviera, who works primarily on the night shift, states in her affidavit that the Director was prone to neglect replenishing for night staff even the small supply of N95 masks authorized for swabbing suspected COVID-19 patients.

[23] According to Ms. Oliviera, as of the second week in April 2020, N95s were still being rationed out of the Director's office. She observes that even with that policy in place, no thought seems to have been given to the times that the Director, who is an administrator rather than medical staff, is not available. As a consequence, there is often an insufficient supply of these protective masks periods even for their limited authorized use.

[24] In addition to the shortage of N95s, the Applicants have submitted evidence that Anson Place has not implemented isolation and cohorting measures. According to Susan Clarke, another nurse employed on the long-term care floor of Anson Place, ward rooms are shared by four residents, and the beds, which are not the required 2 metres apart, are separated merely by a curtain. Ms. Oliviera notes that residents diagnosed with COVID-19 have not been moved from these shared

rooms, and so remain in close proximity to, and are treated by the same nursing staff, as those who are not infected.

[25] Ms. Clarke points out in her affidavit that many staff move between the two floors of Anson Place, thereby having contact with both the somewhat less vulnerable retirement residents and the far more susceptible long-term care residents. All staff apparently share a common elevator, kitchen, and rest areas. Moreover, the affidavit evidence indicates that residents from the first and second floors have been permitted to continue intermingling freely in the building's common lobby.

[26] Carolyn Pepper, another nurse working in the Anson Place long-term care facility, has deposed that on March 29, 2020, with the first acknowledged COVID-19 diagnosis, some PPE – surgical masks, gowns, gloves, and a single pair of goggles – were provided to nurses on the LTC unit. She indicates that they were told at the time that this was only a precautionary measure, as the virus had only been detected in the first floor retirement residence. That very day, however, a COVID-19 outbreak was declared on the second floor LTC facility. According to Ms. Pepper, the management at Anson Place did not put into effect its existing Pandemic Plan. Therefore, residents and staff were not separated, or cohorted, into contagious and non-contagious groupings.

[27] Sherri Ludlaw, a nurse and labour relations officer with the ONA, deposes in an affidavit that on April 9, 2020, the Haldimand-Norfolk Medial Officer of Health was advised that Anson Place was not cohorting residents and staff. The management responded that it could not physically separate residents. Counsel for the Respondents points out that the CMOH's Directive #3 contains a specific qualification for smaller facilities which exempts Anson Place from the requirements:

> Long-term care homes must use staff and resident cohorting to prevent the spread of COVID-19. Resident cohorting may include one or more of the following: alternative accommodation in the home to maintain physical distancing of 2 metres, resident cohorting of the well and unwell, utilizing respite and palliative care beds and rooms, or utilizing other rooms as appropriate. Staff cohorting may include: designating staff to work with either ill residents or well residents. In smaller long-term care homes or in homes where it is not possible to maintain physical distancing of staff or residents from each other, all residents or staff should be managed as if they are potentially infected, and staff should use droplet and contact precautions when in an area affected by COVID-19.

[28] Even a cursory reading of Directive #3 reveals that the small facility exception is not an exemption from the isolation and cohorting protocols. Rather, it is an acknowledgement that those protocols may be physically impossible, together with a directive that adds an extra requirement that "droplet and contact precautions" be taken – i.e. a full PPE compliment, including N95 masks, must be provided to nursing staff.

[29] Anson Place's solution to the space situation – its reading of the "exemption" in Directive #3 – has not been to add any more PPE or N95s to the equipment available to the nurses. It has also not even attempted to separate residents into segregated wards such that COVID-19 positive patients are

not in the same room as those without the virus. Instead, it has opted to keep all residents in place and hang a privacy curtain between beds. It takes the position that, as set out in Directive #3, it is operating on the assumption that all residents have COVID-19. According to Anson Place, this does not mean that they must be vigilant about making PPE available, but it does mean that no effective separation need even being attempted between the sick and the well.

[30] ONA filed a grievance under its collective agreement with Anson Place on April 7, 2020, alleging that the facility has failed to take adequate measures to protect the health and safety of ONA members. The labour arbitration process for this grievance has not been expedited.

c) Hawthorne Place

[31] Dan Belford, a labour relations officer with the ONA whose responsibilities include the employment conditions of nursing staff at the Hawthorne Place facility, has deposed that as of April 12, 2020, there were 6 diagnosed cases of COVID-19 among the 215 residents of Hathorne Place, with one resident having died from COVID-19. There is also one diagnosed case among the home's nursing staff and one more suspected case awaiting test results.

[32] All confirmed cases have been located on the first floor which houses both an LTC unit and a Convalescent Unit for short-stay residents discharged from hospitals. Mr. Belford notes that, in addition, there are presently at least 4 additional residents of the second floor LTC unit exhibiting COVID-19 symptoms. Further, one registered Practical Nurse, the facility's Infection Control nurse, and the home's Director of Care, are all off sick.

[33] As Beverly Mathers, the Chief Executive Officer of the ONA, deposes in her affidavit, "long-term care homes, especially the for-profit homes such as the respondent[s], tend to have very lean staffing of nurses at their homes". Mr. Belford deposes that since the pandemic began in March 2020, Hawthrone Place has been chronically short-staffed, with the base staffing levels seldom being met and nurses compelled to care for a high number of patients in taxing work conditions.

[34] Mr. Belford deposes that since the end of February 2020, staff at Hawthorne Place have been requesting PPE, which has been largely denied. Indeed, the Executive Director has apparently made it clear that staff were not even to wear their own surgical masks that they brought from home, for fear of frightening the residents.

[35] Mr. Belford relates that on April 3, 2020, in response to a nurse's request for an N95 respirator mask, a very limited supply was made available for use but that the supply did not take into account unforeseen emergencies that can often arise with elderly and invalid residents. Moreover, staff in the convalescent unit of Hawthorne Place, where there is an active outbreak of COVID-19, were apparently given no N95s at all. Then, according to Mr. Belford, during the weeks of April 6th and April 13th, protective masks were given out sporadically, with most nurses being given a single mask when they came on shift. The Respondents' evidence is that the masks were replaced when needed, but the nurses do not confirm that this transpired on any regular basis.

[36] Gale Colborn, the Executive Director of Hawthorne Place, has deposed that the facility has had issues not only with ongoing supply of N95s and other PPE but with important equipment disappearing at the facility. She relates that N95 masks were kept on a cart to be available for night nurses where necessary, and that at one point a full box of the masks was either used or removed by morning. After that, the N95s were removed from the cart where they would be available when needed, and locked in the medicine storage unit.

[37] Ms. Colborn states that despite the relocation of the N95s, they and all other PPE are made available to the nurses when called for. Her affidavit makes it clear that management, and not nursing staff, have taken over the allocation of PPE and the decision-making as to when N95s and other PPE are used:

> We continue to actively monitor the situation to ensure that we will not run out of any of the required PPE and that staff are utilizing PPE reasonably and for appropriate purposes. However, N95 masks are in lower supply relative to other PPE including surgical masks, gowns, gloves, goggles, face shields, etc.

[38] Mr. Belford deposes that during this time, a number of Hawthorne Place residents have been readmitted from hospital, with test results outstanding, but have not been isolated while they await the results. At the same time, staff who have been exposed to these patients have been instructed to report for work as usual rather than to self-isolate. Mr. Bedford relates that, on an ongoing basis, residents who have become symptomatic have not been isolated from others while test results are pending, and that no effective cohorting has been done at Hawthorne Place in order to separate the sick from the well.

[39] On March 30, 2020 and April 8, 2020, ONA filed grievances under its collective agreement with Hawthorne Place. Those grievances allege that it has failed to provide access to necessary PPE, failed to isolate new admissions or readmissions, and failed to cohort residents as well as staff. Mr. Belford states that ONA asked that the arbitration of the two grievances be expedited, but that this request was denied.

d) Henley Place

[40] On March 29, 2020, a resident of Henley Place tested positive for COVID-19. Ms. Mathers has deposed that upon being advised of the outbreak, the ONA requested that the Associate Director of Care for the facility provide N95 respirators to staff interacting with patients diagnosed with or suspected of having COVID-19. This request was denied, and the facility's nurses were advised that they would be limited to the use of surgical masks even when providing care to known COVID-19 patients.

[41] Jamie Young, a nurse employed at Henley Place, has stated in his affidavit that the Associate Director advised "that the Facility was 'completely stocked' with N95 respirators, gowns, gloves, and surgical masks." Several days later, on March 31, 2020, an ONA labour relations officer wrote to the management of Henley Place requesting that adequate precautions be taken for the safety of the nursing staff. The letter pointed out that, "The science on the

coronavirus does state the virus could be born of air and therefore I am urging you to please provide N95 masks to any ONA member who is caring for a suspected or confirmed case of coronavirus."

[42] Mr. Young deposes that following this communication, Henley Place removed all of its N95s from the facility's storage room and put them under lock and key in the Administrator's office. Diane Peckham, another labour relations officer with the ONA, deposes that there is a lengthy bureaucratic procedure involved in any staff member requesting an N95, which must go through several layers of management before being approved. Respondents' counsel characterizes this and the home's strict rationing of N95s as "inventory control measures". That may well be an accurate characterization from the point of view of Henley Place's management, but it is the nurses' evidence that these measures have not been adapted to the fast-moving events of the COVID-19 pandemic, which often requires on-the-spot decision-making at the point of care.

[43] Ms. Peckham sets out that this lengthy procedure has caused nurses not to ask for the PPE equipment, lest the patients have to wait for an answer before undergoing a procedure which must be done immediately. As a result, nurses work in intimate proximity to patients – including performing aerosol-generating procedures in which there is a high risk of contagion – without adequate protective gear. Ms. Peckham's affidavit contains specific examples of patients who have undergone emergency COVID-19 procedures by nursing staff who could not access, or not access in a timely fashion, the N95 respirator masks required for the task.

[44] As Ms. Peckham relates it, when Directive #5 was issued by the CMOH on April 2, 2020, the ONA's labour relations officer inveighed upon Henley Place to have its nurses provided with realistic access to personal protective equipment, including N95 respirator masks. The ONA argued that the new Directive required that all appropriate forms of PPE be made available to any medical staff who determined at point of care that that it was required. The record shows that the LTC home's labour relations consultant responded by email on April 13, 2020: "[T]hey will leave a couple of extra N95's in the DOC's office, however, I understand that N95's were used inappropriately over the weekend."

[45] The supposedly "inappropriate" use of an N95 respirator mask is, essentially, a use of the mask pursuant as determined by the nurse at the point of care rather than as determined by Henley Place management. The email chain further states that Henley Place management takes a "daily inventory check" of its N95s, and if a mask has to be used "they should alert the manager on call" to make the decision. The clear indication of these written communications is that managerial personnel rather than medical personnel makes the decision as to what PPE a nurse should access and under what circumstances.

[46] I note that the affidavit of Jamie Young starts off with an anecdote about a conversation with the facility's Director of Care which is telling. The nurse relates that the Director said that she had a pre-existing health condition, and as a consequence she would not visit the LTC home unless she were wearing an N95 respirator, regardless of who she was seeing on the unit. I

concede that this anecdote contains hearsay and, in addition, the affiant has not been cross-examined on it. However, counsel for the Applicants allege that this conversation is emblematic of the situation at Henley Place, and that unlike nursing staff, management personnel have had N95s at their disposal. They appear to have been aware themselves of the risks of proximity to COVID-19 patients and the need for proper PPE.

[47] The ONA has filed a grievance regarding these practices pursuant to its collective agreement with Henley Place, and has requested that the labour arbitration be expedited. As Applicants' counsel point out, the request is premised on the likelihood of harm resulting from delayed adjudication of these issues. The grievance process has to date not been expedited.

III. The labour dispute

[48] Counsel for the Attorney General observes in their factum that this is essentially a labour dispute between the nurses and their employers. That characterization may unduly minimize the health care and policy questions that form the core of the issues; as Applicants' counsel explained at the hearing, implementing COVID-19 protections for the nurses in effect implements them for the patients since LTC nurses move from patient to patient in administering treatment.

[49] That said, the description of this as fundamentally a labour dispute is formally correct. As outlined above, the Applicants have commenced grievances under their collective agreement against each of the four Respondent LTC homes. Like most legal procedures, however, those processes take time. The inability to expedite the labour hearings has led to the Applicants' application to this court for what they describe as urgent interlocutory relief.

[50] What the Applicants seek is in many respects an unusual form of interlocutory Order. It comes to court by way of an Application under the *Rules of Civil Procedure*, and as a self-contained proceeding. Accordingly, the "interlocutory" Order sought by the Applicants is a final Order in the Application. It is only interlocutory in the sense that it will be followed at some point by a labour arbitration (or, more accurately, by four labour arbitrations).

[51] I do not doubt that this court has inherent jurisdiction to deal with this Application: *Courts of Justice Act*, RSO 1990, c C43, ss. 101-2. But I will deal with it without regard to the labour dispute on which it is technically based. That is for an arbitrator to deal with down the road. If an Order is issued as a result of the present Application, the parties may have to return to court at some future point if that is ever to be revised or removed.

[52] For now, Applicants' counsel state that there is simply no other way to have this matter considered by an adjudicative body in less than the 30 days led time required for an arbitration under the *Labour Relations Act*, SO 1995, c 1 Sched A ("*LRA*"). They submit that the issues raised by the Applications require more immediate attention than that.

[53] Respondents' counsel argue that there is, in fact, an alternative procedure available to the Applicants, and that it should be accessed before a court is asked to rule on the issues. They submit

that the issues here are within the jurisdiction of inspectors under section 25(2) of the *OHSA*, who have authority to determine the safety measures required in a work place and to compel an employer to take every reasonable precaution for the protection of a worker. While that may be the case, an inspection regime is not an alternative to adjudication of a dispute over compliance with a collective agreement; indeed, counsel for the Applicants advises that the *OHSA* inspections are no longer being done by visit to the facility and discussion with all concerned parties. According to Applicants' counsel, they are instead being done by telephone call without any attempt made at due process.

[54] Respondents' counsel also note that the decisions of inspectors under the *OHSA* can be appealed to Ontario Labour Relations Board ("OLRB"), and that this includes negative decisions not to take action in a given situation: see *Ontario Nurses' Association and Headwaters Health Care Centre*, Occupational Health and Safety Act section 61 Appeal, filed April 21, 2020. However, as counsel for the Attorney General points out, it is not the mandate of the OLRB in this capacity to make any ruling or policy decision about whether N95s should be available going forward. Applicants' counsel submits, correctly in my view, that the OLRB's limited authority on such an appeal means that it is not an alternative forum to the full adjudication of the issues that will be available with a labour arbitration under the collective agreement.

[55] The real problem raised by this labour dispute is that the arbitral process is a slow and protracted one. In effect, that leaves this court's inherent jurisdiction as the only legal mechanism to realistically fill the void.

IV. The Directives

[56] Section 77.7 of the *HPPA* authorizes the CMOH to issue directives to health care providers where there "exists or there may exist an immediate risk to the health of persons anywhere in Ontario". It further authorizes the CMOH to direct health care workers and organizations with respect to procedures "to be followed to protect the health of persons anywhere in Ontario." Directive #3 was issued on March 22, 2020, and by its terms specifically applies to LTC homes.

[57] The March 22, 2020 Directive was updated on March 30, 2020 and supplemented by an outbreak Directive for LTC facilities on April 1, 2020. While this Directive and its supplement are too lengthy to quote verbatim, a list of the sub-headings of its operative portion denotes the subjects to which it is addressed.

[58] The operative portion of Directive #3 starts off with the explanation that, "Complications from COVID-19 can include serious conditions, like pneumonia or kidney failure, and in some cases, death." It then goes on to discuss "Required Precautions and Procedures" under the following headings: "Active Screening, active screening of all residents, admission and re-admission, short-stay absences, ensure appropriate Personal Protective Equipment (PPE), staff and essential visitor masking, managing essential visitors, limiting work locations, staff and resident cohorting, triggering an outbreak assessment, receiving negative test results, receiving positive test results, management of a single case in a resident, management of a single case in staff, required steps in an outbreak, testing, ensure LTC home's COVID-19 preparedness, communications, food and product deliveries".

[59] The Directive #3 provision on masking states: "Long-term care homes should immediately implement that all staff and essential visitors wear surgical/procedure masks at all times for source control for the duration of full shifts or visits in the long-term care home. For further clarity this is required regardless of whether the home is in outbreak or not." The provision on cohorting states: "Long-term care homes must use staff and resident cohorting to prevent the spread of COVID-19. Resident cohorting may include one or more of he following: alternative accommodation in the home to maintain physical distancing of 2 metres, resident cohorting of the well and unwell, utilizing respite and palliative care beds and rooms, or utilizing other rooms as appropriate. Staff cohorting may include: designating staff to work with either ill residents or well residents."

[60] On April 10, 2020, Directive #5 was issued and updated to specifically apply to LTC facilities. This Directive requires that, "Public hospitals and long-term care homes must explore all available avenues to obtain and maintain a sufficient supply of PPE."

[61] Counsel for the Attorney General submits that this is part of an overall balance of obligations contained in Directive #5. As explained in an affidavit submitted by Phil Graham, the Executive Lead of the Ontario Health Teams Division of the Ministry of Health, the updated version of Directive #5 was issued following consultation between the Ministry and the ONA and other unions representing employees in hospitals and other health care institutions. In a joint statement between the Ministry and the ONA issued March 30, 2020, certain obligations were spelled out for LTC homes. These are succinctly summarized by Mr. Graham, as follows:

- Public hospitals and LTC homes, as well as health care workers and other employees, 'must engage on the conservation and stewardship' of PPE;
- Hospitals and LTC homes 'must assess the available supply of PPE on an ongoing basis' and must explore all available avenues to obtain and maintain a sufficient supply;
- In the event that utilization rates indicate that a shortage of PPE will occur, the government and the public hospital or LTC home will develop contingency plans in consultation with the affected unions;
- At a minimum, for health care workers and other employees in a hospital or long-term care home, contact and droplet precautions must be used for all interactions with suspected, presumed or confirmed COVID-19 patients or residents, including surgical/procedure masks.

[62] Mr. Graham then sets out the obligations that the joint statement set out for health care workers such as nurses:

- A PCRA [point of care risk assessment] 'must be performed' by every health care worker before every patient interaction;

> • The PCRA by the health care worker "should include the frequency and probability of routine or emergent AGMPs [aerosol generating medical procedures], and N95s or equivalent or better protection must be used in the room where AGMPs [as defined in the Directive] are being performed, are frequent or probable.

[63] Mr. Graham then goes on to summarize the crucial portion of the joint statement, especially in terms of access to N95s:

> • If a health care worker determines, based on the PCRA, and based on their professional and clinical judgment, that certain health and safety measures may be required in the delivery of care to the resident or patient, then the public hospital or LTC home must provide the health care work with access to the appropriate measures, including an N95. The public hospital or long-term care home will not unreasonably deny access to the appropriate PPE.

[64] This latter point can be found front-and-centre in Directive #5. That Directive makes it mandatory that, "A point-of-care risk assessment (PCRA) must be performed by every health care worker before every patient or resident interaction in a public hospital or long-term care home." It then goes on to specifically state that nursing staff can make a point-of-care decision as to the appropriate PPE they require:

> If a health care worker determines, based on the PCRA, and based on their professional and clinical judgment, that health and safety measures may be required in the delivery of care to the patient or resident, then the public hospital or long-term care home must provide that health care worker with access to the appropriate health and safety control measures, including an N95 respirator. The public hospital or long-term care home will not unreasonably deny access to the appropriate PPE.

[65] Respondents' counsel states that the word "appropriate" in this Directive gives the LTC home management a say in tempering the nurse's point-of-care judgment. They contend that the balance of obligations built into the Directive, and made more explicit in the joint statement of March 30, 2020 which informs the Directive, means that the management of each facility has input into whether or not a given measure or given use of PPE is required in the circumstances.

[66] As an example, Respondents' counsel makes reference to the expert opinion of Dr. Allison McGeer, who holds an opinion contrary to that of Dr. Brasseau as to the usefulness of N95 masks. It is the Respondents' position that the management of any facility must take the competing views on any relevant item of PPE into account in considering the appropriateness of a nurse's point-of-care assessment under Directive #5.

[67] Dr. McGeer is put forward as an expert scientist by the Attorney General in its Record. She is a microbiologist and former Director of the Division of Infection Control at Mount Sinai Hospital in Toronto, and has a long and impressive list of accomplishments and credentials. She

has in previous cases been recognized as an expert in her field by this court: see *Levac v James* 2016 ONSC 7727. In her affidavit, Dr. McGeer explains the thinking underlying her view as to the limited circumstances in which N95s are necessary:

> In Ontario, recommendations regarding the necessary protection caring for patients when AGMPs were not being performed was changed on March 10, 2020. This change was in part associated with evolving evidence that N95 respirators were not needed, and in part because of the on-going shortage of N95 respirators in Ontario and around the world. **It is clear that the supply of N95 respirators is insufficient to provide them for all care for COVID-19 patients, that that supply is unstable, that re-use is fraught with challenges, and that failure to conserve N95 respirators in Ontario is likely to result in them not being available for workers performing AGMPs in the future weeks.** [Emphasis in the Attorney General's Record]
>
> …In an ideal world, I would be happy with fit-tested N95 respirators being used as a precautionary measure for all interactions with COVID-19 patients (family medicine offices, COVID-19 assessment clinics, hospitals and long-term care homes). However, we simply do not have sufficient N95 respirators for all these circumstances.

[68] It is interesting to see Dr. McGeer providing an explanation for the change in Ontario's public health recommendations on March 10, 2020 that was not made clear in the Public Health Ontario brief entitled "Updated IPAC Recommendations" published that day. As discussed below, that publication focused on the actual, hands-on need for N95 masks, and did so by reference to by now outdated, pre-COVID-19 sources. What Dr. McGeer emphasizes, however, is not so much an analysis of the need for N95 protection with respect to any given patient or procedure, but rather the societal need to preserve a limited supply of these devices.

[69] Other than the need to conserve supply, which is her central point, Dr. McGeer gives two reasons for saying that the lack of N95s is not the cause of the tragic outbreaks in Ontario's LTC homes:

> While data were somewhat limited, clustered infections appeared to occur when two conditions were present: 1) patients were not recognized as having the infection and 2) consequently no personal protective equipment was worn by health care providers.

[70] Dr. McGeer goes on to say that the problem really is that one health care worker who contracts COVID-19 typically will spread it to another. No doubt that is part of the problem. But, of course, it stands to reason that nurses working in close proximity and physically treating COVID-19 patients on a daily basis must equally be exposed to their patients' viruses. It defies reason to think that nurses only contract COVID-19 from nurses and patients only contract it

from patients. They are all together in the LTC facilities, which is the very reason the CMOH issued Directives #3 and #5 in the first place.

[71] In her supplementary affidavit filed by the Applicants in this proceeding, Dr. Brosseau says that "there exists a biological possibility that COVID-19 can be transmitted by airborne particles." This is admittedly rather weak language, although Dr. Brosseau also appends a number of scholarly articles supporting her statement. Applicants' counsel concedes that as an expert report it could have been more fulsome, but it was filed at the last moment in a fast-breaking piece of litigation. I agree that the statement of opinion and method of argumentation in Dr. Brosseau's supplementary affidavit is not the best, but I acknowledge that it is a product of the time pressure all parties are under in this matter.

[72] Dr. Brosseau carries out a parallel debate here with Dr. Gary Garber, the Medical Director for Infection Prevention and Control at Public Health Ontario. Dr. Garber opines in his affidavit that if COVID-19 were transmitted by airborne transmission rather than by respiratory droplets, we would see a far greater rate of infection. He says that evidence to date suggests that COVID-19 – unlike tuberculosis, chicken pox, and measles – is not transmitted through the air. For her part, Dr. Brosseau says this analysis applies only to long-range airborne transmission, not to short-range transmission which it is thought can indeed be airborne.

[73] The only real conclusion I can draw from these battles of experts is that the evidence regarding the transmission of the COVID-19 virus "continues to evolve", as they say. In any case, the difference of opinion between Drs. McGeer and Garber on one hand, and Dr. Brosseau on the other, is not for me to iron out in this Application. It does demonstrate, however, that the expert community is still trying to come to grips with the complexities of the COVID-19 virus.

[74] Directive #5 attempts to take into account the dangers and the unknowns associated with this virus, as well as the rapidity of the contagion which LTC facilities have experienced. It does so by giving the final word on whether the delivery of care to a resident of an LTC facility requires specific health and safety measures or PPE, including N95s, to the nurse at point of care. The LTC facility is to facilitate access to whatever is appropriately required, as determined by that nurse. While it is the case, as the Respondents and the Attorney General submit, that the Directive calls for a balance as between the needs of the moment and the needs of the institution and the future, it is the nurse at point of care that is to do that balancing. The nurse is not directed to call management personnel to weigh in on the issues at point of care.

[75] While it is understandable that privately owned LTC homes will have economic and long-term imperatives of their own, the decision as to what PPE and other health and safety measures are required in delivering care to a resident does not take those economic concerns into account in any direct way. It is to be made by medical staff, based on a variety of health needs and health resource factors, both immediate and long term.

V. The precautionary principle

[76] Article 6.06 of the collective agreement between the ONA and the LTC homes, entitled "Health and Safety" provides:

> (i) The Employer shall:
>
> i. Inform employees of any situation relating to their work which may endanger their health and safety, as soon as it learns of the said situation;
>
> ii. Inform employees regarding the risks relating to their work and provide training and supervision so that employees have the skills and knowledge necessary to safely perform the work assigned to them; When faced with occupational health and safety decisions, the Home will not await full scientific or absolute certainty before taking reasonable action(s) that reduces risk and protects employees.
>
> iii. Ensure that the applicable measures and procedures prescribed in the Occupational Health and Safety Act are carried out in the workplace.

[77] The important *OHSA* provision for the purposes of art. 6.06 is section 25(2)(h), which mandates employers to "take every precaution reasonable" for the protection of the worker. Thus, the collective agreement incorporates what is often referred to as the "precautionary principle".

[78] An important recommendation of the Commission of Inquiry chaired by Justice Archie Campbell in the wake of the SARS outbreak of 2003 – an outbreak of a virus related to COVID-19 – is that the precautionary principle is to be put into action in order to prevent unnecessary illness and death. As explained by Justice Campbell, this principle applies where health and safety are threatened even if it cannot be established with scientific certainty that there is a cause and effect relationship between the activity and the harm. The entire point is to take precautions against the as yet unknown. Thus, section 77.7 of the *HPPA* requires the CMOH to consider the precautionary principle in issuing Directives in the event of an outbreak of infectious disease.

[79] Counsel for the Applicants submit that in the context of COVID-19, where the modes of transmission are not presently known and there exists a possibility that the virus can be transmitted by airborne particles, the precautionary principle supports that fit-tested N95 respirators must be worn when providing up-close care to known or suspected COVID-19 patients.

[80] In early February 2020, Public Health Ontario published a document from its Provincial Infectious Disease Advisory Committee entitled, "Best Practices for Prevention, Surveillance and Infection Control Management of Novel Respiratory Infections in All Health Care Settings". This advisory publication indicated that the means of transmission of COVID-19 had not yet been fully understood, but recommended that health care providers use respiratory PPE such as N95s: "… using a precautionary approach that combines Airborne Precautions and Droplet/Contact Precautions should be observed until the epidemiology of the novel agent is established."

[81] Likewise, on February 11, 2020, the Ontario Ministry of Health released a document entitled "Novel Coronavirus (COVID-19) Guidance for Acute Care", which stated that for treating patients with suspected or diagnosed COVID-19, full precautionary measures should be taken: “Staff must safely use all appropriate PPE including gloves, gown, goggles or eye protection, and N95 fit tested respirators for clinical assessment, examination, and testing.”

[82] The World Health Organization came to the same conclusion on March 11, 2020, when it announced that the COVID-19 virus constituted a pandemic. Its guideline of that date provided the basis for complete respiratory protection: “COVID-19 appears to spread most easily though close contact with an infected person. When someone who has COVID-19 coughs or sneezes, small droplets are released and, if you are too close, you can breathe in the virus.”

[83] It came as some surprise, therefore, when on March 10, 2020, Public Health Ontario released a Technical Brief entitled “Updated IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19”. That Brief said the virus is spread through droplet or contact transmission alone, and removed the recommendation to implement airborne precautions. This conclusion, in turn, led to the removal of the recommendation for nurses to use fit-tested N95 respirator masks when providing direct care to COVID-19 patients. Based on this document, on March 12, 2020, Public Health Ontario released “Updated IPAC Recommendations for Use of Personal Protective Equipment for Care of Individuals with Suspect or Confirmed COVID-19”, which similarly eliminated the recommendation to use airborne precautions, including N95 respirators, for all most COVID-19 care.

[84] Along similar lines, on March 12, 2020 the CMOH issued “COVID-19 Directive #1 for Health Care Providers and Health Care Entities”, which makes reference to the precautionary principle and indicates that understanding the means of transmission for the virus is only now emerging. It also only required droplet and contact precautions for care of COVID-19 patients, except for so-called aerosol generating medical procedures. These include a range of procedures that can be conducted in LTC facilities, from intubation to swabbing to assisting residents with their personal CPAP machines.

[85] Counsel for the Applicants submit that it turns out that the confusion in these various documents comes from the fact that the March 10, 2020 Public Health Ontario updated Technical Brief, which eliminated reference to airborne precautions, was based entirely on studies done between 2012 and 2016 – i.e. before the advent of COVID-19. As Ms. Mathers points out in her affidavit which reviews these developments, none of the sources cited in that document make reference to the transmission of COVID-19, the epidemiology of COVID-19, or PPE as it relates to COVID-19.

[86] In March-April 2020, the CMOH began issuing the series of Directives discussed above aimed specifically at COVID-19 and LTC facilities. As indicated, these Directives set out required precautions and procedures, including for screening, admission, appropriate PPE for visitors and staff, limiting work locations, staff and resident cohorting, outbreak assessment,

management of cases for residents and for staff, testing and overall preparedness. All of these, as Ms. Mathers points out, are well known infection control processes and widely shared precautions for avoiding and dealing with outbreaks.

[87] The CMOH appears to have recognized the controversy over N95s flowing from what the Applicants say was the outdated science behind one of Public Health Ontario's briefs. Accordingly, Directive #5, the latest word on the subject from the CMOH, leaves the choice of protective gear, with specific mention of N95 respiratory masks, to the health care provider at the point of care. While all personnel working in this field are admonished to be reasonable and to take account of long term and short term needs in making their assessments, it is the health and safety question faced by the nurses and other health professionals on the spot that is given priority in the CMOH's Directive.

V. The test for an injunction

[88] It is well known that the applicable test for an interlocutory injunction comes from *RJR-MacDonald v Canada*, [1994] 1 SCR 311, at para 43: a) is there a serious question to be tried; b) will the applicant suffer irreparable harm if the interlocutory relief is not granted; and c) does the balance of convenience favour granting relief pending the final determination of the matter?

[89] The Respondents do not dispute that the Applications and the labour grievances with the four LTC homes represent a serious issue to be tried. From the Applicants' point of view, nurses' and LTC home residents' lives hang in the balance, and from the Respondents' point of view, the supply of medical equipment to LTC homes hangs in the balance. It is difficult to imagine more serious issues to be tried.

[90] The Respondents likewise do not dispute that there is a risk of nurses suffering irreparable harm if the requested relief is not granted. They go on to argue, however, that irreparable harm to the nurses cannot be considered in isolation. They contend that the "harsh reality that quantities of certain forms of PPE such as N95 masks are limited and in demand across the world, the allocation of those masks to one group may well lead to masks not being available to other health care workers working in equally risky circumstances."

[91] Respondents' counsel submit that it is this balance that must be taken into account in the third stage of the injunction test. As they put it in their factum: "While granting the requested relief to the Applicants may minimize their potential risk of suffering irreparable harm to them, it could at the same time increase the potential for others to suffer irreparable harm." Accordingly, they state that the balance of convenience test must assess whether having nurses determine whether they get to use an N95 masks will impact the availability of the limited supply of those masks to others who may need them in LTC homes and across the Province.

[92] The Respondents rely on *Abarquez v Ontario*, 2009 ONCA 374, at paras. 25-26 for the proposition that the CMOH Directives address the interests of the public at large and not just the interest of a particular group. They take that to mean that the balance of convenience between the

parties to this litigation must incorporate the balance of convenience to the public, equating the Applicants to private interests and the Respondents to the public interests. In other words, they suggest that nurses and other medical staff treating COVID-19 patients in LTC homes represent their own narrow, personal interests, while the privately-owned LTC homes represent broad, community-based interests.

[93] I can imagine that the irony of that submission is not lost on the Applicants. One need only read the affidavits of the individual nurses in this Application record to understand that they spend their working days, in particular during the current emergency situation, sacrificing their personal interests to those of the people under their care. And given the nature of the pandemic, they do this not only for the immediate benefit of their patients but for the benefit of society at large. To suggest that their quest for the masks, protective gear, and cohorting that they view as crucial to the lives and health of themselves and their patients represents a narrow, private interest seems to sorely miss the mark.

[94] Under the circumstances, there is no prejudice to the Respondents which outweighs the irreparable harms that could ensue to the Applicants. Where the lives of nurses and patients are placed at risk, the balance of convenience favours those measures that give primacy to the health and safety of medical personnel and those that they treat. As the British Columbia Supreme Court has held in the context of granting an injunction where failure to abide by fire safety rules could place health and safety at risk, "the risk of catastrophic injury and loss of life is too great to ignore": *Maple Ridge (City) v Scott*, 2019 BCSC 157, at para 48.

[95] Accordingly, all three steps in the test for injunctive relief have been met. Nurses are not to be impeded in making an assessment and determination at point of care as to what PPE or other measures are appropriate and required under the circumstances. That assessment and determination is to be made on the basis of their professional judgment, taking into account the immediate situation as well as relevant longer and shorter-term considerations.

VI. Disposition

[96] The Respondents and their agents, employees, and those acting under their instruction are ordered to provide nurses working in their respective facilities with access to fitted N95 facial respirators and other appropriate PPE when assessed by a nurse at point of care to be appropriate and required, as set out in Directive #5 issued by the CMOH. This Order shall be in effect until a final disposition of the ONA's grievances against the Respondents in respect of these and related matters under their collective agreements, or until further Order of this court.

[97] The Respondents are further ordered to implement administrative controls such as isolating and cohorting of residents and staff during the COVID-19 crisis, as set out in Directives #3 and #5 issued by the CMOH. This Order shall be in effect until a final disposition of the ONA's grievances against the Respondents in respect of these and related matters under their collective agreements, or until further Order of this court.

[98] The parties may make written submissions on costs. I would ask that Applicants' counsel email their Bill of Costs and submissions of no more than 3 pages to my assistant within 2 weeks of today, and that Respondents' counsel email their Bill of Costs and equally brief submissions within 2 weeks thereafter. There will be no costs for or against the Attorney General.

– ADDENDUM –

This motion was heard by videoconference while regular court operations are suspended due to the COVID-19 pandemic. Upon the courthouse reopening to the public, each party shall file with the Civil Motions Office a copy of all the material they delivered electronically for this proceeding, with proof of service, and pay the appropriate fees therefor.

Notwithstanding Rule 59.05 of the *Rules of Civil Procedure*, this Order is effective from the date it is made, and is enforceable without any need for entry and filing. In accordance with Rules 77.07(6) and 1.04, no formal Order need be entered and filed unless an appeal or a motion for leave to appeal is brought to an appellate court. Any party to this Order may nonetheless submit a formal Order for original signing, entry and filing when the Court returns to regular operations.

Date: April 23, 2020 Morgan J.