Appendix A to Form 3 – Amendment Form Filed November 28, 2024
Original Filed June 17, 2020

IN THE HUMAN RIGHTS TRIBUNAL OF BRITISH COLUMBIA

BETWEEN:

UNION OF BRITISH COLUMBIA INDIAN CHIEFS

COMPLAINANT

AND:

PROVINCIAL HEALTH SERVICES SOCIETY, VANCOUVER COASTAL HEALTH AUTHORITY, BRITISH COLUMBIA TRANSPLANT SOCIETY, HER MAJESTY THE QUEEN IN RIGHT OF BRITISH COLUMBIA (MINISTRY OF HEALTH)

RESPONDENTS

FURTHER AMENDED NOTICE OF COMPLAINT

Filed by: The Complainant, Union of British Columbia Indian Chiefs

CLAIM OF THE COMPLAINANT

Part 1: STATEMENT OF FACTS

1. Union of British Columbia Indian Chiefs (“UBCIC”) is a non-profit society incorporated pursuant to the *Societies Act*, S.B.C. 2015, c.18. UBCIC has an address for service of 511-55 East Cordova Street, Vancouver, British Columbia.

2. UBCIC is a representative organization representing over half the First Nations communities in British Columbia. UBCIC is dedicated to promoting and supporting the efforts of First Nations in British Columbia to affirm and defend their rights and title, and to generally ensure that Indigenous political, social,

economic and spiritual institutions and rights be strengthened and respected both by Indigenous people and the larger Canadian community.

3. UBCIC's mandate is to work towards implementation, exercise and recognition of Indigenous rights, title and treaty rights, to protect Indigenous land and waters and to implement all aspects of the United Nations Declaration on the Rights of Indigenous Peoples for the establishment and maintenance of minimum standards for the survival, dignity, well-being and rights of Indigenous peoples.

4. UBCIC has existed since 1969 and has created and disseminated numerous press releases, information circulars, research reports, case studies, pamphlets, training programs and other forms of communication to its member First Nations communities, Indigenous persons and the public at large.

5. Liver transplants are a health service customarily made available to the public.

Abstinence Policy

6. To be eligible to receive a liver transplant, an applicant with a history of Alcohol Use Disorder must adhere to a mandatory six month abstinence policy (the "Abstinence Policy") before being considered for placement on the liver transplant waitlist.

7. Indigenous people suffer disproportionately higher rates of Alcohol Use Disorder due to historic and ongoing oppressive and colonialist policies. Contributing factors to the higher rates of Alcohol Use Disorder include a lack of genetic protective factors (metabolizing enzyme variants) combined with genetically mediated factors (externalizing traits, consumptive drive, drugs sensitivity/tolerance) that combine with key environmental factors (trauma exposure, early age onset of use, and environmental hardship/contingencies).

8. The Abstinence Policy places the health of Indigenous persons at risk and is an affront to their sense of self-worth, respect and dignity.

Primary Biliary Cirrhosis

9. Primary Biliary Cirrhosis ("PBC") is a liver-destroying condition that causes premature mortality unless treated by a liver transplant. Primary Biliary Cirrhosis is of much higher prevalence in Indigenous people. Indigenous people with Primary Biliary Cirrhosis are likely to be diagnosed as suffering from liver disease as a consequence of Alcohol Use Disorder on the basis of stereotypical views of

Indigenous people, and are thus also discriminated against on the basis of the Abstinence Policy.

10. Indigenous people with Primary Biliary Cirrhosis are also downgraded in priority for a transplant in British Columbia as a result of how MELD scores are calculated for people with Primary Biliary Cirrhosis (the "PBC/MELD Policy"). MELD (Model for End-Stage Liver Disease) scores are used to set priority for liver transplants. The way MELD scores are calculated for Primary Biliary Cirrhosis is informed by and normed for a heterogenous patient population and the Respondents know or ought to know that it has a discriminatory effect of restricting access to liver transplants for Indigenous patients with PBC.

The Class

11. UBCIC seeks to make this complaint on behalf of Indigenous persons and persons of Indigenous ancestry who have been adversely impacted by the Abstinence Policy and/or PBC/MELD Policy.

12. UBCIC has communicated with the proposed class through a media release shared with its constituency and the press generally regarding a previous complaint filed by David Dennis (BCHRT Case No. 19643) and the discriminatory impact of the Abstinence Policy and PBC/MELD Policy.

13. UBCIC proposes to communicate with the class through press releases, direct communications and its Facebook social media page. The communication will include opt-out options if is so desired by individuals within the class.

14. The interests of UBCIC and the proposed class are in alignment and there is no conflict between them.

The Respondents

~~15. Her Majesty the Queen in Right of the Province of British Columbia as represented by the Ministry of Health (the "Ministry of Health") has overall responsibility for the health services available in British Columbia and for setting health care policy.~~

15. The Provincial Health Services Authority ("PHSA") is a society incorporated pursuant to the *Societies Act*, SBC 2015, c.18. PHSA's purpose is to plan, manage and operate the integrated delivery of Province-wide health care services. PHSA has Province wide responsibility for provincial clinical policy and service delivery, including in the area of organ donation and transplantation

health. PHSA has an address of 200 – 1333 W Broadway Ave, Vancouver, British Columbia.

16. The British Columbia Transplant Society (“BCTS”) is funded by and is an agency of PHSA. BCTS is responsible for maintaining transplant waitlists. BCTS has an address a 350 – 555 W 12th Ave, Vancouver, British Columbia.

17. Vancouver Coastal Health Authority (“VCHA”) is a regional health board incorporated pursuant to the *Health Authorities Act*, RSBC 1996 c. 180. The VCHA is responsible for development of policies, priorities, delivery and allocation of resources for health services within its designated region. VCHA has an address of 601 West Broadway Ave, Vancouver, British Columbia.

18. Vancouver General Hospital is the only location in the Province where liver transplants are performed. The VCHA is responsible for management, delivery and operation of the health care services provided at Vancouver General Hospital.

19. ~~The Province,~~ PHSA, VCHA and BCTS (the “Respondents”) are jointly responsible for developing, sustaining, maintaining and implementing the Abstinence Policy and PBC/MELD Policy. The Abstinence Policy is listed on the VCHA’s Liver Transplant Referral Form – Exclusion Criteria.

Further Facts Since the Commencement of this Complaint

20. The Respondents announced in August of 2020 that the Abstinence Policy was terminated in May of 2020. This initial announcement was false. In September of 2020, one or more of the Respondents issued a letter to specialist gastroenterologists to the effect that the Abstinence Policy was no longer in effect, but no notice was given to the physicians who refer patients to endocrinologists. The Respondents did not follow up with gastroenterologists to ensure that they had received the message and had implemented the Respondents’ decision to terminate the Abstinence Policy. The Abstinence Policy thus continued in effect.

21. The Respondents released a new written policy entitled “Clinical Guidelines for Liver Transplantation, Continuum of Patient Care from Pre-Transplant to Post-

Transplant/Out-Patient", effective February 10, 2022 (the "2022 Policy").[1] The Respondents did not consult with UBCIC or any other Indigenous community organizations when preparing the 2022 Policy.

22. In respect of the PBC/MELD Policy, the 2022 Policy does not implement any changes. Priority for transplants for patients on the transplant list is determined by medical status (Table 9, p.38, ranking 1 to 4F depending on whether at home or in ICU, intubated), MELD/MELD-Na and Child-Pugh scores, and symptoms, with the exception of patients with hepatocellular carcinoma ("HCC"). Under heading 4.1, the 2022 Policy asserts that the MELD score is objective and all non-urgent patients should be ranked according to their MELD-Na scores. The PBC/MELD Policy is thus unchanged by the 2022 Policy.

23. At all material times, the Respondents have failed, refused and resisted making any changes to the PBC/MELD Policy despite their knowledge of its adverse effects on Indigenous patients. The Respondents have also failed and refused to carry out further research on a timely basis despite their assertions that further research is necessary before the PBC/MELD Policy can be changed.

24. The 2022 Policy sets out an admission that Indigenous patients have increased predisposition to PBC and may have lower transplantation rates, but provides no remedy for this. Instead, the 2022 Policy states that more work is needed to fully understand the situation so preventative and management strategies can be designed. The existence of an accommodation or exception for HCC patients but not for PBC patients is not explained by the 2022 Policy.

25. The 2022 Policy notionally terminates the Abstinence Policy, but replaces it with a functionally equivalent restriction on Indigenous access to liver transplants, and introduced additional criteria or thresholds for liver transplant eligibility that perpetuate and extend the barriers to Indigenous access to liver transplants. The criteria and thresholds for Indigenous access to liver transplant under the 2022

[1] A revised version of the 2022 Police was published in January 2023, effective January 8, 2023, but the operative sections discussed herein are unaffected by the 2023 revisions.

Policy are set out in detail below, as they are dispersed throughout the lengthy 2022 Policy in numerous sub-parts, Appendices, Matrixes and Schedules.

26. The notional statement of access is found at page 13 of the 2022 Policy, under heading 2.2.3:

> 2.2.3 Alcohol-associated liver disease
>
> Patients with liver disease caused by alcohol consumption can be considered for liver transplantation if there is a lack of spontaneous improvement after a period of clinical observation following abstinence from alcohol use. Patients with acute alcohol-associated hepatitis (previously known as alcoholic hepatitis) can also be considered for liver transplant if they show no response to treatment to steroids and if there is no previous history of documented alcohol-related disease. ***There is no longer a minimum period of abstinence that is required (i.e., the 6-month rule) to accept a referral***. Patients for whom the reason for decompensation or lack of improvement is ongoing alcohol use, despite previous recommendations for abstinence, will not be considered for transplantation. Patients are still required to read and sign an informed Consent Form (see **Appendix B**), as well as receiving a satisfactory report from an independent alcohol and drug counsellor (see **Appendix C** for the request form for addiction counselling) and favourable assessments from the transplant program staff members who have expertise in the evaluation of patients with history of substance use (see **Appendix E** for sample information for patients about alcohol and drug relapse prevention counselling).
>
> Given the complexity of this situation, a specific guideline for transplantation in alcohol-associated liver disease (ALD) is available for consultation (Refer to Appendix I, Supplement – Clinical Guidelines in Patients with Alcohol Use).
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> [emphasis in original]

27. Under heading 2.2.9 of the 2022 Policy, Psychosocial Factors, transplant social workers will conduct a psychosocial assessment, which includes exploration of each patient's social determinants of health (i.e., finances, housing, vocational, social support, etc.), both to determine resources that are in place and to

"determine what further factors need to be addressed in order to enable a patient to become a candidate". The implication is that the absence of these determinants may well preclude candidacy.

28. Under heading 2.2.9, the transplant social worker will administer the Stanford Integrated Psychosocial Assessment for Transplant ("SIPAT") as part of the psychosocial assessment. The SIPAT includes a standardized scoring matrix that assigns points in the presence of each of a number of factors, including the following: knowledge of the transplant process and the medical illness process that cause the organ failure, desire for treatment, treatment compliance, lifestyle factors (diet, exercise, fluid restrictions and organ-related habits), the availability of a social support system, functionality of social support system, appropriateness of physical living space (i.e. quality of housing), and the presence of psychopathology (including depression and anxiety, using Beck Inventories). In particular, the presence of alcohol abuse or dependence adds significant points to the overall score (up to 25 points). SIPAT adds up the total points and generates rating/recommendation with the following cutoff scores:

Total Score	SIPAT Score Interpretation
0-6	Excellent Candidate – recommend to list without reservations
7-20	Good candidate – recommend to list – although monitoring of identified risk factors may be required
21-39	Minimally Acceptable Candidate – consider listing. Identified risk factors must be satisfactorily addressed before representing for consideration
40-69	Poor candidate – recommend deferral while identified risks are satisfactorily addressed
>70	High Risk candidate, significant risk identified – surgery is not recommended while identified risk factors continue to be present

29. SIPAT also contains a list of "Absolute Contraindications", which includes "inadequate social support system". The presence of only one absolute contraindication is sufficient to defer the decision or decline. The list of indications of "moderate risk" include: reluctance to relocate near care centre, absence of adequate living environment, limited or restricted access to resources. The presence of 3 moderate risk factors creates pressure to defer or decline under the scoring/interpretation guidelines. SIPAT guidelines thus create quite rigid rules requiring complete adherence to abstinence contracts, 12-step programs, and development of an adequate support team.

30. The 2022 Policy refers to a Solid Organ Transplant (SOT) multidisciplinary team. In respect of substance use supports, the 2022 Policy provides:

> Patients identified as having complex substance use histories or concerns for relapse may be referred to the integrated providers on the SOT team, including an addiction medicine physician or concurrent disorder clinician. These providers collaborate with the patient to identify substance use challenges and to determine what interventions or supports might be beneficial to move the patient towards transplant candidacy. Patients can be supported through pharmacological treatment, individual counselling or group counselling, or other programming in their community. Moreover, this support is available to both pre- and post-transplant patients. Although the SOT clinic will try to support patients with these problems, it is not within its scope to treat or manage substance use disorder. …
>
> **Required Documentation**
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> The social support agreement (Appendix D) is discussed with and completed by all transplant candidates and their social support network. The Informed Consent Form (Appendix B) is also included when clinically indicated for support with relapse prevention.

31. The 2022 Policy requires a transplant patient to relocate to the Lower Mainland with at least one member of a social support network. Potential for funding for the relocation is noted but not required.

32. Appendix C is sent to an addictions specialist at the time of referral if a patient has a substance use disorder. Appendix C effectively requires the presence of a social support network for transplant eligibility.

33. The numerous appendices in the 2022 Policy create further criteria. Appendix A (a standard referral form) suggests that demonstration of abstinence is a pre-requisite for a referral for assessment. Exclusion criteria listed in Appendix A include non-compliance with medical management, use of illicit drugs and/or excessive use of therapeutic drugs within the last six months, ongoing smoking, absence of 24/7 social support for recovery period after transplant, unable or not committed to adhere to medical treatment and recent suicide attempt.

34. Appendix B, the "Informed Consent Form", provides for random testing of blood, breath and urine, and that resuming substance use after acceptance into the transplant program may result in being removed from the transplant waiting list.

35. Appendix C, a standard form referring to addictions specialist, requests a report that considers the following:

- Cessation of substance use due primarily to a medical event without patient addressing underlying addiction-related issues
- Limited alternate (substance-free) coping strategies
- Limited sense of responsibility for substance misuse
- Social circle reinforcing substance misuse
- Family history of alcohol misuse
- Significant psychosocial stressors
- Previous repeated treatment failures
- Social instability (poor quality of existing personal relationships)
- Social isolation
- Limited social support
- Previous history of medical treatment non-adherence

36. Appendix D is a standard form contract or declaration that the support person or persons will offer instrumental and emotional support to the transplant patient before and after the transplant period.

37. The Supplemental Guidelines, found under Appendix I of the 2022 Policy, are entitled "Clinical Guidelines in Patients with Alcohol Use". At page 94, the following are listed as "absolute criteria for liver transplantation":

- Absence of pre-existing known liver disease secondary to alcohol consumption
- a previous diagnosis or admission for alcohol-related hepatitis
- liver disease secondary to some other condition for which patient was asked to reduce consumption
- other medical condition (including alcohol withdrawal) for which patient was asked to reduce consumption.
- Presence of strong social support from family or friends
- Stable financial condition
- Assessment using SIPAT
- Assessment of risk for alcohol relapse

38. At page 95 of the 2022 Policy, non-absolute criteria for transplantation include absence of significant legal problems related to alcohol misuse and alcohol consumption estimated at 10 units or more per day.

39. Page 96 of the 2022 Policy effectively reinstates the Abstinence Policy by establishing an observation period of 6-12 months and requiring that the patient address the substance use disorder (ie. maintain abstinence) during the period of observation:

> It is recognized that patients can have a significant improvement of their liver function with alcohol abstinence. Indeed, abstinence is the treatment of alcohol-related liver disease. Patients with decompensated liver disease can completely normalize their liver function after a few months. It is estimated that most of the improvement can occur within the first 6-12 months of abstinence. As such, these patients should be carefully monitored by their physicians/nurse practitioners before being referred to the transplant clinic. ….
>
> … the patient is expected to address the substance use disorder during the period of observation …

40. The conditions above are understood to be accretive. Thus, in addition to a 6-12 month period of abstinence, the 2022 Policy creates the following additional barriers to access to a liver transplant:

    a. Absence of or inadequacy of social support from family or friends;
    b. Stable financial condition;

c. Adequacy of housing;
d. Limited sense of responsibility for substance misuse;
e. Social circle reinforcing substance misuse;
f. Family history of alcohol misuse;
g. Significant psychosocial stressors;
h. Previous repeated treatment failures;
i. Social instability (poor quality of existing personal relationships); and
j. Social isolation.
(the "Additional Barriers")

41. The Additional Barriers are factors that are disproportionately present for Indigenous patients as a result of residential school abuse, community and individual dispossession and displacement and other forms of colonial oppression. The Additional Barriers create systemic disadvantage by tending to deprive Indigenous patients of access to liver transplants.

42. The 2022 Policy establishes criteria analogous to *Gladue* factors (family stability, financial stability, etc.) as factors that preclude or diminish eligibility and priority for a liver transplant. Contrary to the principles in *Gladue*, however, the greater the presence of those factors, the less likely the patient will be referred for assessment or added to the transplant wait list. The result is systemic adverse effect restricting access by Indigenous patients to liver transplant services.

Part 2: RELIEF SOUGHT

UBCIC seeks the following relief:

a. A declaration that the Abstinence Policy and PBC/MELD Policy discriminate against Indigenous persons and persons of Indigenous descent;

b. An order that the Abstinence Policy be removed from the Liver Transplant Referral Exclusion Criteria;

c. An order that the Respondents cease to use MELD-Na scores to prioritize Indigenous patients with PBC for liver transplants and that the PBC/MELD

Policy be revised to eliminate its discriminatory effects against Indigenous patients;

d. An order for damages for class members adversely impacted by the Abstinence Policy and PBC/MELD Policy as compensation for injury to dignity, feelings and self respect, and for deterioration of health;

~~e. Such further and other order as the Tribunal may find just and equitable.~~

f. An order that the Respondents and all persons with notice of this order cease to apply the discriminatory provisions of the 2022 Policy;

g. An order that the Respondents delete all provisions of the 2022 Policy that are found to be discriminatory or that contribute to unlawful discrimination against Indigenous persons;

h. An order that the Respondents disseminate and publicise the revised version of the 2022 Policy to all persons within the health care system whom it may concern, including all practitioners of family medicine and all gastroenterologists and hepatologists;

i. An order that the Respondents develop, offer and produce a minimum of three continuing medical education seminars in respect of the changes within the 2022 Policy for persons within the health care system whom it may concern, including all practitioners of family medicine and all gastroenterologists and hepatologists;

j. An order that the Respondents reasonably accommodate Indigenous patients by assessing whether any barriers to transplant eligibility and priority are the product of historical oppression and, if so, take reasonable positive steps to treat, alleviate, address and accommodate those barriers to establish eligibility and improve priority; and

k. Such further and other order as the Tribunal may find just and equitable.

Part 3: LEGAL BASIS

1. Liver transplants are a service customarily available to the public.

2. The Abstinence Policy and PBC/MELD Policy have an adverse discriminatory impact on Indigenous persons, persons of Indigenous ancestry, persons with Alcohol Use Disorder and persons with Primary Biliary Cirrhosis. The Abstinence Policy and PBC/MELD Policy result in differential treatment and discrimination on the basis of race, ancestry and disability in breach of the *Human Rights Code*, RSBC 1996, c.210.
3. The Abstinence Policy and PBC/MELD Policy lack a reasonable or scientific justification for their use as exclusion criteria for or systemic barriers to liver transplants.
4. Interpretation of the *Human Rights* Code, RSBC 1996, c.210, should be informed by the principles adopted by the Supreme Court of Canada in *R. v. Gladue*, 1999 SCC 679, and the *United Nations Declaration on the Rights of Indigenous Peoples* ("*UNDRIP*").
5. *Gladue* principles support the recognition that Indigenous persons, as patients within British Columbia's medical system, as well as the Respondents' staff and administrators, are affected and influenced by the history of colonial oppression within British Columbia and Canada.
6. The *Gladue* framework is taken from a line of cases within the criminal justice system dealing with sentencing, charge approval, prison policy and parole policy.[2] The *Gladue* line of cases set out a principle of statutory interpretation that:
   a. requires judicial notice to be taken of the history of colonial oppression and its deleterious effects on Indigenous employment, housing, education, social stability, involvement in the criminal justice system, health including substance use disorders, and other indicia of well-being (*"Gladue* Factors"); and

[2] These cases include *R. v. Gladue*, 1999 CanLII 679 (SCC), *R. v. Ipeelee*, 2012 SCC 13, *Ewert v. Canada*, 2018 SCC 30 (CanLII), *Twins v. Canada (Attorney General)*, 2016 FC 537 (CanLII)

b. requires statutory provisions, including any grant of discretionary powers, to be interpreted to accommodate, redress and ameliorate the deleterious effects of colonial oppression as manifested in the life and circumstances of the affected individual.

7. The *Gladue* principles should inform the interpretation of s.8 of the *Human Rights Code* and should inform the interpretation of whether any *prima facie* discriminatory effect can be justified by the Respondents by reference to an enabling statute or discretion.

8. In the health care context, the Tribunal should take judicial notice that the determinants of health for Indigenous people are affected by history and oppression. Both the Abstinence Policy and the Additional Barriers in the 2022 Policy restrict access to liver transplants on the basis of *Gladue* Factors presented in a patient. Substance Use Disorders and instability in social, family, community, financial and housing dimensions are all *Gladue* markers of historical oppression of Indigenous people.

9. Within the health care setting, a human rights compliant approach informed by *Gladue* principles requires that the exercise of medical discretion, as it is applied to each individual Indigenous person, must include an assessment of whether colonial oppression has negatively affected the individual in respect of the decision under consideration, and, if so, requires the discretion to be exercised to avoid penalizing or depriving the individual on the basis of factors resulting from historical or ancestral oppression and the historical iniquity must be rectified if it is reasonably feasible to do so.

10. The *Gladue* framework is relevant to liver transplant decisions because many of the deleterious consequences of inter-generational oppression of Indigenous peoples in Canada are also factors that detract from liver transplant eligibility and priority under the Abstinence Policy and the 2022 Policy. These factors include substance use disorder, the availability of familial and social supports, the availability of housing, level of education and engagement with health planning

and involvement in the criminal justice system. The more *Gladue* Factors are present, the less eligible the patient is for a transplant under the Abstinence Policy and 2022 Policy, and the lower their priority for a transplant if they are eligible. The result is unjustifiable discrimination contrary to s.8 of the *Human Rights Code*.

11. The *Human Rights Code* may also be interpreted by reference to Articles 21, 23, 24 and 29 of *United Nations Declaration on the Rights of Indigenous Peoples*, which provides as follows:

> Article 21
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> 1. Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.
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> 2. States shall take effective measures and, where appropriate, special measures to ensure continuing improvement of their economic and social conditions. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities.
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> Article 23
>
> Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.
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> Article 24
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> 1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also

have the right to access, without any discrimination, to all social and health services.

2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

Article 29 …

3. States shall also take effective measures to ensure, as needed, that programmes for monitoring, maintaining and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.

12. *UNDRIP*, as an interpretive guide for assessing the scope of human rights of Indigenous people in the provision of medical services, brings the following normative principles to bear on liver transplant eligibility and priority decisions: the state shall take measures to ensure restoration of the health of indigenous peoples; the state has a duty to involve Indigenous people in developing and determining health, housing and other economic and social policies and programmes affecting them; the state has a duty to undertake to achieve the full realization of equalization of health care on the basis of outcome. The PBC/MELD Policy, the Abstinence Policy and the 2022 Policy do not comply with these general principles.

13. The PBC/MELD Policy, the Abstinence Policy and the 2022 Policy create adverse effects on Indigenous persons, including class members, without justification and without reasonably accommodating barriers to transplant eligibility and priority facing Indigenous patients.

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The address of the Tribunal is:	The BC Human Rights Tribunal 1270 - 605 Robson Street Vancouver, British Columbia V6B 5J3

Date: November 28, 2024

Signature of lawyer for UBCIC
Jason Gratl