IN THE MATTER OF AN ARBITRATION
BETWEEN:

Queensway Carleton Hospital
(the Hospital or QCH)

and

Canadian Union of Public Employees (Local 2875)
(the Union or CUPE)

and

Justin Hebert, Sanhek Phou, Amber Beach,
Gilbert Goulbourne, Quy Duong, Amanda Joynson
(the Grievors)

RE: Grievances #21110JH, #211110S, #211109AB, #211109GG, #211115QD, #230804JH, #230805SP, #230806AB, #230806GG, #230807QD, #211026AJ

Before

Leslie Reaume, Arbitrator

Appearances

For the Hospital: Porter Heffernan and Pieter Bakker, Counsel, Emond Harnden LLP

For the Union: Peter Engelmann and Sarah-Claude L'Ecuyer, Counsel, Goldblatt Partners LLP

AWARD

INTRODUCTION

[1] This award concerns six Hospital employees who were placed on unpaid leave for failing to comply with the Hospital's mandatory COVID-19 vaccination policy (the Policy), five of whom were terminated on August 4, 2023. The Union filed eleven grievances on their behalf: six challenging the unpaid leaves imposed in the fall of 2021 and five challenging the terminations. One of the Grievors, Amanda Joynson, complied with the Policy and returned to work in the fall of 2023. She challenges only the period of her unpaid leave.

[2] No policy grievance was filed when the Policy was introduced. The Union accepts that the Policy was reasonable from September 7, 2021, when it took effect, through March 14, 2022, when the Chief Medical Officer of Health (CMOH) revoked Directive #6. It also accepts that the unpaid leaves imposed in the fall of 2021 were justified through that date. The Union says the position changed after March 14, 2022, as the immunological landscape shifted with the Omicron variant and waning vaccine effectiveness. Each of the five terminated Grievors filed a human rights-based exemption request, which the Hospital denied. Nothing in this award decides those claims, which have been reserved for later determination.

[3] There are two issues. First, whether the vaccination requirement remained reasonable in March 2022 through the August 4, 2023, terminations. Second, whether the Hospital had just cause to terminate the Grievors who remained non-compliant. The Union accepts that if the Policy is found to be reasonable through the termination date, the Hospital was entitled to terminate their employment.

[4] The Union says that by March 2022, employees who complied with the Policy's vaccination requirement were no better protected against infection and transmission than the Grievors. It says the Hospital did not adequately reassess the unchanged primary-series requirement as protection waned, boosters were recommended, the Omicron variant emerged, and infection became widespread. The Hospital says it continued to assess the Policy, including through regional and public-health processes and to monitor conditions within the Hospital. It maintains that vaccination retained protective benefit, which is particularly relevant to an acute-care hospital, and that no sufficiently reliable, less intrusive alternative to vaccination was established.

[5] For the reasons that follow, I find that the Policy remained reasonable through August 4, 2023, and that the Hospital had just cause to terminate the employment of the Grievors who

remained non-compliant. The grievances are dismissed on the issues decided here. The reserved human rights-based exemption claims remain to be determined.

BACKGROUND

The Hearing

[6] The parties filed an Agreed Statement of Facts (the ASF) and a joint book of documents containing the relevant collective agreement, the Hospital's email announcement and the Policy, the September 1, 2021, update on COVID-19 projections from the Ontario COVID-19 Science Advisory Table, and the documents concerning the Grievors' positions, exemption requests, unpaid leaves, terminations and grievances. Additional documents were admitted through the witnesses. Given the volume of the record, both parties filed outlines identifying the evidence on which they relied before making final oral submissions.

[7] The Hospital called three fact witnesses. Greg Hedgecoe, Vice-President of Human Resources at QCH from January 2017 to July 2022, addressed the development and early administration of the Policy. Jill Nimmo, Director of Occupational Health and Special Advisor of Benefits at QCH, addressed the Hospital's involvement in regional collaboration and the Policy's ongoing assessment. Gisèle Larocque, Vice-President of Organizational Effectiveness, Allied Health, Health Information Management, Chief Privacy Officer and Chief Human Resources Officer, addressed its later administration and the terminations.

[8] The Hospital also called Dr. Jerome Leis, an infectious-diseases specialist and Medical Director of Infection Prevention and Control at Sunnybrook Health Sciences Centre. The Union called Dr. Neil Rau, an infectious-diseases specialist and medical microbiologist and Medical Director of Infection Prevention and Control at Halton Healthcare. Each filed an initial report dated July 24, 2024, followed by replies in September 2024. Both testified and were cross-examined. Each was qualified, without objection, to give opinion evidence on COVID-19 vaccination and infection prevention in healthcare settings.

[9] Two later developments are also relevant to this award. After the hearing, Arbitrator Nyman released *Ontario Nurses' Association v. Orillia Soldiers' Memorial Hospital*, 2025 CanLII 73709 (ON LA) (*Orillia Soldiers*), and the parties filed supplementary submissions. After those submissions were completed, a further development occurred. The Union had relied on

Teamsters Local Union No. 31 v. Purolator Canada Inc., 2023 CanLII 120937 (CA LA) (Glass) (*Purolator*), and the judgment upholding that award, *Purolator Canada Inc. v. Canada Council of Teamster*s, 2025 BCSC 148 (*Purolator BCSC*). The British Columbia Court of Appeal subsequently reversed that judgment, set aside the award and remitted the grievance to a new arbitrator: *Purolator Canada Inc. v. Canada Council of Teamsters*, 2026 BCCA 3 (*Purolator BCCA*). The Canada Council of Teamsters and Teamsters Local Union No. 31 applied for leave to appeal to the Supreme Court of Canada in March 2026. The parties made no further submissions on the Court of Appeal decision but agreed that the Union would provide the leave materials for my consideration.

The agreed facts

[10] The full ASF is attached as Appendix A and forms part of the record. Many vaccination cases preceded this award, and the chronology of events associated with the pandemic is generally well known. The following summary identifies the facts from the ASF, and the Joint Book needed to understand the issues decided in this award.

[11] QCH is a public, 355-bed, full-service acute-care hospital serving Ottawa and surrounding communities. It is West Ottawa's only full-service hospital, serves as a secondary referral centre for the Ottawa Valley and employed approximately 2,700 health professionals by 2023. The Union is the bargaining agent for all hospital employees except professional medical staff, registered and graduate nurses, undergraduate nurses, classifications represented by OPSEU as of September 29, 1989, classifications represented by IUOE, office and clerical staff, supervisors and persons above the rank of supervisor.

[12] The Hospital and the Union are parties to a collective agreement in effect from September 29, 2017, to September 28, 2021. Local bargaining for its renewal was not completed until the release of an interest arbitration award dated June 14, 2024.

[13] Ontario identified its first presumptive case of COVID-19 on January 25, 2020. On January 30, 2020, the World Health Organization (WHO) declared a Public Health Emergency of International Concern as the virus rapidly spread to other countries. On March 11, 2020, the WHO declared a pandemic.

[14] Ontario declared a provincial emergency on March 17, 2020, and lifted it on July 24, 2020. This was followed by a second provincial emergency from January 14 to February 10, 2021, and a third from April 8 to June 2, 2021. The City of Ottawa also declared a state of emergency on March 25, 2020, which remained in place until July 22, 2021.

[15] The virus mutated rapidly, producing successive variants of concern. Alpha became dominant in the spring of 2021 and was more transmissible than earlier strains. Delta became dominant during the summer of 2021, bringing increased transmissibility and more severe symptoms. Omicron was identified in November 2021 and became dominant in Ontario around December. It spread more readily than Delta but generally caused less severe illness.

[16] On September 1, 2021, the Ontario COVID-19 Science Advisory Table advised that Ontario was in the midst of a fourth wave of the pandemic and that vaccination offered substantial protection against severe health outcomes.

[17] Directive #6, issued on August 17, 2021, and effective September 7, 2021, required public hospitals to establish, implement and ensure compliance with a vaccination policy. It required proof of full vaccination, a documented medical exemption, or completion of an approved educational session before declining vaccination for a non-medical reason. It did not prescribe employment consequences and was revoked on March 14, 2022. The Union does not dispute the public health guidance regarding COVID-19 policies and vaccinations.

[18] The Hospital selected a mandatory vaccination option. In announcing the policy on September 3, 2021, the Hospital emphasized the spread of the Delta variant and the vulnerability of its patients. The Policy required all staff, contractors, service providers and learners to be fully vaccinated by October 15, 2021, subject to medical or human rights-based exemptions. Full vaccination meant completing the applicable approved primary series at least fourteen days earlier. For a two-dose series, the final dose was required by October 1, 2021.

[19] The Policy sought to reduce the risk of serious infection among, and transmission to, staff, patients and visitors. It provided that the Hospital would monitor the characteristics of current and future variants to identify the need for policy or practice changes. It provided for unpaid leave and discipline up to and including termination but did not make termination automatic.

[20] Government approved vaccines were readily available to employees free of charge by September 2021. The parties agree that the vaccines were rigorously studied, generally safe and instrumental in preventing severe illness, hospitalization and death in 2021 and early 2022.

[21] Between October 20 and November 10, 2021, the Hospital placed the six Grievors on unpaid leave. Five had filed exemption requests that were denied. The leave letters stated that they could return immediately on providing proof of full vaccination, or proof of a first dose and a booked appointment for the remaining vaccination, subject to the other Policy requirements. The letters also warned that failure to take immediate steps toward vaccination could result in termination.

[22] On May 5, 2023, the WHO declared COVID-19 over as a global health emergency.

[23] On June 26, 2023, the Hospital issued final-warning letters with a deadline for compliance of July 27, 2023. The letters warned that termination would be effective July 28, 2023, for continued non-compliance. The employees who did not provide proof of a first dose (for a two-dose series), including the five Grievors, were terminated on August 4, 2023. Ms. Joynson complied and returned to her first shift on November 4, 2023.

[24] Mr. Hebert, Mr. Phou and Mr. Duong worked as Environmental Service Aides and had been employed since March 2012, August 2018 and June 1989, respectively. Ms. Beach had worked as a Patient Care Aide in the Mother and Baby Unit since April 2005, Mr. Goulbourne as a Registered Practical Nurse since March 2020, and Ms. Joynson as a logistics Dispatcher since September 2020. Before vaccination became mandatory, all six had complied with the Hospital's other COVID-19 precautions, including testing and protective equipment.

[25] The Grievors' job descriptions included nursing care, hands-on assistance to patients, and cleaning in patient rooms and treatment areas. Ms. Joynson's dispatch role involved coordinating porters and responding to requests for supplies and equipment.

OVERVIEW OF THE PARTIES' POSITIONS

[26] The parties provided me with the benefit of extensive oral submissions, supplementary written submissions, and outlines of the evidence most relevant to their positions in this matter. This is an overview of their principal arguments rather than an exhaustive account of their

submissions. I incorporate other relevant portions of those submissions, together with the evidence and authorities on which they rely, into the analysis of each issue below.

The Hospital

[27] The Hospital submits that the Policy remained reasonable through August 4, 2023, and must be assessed against the backdrop of a global pandemic unprecedented in modern times. It emphasizes its statutory obligations to protect staff and its responsibility to provide safe care to a particularly vulnerable patient population. It relies on its witnesses' largely uncontested accounts of the operational pressures it faced, including outbreaks and COVID-related absences that threatened its ability to maintain services. It says its response was informed by public-health guidance and ongoing regional collaboration, which kept it aware of conditions across the region and the evolving science underlying its Policy. In its submission, the Hospital argued that revoking Directive #6 did not remove the risks facing the Hospital or its responsibility to take reasonable precautions.

[28] On the science, the Hospital relies on Dr. Leis's evidence that vaccination continued to reduce the risks of infection and transmission and provided more durable protection against severe illness, with an additional ongoing benefit arising from vaccination combined with prior infection, or hybrid immunity. It says that even a modest reduction in risk mattered in an acute-care setting. The Hospital also says that testing and proof of prior infection were not adequate substitutes for vaccination, and that remaining scientific uncertainty supported a precautionary approach. It also relies on the protective benefit that vaccination would have given a Grievor returning to work at any time between the introduction of the Policy and the terminations.

[29] The Hospital asks that Dr. Leis's evidence be preferred where the experts disagree. It raised concerns about the reliability and impartiality of Dr. Rau's evidence. The Hospital says that his opposition to the employment consequences of mandatory vaccination influenced his selection and interpretation of the research. It further submits that he strayed beyond scientific opinion into judgments about the Policy's reasonableness, which is the ultimate issue before me.

The Union

[30] The Union's central proposition is that the Hospital knew, or ought to have known, that a two-dose COVID-19 vaccine regime did not effectively prevent transmission, and therefore did

not support its policy goals as of mid-March 2022. It contends that the Policy became unreasonable from March 15, 2022, or certainly by the August 2023 terminations. It relies on Dr. Rau's evidence that waning protection was apparent in 2021 and that Omicron sharply reduced the protection against infection and transmission offered by earlier doses. It emphasizes that most QCH employees had been vaccinated before the Policy's deadline and remained compliant without boosters. The Union accepts that vaccination continued to protect against severe illness, but characterizes that primarily as a benefit to the vaccinated employee rather than a sufficient justification for excluding others from the workplace. The question, it submits, is not whether vaccination could be beneficial, but whether this unchanged requirement continued to justify excluding unvaccinated employees. It disputes the extent of the continuing benefit identified by Dr. Leis, including the alleged advantage of hybrid immunity over prior infection alone. It rejects the Hospital's criticisms of Dr. Rau, maintaining that his opinions reflected legitimate scientific disagreement and were supported by research available at the relevant times.

[31] The Union also challenges whether the Hospital meaningfully reassessed the primary-series vaccination requirement as the evidence changed. It says that regional agreement and general vaccination guidance could not replace an assessment of QCH's own Policy, and that reliance on hybrid immunity was an after-the-fact justification rather than a factor the Hospital considered when making its decisions. As vaccine protection waned and immunity from prior infection became widespread, the Union says the balance increasingly favoured returning the small number of unvaccinated employees to work, with appropriate precautions. It notes that the Hospital could have recognized prior infection, together with regular testing and personal protective equipment (PPE), as a less intrusive approach, yet failed to adequately consider it. The Union argues that any remaining protective benefit had to be weighed against employees' interests in bodily autonomy and the serious consequences of prolonged unpaid leave and loss of employment. In its submission, neither the Hospital's general safety obligations nor the precautionary principle could substitute for that balance.

APPLICABLE LEGAL PRINCIPLES

[32] The Hospital imposed the Policy under its management rights. Its validity is governed by *Re Lumber & Sawmill Workers' Union, Local 2537, and KVP Co. Ltd.*, 1965 CanLII 1009 (ON LA) (Robinson) (*KVP*). Of the six *KVP* requirements, only reasonableness is disputed. The Hospital

bears the onus of showing that the Policy remained reasonable while it was maintained and enforced, and that there was just cause for the five terminations.

[33] In *Communications, Energy and Paperworkers Union of Canada, Local 30 v. Irving Pulp & Paper, Ltd.*, 2013 SCC 34 (*Irving*), at paragraph 27, reasonableness requires balancing the interests in all the circumstances. Relevant considerations include the nature of the employer's interests, how well the rule advances them, the effect on employees, and whether less intrusive means are available to address the employer's concerns. No single factor decides the issue.

[34] The acute-care setting is an important part of that balance. In *National Organized Workers Union (NOWU) v. Humber River Hospital*, 2024 CanLII 52386 (ON LA) (Tremayne) (*NOWU*), and *Lakeridge Health v. CUPE, Local 6364*, 2023 CanLII 33942 (ON LA) (Herman) (*Lakeridge Health*), the arbitrators emphasized the vulnerability of hospital patients and the need to preserve the capacity to care for them: *NOWU*, at paragraphs 44 and 161; *Lakeridge Health*, at paragraphs 14 and 177. That context strengthens the Hospital's interests, but the Policy must still be shown to advance those interests on the dates in issue.

[35] Section 25(2)(h) of the *Occupational Health and Safety Act*, R.S.O. 1990, c. O.1, requires an employer to take every reasonable precaution in the circumstances to protect a worker. That duty supports the Hospital's safety interests. As Arbitrator Stout observed in *Electrical Safety Authority v. Power Workers' Union*, 2022 CanLII 343 (ON LA) (Stout) (*ESA*), at paragraph 69, the statutory duty "fits neatly within the *KVP* test." It is a factor to consider, but it is not the complete answer and does not replace the *KVP* and *Irving* balance.

[36] The employee interests are also substantial. They include bodily autonomy, medical choice and privacy, as well as income, benefits, seniority and continued employment. As Arbitrator Mitchell observed in *Power Workers' Union v. Elexicon Energy Inc.*, 2022 CanLII 7228 (ON LA) (Mitchell) (*Elexicon*), at paragraph 92, "the coercive impact of the threat of loss of income, benefits, and employment and the impact on stability and careers is very real." There is, in his words, "little legitimacy in a decision that finds the policy to be reasonable while denying the lived reality of employees faced with the coercive impact of these policies." These interests are weighed against the Hospital's interests rather than treated as decisive: *Humber River Health v. Teamsters Local Union No. 419*, 2025 ONSC 2270 (*Humber River Health*), at paragraphs 44–46 and 55–57.

[37] A rule must remain reasonable for as long as it is maintained. A rule that was reasonable at one stage may cease to be reasonable as circumstances change, and "what constitutes a reasonable mandatory vaccination policy in the course of a pandemic is contextual and highly dynamic": *Elexicon*, at paragraph 4; *ESA*, at paragraphs 68 and 73. The Policy's original justification and the fact that most employees complied do not answer whether it remained reasonable later.

[38] Reassessing a mandatory vaccination policy matters as the virus changes and the science develops, but its form is not prescribed. In *Central West Local Health Integration Network and Mississauga Halton Local Health Integration Network v*. *Canadian Union* of *Public Employees, Local 966*, 2023 CanLII 58388 (ON LA) (Goodfellow) (*Central West*), Arbitrator Goodfellow observed that the absence of a formal review, by itself, does not render a policy unreasonable "because what matters…is not whether things could have changed but whether they did": at paragraph 101.

[39] A precautionary approach can support protective action before the science is settled, but it remains part of the *KVP* and *Irving* balance. In *Ontario Nurses' Association v. Sault Area Hospital*, 2015 CanLII 55643 (ON LA) (Hayes) (*Sault Area Hospital*), Arbitrator Hayes observed at paragraph 340 that reasonable efforts to reduce risk need not wait for scientific certainty, but "one cannot live in a society where only "zero risk" is tolerated". Precaution does not relieve the Hospital of showing that the Policy continued to address a real risk and that its benefits justified the burden on employees, taking available alternatives into account.

[40] *Irving* also requires consideration of any less intrusive means available to address the employer's concerns effectively. It does not impose a separate procedural requirement that an employer demonstrate that it considered every possible alternative. Evidence that alternatives were considered may support the reasonableness of a rule, and a failure to consider an obvious and workable alternative may weaken the employer's case. The rule must still strike a reasonable balance in the circumstances.

[41] An expert must provide fair, objective and non-partisan assistance: *White Burgess Langille Inman v. Abbott and Haliburton Co.*, 2015 SCC 23 (*White Burgess*), at paragraph 2. The trier of fact does not defer to the experts. Choosing between conflicting scientific evidence is "an exercise

of an arbitrator's normal judgment with respect to the weight, relevance and credibility of competing evidence": *Sault Area Hospital*, at paragraphs 265 to 268.

[42] On just cause, *Humber River Health* rejected the proposition that, because vaccination engages bodily integrity and consent to medical treatment, an employee can never be disciplined for failing to comply with a reasonable mandatory vaccination policy: paragraphs 44 to 46, 55 to 57 and 74. The Court left the reinstatement result intact because the employees had been terminated after only two weeks of unpaid leave. *Central West*, at paragraph 157, describes progressive discipline as giving employees "a reasonable opportunity to appreciate the significance of their choice." The Union's acceptance of the terminations here, if the Policy remained reasonable, narrows the issue.

ANALYSIS AND FINDINGS

Factual context and matters not materially disputed

[43] Before considering the expert evidence and the disputed issues, it is useful to identify the relevant factual context that emerged from the Hospital's witnesses, the contemporaneous documents and established through cross-examination. While the facts are not contested, the parties disagree about their significance, and the Union disputes that QCH conducted an appropriate review of its Policy at any point after implementation.

Conditions at the Hospital in late 2021 and early 2022

[44] There is no material dispute about the serious operational pressures facing QCH in late 2021 and early 2022. Outbreaks, employee infections and isolation requirements contributed to staffing shortages. Employees were exhausted, and some reduced their hours or left the profession. These pressures affected QCH's ability to provide care, producing long waits and raising the possibility of reducing services, cancelling surgeries or closing the Emergency Department. By January 2022 Omicron was dominant, QCH was experiencing significant staff infections and fragile staffing, and infections rose again in March and April. The Hospital was managing two serious risks at once: infection and insufficient staff to provide necessary care.

[45] As staffing pressures increased, QCH also adjusted its return-to-work arrangements. Fully vaccinated employees who had been infected could in some circumstances return before the

previously required isolation period had expired, using rapid-antigen testing and other controls. QCH separately developed more extreme staffing-escalation plans for “life and limb” circumstances in which necessary care might otherwise be unavailable. Mr. Hedgecoe testified that QCH did not ultimately have to invoke that extreme contingency.

Sources of information and advice

[46] QCH participated throughout the pandemic in regional coordination. Mr. Hedgecoe was the regional human-resources lead for the Champlain Health Region Incident Command (CHRIC), through which hospital leaders coordinated their response to COVID-19. He was supported by a separate regional human-resources group. Ms. Nimmo participated in the regional Occupational Health and Safety Working Group, led by Dr. Chuck Hui, an infectious-diseases specialist at CHEO. The working group helped participating hospitals interpret rapidly changing public-health and clinical guidance. The regional recommendations were not binding, and each hospital remained responsible for its own decisions.

[47] Through those processes, QCH received information and guidance from Ottawa Public Health, the Ministry of Health, Public Health Ontario (PHO), the Ontario Hospital Association and other hospitals. Ms. Nimmo brought relevant information and recommendations back to QCH’s Occupational Health, IPAC and senior leadership. Within QCH, its internal infection-prevention leads included Dr. Greg Rose, an infectious-diseases physician, and Colette Ouellet, Director of Infection Prevention and Control. Mr. Hedgecoe said that Dr. Rose provided verbal advice on trends, transmission, variants and vaccination. Neither the witnesses nor the documentary record establish the advice Dr. Rose or Ms. Ouellet gave about the continuing value of the unchanged Policy after Omicron emerged.

[48] The working group met frequently through most of the pandemic. Ms. Nimmo described the regional guidance as a “lifeline” and said the written record captures only a fraction of the group’s discussions. By spring 2023 the emergency structures were winding down as guidance changed less rapidly and established occupational-health processes resumed. In May 2023 Dr. Hui raised winding down the COVID-focused working group. Ms. Nimmo testified that the group was wound down at a June wrap-up meeting, and vaccine mandates remained among the outstanding issues discussed in June. There was no discussion at this time about ending mandates as the group considered what the summer and next respiratory season would bring.

QCH continued to receive and consider public-health material and could use the ordinary regional occupational-health structures.

Waning protection and boosters

[49] QCH was aware by late 2021 that vaccine protection waned and that additional doses improved protection. Its November 3, 2021, communication to staff said that boosters protected against the gradual waning of immunity and encouraged employees to receive them. The Hospital and the regional groups discussed whether another dose should become mandatory.

[50] QCH nevertheless left the Policy unchanged. It continued to require completion of the approved primary series and did not require or track boosters as a condition of compliance. An employee vaccinated in 2021 could therefore remain compliant in August 2023 without another dose. The decision not to require a booster reflected several considerations. The Province continued to define the primary series as full vaccination. QCH had concerns about imposing another mandatory dose on employees who were already experiencing exhaustion and staffing pressures. Tracking another mandatory dose would create administrative work, and there was an expectation that a highly vaccinated workforce would continue to take boosters voluntarily. QCH encouraged boosters instead. The decision not to amend the Policy did not mean that an additional dose lacked medical value.

Revocation of Directive #6

[51] Directive #6 was revoked on March 14, 2022. Before the revocation took effect, the regional groups addressed whether existing hospital vaccination policies should continue. The Ontario Hospital Association supported continuation, and the regional working group gathered the views of participating hospitals. The CMOH's March 9, 2022, memorandum referred to improving provincial indicators and high vaccination rates among healthcare workers, while continuing to describe vaccination as a cornerstone of the response and encouraging recommended doses. PHO guidance likewise continued to emphasize vaccination, including additional doses, as part of layered protection. The guidance was not uniform in what it addressed. The material directed specifically to existing hospital vaccination policies supported continuation, while other guidance recommended vaccination without addressing whether it should remain mandatory. None recommended withdrawal of an existing hospital vaccination policy.

[52] Revocation also caused QCH itself to address whether its Policy should continue. Mr. Hedgecoe said the executive team discussed the question and concluded that nothing had changed sufficiently to warrant withdrawal, given continuing transmission, hospitalizations, staffing pressures and safety concerns. Ms. Nimmo's contemporaneous March 9 email confirmed that QCH was keeping its mandatory policy and that the regional hospitals intended to advocate the same course. On April 21 she confirmed that the Policy was being maintained "in its entirety" and would be reconsidered later in the year. This was not a detailed scientific review comparable to the options exercise conducted later in 2022. No written QCH analysis of the protection remaining from the 2021 primary series was produced, and the precise content of any internal advice from Dr. Rose or Ms. Ouellet was not established.

The 2022 and 2023 policy reviews

[53] A more structured regional review occurred in August and September 2022. Three alternatives were considered: maintaining the existing two-dose requirement, requiring an additional dose, or discontinuing mandatory vaccination. The considerations recorded in the options paper included occupational health and safety, staffing and human-resources supply, the statutory duty to take every reasonable precaution, and the legal and labour-relations risks of each course. Ms. Nimmo also spoke of recruitment. The working group recommended maintaining the existing requirement through Fall and Winter 2022/23 and reassessing it by March 31, 2023. An October 27, 2022 email reported that CHRIC had approved that course.

[54] The issue was reconsidered in March and April 2023. The working group considered Ontario Health (Toronto), PHO and Toronto/GTA hospital guidance. The Toronto material recommended no change to existing hospital vaccination policies while encouraging boosters. The PHO material recommended that healthcare workers remain vaccinated and up to date without addressing whether vaccination should be mandatory. On April 6, Dr. Hui reported that the regional human-resources group had decided to continue mandatory vaccination, with reassessment likely in the fall. The working group supported that approach. QCH followed the regional recommendation and continued its Policy. The evidence establishes relatively little separate internal scientific analysis at QCH. Ms. Larocque relied principally on the regional process, Dr. Hui and the public-health material described above.

Conditions and enforcement in 2023

[55] Conditions at QCH had changed substantially by 2023. COVID-19 continued to affect the workforce, but recorded staff infections were much lower than during 2022. QCH was no longer in the acute staffing emergency of the first Omicron wave and was instead recovering services and working through surgical backlogs. Return-to-work practices had also evolved toward a symptom-based approach. The Hospital nevertheless continued to care for vulnerable patients and remained concerned about further waves and respiratory-virus seasons.

[56] The June 2023 final warnings followed the spring decision to maintain the Policy. Ms. Larocque explained that, once QCH had confirmed that the Policy would continue, it was time to resolve the long-standing status of employees on unpaid leave and return them to productive work through compliance. Employees were given a final opportunity to comply, which some did, including Ms. Joynson. The senior leadership team made the ultimate termination decision. The considerations identified by Ms. Larocque included QCH's occupational-health-and-safety obligations, its vulnerable patient population, the possibility of further waves or outbreaks, and guidance identifying vaccination as one of several protective measures.

Other infection-control measures and matters not considered

[57] Vaccination was not QCH's only infection-control measure. It used testing, masking and PPE, together with screening, visitor restrictions and return-to-work measures that changed as the pandemic evolved. Staffed entrance screening and some visitor restrictions were relaxed while self-screening measures remained. QCH knew that most healthcare-worker infections were acquired in the community, although that did not mean transmission within the Hospital had ceased. The Grievors had complied with QCH's other COVID-19 precautions before being placed on leave.

[58] However, QCH did not consider every issue later raised in this proceeding. It did not ask the Grievors whether they had previously been infected or consider serology as a route back to work. Natural and hybrid immunity were not factors QCH was specifically assessing in maintaining the Policy. No individualized scientific assessment was undertaken comparing the transmission risk in 2023 of an unvaccinated employee with prior infection and precautions against that of an employee who remained compliant on vaccinations received in 2021. Ms. Larocque could identify only the broader technical briefs and guidance on which QCH relied. No written assessment by QCH's own infection-prevention leads of the continuing effectiveness of the unchanged primary-series requirement was produced. The record therefore establishes that QCH's decision was

informed by regional and public-health guidance and internal discussion. It does not establish a separate QCH scientific analysis of the residual effectiveness of the unchanged two-dose requirement or of the individualized alternatives later advanced by the Union.

The expert evidence

[59] Both experts were qualified, without objection, to give opinion evidence on infectious diseases, infection prevention and control in a healthcare setting, the transmissibility of COVID-19 and its variants, and the effect of vaccination on transmission. I begin with their substantial areas of agreement, then address the matters on which they differ and the weight I give their evidence.

What the experts agree on

[60] The experts agree on much of the science. COVID-19 vaccines are generally safe. Protection against infection wanes with time. Waning was evident before Omicron and became substantially greater after that variant emerged. Protection against hospitalization, serious illness and death was more durable. Protection following vaccination, infection or both also wanes with time from the most recent “immunity-conferring event”, either vaccination or infection. By mid-to-late 2022 immunity derived from infection had become widespread. Most infections among healthcare workers were acquired in the community rather than at work. Vaccination was never complete protection and did not replace other infection-control measures.

[61] Two other points of agreement are relevant. First, people with hybrid immunity (vaccination plus infection) generally showed the strongest protection in the pooled literature. The experts disagree about how large and durable that advantage was and what explained it. Second, both agreed that a previously unvaccinated Grievor who became vaccinated immediately before returning to work in 2023 would, for a period, have had a lower risk of infection than the same employee returning without vaccination. Dr. Rau described that advantage as transient and noted that the Policy did not require an equally recent dose from employees who were already compliant.

Where the experts disagree

[62] The remaining disputes concern how quickly protection from the 2021 vaccinations waned, what protection remained as Omicron and population immunity evolved, the importance of infection-derived and hybrid immunity, and how much vaccination added when testing, masking and PPE were also used. Whether that remaining protection justified excluding employees from work, and ultimately terminating them, is not a medical question. It is for me to decide under *KVP* and *Irving*.

The vaccination dates

[63] The experts began with different assumptions about when QCH employees had been vaccinated. That is relevant because an earlier vaccination date produces a lower estimate of the protection remaining later. Dr. Rau's initial report assumed that most healthcare workers had received their primary series between January and April 2021, based on his experience at the hospitals where he worked. Dr. Leis used the fall of 2021 (November 1, 2021). The timeline provided to him was close to the Policy deadline, and he considered that date scientifically relevant because employees who became vaccinated in response to a mandatory policy were, in his view, the most relevant comparator. QCH's records show a range of vaccination dates. Of 2,376 employees, 319 had received two doses by April 30, 2021; 59 per cent had done so by mid-June; and an August communication reported approximately 90 per cent of staff and physicians fully vaccinated. By October 15, QCH reported that 98 per cent of its "team members" had chosen vaccination; its employee-status data showed 97 per cent of full- and part-time employees and 92 to 93 per cent of casual employees fully vaccinated. Among CUPE employees, the number recorded with two doses rose from 108 on April 30 to 638 on October 15. Dr. Leis regarded that increase as evidence of a substantial group of later adopters. The data do not establish how many were vaccinated because of the Policy or immediately before the deadline. After reviewing the QCH data, Dr. Rau identified May or June as a reasonable representative point. The records therefore do not support a single vaccination date across the workforce.

Protection against infection as Omicron emerged

[64] Both experts agree that Omicron and the passage of time sharply reduced protection against infection. Dr. Leis relied in part on *Wu*, a meta-analysis that pooled the available research through December 2022. It was published online in February 2023 and provided later evidence

about the protection that had existed during the earlier Omicron period. He estimated approximately 25 to 50 per cent protection against Omicron infection within six months and about 25 per cent at the longest interval studied, approximately ten months. At that later interval, the range within which the true effect could plausibly fall extended to zero. The experts referred to this as the “confidence interval”. Put simply, the data could not rule out little or no remaining protection for employees vaccinated at the earliest dates. When the earlier QCH vaccination dates were put to him, Dr. Leis continued to estimate some residual protection, approximately 20 per cent or somewhat less at six to nine months.

[65] Dr. Rau emphasized the much lower result in *Buchan*, an Ontario study available as a preprint in January 2022 and published in peer-reviewed form in September 2022. It reported approximately 1 to 2 per cent protection against symptomatic Omicron infection after six months. Dr. Leis accepted the result but regarded it as a low estimate within the wider literature. *Buchan* was subsequently included in the evidence pooled in *Wu* and rested toward the low end of those results. Dr. Rau also relied on *Wu* when it became available, emphasizing its uncertainty at longer intervals. His position was that the earlier QCH vaccination dates and the lower estimates supported protection approaching zero for many employees. He nevertheless accepted that this would not be true of an employee vaccinated as late as the fall of 2021. The disagreement is therefore not whether protection fell sharply. It is whether enough protection remained across a workforce vaccinated at different times to continue to matter. Both experts agreed that protection against serious outcomes was substantially better preserved.

Infection-derived and hybrid immunity

[66] By 2023, Dr. Leis considered the more useful comparison to be between people who had both been vaccinated and infected and those who had been infected but never vaccinated. He relied principally on *Bobrovitz*, a systematic review and meta-analysis of fifteen studies available in January 2023, together with *Carazo* and *Tan*. Assuming infection during approximately the BA.1 or BA.2 period by summer 2022, he estimated a 10 to 20 per cent lower relative risk of reinfection about twelve months later for those with hybrid immunity. In his view, earlier vaccination continued to add some protection after a later infection, and the advantage could not be explained entirely by the timing of the last vaccination or infection.

[67] Dr. Rau accepted that hybrid-immunity groups often showed the strongest protection in the pooled literature, but said the comparison was not straightforward. He emphasized the timing and

sequence of vaccination and infection and the difficulty of comparing groups with different immune histories. He relied particularly on *Altarawneh* and *Goldberg*. In *Altarawneh*, protection against BA.1 from prior infection alone and prior infection plus two doses was essentially the same. The BA.2 comparison showed a numerical advantage for hybrid immunity, but the authors described the relevant comparisons as showing "no discernible difference." *Goldberg* showed similar reinfection rates for natural and hybrid immunity at six to eight months, although Dr. Leis cautioned that differences in testing between the groups could have affected that result. Dr. Rau's position was that timing explained much of the advantage Dr. Leis attributed to vaccination and that the evidence did not establish a lasting additional benefit of the size Dr. Leis proposed.

Prior infection, testing and PPE

[68] Dr. Rau proposed recognizing infection-derived immunity together with rapid antigen testing, masking and PPE. He said previous infection could sometimes be established through earlier PCR results and that serology could assist in some cases. He accepted the limits of those methods. A negative antibody result did not exclude earlier infection, and antibody levels waned. His view was that once vaccine protection had substantially waned, any remaining difference in risk for this small group would be negligible when prior infection and the other precautions were taken into account.

[69] Dr. Leis agreed that infection alone can provide protection comparable to vaccination, all else being equal. His concern was whether that approach could be applied reliably in practice. Previous infection could not be established and dated for every employee. Serology could miss remote infection and could not reliably establish when it occurred. He knew of no Ontario hospital that had used serology in this way. Rapid antigen testing was useful but could miss infection, particularly before symptoms. His own hospital retained an education-and-testing option for a small number of employees under Directive #6 despite his IPAC recommendation that vaccination be required. There is no dispute that testing and PPE reduce risk. The disagreement is over how much additional protection vaccination still provided once prior infection and those other precautions were considered. Dr. Rau regarded the remaining difference as negligible in the circumstances he assumed. Dr. Leis considered that some additional protection from vaccination remained, particularly its contribution to hybrid immunity.

The parties' submissions about the experts

[70] The Hospital asks me to prefer Dr. Leis where the experts disagree. It says his opinions better reflect the overall scientific evidence and that Dr. Rau placed too much weight on studies producing the lowest estimates, including *Buchan* on waning and *Altarawneh* on hybrid immunity. It also says Dr. Rau relied on hindsight, including the January 2022 *Buchan* preprint and a study published after the terminations. The Hospital points as well to his initial assumptions about vaccination dates, his acknowledgment that hybrid immunity generally ranked highest in the pooled evidence, and his concession that fresh vaccination would temporarily reduce a returning Grievor's risk of infection.

[71] The Hospital also relies on Dr. Rau's public comments about vaccination mandates and their employment consequences. By September 2022 his criticism of mandate-related dismissal was emphatic, using language such as "virtue signalling," "spanking" and teaching the unvaccinated a lesson. He explained in cross-examination that the first expression referred to shaming and punishment, particularly dismissal, rather than to the mandate itself. The Hospital says those pre-existing views affected his interpretation of the science.

[72] The Hospital further says Dr. Rau crossed from science into the ultimate issue. His reports addressed whether the Policy was reasonable, whether it should have been retired, and whether the remaining benefit justified exclusion or termination. It contrasts Dr. Leis, who said the science informed but did not decide the overall reasonableness of QCH's Policy. In its supplemental submissions, the Hospital also relies on Arbitrator Nyman's criticisms of Dr. Rau in *Orillia Soldiers*, including that he sometimes moved from expert to advocate and was more willing than Dr. Loeb to project where the science was going. Arbitrator Nyman also recorded Dr. Rau as treating 50 per cent effectiveness as a threshold and a 10 to 15 per cent benefit as "juice that isn't worth the squeeze", an expression Dr. Rau also used in this proceeding. Arbitrator Nyman ultimately preferred Dr. Loeb where their interpretations differed.

[73] The Union rejects those criticisms. It says Dr. Rau relied on pooled evidence, including *Wu* and *Bobrovitz*, as well as the individual studies he preferred, and that much of the waning and transmission evidence was available at the relevant times. It says his public comments do not make his scientific opinions unreliable and emphasizes his substantial infectious-disease, microbiology and IPAC experience. The Union also notes that he did not adopt a fixed 50 per cent threshold in this proceeding. It relies on *Quinte Health v. Ontario Nurses Association*, 2024 CanLII

14991 (ON LA) (Hayes) (*Quinte Health*), where Arbitrator Hayes described Drs. Rau and Loeb as "highly accredited and accomplished physicians" whose opinions were supported by international research in leading journals and cautioned against resolving the dispute simply by choosing one expert over the other.

Findings on weight

[74] I have not found that Dr. Rau failed in his duty of impartiality. He is a highly qualified expert, and I have considered his scientific opinions on their merits. Even so, where the experts differ on the protective benefit that vaccination likely continued to provide in March 2022 and again in the spring and summer of 2023, I prefer Dr. Leis's evidence. I do so primarily because, on the record before me, his interpretation is better supported by the broader body of research, while still taking account of the cautions and limitations identified by Dr. Rau.

[75] The Hospital's criticism has some force in relation to Dr. Rau's use of *Buchan* to say what QCH ought to have concluded by March 2022. The study was then available only as a preprint. Dr. Leis did not encounter it until its peer-reviewed publication later that year, and the public-health and regional guidance QCH was receiving did not adopt it as a basis for withdrawing vaccination policies. I therefore give *Buchan* limited weight in deciding what QCH ought reasonably to have known at that time. I do not, however, accept "cherry-picking" as a general description of Dr. Rau's evidence. He also relied on pooled evidence and other Omicron-era studies. I have considered his preferred studies with the broader literature.

[76] Dr. Rau's public statements require a measured response. I place no weight on his early-pandemic views about lockdowns, border restrictions or quarantine because they are too remote from the issues before me. His views about hospital vaccination mandates and dismissal are more relevant. He opposed the employment consequences of mandatory vaccination policies during the period when the Union says the Policy in this case was reasonable. By September 2022 his public opposition to dismissal because of failing to comply with a vaccine mandate was emphatic. That does not cause me to reject his scientific evidence or question his good faith. It does require care in separating his interpretation of the science from his view of what employers should do with it. I have given no weight to his opinions about whether the remaining scientific benefit justified exclusion, termination or the Policy as a whole.

[77] Dr. Leis also had a prior view in favour of mandatory vaccination, but I do not regard his position as equivalent to Dr. Rau's. His view arose mainly from his responsibility for infection prevention at Sunnybrook, where management ultimately weighed staffing and other institutional considerations differently from his IPAC recommendation. In this proceeding he consistently separated the scientific question from the legal and labour-relations judgment and declined to decide whether QCH's Policy was reasonable. That does not mean I prefer him automatically. However, where the science is otherwise closely balanced, as it is for the spring and summer of 2023, I have greater confidence that his opinion is confined to the scientific issue rather than extending to the employment consequences that should follow from it.

[78] The important distinction is between the science and the judgment I must make under *KVP* and *Irving*. An infection-prevention specialist can explain how much protection remained, how long it lasted, whether another measure reduced the same risk, and the practical consequences of different infection-control choices. That evidence informs the balance. Whether the remaining protection justified prolonged exclusion from work or dismissal requires consideration of employee interests, alternatives, the collective agreement and the Hospital's obligations. That judgment is mine. I do not find that Dr. Rau adopted a fixed 50 per cent threshold in this proceeding. However, I give no expert weight to his conclusions that the Policy was reasonable or unreasonable, should have been retired, or justified its employment consequences. I likewise give no weight to any view of Dr. Leis about whether the scientific benefit he identified justified maintaining the vaccination requirement. As Arbitrator Hayes observed in *Sault Area Hospital*, at paragraph 338, medical expertise is important but "not controlling in and of itself."

[79] Hindsight also requires care. Evidence available at the time may show what QCH knew or reasonably ought to have known. Later research may tell us more precisely what protection actually existed, but it cannot be treated as knowledge QCH possessed earlier. I apply the expert evidence on that basis. The same distinction applies to hybrid immunity. Later evidence may establish that vaccination continued to add protection even though QCH did not itself rely on hybrid immunity when it maintained the Policy.

Findings on the scientific disputes

[80] On vaccination dates, I do not accept either expert's assumptions as describing the workforce as a whole. An employee vaccinated near the Policy deadline is relevant to what a non-compliant employee would gain by becoming vaccinated, but the Policy applied to employees

vaccinated throughout 2021 and did not require boosters. I take the range of QCH's vaccine uptake data into account rather than assign a single vaccination date to the workforce.

[81] On the earlier Omicron period, I find that protection against infection from a 2021 primary series had fallen sharply but had not disappeared across the workforce. Some evidence available by March 2022, including the January *Buchan* preprint, suggested very low protection at longer intervals, and employees vaccinated earliest would have had the least protection remaining. I give the preprint limited weight in assessing what QCH ought to have concluded at the time, for the reasons already given. The later pooled evidence supports some remaining protection across a workforce vaccinated at different times. I accept Dr. Leis's evidence that, for employees vaccinated approximately six to nine months earlier, protection against Omicron infection was about 20 per cent or somewhat less. That estimate would be higher for employees vaccinated more recently and lower for those vaccinated earlier. I do not apply it as a single percentage to the workforce as a whole. Protection against serious illness was substantially better preserved.

[82] Infection-derived immunity became increasingly important as Omicron spread. I accept Dr. Rau's evidence that prior infection could provide protection comparable to a primary series alone and could provide better protection where the infection was more recent. Dr. Leis substantially accepted that proposition when comparing like with like. As infection became widespread through 2022, more vaccinated people also acquired infection, and hybrid immunity became increasingly common.

[83] On hybrid immunity, I prefer Dr. Leis's interpretation, but with important qualifications. Both experts accepted that hybrid-immunity groups generally showed the strongest protection. Dr. Rau's emphasis on the most recent immune event is also well founded. I am not satisfied, however, that recency explains the entire difference observed in the literature. The studies relied on by Dr. Leis show a continuing advantage for hybrid immunity. *Altarawneh* and *Goldberg* provide important contrary evidence and prevent me from finding a uniform or substantial advantage in every individual.

[84] On the evidence as a whole, I find it more likely than not that earlier vaccination still added a modest amount of protection after a later infection. This is a different comparison from the remaining protection of the primary series discussed above. Assuming infection during approximately the BA.1 or BA.2 period by summer 2022, the evidence supports Dr. Leis's

estimate of about a 10 to 20 per cent lower relative risk of reinfection about a year later compared with infection alone. That is an average estimate, not a measured benefit for any particular employee. The evidence becomes less certain as more time passes after the later infection. I take that limitation into account. I do not rely on Dr. Leis's separate estimate of protection from the 2021 primary series alone in 2023. By then the more useful comparison was hybrid immunity against infection-derived immunity alone.

[85] The Union's proposed alternative was workable and the small number of affected employees made individual arrangements more practical. I accept Dr. Rau's distinction between relative and absolute risk. A relative reduction does not establish how many infections would actually be prevented, and the record does not permit that number to be calculated for QCH. I also accept that previous infection could be established for some employees. It could not, however, be reliably established and dated for all employees, nor did infection history itself establish how much protection remained at a given time. Rapid antigen testing could miss infection, particularly before symptoms, and PPE did not prevent every infection. I therefore accept Dr. Leis's narrower proposition that vaccination still added some protection beyond the Union's proposed alternatives. Whether that additional protection justified the greater intrusion is for the *Irving* balance.

[86] The fact that most healthcare-worker infections were acquired in the community does not resolve the issue. Most healthcare workers caught COVID in the community, but an employee infected there could still bring the virus into the hospital. Reducing an employee's chance of becoming infected anywhere therefore reduced the opportunity to expose patients or colleagues.

[87] In summary, the experts agree that protection against infection waned substantially, protection against severe disease lasted longer, prior infection became widespread, and the timing of the most recent vaccination or infection mattered. For the earlier Omicron period, I accept Dr. Leis's evidence that the primary series continued to provide a modest degree of protection against infection, while recognizing that the amount varied with the timing of vaccination. Protection against serious illness remained substantially stronger. For the later period, I also prefer Dr. Leis on the narrower proposition that earlier vaccination continued to add a modest amount of protection after later infection. The science does not itself decide whether the Policy remained reasonable.

THE POLICY REMAINED REASONABLE AS CIRCUMSTANCES EVOLVED

[88] The Union accepts that the Policy was reasonable through March 14, 2022, but says that the circumstances which initially justified it had changed by then, or changed sufficiently before the terminations, that it could no longer reasonably be maintained. There is no dispute that a rule that is reasonable when introduced can become unreasonable as the circumstances underlying it change. What matters is whether the changes were of such a nature and degree that the balance no longer supported the rule. The pandemic and its aftermath were highly dynamic. Many things changed over the period before me, and QCH was required to remain responsive to those changes in protecting its staff and vulnerable patients. For the reasons that follow, I find that QCH acted reasonably in maintaining its Policy as those circumstances evolved.

Why the Policy was adopted

[89] QCH adopted the Policy during the Delta wave, when vaccination provided strong protection against infection and even stronger protection against serious illness. As an acute-care hospital, QCH cared for patients who could suffer serious consequences from COVID-19 and depended on a healthy workforce to provide that care. The Policy sought to reduce both serious illness among staff and transmission to staff, patients and visitors. Vaccination was one part of a broader infection-control response that also included testing, masking, PPE and screening.

[90] The Union does not dispute that a mandatory vaccination requirement was reasonable in those circumstances. The Policy therefore began with a strong scientific and operational basis. Later developments must be assessed against that starting point.

Waning, Omicron and the revocation of Directive #6

[91] By late 2021, the circumstances underlying the Policy were already changing. QCH knew that vaccine protection waned with time. It encouraged boosters and considered whether another dose should become mandatory, but for the operational, staffing and administrative reasons described earlier, it continued to treat the primary series as its minimum requirement.

[92] Omicron brought a more significant change. It spread more readily and sharply reduced the protection against infection provided by earlier doses. At the same time, infection levels rose dramatically. QCH began 2022 with significant levels of infection in January, staff illness and

isolation, serious staffing pressures and concern about maintaining essential services. Across hospitals, healthcare-related infection and outbreaks also increased. However, protection against hospitalization and serious illness remained substantially more durable than protection against infection.

[93] It was against that backdrop that Directive #6 was revoked on March 14, 2022. Revocation ended the provincial requirement that hospitals maintain vaccination policies. It did not require QCH to withdraw its own Policy. An employer could continue protective measures beyond the provincial minimum if they remained reasonable: *Regional Municipality of York v. Canadian Union of Public Employees, Local 905 (Long Term Care Unit)*, 2022 CanLII 78173 (ON LA) (Raymond) (*Regional Municipality of York*), at paragraphs 14 and 25; *Elementary Teachers' Federation of Ontario v. Ottawa-Carleton District School Board*, 2022 CanLII 53799 (ON LA) (Flaherty) (*ETFO*), at paragraph 55.

[94] The regional hospitals and QCH considered whether their policies should continue. The material directed specifically to hospital vaccination policies supported continuation. Other public-health guidance continued to recommend vaccination and additional doses. None of the guidance QCH received recommended withdrawing existing hospital vaccination policies. Mr. Hedgecoe said QCH's executive considered the issue and concluded that continuing transmission, hospitalizations, staffing pressures and safety concerns did not warrant withdrawal. QCH maintained its Policy, with a plan to reconsider it later that year.

[95] The Union is correct that this was not a detailed or well-documented scientific review. There are no minutes, reports or internal analysis quantifying the protection remaining from the primary series. The precise advice of Dr. Rose and Ms. Ouellet was not established, and there is no evidence that QCH examined prior infection as an alternative source of protection. I do not, however, infer from their absence that Dr. Rose or Ms. Ouellet would have supported Dr. Rau's interpretation of the science. The matters the Union says they would have addressed, including waning, immune escape, boosters and community acquisition, are otherwise established in the record.

[96] Neither *KVP* nor *Irving* requires QCH to conduct its review in a particular form. *Central West* makes clear that the absence of a formal review mechanism is not itself determinative. The Policy itself also contemplated ongoing monitoring to identify whether changes were needed. That

is consistent with *Alectra Utilities Corporation v. Power Workers' Union*, 2022 CanLII 50548 (ON LA) (Stewart) (*Alectra*), at paragraph 24, which recognizes that a reasonable policy should contemplate amendment as circumstances change. That made reassessment important. It did not mean that every change in circumstances required an amendment, but it required QCH to consider whether an amendment had become necessary. QCH was entitled to inform itself through public-health authorities, the regional working group and the infectious-disease expertise available through that system. Regional coordination did not relieve QCH of responsibility for its own Policy, but the information reached its decision-makers and QCH made the decision for itself. I find that its review at the time Directive #6 was revoked was genuine and proportionate to the circumstances. QCH knew protection was waning, was dealing with Omicron outbreaks and severe staffing pressure, and was receiving consistent advice that vaccination remained an important layer of protection. The limitations of its review are relevant, but they did not make the decision to maintain the Policy unreasonable.

What the science supported in early 2022

[97] By March 2022, waning was established but its effect across QCH's workforce was not. The studies Dr. Rau relied on from the Delta period showed declining protection over time but still reported substantial protection several months after vaccination. *Buchan* was different. It reported almost no protection against symptomatic Omicron infection at longer intervals. But in March 2022 it was still an unreviewed preprint, and I have given it less weight for the reasons given above. It was an Ontario-based study, but QCH was not required to treat its preliminary result as determinative, even if it had been aware of it.

[98] The later expert evidence, given at this hearing, makes the picture somewhat clearer. Protection against infection had fallen sharply, particularly for employees vaccinated earliest, but it had not disappeared across a workforce vaccinated at different times. Protection against serious illness remained much stronger. That later evidence cannot be treated as knowledge QCH possessed in March 2022. What QCH reasonably should have understood at the time was that protection against infection had materially waned, that protection against serious illness was better preserved, and that Omicron was causing high levels of infection in hospitals and the community.

[99] Arbitrator Nairn recognized this distinction in *FCA Canada Inc. v. Unifor, Locals 195, 444, 1285*, 2022 CanLII 52913 (ON LA) (Nairn) (*FCA*). She accepted that a vaccination requirement

can become unreasonable as the evidence develops, but also recognized that scientific assessment inevitably lags behind a changing virus: paragraphs 106 to 108. She rejected the suggestion that her later conclusion had necessarily been available months earlier. I take the same approach here. In early 2022 there was still real uncertainty about how much protection remained and how Omicron would evolve. Precaution therefore had legitimate weight, though it did not replace the *Irving* balance. Given the protection that remained, the serious conditions QCH was facing and the guidance it was receiving, maintaining the Policy while continuing to reassess it was reasonable.

Reassessment through the remainder of 2022

[100] Circumstances continued to change through 2022. Infection-derived immunity became widespread. A recently infected unvaccinated employee could, in some circumstances, have greater protection against infection than a compliant employee whose last vaccination had been in 2021. At the same time, hybrid immunity was becoming more common.

[101] QCH and the regional hospitals revisited the Policy against that changing background. In August and September 2022, the working group considered three choices: maintaining the existing two-dose requirement, requiring another dose, or ending mandatory vaccination. The review recognized waning effectiveness and considered safety, staffing and legal concerns. It recommended maintaining the existing requirement through Fall and Winter 2022/23 and reconsidering it by March 31, 2023. CHRIC also approved the recommendation.

[102] The review did not answer every scientific question later raised in this proceeding, but it shows that the Policy was not simply left in place. The regional hospitals expressly considered whether to strengthen, maintain or withdraw their requirements. QCH remained responsible for its own Policy, but participation in an integrated regional system was a legitimate source of information and advice: *Orillia Soldiers,* at paragraph 130.

Spring 2023

[103] By spring 2023, the circumstances were quite different from those of early 2022. Staff infections had fallen substantially from their earlier peaks. QCH was working through surgical and service backlogs rather than managing the acute staffing crisis of the first Omicron wave. Return-

to-work practices had become symptom-based, the regional emergency structures were winding down, and the Grievors had been without regular QCH earnings for well over a year.

[104] The scientific picture had also changed. Waning was well established, and the expert evidence given at this hearing establishes that the timing of the most recent vaccination or infection mattered. QCH knew that vaccine protection declined with time and that boosters provided more current protection. The Policy tracked neither boosters nor prior infection.

[105] That did not mean vaccination had ceased to provide protection. As I have already found, earlier vaccination continued to make a modest average contribution after later infection, although the size of that benefit became harder to measure over time. By 2023, protection against serious illness was mainly a benefit to the individual employee. The institutional benefit rested principally on the remaining reduction in the risk of infection and the resulting opportunities for onward transmission.

The spring 2023 decision

[106] The Policy was reconsidered again in March and April 2023. On April 6, Dr. Hui reported that the regional HR group had decided to continue mandatory vaccination, with another review likely in the fall. The working group supported that course. Toronto-area hospital guidance recommended no change to existing vaccination policies. PHO continued to recommend that healthcare workers remain vaccinated and up to date, although its April brief did not address whether vaccination should remain mandatory. No guidance received by QCH that addressed existing hospital vaccination policies recommended their withdrawal.

[107] QCH followed the regional recommendation. Its own review remained limited. Ms. Larocque relied mainly on the regional process, Dr. Hui and the public-health material, and her discussions with Ms. Nimmo were informal and undocumented. QCH did not examine the Grievors' prior infections, consider serology as a route back to work, or compare the protection of a recently infected unvaccinated employee using other precautions with that of an employee who remained compliant on two doses received in 2021.

[108] Those limitations are relevant, but they do not amount to a separate procedural breach of *KVP*. The authorities do not prescribe a particular form of review. The Policy must nevertheless remain reasonable as circumstances change. QCH was not required to recreate the scientific

analysis for itself. As the Court observed in *Rogelstad v. Middlesex Health Alliance*, 2025 ONSC 263 (*Rogelstad)*, at paragraphs 67 to 69, an employer may reasonably rely on public-health and other external expertise in assessing workplace risk. The Union distinguishes *Rogelstad* because QCH is a large urban hospital with its own infection-prevention expertise. I accept that factual distinction. It does not make QCH's reliance on regional and public-health expertise unreasonable, although QCH remained responsible for making the decision for itself.

[109] QCH knew protection against infection had waned, knew boosters were recommended, and participated in both the structured 2022 review and the further review in spring 2023. The information from those processes reached its senior decision-makers. Although the regional working group was winding down in May and June, QCH continued to receive and consider guidance. It then chose to maintain the Policy. The review was informal and less scientifically detailed than the Union says it should have been, but it was real. The Policy was reconsidered rather than simply carried forward.

Employee interests and less intrusive means

[110] A central part of the Union's case is that, once the protection from the original doses had waned, employees who remained compliant with the Policy were no better protected against infection and transmission than the Grievors, particularly if a Grievor had previously been infected and returned with testing, masking and PPE. I accept an important part of that argument. By 2023, a recently infected unvaccinated employee could in some circumstances be better protected than an employee whose last vaccination was in 2021. However, I have not accepted the broader proposition that vaccination had ceased to add protection. On the expert evidence before me, earlier vaccination continued to provide a modest additional benefit after later infection. That difference is what must be weighed against the intrusion imposed on the Grievors and the less intrusive alternative proposed by the Union.

[111] The employee interests were substantial throughout. The Policy engaged bodily autonomy and medical choice, and the Grievors lost their regular QCH earnings while they remained on leave. By March 2022 that loss had continued for four to five months. By spring 2023 it had continued for well over a year, and termination was becoming a real prospect. As *Elexicon* recognizes, those consequences form part of the balance required by *Irving*.

[112] The Union proposed a less intrusive route back to work based on prior infection, rapid antigen testing, masking and PPE. Directive #6 itself had also contemplated regular testing for employees who declined vaccination under one of the permitted policy models. I have already made the relevant scientific findings. That approach was workable and would have reduced risk. It did not, however, remove the additional protection associated with vaccination. Prior infection could not reliably be established and dated for everyone, testing could miss infection before symptoms, and PPE did not prevent every infection.

[113] The Union did not have to show that its alternative provided protection identical to vaccination. Nor did QCH have to adopt it simply because it reduced risk. *Irving* requires the remaining benefit from vaccination to be weighed against the additional intrusion imposed on the Grievors.

[114] That balance looked different in March 2022 than it did in 2023. In March 2022 QCH was dealing with active outbreaks, serious staffing disruption and vulnerable patients. Protection against serious illness remained strong, and reducing infection and illness across a workforce of more than 2,000 employees directly supported QCH's ability to maintain care. In those circumstances, the additional protection from vaccination continued to justify the greater intrusion.

[115] By 2023, the Union's alternative carried more weight. Prior infection was widespread, only a small number of employees remained affected, individualized measures were practical, and QCH already had experience administering testing arrangements. The small number of remaining employees also reduced the absolute institutional risk attributable to this group. Their small number did not entitle them to avoid an otherwise reasonable rule, but it was relevant to the feasibility and protective value of a less intrusive alternative under *Irving*.

[116] I have also considered the Union's argument that QCH used rapid testing to return some infected vaccinated employees to work early while treating testing as inadequate for the remaining unvaccinated employees. The situations were different. The early-return arrangements involved employees with known recent infection, for a defined period and in response to staffing pressures. But the comparison does support the Union's broader point that individualized testing was feasible. By 2023, therefore, the less intrusive alternative weighed considerably more heavily against continuation than it had in early 2022.

The balance in spring 2023

[117] By spring 2023, the case for continuing the Policy was much closer. The Grievors had been excluded from regular employment for about seventeen months. The two-dose rule no longer tracked either boosters or prior infection. Individual arrangements were feasible, and the scientific advantage associated with vaccination had become modest and harder to quantify. Those considerations weigh substantially against continuation.

[118] There remained important considerations on the other side. QCH continued to be an acute-care hospital caring for frail, medically complex and immunocompromised patients. An employee infected in the community could still introduce COVID-19 into the Hospital. On the scientific findings I have made, vaccination continued to provide some additional protection against infection, including through hybrid immunity. QCH's acute-care setting and its statutory obligation to take reasonable precautions gave that remaining benefit greater weight than it might have carried in another workplace. The benefit was modest, but it was real.

[119] *Sault Area Hospital*, at paragraph 340, cautions that a rule cannot be sustained simply because "some" weak or imperfect evidence is better than none. I agree. My conclusion does not rest on a theoretical possibility of benefit. The expert evidence establishes a measurable protective contribution, although its size and practical effect became increasingly difficult to quantify.

[120] *Orillia Soldiers* is persuasive on a limited but relevant point. Arbitrator Nyman recognized that even a modest reduction in risk may carry greater weight in an acute-care hospital because of the vulnerability of the patients who may be exposed and the hospital's responsibility to maintain care. He also recognized that a hospital operating within an integrated regional system need not be assessed as though it made its decisions in isolation. I accept those general propositions. I also accept the Union's caution about carrying the decision further. The employment consequences in *Orillia Soldiers* arose mainly in late 2021 and early 2022, and Arbitrator Nyman's comments about vaccine effectiveness into the summer or fall of 2023 were not necessary to decide that case. I do not treat Dr. Loeb's evidence in that proceeding as evidence here, or *Orillia Soldiers* as establishing how long another hospital's vaccination policy could reasonably remain in force. My findings about the protection that remained in 2023, and the weight to give that protection in the *Irving* balance, are based on the evidence in this proceeding.

[121] The Union relies on *FCA* and *Toronto (City) v. Toronto Civic Employees' Union, CUPE, Local 416*, 2022 CanLII 109503 (ON LA) (Herman) (*Toronto (City)*) to show that a vaccination policy that was reasonable when introduced may later become unreasonable. I accept that principle. Those decisions were based on their own records and do not establish a general date on which vaccination policies ceased to be reasonable. As *Alectra* also recognizes, different employers facing different workplaces and risks may reasonably respond differently to the same broader developments: at paragraphs 21 and 22. Another hospital could therefore reasonably have withdrawn its policy without making QCH's decision to retain this one unreasonable.

[122] The Union also relies on *Purolator*, where Arbitrator Glass found on the evidence before him that by June 2022 two-dose vaccination no longer reduced the risk of Omicron infection sufficiently to justify excluding unvaccinated workers. I have not made that scientific finding on this record. The evidence here also includes a substantial body of evidence concerning hybrid immunity and arises in an acute-care hospital rather than a transportation workplace. The arbitral award has also since been set aside.

[123] Precaution also carried less weight by 2023 than it had when Omicron first emerged. By then the sharp decline in protection against infection was established. Uncertainty about another wave could not justify a rule that no longer worked, and disagreement between retained experts does not itself engage the precautionary principle. My conclusion therefore does not rest on precaution. It rests on the protective benefit I have found remained, the acute-care setting, the employee interests, the available alternative and the guidance before QCH.

[124] The circumstances had changed substantially. Protection against infection had waned, prior infection was widespread, conditions at QCH had improved and the burden on the Grievors had become very significant. QCH's own review also had important limits. All of those matters weigh against continuation.

[125] On the other side, vaccination still provided a real, though modest, additional benefit. QCH continued to care for vulnerable patients. The Union's alternative was practical and reduced risk, but it did not remove that benefit. The regional hospital system and the guidance that directly addressed existing vaccination policies continued to support continuation. Taking the employee burden fully into account, I find that those considerations were sufficient to maintain the balance in favour of the Policy.

[126] This was a close balance. It does not mean that any residual benefit would justify a mandatory vaccination rule, or that the Union had to prove an equally protective alternative. Nor does it mean QCH was required to maintain the Policy. Another hospital could reasonably have chosen differently. I find only that QCH's decision remained within the range of reasonableness permitted by *KVP* and *Irving*.

The June 2023 enforcement decision

[127] After reaffirming the Policy in the spring, QCH moved to enforcement. The June 26, 2023 letters gave the remaining employees a final opportunity to comply. Conditions were less acute than in early 2022. Staff infections were much lower, some other precautions had been relaxed, the WHO had declared the global health emergency over in May, and QCH was recovering services rather than managing an acute staffing crisis. Those developments reduced the weight of some earlier considerations, but they did not establish that the remaining protective benefit had disappeared.

[128] The Hospital also relies on the fact that a Grievor vaccinated in response to the final warning would, for a time, have had a lower risk of infection than the same employee returning unvaccinated. I give that point some weight, but it is not determinative. The Policy did not require employees who were already compliant to have an equally recent dose.

[129] The record identifies no intervening scientific development, change in conditions at QCH, or further policy review between the spring decision and the August 4 terminations that undermined the basis on which QCH had decided to maintain the Policy. The terminations were the consequence of continued non-compliance, not a new decision about the science or conditions underlying the Policy.

Conclusion on reasonableness

[130] Considering the chronology as a whole, QCH did not simply leave the Policy in place. It reconsidered it when Directive #6 was revoked, participated in the structured 2022 review and revisited the issue again in spring 2023.

[131] The circumstances changed significantly, and by spring 2023 the balance was close. Applying *Central West*, however, those changes were not sufficient on this record to alter the balance that had previously justified the Policy.

[132] The Hospital has therefore met its onus. This conclusion is confined to QCH, this Policy, this record and the period before me.

THE HOSPITAL HAD JUST CAUSE FOR TERMINATION

[133] The Hospital says the five Grievors remained unwilling to comply with a reasonable rule despite clear warnings and a genuine opportunity to keep their jobs. Compliance remained a genuine route back to work. The Policy and the possibility of termination were clearly communicated before the original deadline and again in the leave letters. QCH then left the Grievors on unpaid leave for roughly twenty months before issuing the final warnings. I accept the Union's criticism of the long silence and do not treat that period as progressive discipline.

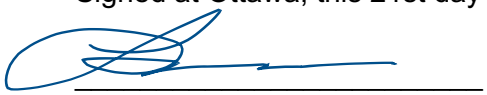
[134] The June 26 letters nevertheless gave renewed, clear notice and more than a month to reconsider. Full vaccination would have allowed the Grievors to return, and proof of a first dose with booked appointments for the remaining dose would have extended the leave while vaccination was completed. None of the five provided proof of a first dose. Ms. Joynson's later compliance and return confirm that the opportunity was real.

[135] The opportunity for the Grievors to reconsider and appreciate the significance of their choice was materially longer than the two-week period considered in *Humber River Health*, and QCH was not required to maintain unpaid leave indefinitely once a reasonable rule had been clearly reaffirmed: *Central West*, at paragraph 157. I have considered the Grievors' long service and the serious consequences of dismissal. A further suspension would have achieved little beyond what the lengthy unpaid leave and final warning had already attempted to achieve. The Union advances no separate rationale for a lesser penalty once the Policy's reasonableness is established. I therefore find that the Hospital had just cause to terminate the five Grievors on the issues before me. The reserved exemption claims remain undecided.

DISPOSITION

[136] The Policy remained reasonable after Directive #6 was revoked and through August 4, 2023. The grievances challenging the leaves of absence and terminations for that period are dismissed on the issues decided here. The reserved human rights-based exemption claims remain to be determined. I remain seized of those claims and any resulting remedy, and the interpretation or implementation of this award.

Signed at Ottawa, this 21st day of September 2026.



Leslie Reaume
Arbitrator

Appendix A – Agreed Statement of Facts

IN THE MATTER OF THE ARBITRATION

BETWEEN:

QUEENSWAY CARLETON HOSPITAL

(the Hospital or QCH)

- and -

CANADIAN UNION OF PUBLIC EMPLOYEES (Local 2875)

(the Union or CUPE)

- and -

JUSTIN HEBERT, SANHEK PHOU, AMBER BEACH, GILBERT GOULBOURNE, QUY DUONG, AMANDA JOYNSON

(the Grievor or Grievors)

(together the Parties)

RE: Grievances #21110JH, #211110S, #211109AB, #211109GG, #211115QD, #230804JH, #230805SP, #230806AB, #230806GG, #230807QD, #211026AJ

AGREED STATEMENT OF FACTS

WHEREAS the Union filed grievances #21110JH and #230804JH on Justin Hebert's behalf on November 10, 2021 and August 4, 2023, grievances #211110S and #230805SP on Sanhek Phou's behalf on November 10, 2021 and August 5, 2023, grievances #211109AB and #230806AB on Amber Beach's behalf on November 9, 2021 and August 6, 2023; grievances #211109GG and #230806GG on Gilbert Goulbourne's behalf on November 9, 2021 and August 6, 2023, grievances #211115QD and #230807QD on Quy Duong's behalf on November 10, 2021 and August 7, 2023 and grievance #211026AJ on Amanda Joynson's behalf on October 21, 2021 ("the Grievances");

1

AND WHEREAS the Parties wish to agree on certain facts which may be admitted into the evidence of the hearing of the Grievances;

AND WHEREAS the Parties agree that these facts are admitted only for the purpose of the hearing of the Grievances and not for any other purpose;

NOW THEREFORE the Parties agree as follows:

The Parties

1. Queensway Carleton Hospital is a public hospital under the *Public Hospitals Act*, RSO 1990, c P 40.

2. QCH delivers acute care to the public, offering medical and surgical programs to Ottawa and the surrounding communities. It is West Ottawa's only full-service hospital with 355 beds. QCH serves as a secondary referral center for the Ottawa Valley. QCH employs approximately 2,700 health professionals.

3. The Canadian Union of Public Employees ("CUPE") is the bargaining agent for all QCH employees except professional medical staff, registered and graduate nurses, undergraduate nurses, classification represented by OPSEU (as of September 29, 1989), classification represented by IUOE, office and clerical staff, supervisors and persons above the rank of supervisor.

The Collective Agreement and the Bargaining Unit

4. QCH and CUPE are parties to a collective agreement with a term of September 29, 2017 – September 28, 2021. Local bargaining for renewal of this agreement was not completed until the release of an interest arbitration award dated June 14, 2024. A copy of the collective agreement, the "agreed to" items between the parties reflecting the changes to the last collective agreement and the June 14, 2024 interest arbitration award are attached at **Tabs 1A-1C of the Joint Book of Documents** ("JBOD").

The COVID-19 Pandemic

5. Severe acute respiratory syndrome coronavirus 2 ("SARS-CoV-2") is a strain of coronavirus that causes coronavirus disease ("COVID-19"), which is the respiratory illness

responsible for the COVID-19 pandemic. The COVID-19 pandemic was a global pandemic with an estimated 750 million confirmed cases of COVID-19 and 7 million officially reported deaths worldwide (with estimates ranging between 18 and 33 million deaths).

6. On January 25, 2020, Ontario identified its first presumptive confirmed case of COVID-19.

7. On January 30, 2020 the World Health Organization ("WHO") declared a Public Health Emergency of International Concern due to SARS-CoV-2 spreading rapidly to other countries.

8. On March 11, 2020, The World Health Organization ("WHO") declared the spread of SARS-CoV-2 a pandemic. On May 5, 2023, the WHO "declare[d] COVID-19 over as a global health emergency."

9. On March 17, 2020, the Government of Ontario declared an emergency in Ontario under the *Emergency Management and Civil Protection Act*, RSO 1990, c E.9. Ontario lifted the state of emergency on July 24, 2020 with the *Reopening Ontario (A Flexible Response to COVID-19) Act, 2020*, SO 2020 c 17. The Government of Ontario declared a second provincial emergency effective January 14, 2021, which was lifted on February 10, 2021 and a third state of emergency on April 8, 2021, which was lifted on June 2, 2021.

10. On March 25, 2020, the City of Ottawa declared a state of emergency to fight the spread of SARS-CoV-2. The City of Ottawa lifted the state of emergency on July 22, 2021.

11. SARS-CoV-2 mutated rapidly and many variants were labelled by the WHO as variants of concern and variants of interest, including, most notably, Alpha, Delta and Omicron. Many variants, and their further mutations, demonstrated increased rates of transmissibility, hospitalization and mortality relative to the previously circulating variant at the time and place of emergence.

12. Between March 1, 2021 to July 31, 2021, the Alpha variant of the virus emerged as the dominant strain, demonstrating increased transmissibility.

13. Between July 23 and November 3, 2021, the Delta variant of the virus emerged as the dominant strain, demonstrating increased transmissibility, and causing more severe symptoms compared to earlier variants.

14. Following the identification of the Omicron variant in November 2021, it became the

dominant strain in Ontario around December 2021. The Omicron variant demonstrated an increased transmissibility as compared to the Delta variant but caused less severe symptoms.

15. On August 17, 2021, the Ontario Chief Medical Officer of Health issued Directive #6, with an effective date of September 7, 2021. Directive #6 required public hospitals within the meaning of the *Public Hospitals Act* to establish, implement and ensure compliance with a COVID-19 vaccination policy that required employees, staff, contractors, volunteers and students to provide:

    a. proof of full vaccination against COVID-19; or
    b. written proof of a medical reason, provided by a physician or registered nurse in the extended class that sets out:
        i. a documented medical reason for not being fully vaccinated against COVID-19, and
        ii. the effective time-period for the medical reason; or
    c. proof of completing an educational session approved by the employer about the benefits of COVID-19 vaccination prior to declining vaccination for any reason other than a medical reason.

16. Directive #6 was revoked on March 14, 2022 by the Ontario Chief Medical Officer of Health.

17. The Union does not dispute the public health guidance regarding COVID-19 policies and vaccinations.

18. In early September 2021, QCH informed its employees that it would implement a vaccination policy that would require all employees to be fully vaccinated, save for those with medical or human rights based exemptions (**Tab 2 of the JBOD**).

19. On or about September 1, 2021, the Ontario COVID-19 Science Advisory Table advised that Ontario was in the midst of a fourth wave of the COVID-19 pandemic, and that vaccination offered substantial protection against severe health outcomes. A copy of the Science Table's advice is attached at **Tab 3 of the JBOD**.

20. QCH opted to develop a mandatory vaccination policy ("Vaccination Policy"), effective September 7, 2021 (see **TAB 4 of the JBOD)** which was one of the options under Directive

#6. Under Stage 2 of the Vaccination Policy all staff, contractors, service providers and learners (as defined in the Vaccination Policy) were required to be fully vaccinated (also as defined in the Vaccination Policy) effective October 15, 2021, unless medically contraindicated or exempted by QCH for reasonable considerations pursuant to the Ontario *Human Rights Code*.

21. Government approved COVID-19 vaccines were readily available to all QCH employees as of September 2021, free of charge.

22. Following publication of the Vaccination Policy, QCH provided COVID-19 Vaccine Exemption Request Forms to employees seeking a human rights based exemption from the requirement to become fully vaccinated.

23. COVID-19 vaccines are some of the most robustly studied and utilized vaccines in the world and have been found to be safe for use on humans. The Union does not dispute that COVID-19 vaccines were found to generally be safe. Neither does CUPE dispute that COVID-19 vaccines played an instrumental role in preventing severe disease, including hospitalization and death resulting from COVID-19 in 2021 and early 2022.

24. Under the Vaccination Policy, QCH permitted an implementation period lasting several weeks for unvaccinated staff to get vaccinated and they were provided with a comprehensive timetable to ensure compliance with the Vaccination Policy.

25. In accordance with the Vaccination Policy, in early November 2021 QCH placed non-exempted employees who remained unvaccinated on a leave of absence without pay.

26. In June 2023, QCH notified these unvaccinated employees in writing that their employment would be terminated if they remained non-compliant with the Vaccination Policy ("Final Warning Letter").

27. The employment of several unvaccinated employees who remained non-compliant with the Vaccination Policy, including Justin Hebert, Sanhek Phou, Amber Beach, Gilbert Goulbourne and Quy Duong ("the Grievors"), was subsequently terminated on August 4, 2023.

28. Amanda Joynson made the decision to comply with the Vaccination Policy after receiving the Final Warning Letter and had her first shift back at QCH on November 4, 2023.

About the Grievors

Justin Hebert (#21110JH and #230804JH)

29. Justin Hebert ("Hebert") is the Grievor in the above noted grievances.

30. Until the day of the termination of their employment, Hebert held the position of Environmental Service Aide in the Environmental Service Department at QCH where he was employed since March 13, 2012.

31. The Job Description for the position of Environmental Service Aide is attached at **Tab 5 of the JBOD**.

32. On October 15, 2021, Hebert submitted their COVID-19 Vaccine Exemption Request Form to QCH, requesting an exemption from becoming fully vaccinated based on their religious belief/creed. Hebert submitted that because of the Roman Catholic Church's teachings, they were morally obligated to refuse any COVID-19 vaccine (**Tab 6 of the JBOD**).

33. On November 10, 2021, QCH informed Hebert in writing that, based on the materials submitted, their exemption request was denied and that, in accordance with the Vaccination Policy, they were placed on unpaid leave with immediate effect due to non-compliance with the Vaccination Policy. They were instructed that they would be permitted to return to work immediately upon providing proof of full vaccination within the meaning of the Vaccination Policy or proof of having received at least one dose of a COVID-19 vaccine and proof of a booked appointment for the remaining vaccination. They were informed that failure to take immediate steps to become vaccinated could lead to termination of employment (**Tab 7 of the JBOD**).

34. That same day CUPE filed grievance #21110JH on behalf of Hebert, alleging that QCH had violated the collective agreement and the Ontario *Human Rights Code* for disciplining Hebert for making a personal health decision to decline vaccination (**Tab 8 of the JBOD**).

35. On December 15, 2021, in its Step 2 Response, QCH denied violating the collective agreement or the Ontario *Human Rights Code* (**Tab 9 of the JBOD**). The grievance was put in abeyance by agreement of the Hospital and the Union.

36. On June 26, 2023, QCH notified Hebert in writing that the Hospital would proceed with terminating their employment if they remained non-compliant with the Vaccination Policy by July 27, 2023 (**Tab 10 of the JBOD**).

37. Despite these instructions, Hebert failed to submit proof of having received at least one vaccine dose and remained non-compliant with the Vaccination Policy past July 27, 2023. In response, on August 4, 2023, QCH notified Hebert of the termination of their employment in writing (**TAB 11 of the JBOD**).

38. On August 4, 2023, CUPE filed grievance #230804JH on behalf of Hebert alleging that QCH terminated Hebert without just cause and in violation of the Ontario *Human Rights Code* for making a personal health decision to decline vaccination (**Tab 12 of the JBOD**).

39. Herbert respected the Hospital's COVID-19 related safety measures, including testing and protective equipment, up until mandatory vaccination.

40. Hebert has not received a dose of any recognized vaccine against COVID-19 as of the date of drafting of this Agreed Statement of Facts.

Sanhek Phou (#211110S and #230805SP)

41. Sanhek Phou ("Phou") is the Grievor in the above noted grievance.

42. Until the day of the termination of their employment, Phou held the position of Environmental Service Aide in the Environmental Service Department at QCH where he was employed since August 14, 2018.

43. On October 15, 2021, Phou submitted their COVID-19 Vaccine Exemption Request Form to QCH, requesting an exemption from becoming fully vaccinated based on their religious belief/creed. Phou submitted that based on their Buddhist and Christian teachings, they could not take a vaccine that has harmed animals and humans during the process of its development (**Tab 13 of the JBOD**).

44. On November 10, 2021, QCH informed Phou in writing that, based on the materials submitted, their exemption request was denied and that, in accordance with the Vaccination Policy, they were placed on unpaid leave with immediate effect due to non-compliance with the Vaccination Policy. They were instructed that they would be

permitted to return to work immediately upon providing proof of full vaccination within the meaning of the Vaccination Policy or proof of having received at least one dose of a COVID-19 vaccine and proof of a booked appointment for the remaining vaccination. They were informed that failure to take immediate steps to become vaccinated could lead to termination of employment (**Tab 14 of the JBOD**).

45. That same day CUPE filed grievance #211110S on behalf of Phou, alleging that QCH had violated the collective agreement and the Ontario *Human Rights Code* for disciplining Phou for making a personal health decision to decline vaccination (**Tab 15 of the JBOD**).

46. On December 15, 2021, in its Step 2 Response, QCH denied violating the collective agreement or the Ontario *Human Rights Code* (**Tab 16 of the JBOD**). The grievance was put in abeyance by agreement of the Hospital and the Union.

47. On June 26, 2023, QCH notified Phou in writing that the Hospital would proceed with terminating their employment if they remained non-compliant with the Vaccination Policy by July 27, 2023 (**Tab 17 of the JBOD**).

48. Despite these instructions, Phou failed to submit proof of having received at least one vaccine dose and remained non-compliant with the Vaccination Policy past July 27, 2023. In response, on August 4, 2023, QCH notified Phou of the termination of their employment in writing (**TAB 18 of the JBOD**).

49. On August 5, 2023, CUPE filed grievance #230805SP on behalf of Phou alleging that QCH terminated Phou without just cause and in violation of the Ontario *Human Rights Code* for making a personal health decision to decline vaccination (**Tab 19 of the JBOD**).

50. Phou respected the Hospital's COVID-19 related safety measures, including testing and protective equipment, up until mandatory vaccination.

51. Phou has not received a dose of any recognized vaccine against COVID-19 as of the date of drafting of this Agreed Statement of Facts.

<u>Amber Beach (#211109AB and #230806AB)</u>

52. Amber Beach ("Beach") is the Grievor in the above noted grievances.

53. Until the day of the termination of their employment, Beach held the position of Patient

Care Aide in the Mother and Baby Unit at QCH where she was employed since April 27, 2005.

54. The Job Description for the position of Patient Care Aide is attached at **Tab 20 of the JBOD**.

55. On September 15, 2021, Beach submitted their COVID-19 Vaccine Exemption Request Form to QCH, requesting an exemption from becoming fully vaccinated based on their religious belief/creed. Beach submitted that based on their Christian teachings from youth, God had given them free will to decide to get vaccinated and a natural ability to protect themself and others (**Tab 21 of the JBOD**).

56. On November 9, 2021, QCH informed Beach in writing that, based on the materials submitted, their exemption request was denied and that, in accordance with the Vaccination Policy, they were placed on unpaid leave with immediate effect due to non-compliance with the Vaccination Policy. They were instructed that they would be permitted to return to work immediately upon providing proof of full vaccination within the meaning of the Vaccination Policy or proof of having received at least one dose of a COVID-19 vaccine and proof of a booked appointment for the remaining vaccination. They were informed that failure to take immediate steps to become vaccinated could lead to termination of employment (**Tab 22 of the JBOD**).

57. That same day CUPE filed grievance #211109AB on behalf of Beach, alleging that QCH had violated the collective agreement and the Ontario *Human Rights Code* for disciplining Beach for making a personal health decision to decline vaccination (**Tab 23 of the JBOD**).

58. On December 15, 2021, in its Step 2 Response, QCH denied violating the collective agreement or the Ontario *Human Rights Code* (**Tab 24 of the JBOD**). The grievance was put in abeyance by agreement of the Hospital and the Union.

59. On June 26, 2023, QCH notified Beach in writing that the Hospital would proceed with terminating their employment if they remained non-compliant with the Vaccination Policy by July 27, 2023 (**Tab 25 of the JBOD**).

60. Despite these instructions, Beach failed to submit proof of having received at least one vaccine dose and remained non-compliant with the Vaccination Policy past July 27, 2023. In response, on August 4, 2023, QCH notified Beach of the termination of their

employment in writing (**TAB 26 of the JBOD**).

61. On August 5, 2023, CUPE filed grievance #230806AB on behalf of Beach alleging that QCH terminated Beach without just cause and in violation of the Ontario *Human Rights Code* for making a personal health decision to decline vaccination (**Tab 27 of the JBOD**).

62. Beach respected the Hospital's COVID-19 related safety measures, including testing and protective equipment, up until mandatory vaccination.

63. Beach has not received a dose of any recognized vaccine against COVID-19 as of the date of drafting of this Agreed Statement of Facts.

Gilbert Goulbourne (#211109GG and #230806GG)

64. Gilbert Goulbourne ("Goulbourne") is the Grievor in the above noted grievance.

65. Until the day of the termination of their employment, Goulbourne held the position of Registered Practical Nurse at QCH where he was employed since March 2, 2020.

66. The Job Description for the position of Registered Practical Nurse is attached at **Tab 28 of the JBOD**.

67. On October 22, 2021, Goulbourne submitted their COVID-19 Vaccine Exemption Request Form to QCH, requesting an exemption from becoming fully vaccinated based on their religious belief/creed. Goulbourne submitted that as a devoted Christian and firm believer in Jesus Christ and his teachings, they oppose abortion and because all COVID-19 vaccines "made use of aborted fetal cells in some way(s)", their religious belief prevented them from getting vaccinated (**Tab 29 of the JBOD**).

68. On November 9, 2021, QCH informed Goulbourne in writing that, based on the materials submitted, their exemption request was denied and that, in accordance with the Vaccination Policy, they were placed on unpaid leave with immediate effect due to non-compliance with the Vaccination Policy. They were instructed that they would be permitted to return to work immediately upon providing proof of full vaccination within the meaning of the Vaccination Policy or proof of having received at least one dose of a COVID-19 vaccine and proof of a booked appointment for the remaining vaccination. They were informed that failure to take immediate steps to become vaccinated could lead

to termination of employment (**Tab 30 of the JBOD**).

69. That same day CUPE filed grievance #211109GG on behalf of Goulbourne, alleging that QCH had violated the collective agreement and the Ontario *Human Rights Code* for disciplining Goulbourne for making a personal health decision to decline vaccination (**Tab 31 of the JBOD**).

70. On December 15, 2021, in its Step 2 Response, QCH denied violating the collective agreement or the Ontario *Human Rights Code* (**Tab 32 of the JBOD**). The grievance was put in abeyance by agreement of the Hospital and the Union.

71. On June 26, 2023, QCH notified Goulbourne in writing that the Hospital would proceed with terminating their employment if they remained non-compliant with the Vaccination Policy by July 27, 2023 (**Tab 33 of the JBOD**).

72. Despite these instructions, Goulbourne failed to submit proof of having received at least one vaccine dose and remained non-compliant with the Vaccination Policy past July 27, 2023. In response, on August 4, 2023, QCH notified Goulbourne of the termination of their employment in writing (**TAB 34 of the JBOD**).

73. On August 6, 2023, CUPE filed grievance #230806GG on behalf of Goulbourne alleging that QCH terminated Goulbourne without just cause and in violation of the Ontario *Human Rights Code* for making a personal health decision to decline vaccination (**Tab 35 of the JBOD**).

74. Goulbourne respected the Hospital's COVID-19 related safety measures, including testing and protective equipment, up until mandatory vaccination.

75. Goulbourne has not received a dose of any recognized vaccine against COVID-19 as of the date of drafting of this Agreed Statement of Facts.

<u>Quy Duong (#211115QD and #230807QD)</u>

76. Quy Duong ("Duong") is the Grievor in the above noted grievances.

77. Until the day of the termination of their employment, Duong held the position of Environmental Service Aide in the Environmental Service Department at QCH where he worked since June 8, 1989.

78. On October 14, 2021, Duong submitted their COVID-19 Vaccine Exemption Request Form to QCH, requesting an exemption from becoming fully vaccinated based on their religious belief/creed. Duong attached letters from an Edmonton-based religious leader stating, *inter alia*, that Duong is a Christian and that Christians are to view their bodies as temples of the Holy Spirit, and that accepting a COVID-19 vaccine would violate this instruction (**Tab 36 of the JBOD**).

79. On November 9, 2021, QCH informed Duong in writing that, based on the materials submitted, their exemption request was denied and that, in accordance with the Vaccination Policy, they were placed on unpaid leave with immediate effect due to non-compliance with the Vaccination Policy. They were instructed that they would be permitted to return to work immediately upon providing proof of full vaccination within the meaning of the Vaccination Policy or proof of having received at least one dose of a COVID-19 vaccine and proof of a booked appointment for the remaining vaccination. They were informed that failure to take immediate steps to become vaccinated could lead to termination of employment (**Tab 37 of the JBOD**).

80. On November 10, 2021, CUPE filed grievance #211115QD on behalf of Duong, alleging that QCH had violated the collective agreement and the Ontario *Human Rights Code* for disciplining Duong for making a personal health decision to decline vaccination (**Tab 38 of the JBOD**).

81. On December 15, 2021, in its Step 2 Response, QCH denied violating the collective agreement or the Ontario *Human Rights Code* (**Tab 39 of the JBOD**). The grievance was put in abeyance by agreement of the Hospital and the Union.

82. On June 26, 2023, QCH notified Duong in writing that the Hospital would proceed with terminating their employment if they remained non-compliant with the Vaccination Policy by July 27, 2023 (**Tab 40 of the JBOD**).

83. Despite these instructions, Duong failed to submit proof of having received at least one vaccine dose and remained non-compliant with the Vaccination Policy past July 27, 2023. In response, on August 4, 2023, QCH notified Goulbourne of the termination of their employment in writing (**TAB 41 of the JBOD**).

84. On August 6, 2023, CUPE filed grievance #230807QD on behalf of Duong alleging that

QCH terminated Goulbourne without just cause and in violation of the Ontario *Human Rights Code* for making a personal health decision to decline vaccination (**Tab 42 of the JBOD**).

85. Duong respected the Hospital's COVID-19 related safety measures, including testing and protective equipment, up until mandatory vaccination.

86. Duong has not received a dose of any recognized vaccine against COVID-19 as of the date of drafting of this Agreed Statement of Facts.

Amanda Joynson (#211026AJ)

87. Amanda Joynson ("Joynson") is the Grievor in the above noted grievance.

88. Joynson worked as a Dispatcher for logistics since she began working at QCH on September 14, 2020.

89. The Job Description for the position of Dispatcher for Logistics is attached at **Tab 43 of the JBOD**.

90. On October 20, 2021, QCH informed Joynson in writing that she was being placed on an unpaid leave with immediate effect due to non-compliance with the Vaccination Policy. They were instructed that they would be permitted to return to work immediately upon providing proof of full vaccination within the meaning of the Vaccination Policy or proof of having received at least one dose of the COVID-19 vaccine and proof of a booked appointment for the remaining vaccination. They were informed that failure to take immediate steps to become vaccinated could lead to termination of employment (**Tab 44 of the JBOD**).

91. The next day, CUPE filed grievance #211026AJ on behalf of Joynson, alleging that QCH had violated the collective agreement and the *Ontario Human Rights Code* for disciplining Joynson for making a personal health decision to decline vaccination (**Tab 45 of the JBOD**).

92. On February 4, 2022, in its Step 2 Response, QCH denied violating the Collective Agreement or the Ontario *Human Rights Code* (**Tab 46 of the JBOD**).

93. Joynson respected the Hospital's COVID-19 related safety measures, including testing and protective equipment, up until mandatory vaccination.

94. Approximately 5 months after receiving the Final Warning Letter on June 26, 2023 (**Tab 47 of the JBOD**), Joynson made the decision to comply with the Vaccination Policy and returned to work at QCH after being on unpaid leave for over 20 months.

Issues in Dispute

95. The Parties agree that from its effective date until the revocation of Directive #6 on March 14, 2022, the Vaccination Policy was reasonable.

96. The Parties also agree that QCH did not breach the collective agreement when, in 2021, the Hospital placed its unvaccinated employees not in possession of a valid exemption to become fully vaccinated, on a leave of absence without pay.

97. However, the Parties disagree on whether QCH properly denied the Grievors an exemption from the requirement to become fully vaccinated based on their individual COVID-19 Vaccine Exemption Requests, and therefore whether their leave without pay and subsequent termination constitutes a violation of the collective agreement and/or the Ontario *Human Rights Code*. The Parties have agreed to deal with the religious exemption grievances at a later date, if required.

98. The Parties further disagree on whether the requirement under the Vaccination Policy to be fully vaccinated was still reasonable following the revocation of Directive #6 on March 14, 2022. CUPE's position is that from March 15, 2022 onwards, the Policy was unreasonable because employees fully vaccinated under the Vaccination Policy were no longer better protected than the Grievors against COVID-19 infection and transmission. For this reason, CUPE contends that the continued leave of absence and termination of the Grievors for non-compliance with the Vaccination Policy constitutes a violation of the collective agreement and/or the Ontario *Human Rights Code*. QCH's position is that the Vaccination Policy continues to be reasonable, that the Grievors had ample opportunity to comply with the Policy, and that they had no reasonable excuse for their continued refusal to become vaccinated. QCH's position is that termination was reasonable in all the circumstances as a response to the Grievors' sustained non-compliance with a reasonable workplace rule.

99. The Parties are free to supplement the facts agreed herein so long as this evidence does not

contradict the facts agreed to. The Parties are free to call *viva voce* evidence and expert evidence as long as it does not contradict the facts herein.

15

Appendix B – Authorities

Authorities filed by the Union:

Re Lumber & Sawmill Workers' Union, Local 2537, and KVP Co. Ltd., 1965 CanLII 1009 (ON LA) (Robinson)

Communications, Energy and Paperworkers Union of Canada, Local 30 v. Irving Pulp & Paper, Ltd., 2013 SCC 34

Teamsters Local Union No. 31 v. Purolator Canada Inc., 2023 CanLII 120937 (CA LA) (Glass) — set aside in 2026 BCCA 3

Purolator Canada Inc. v. Canada Council of Teamsters, 2025 BCSC 148 — reversed in 2026 BCCA 3

Occupational Health and Safety Act, R.S.O. 1990, c. O.1, s. 25(2)(h)

Power Workers' Union v. Elexicon Energy Inc., 2022 CanLII 7228 (ON LA) (Mitchell)

Electrical Safety Authority v. Power Workers' Union, 2022 CanLII 343 (ON LA) (Stout)

Quinte Health v. Ontario Nurses Association, 2024 CanLII 14991 (ON LA) (Hayes)

Toronto (City) v. Toronto Civic Employees' Union, CUPE, Local 416, 2022 CanLII 109503 (ON LA) (Herman)

FCA Canada Inc. v. Unifor, Locals 195, 444, 1285, 2022 CanLII 52913 (ON LA) (Nairn)

Alectra Utilities Corporation v. Power Workers' Union, 2022 CanLII 50548 (ON LA) (Stewart)

Authorities filed by the Hospital:

Re Lumber & Sawmill Workers' Union, Local 2537, and KVP Co. Ltd., 1965 CanLII 1009 (ON LA) (Robinson)

Communications, Energy and Paperworkers Union of Canada, Local 30 v. Irving Pulp & Paper, Ltd., 2013 SCC 34

National Organized Workers Union (NOWU) v. Humber River Hospital, 2024 CanLII 52386 (ON LA) (Tremayne)

Lakeridge Health v. CUPE, Local 6364, 2023 CanLII 33942 (ON LA) (Herman)

Toronto District School Board v. CUPE, Local 4400, 2022 CanLII 22110 (ON LA) (Kaplan)

Regional Municipality of York v. Canadian Union of Public Employees, Local 905 (Long Term Care Unit), 2022 CanLII 78173 (ON LA) (Raymond)

Elementary Teachers' Federation of Ontario v. Ottawa-Carleton District School Board, 2022 CanLII 53799 (ON LA) (Flaherty)

Quinte Health v. Ontario Nurses Association, 2024 CanLII 14991 (ON LA) (Hayes)

Central West Local Health Integration Network and Mississauga Halton Local Health Integration Network v. Canadian Union of Public Employees, Local 966, 2023 CanLII 58388 (ON LA) (Goodfellow)

Faryna v. Chorny, 1951 CanLII 252 (BCCA)

R. v. H.C., 2009 ONCA 56

2287913 Ontario Inc. v. ERSP International Enterprises Ltd., 2021 ONSC 3080

R. v. Mohan, 1994 CanLII 80 (SCC), [1994] 2 S.C.R. 9

White Burgess Langille Inman v. Abbott and Haliburton Co., 2015 SCC 23

Ontario Nurses' Association v. Sault Area Hospital, 2015 CanLII 55643 (ON LA) (Hayes)

FCA Canada Inc. v. Unifor, Locals 195, 444, 1285, 2022 CanLII 52913 (ON LA) (Nairn)

Coca-Cola Canada Bottling Limited v. United Food and Commercial Workers Union Canada, Local 175, 2022 CanLII 83353 (ON LA) (Herman)

Toronto Professional Fire Fighters' Association, I.A.F.F. Local 3888 v. Toronto (City), 2022 CanLII 78809 (ON LA) (Rogers)

Rogelstad v. Middlesex Health Alliance, 2025 ONSC 263

Humber River Hospital v. Teamsters Local Union No. 419, 2024 CanLII 19827 (ON LA) (Parmar)

Humber River Health v. Teamsters Local Union No. 419, 2025 ONSC 2270

Corporation of the City of North Bay v. Canadian Union of Public Employees, Local 122-1, 2023 CanLII 83430 (ON LA) (Newman)

Chartwell Housing REIT v. Healthcare, Office and Professional Employees Union, Local 2220, UBCJA, 2022 CanLII 6832 (ON LA) (Misra)

London Health Sciences Centre v. Unifor Local 27, 2024 CanLII 48714 (ON LA) (Wright)

Seneca College v. OPSEU, Local 561, 2024 CanLII 120570 (ON LA) (Randazzo)

Ontario Public Service Employees Union, Local 461 v. Hawkesbury and District General Hospital, 2024 CanLII 51817 (ON LA) (Flaherty)

Post-hearing authorities noted in the award:

Ontario Nurses' Association v. Orillia Soldiers' Memorial Hospital, 2025 CanLII 73709 (ON LA) (Nyman) — supplemental submissions

Purolator Canada Inc. v. Canada Council of Teamsters, 2026 BCCA 3