CITATION: Sprague v. Her Majesty the Queen in right of Ontario, 2020 ONSC 2335
DIVISIONAL COURT FILE NO.: CVD-TO-3-20JR
DATE: 20200417

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

Backhouse, Lederer and Penny JJ

BETWEEN:	
EDWARD L. SPRAGUE, AS REPRESENTED BY HIS LITIGATION GUARDIAN, J. ANDREW SPRAGUE Applicant	*J. Andrew Sprague* for the applicant, in person
– and –	
HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO, AS REPRESENTED BY THE MINISTER OF HEALTH; NORTH YORK GENERAL HOSPITAL Respondent	*Andrea Bolieiro*, *Ravi Amarnath* and *Kristin Smith* for the Respondent The Minister of Health; *Anna Marrison*, *Ewa Krajewska, Barbara J. Walker-Renshaw* and *John McIntyre* for the Respondent North York General Hospital
	HEARD: April 9, 2020

Overview

[1] This is an application for judicial review brought on behalf of Mr. Edward Sprague (Mr. Sprague) by his son and power of attorney for personal care, Andrew Sprague (the applicant). Mr. Sprague is a 77-year-old, medically stable inpatient who was admitted to the North York General Hospital on March 10, 2020. Mr. Sprague suffered an acquired brain injury in 2018 which has rendered him incapable of personal care and, since then, the applicant has acted as his father's substitute decision maker for personal care decisions, including medical treatment.

[2] Due to the circumstances of the COVID-19 pandemic, the Hospital, like many other healthcare entities in Ontario, has changed its day-to-day operations to address the significant healthcare risks posed by the pandemic to patients and their families, the Hospital's healthcare providers, staff and volunteers and, to the public at large.

[3] Specifically, the Hospital, on March 20, 2020, instituted a "no visitor" policy with discretion to grant exceptions for patients/visitors in certain categories (the Visitor Policy). Mr. Sprague and the applicant do not fall within the exceptional categories for which limited visitor access has been provisionally authorized. The applicant, with one exception, has not been granted in-person access to his father since this policy was implemented. The applicant challenges the Visitor Policy which limits his ability to visit Mr. Sprague in person in the Hospital. The applicant alleges that this limitation has violated Mr. Sprague's rights under ss. 7, 12 and 15 of the *Canadian Charter of Rights and Freedoms*. The applicant asks that the Visitor Policy be declared of no force or effect and that the Hospital be ordered to grant him full and unfettered access to visit Mr. Sprague in person.

[4] Just prior to the Visitor Policy, on March 19, 2020, the Chief Medical Officer of Health for Ontario (CMOH) sent a Memorandum to Ontario's hospitals recommending that the hospitals allow only essential visitors and containing guidance on what "essential" visitors might mean (the CMOH Memorandum). The applicant, in an amended notice of application, alleges that the CMOH Memorandum to hospitals, because it was instrumental in bringing about the Visitor Policy, also prevents him from being able to see his father on an ongoing basis. The CMOH Memorandum, he argues, also violates his father's rights under s. 15 of the *Charter*. The applicant asks for a declaration that the CMOH Memorandum is of no force or effect.

Issues

[5] The application gives rise to the following issues:

(1) Is the Visitor Policy subject to judicial review?

(2) Is the CMOH Memorandum subject to judicial review?

(3) (a) Does the Visitor Policy infringe Mr. Sprague's rights under the *Charter* in respect of:

(i) s. 15

(ii) s. 7 or

(iii) s. 12?

(b) Is the infringement, if any, saved by s. 1 of the *Charter*?

(4) (a) Does the CMOH's Memorandum infringe Mr. Sprague's rights under s. 15 of the *Charter*? and

(b) Is the infringement, if any, saved by s. 1 of the *Charter*?

Background

Mr. Sprague

[6] As noted, Mr. Sprague is a 77-year-old man. He has an acquired brain injury as a result of being hit by a car in 2018. He is, however, medically stable with no acute illness. It is common ground that Mr. Sprague is incapable of personal care and that the applicant is Mr. Sprague's authorized substitute decision-maker. Mr. Sprague also suffers from a condition that prevents him from swallowing. He therefore requires a gastrostomy tube ("g-tube") to take nourishment and oral medications. The g-tube is surgically inserted into the patient's stomach. Mr. Sprague also has a history of respiratory illness.

[7] Mr. Sprague was a resident at a long-term care home, Extendicare. He was brought to the Hospital via ambulance on March 10, 2020 after pulling out his g-tube while at the long-term care home. Mr. Sprague was admitted to the Hospital's medical unit for patients with respiratory concerns. He is sharing a semi-private room with another patient. This unit has 38 patient beds and is almost exclusively populated by patients over 65 with chronic respiratory issues. These patients are particularly vulnerable to a respiratory illness like COVID-19. Many of these patients are incapable with respect to treatment decisions.

[8] The applicant concedes that there has been no issue with the quality of his father's care at the Hospital. In addition to the Hospital's services, Mr. Sprague is provided supplementary personal care by a privately-hired personal support worker ("PSW") about three or four times per week. The PSW still attends in person at the Hospital and complies with the Hospital's security/decontamination measures.

[9] Since his admission, Mr. Sprague has had to have his g-tube reinserted via non-surgical interventional radiology on five separate occasions. To try to prevent him from pulling out his g-tube, his clinical team has been working to optimize his medication to minimize his agitation. They have also used an abdominal binder to secure the g-tube and soft restraints (such as mittens and a wrist restraint with slack), all with the consent of the applicant. The restraints are released when either the applicant or the PSW is present.

The CMOH Memorandum and the Visitor Policy

[10] The background to the current COVID-19 pandemic is well documented in the affidavits filed by the Hospital and the government, all of which is also summarized in their respective factums. Given widespread public information about the pandemic and the urgency of this matter, I will not repeat that background here.

[11] Between March 10 and March 20, the applicant visited his father on several occasions.

[12] On March 19, 2020 the CMOH issued his Memorandum to hospitals to maintain the safety of vulnerable patients and staff in acute care settings by strongly recommending that

only essential visitors be permitted, including "those who have a patient who is dying or very ill or a parent/guardian of an ill child or youth, a visitor of a patient undergoing surgery or a woman giving birth."

[13] Following the CMOH's recommendation to restrict access to hospitals to essential visitors only, the Hospital management decided on March 20, 2020 to revise the Hospital's visitor policy effective immediately. The new Visitor Policy stated: "as of March 20, no visitors are allowed. Exceptions will be made on a case-by-case basis, such as those requiring end-of-life care, labouring persons and patients under the age of 18."

[14] Hospital management considered the available information, recommendations and guiding principles set out by the CMOH, visitors' policies from other hospitals in the greater Toronto area, and expert input. They weighed the risks posed by COVID-19 to the Hospital community against the benefit of visitor access to patients and family members.

[15] In particular, they identified two central considerations - the need to: a) minimize non-essential contact with those in the community and b) maximize the availability and use of Hospital resources, including physical resources (e.g., Personal Protective Equipment ("PPE") and ventilators) and human resources (e.g., health care providers and administrative staff). Against these considerations, the Hospital also weighed other, compassionate factors such as the emotional vulnerabilities of patients at the end of life and their families, the need of younger children for family support and the unique support needs of birthing mothers.

[16] A very low proportion of the Hospital's patients fall into the end of life category at the present time. Hospital management concluded that those who are not at imminent risk of death cannot receive visitors as this would significantly increase the number of visitors and create unacceptable risks for patients and staff.

[17] Regarding children under the age of 18, the available medical data suggests that a low number of children contract COVID-19 and, when it is contracted, children generally only experience mild symptoms. Further, as the Hospital is not a pediatric Hospital, it has few patients under the age of 18 and they are all segregated on the pediatric unit with staff dedicated to that unit. The risk to other patients and staff in allowing visitors to children was therefore regarded as manageable at this time.

[18] Labouring mothers are under the age of 65, so are generally not in a COVID-19 high-risk group. They are also in a segregated unit at the Hospital with staff dedicated to that unit, thus presenting another manageable risk.

[19] The Hospital did not make an exception for incapable adults. The Hospital's evidence is that while requests for exceptions will be considered on a case-by-case basis, almost all of this category of patient is in one or more of the high-risk groups to a COVID-19 infection and surrounded by other similar patients on their unit. The Hospital determined that alternatives, such as phone and video communication, which were already part of the Hospital's routine practice in relation to the incapable, was more appropriate.

Analysis

1. Is the Visitor Policy Subject to Judicial Review?

[20] Whether a decision of a public authority is subject to judicial review is governed by the *Judicial Review Procedure Act*, R.S.O. 1990, c. J.1 as interpreted by the jurisprudence. Section 2(1) of the *JRPA* sets out the Divisional Court's jurisdiction to hear an application for judicial review. That jurisdiction turns on the availability of the traditional prerogative writs and, more broadly, on the exercise of a statutory power of decision. In order to be judicially reviewed, a statutory power of decision "must be a specific power or right to make the very decision in issue", *Paine v. University of Toronto*, (1981), 34 O.R. (2d) 770 (C.A.) at p. 722.

[21] The applicant has not identified a statutory power that is being relied upon in the exercise of the Visitor Policy to restrict access to its premises. There is no evidence upon which to conclude that the Visitor Policy falls within the definition of statutory power under the *JRPA*. The *Public Hospitals Act*, R.S.O. 1990, c. P.40 and its regulations do not dictate how a hospital is to regulate access to its premises for visitors.

[22] Even where the decision at issue is exercised under a statutory power, the case law has established that judicial review is only available where the decision is also "the kind of decision that is reached by public law and therefore a decision to which a public law remedy can be applied". In *Highwood Congregation of Jehovah's Witnesses (Judicial Committee) v. Wall*, 2018 SCC 26, the Supreme Court explained the limited reach of public law and judicial review and the conjunctive two-step process as follows:

> Not all decisions are amenable to judicial review under a superior court's supervisory jurisdiction. Judicial review is *only available where there is an exercise of state authority and where that exercise is of a sufficiently public character*. Even public bodies make some decisions that are private in nature - such as renting premises and hiring staff - and such decisions are not subject to judicial review: *Air Canada v Toronto Port Authority*. In making these contractual decisions, the public body is not exercising "a power central to the administrative mandate given to it by Parliament", but is rather exercising a private power (ibid.). Such decisions do not involve concerns about the rule of law insofar as this refers to the exercise of delegated authority. (emphasis added)

[23] The list of factors to determine whether a decision has a sufficient public character is set out in *Air Canada v Toronto Port Authority and Porter Airlines Inc.,* 2011 FCA 347 at para. 60. I agree with and accept the submissions of the Hospital in para. 71 of its factum, as they pertain to the availability of judicial review generally:

(a) The character of the matter for which review is sought. Is it a private commercial matter, or is it of broader import to members of the public?

While the Visitor Policy has an effect on a subset of members of the public, the exercise of authority derives from the Hospital's authority as owner/occupier to

control access to its premises and to protect its patients and staff to whom it has a duty at common law. It is important to distinguish between cases that deal with the "public" in the generic sense and the "public" in the public law sense. A decision is public when it involves questions about the rule of law and the limits of an administrative decision-maker's exercise of power. Simply because a decision impacts a broad segment of the public does not mean that it is "public" in the administrative law sense.

(b) The nature of the decision maker and its responsibilities. Is the decision-maker public in nature, such as a Crown agent or statutorily-recognized administrative body, and charged with public responsibilities? Is the matter under review closely related to those responsibilities?

Public hospitals in Ontario are incorporated under the *Corporations Act* as independent, non-share capital corporations with independent boards of directors. Although hospitals are funded by the provincial government, the management of resources for the purposes of health care service provision is the responsibility of the (former) local health integration networks which are independent organizations. There is no statutory duty upon hospitals to provide general and uninhibited access to their premises or to visitors.

(c) The extent to which a decision is founded in and shaped by law as opposed to private discretion?

The Visitor Policy was shaped by medical and clinical criteria that were informed by scientific and epidemiological evidence. The Hospital's authority to exclude visitors arose from its rights as a corporate owner and occupier of private property.

(d) The body's relationship to other statutory schemes or other parts of government?

Hospitals are publicly regulated under the *Public Hospitals Act* in respect of some of their functions. These regulated functions do not include, however, access to hospital premises or visitor policies.

(e) The extent to which a decision-maker is an agent of government or is directed, controlled or significantly influenced by a public entities?

Hospitals are not agents of government. They are independent corporations. While the recommendation from the CMOH to hospitals influenced the Visitor Policy, it is not binding on the Hospital. The Hospital customized that recommendation to its particular circumstances and patient population.

(f) The suitability of public law remedies?

This is a decision that was made by a Hospital in the circumstances of a pandemic when it must protect the safety of its patients and staff using the best clinical evidence available to it and its experience and expertise in hospital management.

(g) The existence of compulsory power?

The Hospital is not exercising a compulsory power.

(h) An "exceptional" category of cases where the conduct has attained a serious public dimension?

The pandemic itself is clearly an exceptional circumstance. However, hospitals permit and restrict access to their premises and use their discretion about which and how many visitors may access hospitals at any given time based on clinical considerations, available resources and scientific evidence that take into account the hospital's duties to protect its patients and staff. These considerations are always in play, pandemic or no.

[24] These factors lead me to the conclusion that the Visitor Policy to restrict visitors during the COVID-19 pandemic did not involve the exercise of a statutory authority nor is it of a sufficiently "public" character (in the public law sense of the word) to meet the test for judicial review. During argument, however, the Panel raised with the parties whether there was another, more direct route to the application of the *Charter* and its remedial powers by virtue of ss. 24 and 32 of the *Charter*.

[25] The notice of application in this case is for judicial review and was, accordingly, brought before a full panel of the Divisional Court. It was not pleaded, nor were the parties in a position to argue, whether a different threshold test might apply under an application for declarations of a breach of the *Charter* under ss. 24 and 32. Because this alternative approach was not pursued (leaving, perhaps, an open question on the point), we considered it appropriate not to dispose of this application solely on the threshold question but to consider the *Charter* arguments on their merits as well.

[26] For reasons that are set out below, we are not satisfied there has been any breach of the *Charter*, such that it would not matter whether the threshold under an application under ss. 24 and 32 of the *Charter* is different from the threshold for an application for judicial review.

2. Is the CMOH Memorandum Subject to Judicial Review?

[27] The applicant has characterized the CMOH Memorandum as a binding directive under s. 77.7(1) of the *Hospital Protection and Promotion Act*. Under s. 77.7(3), healthcare providers in Ontario are required to comply with a section 77.7(1) directive. The applicant therefore argues that the decision to issue the CMOH Memorandum is an exercise of statutory power within the meaning of the *JRPA* and is subject to judicial review.

[28] I am unable to agree.

[29] As noted above, the Supreme Court has recently confirmed that "[n]ot all decisions are amenable to judicial review under a superior court's supervisory jurisdiction. Judicial review is only available where there is an exercise of state authority and where that exercise is of a sufficiently public character", *Highwood Congregation*, at paras. 14 and 20.

[30] Similarly, this Court held in *McLeod v. City of Brantford* that the decision under judicial review must relate to a power "conferred 'by or under a statute'…There must be a specific power or right to make the very decision in issue", 2018 ONSC 943 (Div. Ct.) at paras. 9 to 12.

[31] The CMOH Memorandum does not constitute an exercise or purported exercise of a statutory power. It was not issued pursuant to statutory authority, nor was such authority necessary. The CMOH Memorandum has no legal force. It does not statutorily compel any person or party to take or refrain from taking any action. The CMOH Memorandum instead merely provides the CMOH's recommendation that hospitals limit visitors to "essential visitors" in order to prevent the spread of COVID-19. While it is expected that hospitals will follow the CMOH's recommendation, they are not statutorily compelled to do so.

[32] Contrary to the applicant's suggestion, therefore, the CMOH Memorandum is not a binding directive to hospitals issued under s. 77.7 of the *HPPA*. As confirmed by Mr. Shingler, the Ministry's affiant, no directive has been issued to public or private hospitals in relation to visitor policies in response to COVID-19. The CMOH Memorandum is merely a recommendation that hospitals limit visitors to "essential visitors" in order to prevent the spread of COVID-19.

[33] I conclude, therefore, that judicial review is not available in respect of the CMOH Memorandum.

3. Does The Visitor Policy Infringe Mr. Sprague's Rights Under the Charter?

Section 15

[34] The essence of the applicant's argument is that because Mr. Sprague is elderly and incapable, it is unconstitutional to deprive him of in-person access to his substitute decision-maker. The principal ground upon which the applicant asserts this unconstitutionality is s. 15 of the *Charter*. The applicant submits that the Visitor Policy, by identifying some visitors as "essential" and others "non-essential", makes a distinction which places an undue burden on the elderly and those with mental disabilities such as incapacity.

[35] Section 15(1) of the *Charter* protects against discrimination on the basis of an enumerated or analogous ground. There is an infringement of s. 15 when: (1) on its face or in its impact, the impugned law or state action creates a distinction based on enumerated or analogous grounds; and, (2) in doing so burdens or denies a benefit in a manner that has the effect of reinforcing, perpetuating, or exacerbating a disadvantage. In other words, where there is a distinction and where that distinction is discriminatory, s. 15(1) is engaged.

[36] The Supreme Court has confirmed that "not every distinction on a prohibited ground will constitute discrimination and that, in general, distinctions based on presumed rather than actual characteristics are the hallmarks of discrimination have particular significance when

applied to physical and mental disability", *Eaton v. Brant County Board of Education*, [1997] 1 S.C.R. 241 at para. 66.

[37] In this case, neither aspect of the test is met. The Visitor Policy does not create a distinction on the basis of an enumerated or analogous ground nor does it reinforce, perpetuate, or exacerbate a disadvantage.

[38] The impugned decision is not rooted in presumed characteristics of patients or, for that matter, visitors. The decision is rooted in the expertise of medical and public health professionals exercising their professional judgment, which is in turn based on scientific evidence and epidemiological data that elderly patients are more severely impacted by the COVID-19 pandemic. The Visitor Policy is not, in its intent or impact, based on presumed characteristics of those who are over a certain age or who have mental disabilities.

[39] Here, the unchallenged evidence is that patients who are elderly and have other underlying medical conditions suffer more severe consequences of being infected with COVID-19 and that they are more likely than other patients to succumb to the disease. As such, the decision to restrict visitors to the Hospital is a valid medical concern relevant to protecting patient safety. The Visitor Policy is demonstrably not arbitrary, but based on medical knowledge and expert judgment; it is therefore not discriminatory—it is a responsive medical determination.

[40] The sample exceptions which the Visitor Policy makes to the "no visitor" policy are also rooted in medical opinion, scientific judgment and/or epidemiological evidence. For example, the applicant argues that if children under 18 can have visitors, so should his incapable father, analogizing the status of children to his father's lack of capacity. The issue, however, is not cognitive capacity. The distinction the Hospital has made is on the basis of the severity of the impact of the virus on the population. The medical and epidemiological data shows that children only make up a very small percentage of confirmed COVID-19 cases, and when infected, do not suffer nearly as grave consequences from the virus as the elderly. In addition, the Hospital has a relatively small paediatric population restricted to a specific ward; in contrast, the Hospital serves a high volume of patients over 65 years of age, who are admitted to programs throughout the Hospital.

[41] There is also evidence, again unchallenged, that the Hospital is able to obtain informed consent from the applicant by communicating with him by telephonic or electronic means. The *Health Care Consent Act* does not require the physical presence of a substitute decision-maker in order to obtain informed consent. Such a requirement would not be practical or possible to fulfill. This is not unique to the pandemic. Hospitals regularly obtain consent from substitute decision-makers in this manner. A substitute decision-maker does not need to be physically present with the patient in order to provide informed consent.

[42] During oral argument the applicant essentially narrowed his argument, focusing on his inability to communicate with his father other than by face-to-face communication, given Mr. Sprague's incapacity, and the need for his father's restraints which, the applicant argues, can be released or reduced while he is physically present with his father. These limitations arising out of his father's medical condition cannot, however, be construed as a violation of s. 15 of the *Charter*.

The Visitor Policy has nothing to do with Mr. Sprague's age or mental condition. The evidence clearly establishes that the applicant is able to fulfil his statutory obligations as statutory decision-maker with or without physical access to his father. And, importantly, when the critical issue of Mr. Sprague's potential end-of-life decisions came up, the Hospital agreed to an in-person visit to ensure that the applicant had every opportunity to assess his father's wishes.

[43] Further, a paid PSW visits Mr. Sprague several times per week. The evidence is that the PSW has the opportunity to communicate with Mr. Sprague and assess his condition and that she routinely and regularly communicates with the applicant.

[44] Regarding the restraints, the applicant concedes that these are necessary to keep Mr. Sprague alive and that the applicant has consented to their use. During the PSW's visits, the restraints are able to be reduced somewhat. While the applicant's visits might afford a further opportunity for a temporary lessening of Mr. Sprague's restraints, the loss of this opportunity is not based on disability or age nor could it possibly be regarded as reinforcing, perpetuating or exacerbating an age or disability-based historical disadvantage.

[45] Finally, I would observe that the applicant's criticisms of the Visitor Policy, and its alleged inconsistencies and logical flaws, are really an attempt to engage the Court in a re-weighing of the complex and often difficult factors, considerations and choices that must be evaluated by a hospital administration during a pandemic. This is not the Court's role. The Hospital has enormous expertise and specialized knowledge available to it in exercising its discretion around hospital administration issues during a pandemic, only one of which is visitor policy. Significant deference must be afforded to the Hospital in the circumstances. There is ample evidence to support the conclusion that the Visitor Policy to limit visitors was founded on sound medical, scientific and epidemiological evidence, not on presumed characteristics of persons suffering historical disadvantage.

[46] For these reasons, the challenge to the Visitor Policy based on s. 15 of the *Charter* is dismissed.

Section 7

[47] For the purpose of this application, the Hospital has conceded that, if the *Charter* applies at all, its Visitor Policy could engage the right to security of the person. However, we agree with the Hospital's submission that the Visitor Policy is in accordance with the principles of fundamental justice.

[48] The Visitor Policy is not arbitrary. An arbitrary rule is one that is not capable of fulfilling its objective and exacts a constitutional price in terms of rights, without furthering the public good that is said to be the object of the law. Therefore, the Visitor Policy would only be arbitrary if there was no link between the decision to restrict visitors and the severe health outcomes of being unable to limit the spread and contagion of the virus. The evidence is entirely to the contrary.

[49] The policy to limit visitors is also not overbroad. An overbroad rule is one that takes away rights in a way that generally supports the object of the rule but goes too far by denying the

rights of some individuals in a way that bears no relation to the object. For example, the policy to restrict visitors might be overly broad if it never provided for any consideration of exceptions. Here, the Visitor Policy is tailored to consider exceptions to (1) low risk groups where the visitors are involved in care on wards where the risk to other patients is not as severe and (2) for patients at end-of life, as a matter of compassion, even though this does expose staff to an increased risk of infection.

[50] A rule is grossly disproportionate if the negative effects on the rights of the claimant are out of sync with the object of the law, taking the object of the law at "face value". On the evidence, the Visitor Policy is not a grossly disproportionate response to the pandemic.

[51] The challenge under s. 7 of the *Charter* is therefore dismissed.

Section 12

[52] The applicant also argues that the Visitor Policy infringes upon s. 12 of the *Charter*. Under s. 12, "punishment" is understood to be state action that: (1) is a consequence of conviction that forms part of the arsenal of sanctions to which an accused may be liable in respect of a particular offence, and either (2) is imposed in furtherance of the purpose and principles of sentencing, or (3) has a significant impact on an offender's liberty or security interests.

[53] Under s. 12, "treatment" is understood to be a condition imposed on someone by the state, but outside of the sanction or sentencing context. A prohibition imposed by the state only constitutes "treatment" for the purpose of s. 12 where the sufferer is in some way within the special administrative control of the state - there must be some more active state process in operation, involving an exercise of state control over the individual, in order for the state action in question to constitute 'treatment' under s. 12.

[54] The Visitor Policy is not a sanction imposed by virtue of a conviction or anything akin to a conviction. Neither Mr. Sprague as patient nor the applicant as visitor are subject to active state control of any kind. Section 12 is simply not engaged in the circumstances of this case.

[55] The challenge under s. 12 of the *Charter* is also dismissed.

Section 1

[56] As we have concluded there is no *Charter* violation, it is not necessary to consider whether an infringement can be justified under s. 1.

4. Does the CMOH memorandum Infringe s. 15 of the Charter?

[57] Similarly, the applicant argues that the CMOH Memorandum, by recommending that Ontario's hospitals impose visitor restrictions, discriminates against Mr. Sprague on the basis of his age and disability contrary to s. 15 of the *Charter*.

[58] Not all government-issued "guidelines" are to be viewed as "law" for the purposes of *Charter* review. A guideline may be "administrative" in nature, meaning it is meant for internal

use and intended to serve as an "aid" as opposed to a prescribed requirement. In such cases, a guideline cannot, standing alone, be viewed as "law" that prescribes a limit on a *Charter* right. An interpretative guideline or policy is not intended to establish individuals' rights and obligations or to create entitlement and is not intended to be a legal basis for government action, *Greater Vancouver Transportation Authority v. Canadian Federation of Students – British Columbia Component*, 2009 SCC 31 at para. 63.

[59] The courts are concerned with the legality of decisions, not the quality of guidebooks, even if the guidebooks might contribute to a decision that violates the *Charter*, *Little Sisters Book and Art Emporium v. Canada (Minister of Justice)*, 2000 SCC 69 at para. 85.

[60] The CMOH Memorandum has no legal force and does not statutorily compel any health care provider or health care entity to make or refrain from making any particular decision with respect to visitors. The CMOH Memorandum provides the CMOH's recommendation that the number of hospital visitors be kept as low as possible, and that there should be proper screening for essential visitors to prevent the spread of COVID-19. The Ministry considers hospitals to be in the best position to determine which visitors should be admitted in the context of the hospitals' own operations, their patient populations and resources, as well as the context of an unprecedented global public health emergency.

[61] In any event, as with the Visitor Policy, the applicant has not established that the CMOH Memorandum creates differential treatment based on an enumerated or analogous ground or that any distinction contemplated is "discriminatory" in nature.

[62] The CMOH Memorandum does not prescribe an exhaustive list of which visitors should be permitted entry into hospitals. Instead, the CMOH Memorandum provides a non-exhaustive list of examples of "essential visitors" that hospitals should consider when making visitor admission decisions. The provision of examples in a guidance document does not provide a benefit to one group identified by an enumerated or analogous ground, nor deny a benefit to another group identified by another enumerated or analogous ground. As the Memorandum does not categorically exclude substitute decision-makers in general, or the applicant in particular, Mr. Sprague is not subject to any differential treatment. To the extent the CMOH Memorandum does make a distinction between patients whose visitors are "essential" versus "non-essential", this is not a distinction that falls within the list of enumerated grounds under *Charter* s. 15(1).

[63] Nor does the category of an "essential visitor" constitute an analogous ground under s. 15(1). Analogous grounds are immutable personal characteristics or personal characteristics which are changeable only at unacceptable cost to personal identity. To date, very few analogous grounds have been accepted under s. 15 of the *Charter*; they include: sexual orientation, marital status, citizenship and aboriginality-residence (i.e. status of living off-reserve). Patients who have "essential visitors" are a heterogeneous group who share no common personal characteristics that are capable of meeting the stringent threshold to qualify as an analogous ground under s. 15 of the *Charter*, *Platnick v. Bent*, 2018 ONCA 687 at para. 116.

[64] The applicant argues that the CMOH Memorandum confers a benefit in a manner that has the effect of reinforcing, perpetuating and exacerbating the disadvantage that persons with

catastrophic mental and physical disabilities all too frequently encounter in Canadian society. Specifically, he argues that the CMOH Memorandum confers a benefit upon certain persons who may not need the benefit but denies persons like his father from receiving the same benefit.

[65] The evidence, however, is that the CMOH Memorandum does not categorically prohibit substitute decision-makers from visiting hospitals. There is no "benefit" that the CMOH Memorandum provides to certain groups that is not provided to substitute decision-makers. Moreover, the purpose and effect of the CMOH Memorandum is to identify examples of essential visitors for hospitals such that they can adjust their hospital visitor policies and operations so that any visitors who come into the hospital are effectively screened for COVID-19 in order to ensure the safety of patients, staff, visitors and the public. The CMOH Memorandum does not confer or deny a benefit in a manner that exacerbates any disadvantage, prejudice or stereotypes faced by the elderly or persons with disabilities.

[66] For these reasons, the application for a declaration that the CMOH Memorandum violates Mr. Sprague's rights under s. 15 of the *Charter* is dismissed.

Section 1

[67] As with the Visitor Policy, because the CMOH Memorandum did not give rise to any infringement, there is no need to consider s.1.

Conclusion

[68] For the reasons stated above, we conclude that neither the Visitor Policy nor the CMOH Memorandum are amenable to judicial review. Even if they were, we find the Visitor Policy and the CMOH Memorandum do not infringe Mr. Sprague's rights under the *Charter*. Accordingly, the application for judicial review is dismissed.

Costs

[69] These are challenging times. The issues raised in this application were similarly challenging and novel. The applicant pursued this application in what he believed, in good faith, were Mr. Sprague's best interests and in order to fulfil his solemn obligations as Mr. Sprague's substitute decision-maker. In the circumstances, although we were unable to agree with the applicant's submissions, we make no order as to costs.

_____
Penny J.

I agree _____
Backhouse J.

I agree _____
Lederer J.

Released: April 17, 2020

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SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

Backhouse, Lederer and Penny JJ

BETWEEN:

EDWARD L. SPRAGUE, AS REPRESENTED BY HIS LITIGATION GUARDIAN, J. ANDREW SPRAGUE

Applicant

– and –

HER MAJESTY THE QUEEN IN RIGHT OF ONTARIO, AS REPRESENTED BY THE MINISTER OF HEALTH; NORTH YORK GENERAL HOSPITAL

Respondent

REASONS FOR DECISION

Released: April 17, 2020