Recommendations

Introduction

The first interim report, *SARS and Public Health in Ontario*, focused on public health renewal. The Commission said:

> Because government decisions about fundamental changes in the public health system are clearly imminent, this interim report on the public health lessons of SARS is being issued at this time instead of awaiting the final report … The fact that the Commission must address public health renewal on an interim basis is not to say it is more important than any other urgent issue such as the safety and protection of health care workers. It is simply a case of timing.[18]

The Commission set out 21 principles for reforming the shortcomings of the public health system demonstrated by SARS. It also made recommendations to address urgent problems that had to be corrected to prevent another tragedy like SARS, including a lack of provincial public health leadership, insufficient public health capacity and resources, inadequate provincial laboratory capacity, a lack of central public health coordination and expertise, an absence of public health emergency preparedness, and a lack of public health links with hospitals, health workers and others.

The second interim report, *SARS and Public Health Legislation*, focused on public health legislation. The Commission said:

> This second interim report deals with legislation to strengthen the *Health Protection and Promotion Act* and to enact emergency powers for public health disasters like SARS or flu pandemics. It is produced now to respond to current government plans for further amendments to *Health*

18. SARS Commission, first interim report, p. 1.

> *Protection and Promotion Act* and radical changes to the *Emergency Management Act*.[19]

The Commission made recommendations regarding Chief Medical Officer of Health independence and leadership, local public health governance, public health legal preparedness and emergency legislation, public health resources, and overhauling the *Health Protection and Promotion Act*, including strengthening health protection powers and clarifying infectious disease reporting requirements.

This third and final report makes recommendations arising from the story of how SARS devastated Ontario and was not contained until 375 people contracted the disease and 44 died. Not surprisingly in an outbreak where nurses, doctors and other health workers constituted the largest single group of SARS cases, many of the recommendations address worker safety issues. As the Commission noted in its second interim report:

> Suggestions have been received for legislation to strengthen occupational health and safety protection for health workers. That issue will be dealt with in the final report. Occupational health and safety is a vital aspect of the Commission's work.[20]

The Commission benefited greatly from written and oral submissions delivered during the course of the public hearings and in response to several calls for submissions from the beginning to the end of the investigation. Many submissions and presentations from the public hearings are on the Commission's website.

The submissions from government, hospitals, unions and many sectors of the health community noted significant improvements since SARS and significant areas where more needs to be done. These submissions constitute just under a banker's box of material. This material, together with all public records of the Commission's work, have been transmitted to the Archives of Ontario[21] and will be available to the public according to archival policy.

---

19. SARS Commission, second interim report, p. 1.
20. SARS Commission, second interim report, p. 1.
21. The Commission has transmitted to the Archives of Ontario all non-confidential material. The Commission's report is by its terms of reference subject to Ontario's privacy and freedom of information legislation, in the sense that the report itself is publicly available and must respect the confidentiality of personal health information. Because the Commission is independent from government, its confidential work product is not subject to those statutes. Much of the

Precautionary Principle

In *The Commission of Inquiry on the Blood System in Canada*, Mr. Justice Krever said:

> Where there is reasonable evidence of an impending threat to public health, it is inappropriate to require proof of causation beyond a reasonable doubt before taking steps to avert the threat.[22]

The importance of the precautionary principle that reasonable efforts to reduce risk need not await scientific proof was demonstrated over and over during SARS. The need to apply it better is noted throughout this report.

One example was the debate during SARS over whether SARS was transmitted by large droplets or through airborne particles. The point is not who was right and who was wrong in this debate. When it comes to worker safety in hospitals, we should not be driven by the scientific dogma of yesterday or even the scientific dogma of today. We should be driven by the precautionary principle that reasonable steps to reduce risk should not await scientific certainty.

A precautionary approach also was in use at Vancouver General Hospital when it received B.C.'s first SARS case on March 7, 2003, the same day Ontario's index case presented at Scarborough Grace Hospital. When dealing with an undiagnosed respiratory illness, health workers at Vancouver General automatically go to the highest level of precautions, and then scale down as the situation is clarified. While the circumstances at Vancouver General and the Grace were different, it is not surprising that SARS was so effectively contained at an institution so steeped in the precautionary principle.

In Ontario there was a systemic failure to recognize the precautionary principle in health worker safety, and in the identification and diagnosis of a respiratory illness that mimicked the symptoms of other, better-known diseases. Amid this systemic absence of the precautionary principle, it is not surprising that in Ontario, unlike in Vancouver, SARS caused such devastation, infecting 375 people, including 169 health workers, and killing 44, including two nurses and a physician.

Commission's work product consists of confidential informant interviews, notes and documents produced or obtained under a promise of confidentiality that attracts in law.

22. The Krever Report, p. 295; see also pp. 989-994.

The Commission therefore recommends:

- That the precautionary principle, which states that action to reduce risk need not await scientific certainty, be expressly adopted as a guiding principle throughout Ontario's health, public health and worker safety systems by way of policy statement, by explicit reference in all relevant operational standards and directions, and by way of inclusion, through preamble, statement of principle, or otherwise, in the *Occupational Health and Safety Act,* the *Health Protection and Promotion Act*, and all relevant health statutes and regulations.

- That in any future infectious disease crisis, the precautionary principle guide the development, implementation and monitoring of procedures, guidelines, processes and systems for the early detection and treatment of possible cases.

- That in any future infectious disease crisis, the precautionary principle guide the development, implementation and monitoring of worker safety procedures, guidelines, processes and systems.

Public Health System

SARS showed that Ontario's public health system is broken and needs to be fixed. Since then, while much progress has been made, after long periods of neglect, inadequate resources and poor leadership, much more remains to be done. Every recommendation to the Commission in respect of public health noted the need for more resources.[23]

---

23. One of the best examples is the July 19, 2006, submission by Dr. David McKeown, the Toronto Medical Officer of Health, who noted in particular these six problems:

    1. The role and authority of Public Health with respect to non-reportable diseases must be strengthened.

    2. The reporting capability of iPHIS [the integrated Public Health Information System] must be improved. In addition, the Ministry of Health and Long-Term Care (MOHLTC) must move forward more rapidly to enable electronic reporting of cases from laboratories, hospitals and physicians to local Public Health.

    3. The MOHLTC and the College of Physicians and Surgeons of Ontario must develop mech-

As the Commission's second interim report said:

> As the province moves into the latter stages of Operation Health Protection, stages when significant funding will be required, the challenge will be to provide the necessary resources to sustain the momentum for change despite the government's other budgetary pressures.
>
> The point has to be made again and again that resources are essential to give effect to public health reform. Without additional resources, new leadership and new powers will do no good. To give the Chief Medical Officer of Health a new mandate without new resources is to make her powerless to effect the promised changes. As one thoughtful observer told the Commission:
>
> > The worst-case scenario is basically to get the obligation to do this and not get the resources to do it. Then the Chief Medical Officer of Health would have a legal duty that [he or she] can't exercise.
>
> To arm the public health system with more powers and duties without the necessary resources is to mislead the public and to leave Ontario vulnerable to outbreaks like SARS.[24]

SARS also disclosed many problems with the *Health Protection and Promotion Act* that

---

anisms to enable all licensed physicians in the province to receive urgent health alerts electronically.

4. The MOHLTC must clarify the role and authority of Public Health with respect to infection control in hospitals and other institutions.

5. Overall public health capacity must be strengthened. This requires an enhanced budget, not just a change in the cost-sharing formula. In addition the human resources issues are serious and growing, in particular with respect to Community Medicine physician specialists who are critical in an infectious disease emergency.

6. The full independence of the Chief Medical Officer of Health role is required. The current position combines this independent role, which may lead to conflict between government interests and health needs of the public.

24. SARS Commission, second interim report, p. 303.

were the subject of extensive recommendations in the second interim report.[25] These included problems arising from the necessary use of a blunt instrument like the Code Orange status, and confusion about infectious disease reporting obligations.

The Commission therefore recommends:

- That the Government complete the process of fixing the public health system, including:
  - — Conducting the major overhaul of the *Health Protection and Promotion Act* recommended in the Commission's second interim report to remove dangerous uncertainties like the confusion about infectious disease reporting obligations that occurred during SARS, and to provide authorities with the ability to provide a more tightly focused response than was possible under the blunt instrument of the Code Orange status;
  - — Completing the review of the Mandatory Health Programs and Services Guidelines, and moving from a system of guidelines to a more accountable one based on performance-linked program standards;
  - — Establishing the Ontario Health Protection and Promotion Agency;
  - — Revitalizing the Central Public Health Laboratory; and
  - — Providing sufficient and sustained funding for public health.

Ontario Agency for Health Protection and Promotion, and the CMOH

Although there is much wisdom in the proposal for an Ontario Agency for Health Protection and Promotion, the recommended structure[26] fails to take into account the major SARS problem of divided authority and accountability.

25. SARS Commission, second interim report, pp. 404-416.
26. See Final Report of the Agency Implementation Task Force, *From Vision to Action: A Plan for the Ontario Agency for Health Protection and Promotion*, March 2006; Report of the Agency Implementation Task Force, *Building an Innovative Foundation: A Plan for the Ontario Agency for Health Protection and Promotion*, October 2005.

As the Commission noted in its second interim report:

> … the SARS response was also hamstrung by an unwieldy emergency leadership structure with no one clearly in charge. A *de facto* arrangement whereby the Chief Medical Officer of Health of the day shared authority with the Commissioner of Public Safety and Security resulted in a lack of clarity as to their respective roles which contributed to hindering the SARS response.[27]

An important lesson from SARS is that the last thing Ontario needs, in planning for the next outbreak and to deal with it when it happens, is another major independent player on the block.

The first report of the Agency Implementation Task Force said:

> A body at arm's-length from the government was recommended in the Walker, Campbell and Naylor reports, was a commitment in *Operation Health Protection* and aligns with the successful experience of the INSPQ [L'Institut national de santé publique du Québec].[28]

The Commission in fact recommended a much different arrangement in its first interim report, and warned against creating another "silo," another autonomous body, when SARS demonstrated the dangers of such uncoordinated entities:

> First, the structure of the new agency or centre, which will combine advisory and operational functions, must reflect the appropriate balance between independence and accountability whether it is established as a Crown corporation or some other form of agency insulated from direct Ministerial control.
>
> Second, it should be an adjunct to the work of the Chief Medical Officer of Health and the local Medical Officers of Health, not a competing body. SARS showed that there are already enough autonomous players on the block who can get in each other's way if not properly coordinated. There is always a danger in introducing a semi-autonomous body into a

27. SARS Commission, second interim report, p. 323.
28. Report of the Agency Implementation Task Force, *Building an Innovative Foundation: A Plan for the Ontario Agency for Health Protection and Promotion*, October 2005, p. 16.

> system like public health that is accountable to the public through the government. The risk is that such a body can take on a life of its own and an ivory tower agenda of its own that does not necessarily serve the public interest it was designed to support.[29]

Consequently, the Commission recommended that the Chief Medical Officer of Health have a hands-on role at the agency, including a seat on the board.[30]

The Agency Implementation Task Force took a completely opposite approach, recommending against giving the Chief Medical Officer of Health a seat as a voting member of the board, and recommending a very autonomous role for the agency.

This proposed arrangement ignores important lessons from SARS.

The Commission, far from recommending a completely arm's-length organization, pointed out the need for the Chief Medical Officer of Health to be in charge with the assistance of the agency, which should, albeit with a measure of policy independence, be operationally accountable to the Chief Medical Officer of Health.

The Commission therefore recommends:

- That the government reconsider in light of the lessons of SARS the Agency Implementation Task Force's recommendation regarding the relationship between the Chief Medical Officer of Health and the agency.

---

29. SARS Commission, first interim report, p. 19.
30. The first interim report said:

> To ensure that the new Ontario agency complements the service mandate of the public health system, the relationship must be clear between the new Ontario agency and the Chief Medical Officer of Health. Unless he or she has a clear say in the ongoing work and overall direction of the agency, and the ability to mobilize the resources of the agency to meet a public health problem when required, the agency will not fulfill its role as a source of support to public health operations. The Chief Medical Officer of Health must have more than a token role in the direction of any such agency. If the new agency is to have a Board of Directors, the Chief Medical Officer of Health, if not its Chair, should be at least its Associate Chair. To the extent the agency is operational as opposed to purely advisory, the Chief Medical Officer of Health must, in the face of a public health problem, be able to direct the operational resources of the agency so as best to meet the problem at hand, whether the resources are epidemiological, laboratory, or other.

SARS Commission, first interim report, p. 188.

Emergency Plans for Orderly Hospital Closure

Before SARS no one was prepared for the possibility that a hospital might need to be closed to contain an infectious disease outbreak. Yet this is what happened on three occasions during SARS, at the Scarborough Grace Hospital, York Central Hospital and North York General Hospital. No one in Ontario had had to do this before. SARS demonstrated the immense difficulty of closing a hospital in the middle of an outbreak, when no one had done it before, when no one had planned for this possibility, and when no exercises and education had been conducted to train staff on how to do it. It is to the credit of all those involved in closing Scarborough Grace, York Central and North York General that they accomplished the task despite having never had the experience of and knowledge from doing so before.

The Commission therefore recommends:

- The development of emergency plans for orderly hospital closure to avoid problems of the kind that arose at the Grace, York Central and North York General, to cover all eventualities and in particular:

  — Effective means for immediately notifying staff at the institution of any potential risk.

  — Effective means for immediately notifying staff not on duty at the institution of any potential risk.

  — Systems for rapidly securing the names and tracing information of everyone at the hospital at the time including visitors to patients.

  — Amendment of the *Health Protection and Promotion Act* to ensure duty to identify for purpose of public health tracing.[31]

31. The second interim report said:

> A submission to the Commission from a group of experts, who were all closely involved in the SARS response, recommended that the reporting sections of the *Health Protection and Promotion Act* be amended to support the work of health units in tracing the contacts of patients with infectious diseases:
>
> > The current HPPA does not give specific reference to contacts of infectious cases. Release of information on the cases as well as contacts is essential for infectious disease control. This was a major obstacle during the management of the SARS outbreak. We believe that

— Prearranged, rehearsed protocols for police assistance.

— Immediate medical backup for those dependent on the hospital, such as obstetrics, dialysis and oncology.

— Effective means for immediately informing the public, families of patients and the wider hospital community.

- That hospital emergency closing plans be rehearsed and reviewed on a periodic basis to reflect lessons learned in training exercises and emergency management best practices.

Effective Distribution of Outbreak Alerts

When Mr. T presented to the Grace on March 7, 2003, health workers did not know to be on the lookout for unusual respiratory illnesses. Unlike their counterparts in B.C., they had not been alerted to the emergence of a mysterious new disease in China and Hong Kong. Three years after SARS, public health officials told the Commission there is still no means to communicate quickly and effectively with Ontario's physicians. SARS demonstrated that alerts and other communications need to quickly reach all workplace parties, including employers, health workers, unions and Joint Health and Safety Committees.

The Commission therefore recommends:

- That the Ministry of Health develop and implement an effective means to alert all workplace parties, including health workers,

---

the requirement to report contacts referred to specifically in the legislation will allow practitioners to provide this information to their medical officer of health.

The amendments to Regulation 569, effected in Regulation 01/05, address this issue.

Contacts initially identified or later traced are included in most of the lists specifying additional information that must be reported to the medical officer of health. In particular, it is included in the case of SARS, TB, influenza and febrile respiratory illness. This means that those who have reporting obligations under the Act are now required to provide contact information.

Source: SARS Commission, second interim report, p. 199.

employers, unions and Joint Health and Safety Committees, in a timely manner about infectious disease threats.

- That in preparation for the possibility of a public health crisis like SARS or a pandemic, health institutions develop and implement effective means to communicate to their workers information regarding the outbreak, the health risk, the containment strategy, and measures to protect workers, patients and visitors.

Directives

Directives on N95 respirators and other worker safety issues were prepared without appropriate oversight by the Ministry of Labour, adequate input from worker safety experts, and sufficient participation by workplace parties including unions, employers and Joint Health and Safety Committees. The inadequacies of directives do not reflect on those who prepared them, and who deserve praise for their remarkable effort under difficult circumstances with insufficient resources, infrastructure or planning. Regardless of the reasons for the directives' failings, the reality is that for most of the outbreak they failed to provide the detailed advice that health workers, their supervisors and their employers needed. Workplace parties also reported their continuing difficulties in providing feedback to the Provincial Operations Centre on issues that arose when implementing directives.

The Commission therefore recommends:

- That in any future infectious disease crisis, the preparation of directives involving worker safety be supervised, reviewed and approved by the Ministry of Labour in a process that is transparent and easily understood by all workplace parties.

- That in any future infectious disease crisis, directives involving worker safety be jointly prepared by infection control and worker safety experts to reflect their overlapping responsibilities and thereby ensure that patients, workers and visitors are kept safe.

- That in any future infectious disease crisis, directives involving worker safety be prepared with input from the workplace parties who have to implement them, including employers, health worker representatives and Joint Health and Safety Committees.

- That in any future infectious disease crisis, directives and other communications involving worker safety reference the specific applicable sections of the *Occupational Health and Safety Act*, and its regulations, so that employers and workers are fully informed of worker safety legal requirements.

- That the Ministry of Labour and the Ministry of Health cooperate in developing and implementing an effective communication system for receiving timely feedback from workplace parties, including employers, unions and Joint Health and Safety Committees, regarding any problems encountered when implementing worker safety directives, policies, procedures and systems.

- That when issuing any communication affecting worker safety, the Ministry of Health consult with the Ministry of Labour, and ensure that there are clear, specific references to relevant worker safety laws, regulations, guidelines and best practices, and that employers are fully informed of their legal obligations to protect workers.

Effective Crisis Communication

There were many systemic problems with crisis communications during SARS. Workplace parties, including unions and the Ministry of Labour, told the Commission of their difficulties in receiving directives in a timely manner and in gaining access to Ministry of Health websites. Employers and workers' representatives often had great difficulty in receiving timely responses to questions to the Provincial Operations Centre, Ministry of Health and the Ministry of Labour, on important issues, including work refusals, safety of pregnant workers, and safety of immunocompromised workers. Workers' representatives also said they were not aware of such internal Ministry of Labour documents as the 1984 agreement with the Ministry of Health and the protocol dated April 2, 2003. In some cases, media reports were more informative on SARS than communications by health institutions to their workers.

The Commission therefore recommends:

- That the Ministry of Labour and the Ministry of Health cooperate in developing and implementing an effective communication system to ensure that in the event of an infectious disease outbreak all workplace parties, including front-line health workers, employers, unions

and Joint Health and Safety Committees, receive relevant communications, including directives, in a timely manner.

- That in the event of any future infectious disease crisis, the Ministry of Labour provide in a timely manner clear direction and information regarding guidelines for work refusals, pregnant workers and immunocompromised workers.

- That in the event of an infectious disease outbreak, any protocol regarding the Ministry of Labour's response, such as the Ministry's April 2, 2003, protocol, be communicated in a timely manner to employers, unions, Joint Health and Safety Committees and other workplace parties.

Risk Communication

The story of the psychiatric patients and the clusters of family illness in May at North York General demonstrates the importance of clear communication and a clear understanding of the respective roles and responsibilities in an outbreak investigation. Front-line nurses and physicians believed these patients had SARS. Public Health believed these patients, while not classified as having SARS, were being treated as persons under investigation and were being investigated and monitored. The hospital, in good faith, sincerely believed that SARS had been ruled out. In good faith, it also repeated this message to staff and tried to convince staff they were safe. This led to an important disconnect at North York General between what front-line nurses and physicians saw and what the hospital told its employees. The Commission accepts that everyone involved was doing what they thought was right. The problem was that staff in good faith were given assurances with a confidence that was not warranted in the circumstances.

The Commission therefore recommends:

- That the Ministry of Health ensure that the respective roles and responsibilities of public health and hospitals during an infectious disease outbreak are clarified and clearly understood by all parties.

- That public health and hospitals jointly develop processes to ensure that public health advice to hospitals regarding patient diagnosis in a disease outbreak, especially with an infectious disease like SARS that is difficult to identify, clearly reflect all the attendant health risks.

- That risk communication to staff reflect a precautionary approach, that it is better to err on the side of caution, especially when dealing with a little-understood new disease like SARS.

Listening to Front-Line Health Workers

During SARS, front-line doctors, nurses and other health workers had the greatest clinical experience in diagnosing and treating SARS patients. Yet there was no process in place to ensure that their voices and experience were heard.

At North York General, for example, before the events of May 23, 2003, some nurses, doctors and other health workers worried that, despite what they were being told, SARS had not gone away. The hospital felt, based on consultations with outside experts, including Public Health, that the psychiatry patients and the family cluster of illness in May were not SARS. Hospital officials believed in good faith that staff concerns were unfounded and that they needed to convince staff that it was safe. What angered health workers was that their concerns, which turned out to be well founded, were dismissed, and the well-intentioned messages of the hospital were disconnected from front-line staff concerns.

The Commission therefore recommends:

- That effective processes and systems be established to provide a path for communication and consultation with front-line staff.

- That the health concerns of health workers be taken seriously, and that in the spirit of the precautionary principle health workers be made to feel safe, even if this means continuing with levels of heightened precautions that experts believe are no longer necessary.

Listening to Unions

Just as hospitals should listen more carefully to the concerns of nurses and other front-line health workers, the Ministry of Health would be well advised to listen more carefully to the reasonable concerns of health worker unions which have enormous front-line experience in the actual problems of worker safety on the ground. Their expertise is reflected in the thoughtful and detailed presentations by unions that represent Ontario's health workers, and in particular the joint work of the Ontario

Nurses' Association and the Ontario Public Service Employees Union. The problems of worker safety have been explicitly recognized by Minister of Health George Smitherman speaking to an audience of nurses in May 2005:

> One of the things I was struck by … [was] the number of nurses that work in environments, hospital environments perhaps more particularly, that actually are unsafe … We have a lot of work to do on that.

It is important for Ministry officials to take this ministerial direction seriously. It is important for Ministry officials to avoid any impression that the Ministry has adopted an adversarial or dismissive attitude towards those who voice the legitimate concerns of those at risk on the front lines.[32]

Surveillance

One of the most important systemic failures of SARS was the failure to quickly identify clusters of illness among staff and to convey that information to infection control practitioners at affected hospitals and to those leading the fight against SARS. These systemic failures prevented the timely identification of SARS cases at the Grace and at North York General, the sites of the two largest nosocomial outbreaks.

Before May 23, 2003, when it appeared that SARS had been contained, there was no system-wide surveillance in place to ensure that undetected cases were caught. Responsibility for surveillance for undetected cases of SARS was left to individual institutions and to front-line practitioners. Any system that might have identified clusters of illness or death could have been helpful. However, surveillance standards at individual hospitals in Ontario were insufficient and not mandated. Witnesses told the Commission that such surveillance is possible only with a sufficiently resourced infection control function.

The Commission therefore recommends:

32. One example of this impression arose after a Ministry of Health official, responding to union concerns that safety issues had been ignored in pandemic planning, did not address the issue on the merits but dismissed the well-expressed union concerns by saying, "I am not sure we will ever meet the expectations of organized labour regarding health and safety…" This comment led the union to believe "that key bureaucrats in MOHLTC view occupational health and safety as a partisan issue, with occupational health and safety proponents as their adversaries."

- That appropriate surveillance standards be established, mandated and funded in Ontario hospitals.

- That special care be paid to identifying clusters of illness among staff and to initiating immediate investigation.

- That where suspicious clusters of illness are identified, this be communicated to health workers, especially to those who might have been in contact with sick staff, or have worked in the same areas of the hospital.

- When an outbreak appears to be waning of a difficult-to-diagnose infectious disease like SARS, system-wide surveillance be implemented to ensure that undetected cases are identified.

- Infection control functions in Ontario hospitals and in public health be sufficiently resourced so that they could contribute to, and participate in, system-wide surveillance when an outbreak appears to be waning of a difficult-to-diagnose infectious disease like SARS.

Infection Control

Many witnesses have told the Commission that, since SARS, infection control standards and practices have improved at hospitals affected by SARS. It will be important to ensure that improvements occur across the health system. Witnesses voiced a concern that as memories of the SARS outbreak fade, so will attention to infection control. Part of that concern is over the lack of consistent system-wide policies on visitor access at hospitals. They also told the Commission that many Ontario hospitals are in older buildings whose structure does not lend itself to modern infection control practices.

The Commission therefore recommends:

- That the Ministry of Health ensure that all Ontario hospitals have infection control personnel, resources and program components, including surveillance, control and education, consistent with Canadian

recommendations and best practices.[33]

- That consistent and clear visitor policies be developed across the health system to ensure that visitor access, while important in caring for the ill, does not overcome infection control standards.

- That the Ministry of Health and every health institution develop consistent, safe and humane policies to lessen the impact of infectious outbreaks on the vital priority for the sick to receive visitors, unless medically dangerous.

- That visitors be educated to their important role in keeping hospitals safe, and to the need to respect limits on the number of visitors, particularly where the illness is not serious or life-threatening.

- That the Ministry of Health help hospitals to incorporate leading practices in infection control standards into facility design and renovation.

Safety Culture in Health Workplaces

The heavy burden of disease that fell on nurses, doctors and other health workers demonstrated the lack of a safety culture[34] in the Ontario health system. A single

33. "It's critical that all hospitals have specific human resources, in the form of ICPs (Infection Control Professionals) and support staff, for an effective infection prevention program," says Dr. [Richard] Zoutman. Such programmes must include surveillance (counting infections), control (interventions to prevent them from occurring), and education components.

    Source: Queen's News Centre, "Canadian hospitals below standards for preventing infection," Tuesday, August 05, 2003, http://qnc.queensu.ca/story_loader.php?id=3f2fb55a816fc.

34. A definition of safety culture suggested by the Health and Safety Commission in the U.K. is as follows:

    The safety culture of an organisation is the product of the individual and group values, attitudes, competencies and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organisation's health and safety programmes. Organisations with a positive safety culture are characterised by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventative measures.

event like the spread of SARS at the Grace was warning enough that a safety culture was lacking. The fact that health workers continued to get sick in April and May after the events at the Grace demonstrated the extent to which a safety culture was lacking. Nothing better demonstrates the absence of a safety culture than the inability to fix worker safety problems in a timely manner once they have been identified by a tragedy like the Grace.

The Vancouver experience demonstrated the value of a safety culture in health workplaces. Expressions of this safety culture included the close cooperation and mutual respect between infection control and worker safety, the emphasis on listening to health workers, and the deployment of joint teams of infection control and worker safety experts to Royal Columbian Hospital after a nurse contracted SARS.

In Ontario, infection control and worker safety disciplines generally operated as separate silos during SARS. Until this divide is bridged and infection control and worker safety disciplines begin to actively and effectively cooperate, it will be difficult to establish a strong safety culture in Ontario.

As a landmark study on worker safety in health care said:

> … if the safety climate within healthcare was better and workers had more confidence in their employers' commitment to worker health and

---

A positive safety culture implies that the whole is more than the sum of the parts. The different aspects interact together to give added effect in a collective commitment. In a negative safety culture the opposite is the case, with the commitment of some individuals strangled by the cynicism of others. From various studies it is clear that certain factors appear to characterise organisations with a positive safety culture.

These factors include:

- The importance of leadership and the commitment of the chief executive
- The executive safety role of line management
- The involvement of all employees
- Effective communications and commonly understood and agreed goals
- Good organisational learning and responsiveness to change
- Manifest attention to workplace safety and health
- A questioning attitude and a rigorous and prudent approach by all individuals

Source: The Institution of Engineering and Technology, "IEE – Health and Safety Briefing 07 – Safety Culture," http://www.iee.org/Policy/Areas/Health/hsb07.cfm.

> safety, employees would have more confidence in the messages and directives they received during a crisis situation such as SARS. The relatively low profile of occupational health and safety within healthcare is perhaps best reflected in the observation that very few focus groups, aside from those containing health and safety professionals, seemed to be aware of occupational health and safety professionals at all. Tasks such as fit-testing of respirators often fell to infection control practitioners, not to occupational health and safety professionals (although this appears to vary from facility to facility) as it would have in other industries.[35]

The study identified the following organizational factors that promote a safety culture:

- There is general agreement that the safety-related attitudes and actions of management play an important role in creating a good or bad safety climate.

- Studies of safety program effectiveness in non-healthcare settings have repeatedly shown that a positive or supportive safety climate is an important contributing factor to good safety performance. Specifically, it is known that as safe behaviours are adopted throughout an organization, increasing pressure is put on non-compliers to "come in line."

- It has been shown that the safety climate has an important influence on the transfer of training knowledge.[36]

While important research has been conducted on infection control standards,[37]

35. Dr. Annalee Yassi and Dr. Elizabeth Bryce, "Protecting the faces of healthcare workers: knowledge gaps and research priorities for effective protection against occupationally-acquired respiratory infectious diseases" (Occupational Health and Safety Agency for Healthcare in B.C., April 30, 2004), p. 67.
36. Dr. Annalee Yassi and Dr. Elizabeth Bryce, "Protecting the faces of healthcare workers: knowledge gaps and research priorities for effective protection against occupationally-acquired respiratory infectious diseases" (Occupational Health and Safety Agency for Healthcare in B.C., April 30, 2004), pp. 32-3.
37. See Zoutman et al., "The state of infection surveillance and control."

worker safety experts have noted that similar research has not been undertaken in occupational health and safety.[38]

The Commission therefore recommends:

- That the Ministry of Labour use its enforcement and standard-setting activities, and the Ministry of Health its funding and oversight activities, to promote organizational factors that give rise to a safety culture in health workplaces.

- That the Ministry of Labour and the Ministry of Health jointly promote a safety culture in health workplaces that emphasizes close cooperation and collaboration between infection control and worker safety experts, and reflects the principles and practices of their respective disciplines.

- That in preparation for the possibility of a future infectious disease outbreak, the Ministry of Labour and the Ministry of Health jointly establish teams of trained and equipped infection control experts, occupational physicians, occupational hygienists and Labour inspectors who could be rapidly deployed to sites of workplace outbreaks.

- That occupational health and safety standards, including optimal staffing levels for worker safety practitioners, be established, similar to the SENIC standards for infection control.[39]

---

38. "Certainly more research on what levels or standards are needed to promote effectiveness in occupational health, similar to the SENIC studies for infection control, is needed." Source: Dr. Annalee Yassi and Dr. Elizabeth Bryce, "Protecting the faces of healthcare workers: knowledge gaps and research priorities for effective protection against occupationally-acquired respiratory infectious diseases" (Occupational Health and Safety Agency for Healthcare in B.C., April 30, 2004), p. 67.

39. The most important determinants of successful general nosocomial infection control programs in hospitals have been understood since the mid-1980s when the Study on the Efficacy of Nosocomial Infection Control (SENIC) was published. The following organizational factors were found to be important in determining effective infection control and lower rates of nosocomial-transmitted disease: having one infection control practitioner per 250 acute care beds, having at least one full-time physician interested in infection control, having an intensive surveillance program for nosocomial diseases and having intensive control policies and procedures. However, in a recent survey of 172 hospitals in Canada, only about 60 per cent of hospitals had evidence of compliance for each of the SENIC factors. The number of institutions who had all four factors was likely much less.

- That once occupational health and safety standards are established, the Ministry of Health provide consistent and sustained funding and strategic planning to ensure that these requirements are achieved, and the Ministry of Labour ensure they are maintained through its enforcement and monitoring functions.

- That the best practices of worker safety disciplines and infection control be reflected in hospital accreditation standards.

- That additional resources be dedicated by the Ministry of Health for the training and certification of worker safety experts, including occupational physicians and occupational hygienists.

- That worker safety programs at health care institutions include training for workers, management, officers and directors on their roles and responsibilities with regard to worker safety laws and regulations.

- That the Ministry of Training, Colleges and Universities, in collaboration with the Ministry of Health, the Ministry of Labour and Ontario institutions that train health care professionals, establish baseline standards on occupational health and safety and infection prevention and control measures and procedures, to be incorporated into the curricula of medical and nursing schools and schools for the allied health professions in Ontario colleges and universities.

Regional Infection Control Networks

The Ministry of Health has helped to improve infection control standards in health care by establishing Regional Infection Control Networks. To promote a safety culture in health care, it will be important that these networks foster close cooperation and collaboration between infection control and worker safety.

The Commission therefore recommends:

Source: Dr. Annalee Yassi and Dr. Elizabeth Bryce, "Protecting the faces of healthcare workers: knowledge gaps and research priorities for effective protection against occupationally-acquired respiratory infectious diseases" (Occupational Health and Safety Agency for Healthcare in B.C., April 30, 2004), p. 67.

- That Regional Infection Control Networks have, as integral members, experts in occupational medicine and occupational hygiene, and representatives of the Ministry of Labour.

- That members of Regional Infection Control Networks be fully educated in the requirements of the *Occupational Health and Safety Act*, and its regulations.

- That regional Infection Control Networks, in dealing with worker safety issues, consult on an ongoing basis with the Ministry of Labour, workplace parties and worker safety experts.

Role of the Ministry of Labour

Despite its legal mandate to protect workers, the Ministry of Labour was largely sidelined during SARS. It was not given a role in the SARS response commensurate with its statutory duties. It was also not consulted before West Park Healthcare Centre's old tuberculosis unit was opened to accept sick health workers from the Grace, even though its perspective would have been very germane to the decision. The outbreak at the Seven Oaks Home for the Aged demonstrated that issues still remain unresolved about the role of the Ministry of Labour during an infectious disease outbreak.

The Commission therefore recommends:

- That the Ministry of Labour have the lead responsibility for setting and enforcing work safety policies, procedures and standards in the health care sector, as it does in all workplaces.

- That the Ministry of Health, as the Ministry that funds and oversees the health care delivery system, not be placed in the position of acting as an independent worker safety watchdog over its own system.

- That the Ministry of Health have the lead responsibility for developing and implementing infection control measures in the health care sector to protect patients, residents and/or clients.

- That the Ministry of Labour and Ministry of Health develop protocols, processes and procedures to ensure effective and active cooperation and coordination where their respective worker safety and infection control responsibilities overlap.

- That in any future infectious disease crisis, the Ministry of Labour have a clearly defined decision-making role on worker safety issues in a future Provincial Operations Centre, and that this role be clearly communicated to all workplace parties.

- That the role and authority of the Ministry of Labour be clearly defined during a declared emergency. Under the *Emergency Management and Civil Protection Act*, the *Occupational Health and Safety Act* prevails, and, as such, the Ministry of Labour's mandate to communicate and enforce occupational health and safety standards for workplaces under provincial jurisdiction will remain during an emergency. How the designated lead ministry in any emergency will interact with the Ministry of Labour, so that the Ministry of Labour can continue to fulfill its mandate, should be established prior to an emergency.

- That in any future infectious disease crisis, the Ministry of Labour be consulted when health facilities that had previously been decommissioned, such as West Park's old tuberculosis unit, are reopened in response to exigent circumstances.

- That the Ministry of Health and the Ministry of Labour work together to establish an agreement and mechanism, including information technology systems, to share information related to outbreaks of infectious diseases. Such information sharing should include information about Ontario's health care facilities. The objective is to ensure compliance with the reporting of occupational illnesses to the Ministry of Labour under the *Occupational Health and Safety Act*, and to ensure that the Ministry of Labour has at its disposal all relevant information to appropriately address outbreaks of infectious diseases in health care and other workplaces.

- That the Ministry of Health and the Ministry of Labour work together to establish integrated enforcement strategies to improve compliance with occupational health and safety legislation and with legislation administered by the Ministry of Health.

- That the Ministry of Health establish a process, similar to the one available under the *Occupational Health and Safety Act*, to hold directors and officers of health care organizations accountable for compliance

with provincial legislation. This may be accomplished by performance specifications in contracts or service agreements that the Local Health Integration Networks will establish with health care organizations.

The Ministry of Labour and the 1984 Agreement

During SARS, the Ministry of Labour deferred its worker safety responsibilities to the health sector, believing the health sector had the expertise and capabilities to protect workers in a manner that was consistent with provincial laws and regulations. It did this, in part, because of a 1984 Memorandum of Understanding with the Ministry of Health that was unauthorized by statute, unclear, not disseminated to interested parties like the unions, and of questionable legal authority to the extent that it might require ministry personnel to fetter their discretion and so fail to fulfill their duties in workplaces affected by infectious diseases.

The Commission therefore recommends:

- That the 1984 agreement between the Ministry of Health and the Ministry of Labour be replaced by an agreement that ensures that the Ministry of Labour, in consultation and cooperation with the Ministry of Health, take the lead in investigating infectious disease outbreaks that affect workers in a workplace.

- That the existence of any agreement setting out the respective roles and responsibilities of the Ministry of Labour and the Ministry of Health in a public health emergency be fully communicated to unions, employers, Joint Health and Safety Committees and other workplace parties.

Ministry of Labour Investigations and Prosecutions

When the Ministry of Labour decided not to lay any charges in connection with the deaths of Tecla Lin, Nelia Laroza and Dr. Nestor Yanga it did not disclose the reasons for doing so.

After SARS, critical injury and occupational illness investigations were begun very late in the one-year window for instituting prosecutions, and investigators had a very limited period to complete their work.

The Commission therefore recommends:

- Legislative amendments and policies in relation to the waiver of potential Crown privilege claims, such that in such cases where charges do not result from Ministry of Labour and other investigations of deaths and critical injuries in health workplaces, the results of the investigation and the reasons for the decision not to prosecute be made public.

- That Ministry of Labour investigations into critical injuries and occupational illnesses arising from a disaster of the magnitude of SARS be commenced and completed expeditiously.

- That a review be undertaken of section 69 of the *Occupational Health and Safety Act*, as to whether the limit on the institution of a prosecution to no more than one year after the last act or default occurred be amended.

Ministry of Labour Proactive Inspections

For reasons set out in this report, the Ministry of Labour did not conduct any proactive inspections of SARS hospitals during virtually all the outbreak. Labour's approach was vastly different from what occurred in British Columbia, where the workplace regulator began proactive inspections in early April 2003 and paid special regulatory attention to a hospital where a nurse contracted SARS. This was a missed opportunity in Ontario, although we will never know what impact that might have had on the SARS response.

The Commission therefore recommends:

- That in any future infectious disease outbreak, the Ministry of Labour take a proactive approach throughout the outbreak to ensure that health workers are protected in a manner that is consistent with worker safety laws, regulations, guidelines and best practices.

- That in any future infectious disease outbreak, the Ministry of Labour's proactive approach be clearly communicated to all workplace parties, including the Ministry of Health, public health units, employers, workers' representatives and Joint Health and Safety Committees.

- That in preparation for the possibility of a future infectious disease outbreak, the Ministry of Labour prepare effective operational plans for playing a proactive role, including establishing and training teams of occupational physicians, hygienists and inspectors to spearhead any proactive effort.

Investigations Led by the Ministry of Health

During SARS, a team from the U.S. Centers for Disease Control (CDC) was invited by the province to investigate the incident at Sunnybrook on April 13, 2003, when nine health workers were infected. Because of systemic failings, no one thought to invite the Ministry of Labour to participate, or to advise it that such an investigation was taking place. Similarly, after the Seven Oaks outbreak of legionellosis in the fall of 2005, the Ministry of Labour was not invited to participate in a Ministry of Health investigation into the response to the outbreak. In addition, the Seven Oaks investigation also would have benefited from the inclusion of worker safety experts.

The Commission therefore recommends:

- That the Ministry of Labour play an integral role in any future Ministry of Health investigation into an infectious outbreak where workers were infected, such as occurred at Sunnybrook and Seven Oaks.

- That the Ministry of Labour be given the responsibility for ensuring that any worker safety–related findings in any future Ministry of Health investigation be consistent with worker safety laws and principles.

- That any investigation into an infectious outbreak where workers were infected, such as the investigations at Sunnybrook and Seven Oaks, include experts in occupational hygiene and other worker safety disciplines.

Ministry of Labour Physician Resources

Prior to SARS, the Ministry of Labour's complement of inspectors and physicians had been sharply reduced. SARS also revealed that many Ministry of Labour inspectors lacked sufficient health care–related training. Since SARS, the Ministry of Labour has hired additional inspectors, including some dedicated to the health care sector, and increased its health care–related staff training. But it has not increased its occupational physician cadre, which had once had province-wide coverage but is now concentrated in Toronto.

The Commission therefore recommends:

- That the Ministry of Labour expand its internal resources of occupational physicians and ensure that their capabilities are available province-wide.

Worker Safety Laws and Regulations

The evidence reveals widespread, persistent and ingrained failures by the health system to understand and comply with Ontario's safety laws including the *Occupational Health and Safety Act* and related regulations. Ontario's worker safety laws are based on the Internal Responsibility System.[40] SARS revealed an important structural problem when implementing the Internal Responsibility System in the health care sector: the fact that physicians often make worker safety decisions even though they may not be hospital employees.

The Commission therefore recommends:

---

40. The Ministry of Labour described the Internal Responsibility System as follows:

> Employers, workers and others in the workplace share the responsibility for occupational health and safety. Each party is responsible to act to the extent of the authority that they have in the workplace. This concept of the internal responsibility system is based on the principle that the workplace parties themselves are in the best position to identify health and safety problems and to develop solutions. This concept emerged from the Royal Commission into health and safety in mines in Ontario in 1976 and was soon adopted as the basis of the new *Occupational Health and Safety Act* in 1978.

Source: Ministry of Labour, presentation to the SARS Commission, November 17, 2003, p. 6.

- Worker safety in hospitals and other health care institutions requires reasonable legislative measures to include all physicians within the worker safety regime without interfering with the essential independence of physicians and without making them hospital employees. Such legislative measures may need to include not only the *Occupational Health and Safety Act* but also those statutes that govern the administration of health care institutions and the medical profession. It would be presumptuous for the Commission to recommend a prescriptive solution at this time. That task will require a good measure of consultation and a thorough analysis of the complex professional and statutory framework within which doctors work in health care institutions. The Commission recommends the amendment of worker safety, health care, and professional legislation to ensure that physicians who affect health worker safety are not excluded from the legislative regime that protects health workers. Because the prescriptive solution will require consultation and analysis and time and patience, it is essential to start now.

- That the Ministry of Labour conduct a meaningful review of the *Occupational Health and Safety Act* and related regulations in consultation with workplace parties and worker safety experts to examine how the Internal Responsibility System can better be implemented in the unique conditions of the health care system.

- That the Ministry of Labour and the Ministry of Health work together to harmonize requirements addressing health and safety in legislation and/or regulations administered by both ministries, which may overlap or conflict.

- That the Ministry of Labour and the Ministry of Health work together to review possible statutory or regulatory amendments to enhance the process for reporting, tracking and sharing of information, and removal of any barriers to information sharing related to outbreaks of infectious disease.

Joint Health and Safety Committees

The evidence reveals that Joint Health and Safety Committees, a fundamental component of Ontario's worker safety regime, were often sidelined during SARS.

The Commission therefore recommends:.

- That in any future infectious disease outbreak, the emergency response ensure the involvement of Joint Health and Safety Committees in a manner consistent with their statutory role in keeping workplaces safe.

- That worker safety programs at health care institutions include training for senior management on their roles and responsibilities with regard to Joint Health and Safety Committees.

- That management and worker representatives on Joint Health and Safety Committees be provided with appropriate training and sufficient time from their other duties to fulfill their JHSC obligations in a meaningful way, especially during public health crises.

Ontario Agency for Health Protection and Promotion, and Worker Safety

On June 22, 2004, Health Minister George Smitherman released a three-year public health action plan called Operation Health Protection. It indicated that the Ontario Health Protection and Promotion Agency and its new laboratory would begin operations in the 2006/7 fiscal year.[41] It will be important for the Agency to play an active role in worker safety issues.

---

41. The action plan said:

> An Agency Implementation Task Force is being struck to provide technical advice on the development and implementation of the Agency. Together with the advice of international and national experts, the Ministry will establish the Agency by 2006/07.

Source: Ministry of Health and Long-Term Care, *Operation Health Protection: An Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario* (June 22, 2004), p. 23.

The Commission therefore recommends:

- That just as NIOSH, the main U.S. federal agency responsible for worker safety research and investigation,[42] is part of the Centers for Disease Control (CDC), so the Ontario Agency for Health Protection and Promotion should have a well-resourced, integrated section that is focused on worker safety research and investigation, and on integrating worker safety and infection control.

- That any section of the Ontario Agency for Health Protection and Promotion involved in worker safety have, as integral members, experts in occupational medicine and occupational hygiene, and representatives of the Ministry of Labour, and consult on an ongoing basis with workplace parties.

- That the Ontario Agency for Health Protection and Promotion serve as a model for bridging the two solitudes of infection control and worker safety.

- That the Ontario Agency for Health Protection and Promotion ensure that it become a centre of excellence for both infection control and occupational health and safety.

- That the mandate of the Ontario Agency for Health Protection and Promotion include research related to evaluating the modes of transmission of febrile respiratory illnesses and the risk to health workers.

---

42. The duties of NIOSH (the National Institute for Occupational Safety and Health) include:

    - Investigating potentially hazardous working conditions as requested by employers or employees.
    - Evaluating hazards in the workplace, ranging from chemicals to machinery.
    - Creating and disseminating methods for preventing disease, injury, and disability.
    - Conducting research and providing scientifically valid recommendations for protecting workers.
    - Providing education and training to individuals preparing for or actively working in the field of occupational safety and health.

    See: http://www.er.doe.gov/ober/humsubj/appendix_b.pdf7. Naylor Report, pp. 52-5.

This research should also identify the hierarchy of control measures required to protect the health and safety of workers caring for patients with the respiratory illnesses.

Pandemic Planning

As occurred during SARS, there is now a debate over how influenza is spread and how health workers should be protected during a pandemic. Some experts believe influenza is mostly droplet-spread and surgical masks would be sufficient protection for health workers. Others believe that airborne transmission is a possible means of spreading influenza, and health workers should, as a result, wear fit-tested N95 respirators when caring for people suffering from a pandemic flu virus. The Commission is not in a position to wade into this evolving scientific debate. However, it is worth noting how the CDC has used the precautionary principle in addressing this issue. The CDC is saying, in effect, we don't know enough about how a pandemic influenza might be spread, so it's better to be safe than sorry. It is the kind of precautionary approach all pandemic planners should carefully consider.

The Commission therefore recommends:

- That the precautionary principle guide the development of pandemic-related worker safety policies, practices, procedures and guidelines.

- That in the development and implementation of the Ontario pandemic plan, the Ministry of Labour have responsibility for, and oversight over, all worker safety policies, practices, procedures and guidelines.

- That the Ministry of Labour ensure that the Internal Responsibility System and Joint Health and Safety Committees play a meaningful role in a pandemic response.

Pre-Planned Emergency Response Regarding Funerals

The families of SARS victims often were unable to have a traditional funeral. In some cases, funeral visitations were forbidden, or restricted. Mourners had to stand off at a distance at one burial. For some, there was no closure. Learning from this will be important in the event of another public health crisis like SARS, or if there is a flu pandemic.

The Commission therefore recommends:

- A pre-planned response involving the funeral industry, the Ministry of Health, public health, the hospital community, Emergency Measures Ontario and the office of the Chief Coroner, supported by agreed policies, procedures, protocols, memoranda of understanding and tabletop drill exercises to prevent the problems that arose during SARS.

Emergency Legislation

Ontario has passed into law the *Emergency Management and Civil Protection Act*, to fill the emergency power vacuum that existed at the time of SARS. It is understandable that the government, in its determination to have some kind of law in place before the next emergency struck, did not stop to address all the specific emergency legislation problems noted in detail in the hundred pages of Chapter 11 of the Commission's second interim report of April 5, 2005. These problems are serious but easily remedied now. They include:

- The overreaching power to suspend the *Habeas Corpus Act*, the *Elections Act*, the *Legislative Assembly Act*, and other constitutional foundations of ordered liberty under law.

- The power to lock up journalists without trial for violating gag orders.

- The failure to blueprint compensation for those who really need it, such as those quarantined, medical workers deprived of their livelihood and those whose jobs are disrupted.

- The failure to protect medical decisions of the Chief Medical Officer of Health from Emergency Commissioner encroachment.

- The failure to carry out clause-by-clause legal and constitutional scrutiny and obtain a detailed bill of health from the Attorney General.

- The confusion between the emergency powers and the regular *Health Protection and Promotion Act* powers.

It is understandable that the government in its desire to get the emergency legislation into place before the next disaster did not pause to address and to answer in detail the flaws referred to in the Commission's April 2005 report, flaws which are serious but easily remedied. The government has taken no public position in respect of the detailed flaws noted by the Commission. It is not as if the unimplemented recommendations have been considered and rejected for publicly stated reasons. The unimplemented recommendations have simply not been addressed publicly. The problems that have not been addressed and answered are noted in the chart at the end of this section.

The problem is not with the good intentions of those who will administer and exercise the emergency powers. The problem is that these awesome powers represent a profound change in our legal structure and raise issues that need to be addressed further in this statute that so fundamentally alters our system of government by law. Extraordinary powers like those in the *Emergency Management and Civil Protection Act* are inherently dangerous and require now the sober second thought and detailed legal clause-by-clause review and publicly stated justification which they did not explicitly receive before.

Ontario's emergency legislation brings to mind what President Lyndon Johnson said about the potential danger of all laws:

> You do not examine legislation in the light of the benefits it will convey if properly administered, but in the light of the wrongs it would do and the harms it would cause if improperly administered.

The Commission recommends the review and amendment of the emergency legislation in accordance with the unimplemented recommendations in Chapter 11 of the Commission's April 2005 second interim report.

Emergency Recommendations

Topic	Recommendation	Status
Encourage Compliance	• Include basic blueprint for compensation for loss caused by emergency powers, for example, quarantine wage loss.	Not yet implemented
Prevent Prepare Cooperate	• Provide for integration of emergency plans, and include explicit requirement that emergency plans establish clear allocations of powers and lines of authority.	Not yet implemented
Clarify Overlap with Existing Public Health Powers	• Clarify the relationship between the emergency powers conferred by this Bill and the powers conferred by the HPPA.	Not yet implemented
Primacy of CMOH	• Recognize explicitly the primary authority of CMOH in respect of the public health aspects of emergencies.	Not yet implemented
Emergency Commissioner Must Consult CMOH	• Require consultative exercise of powers as between the CMO and the CEM.	Not yet implemented
Emergency Powers	• Attorney General to conduct detailed clause-by-clause review of each proposed power for viability against legal and constitutional challenges.	Not yet implemented
	• Clarify whether the Bill incorporates the specific public health emergency powers listed in Commission's second interim report.	Not yet implemented

	• No power of compulsory immunization before evidence as to its efficacy is available.	Accepted
	• Review compulsory immunization legal issues to develop procedures that encourage immunization of health workers and public, akin to school-child immunization system	Not yet implemented
Property Seizure	• Clarify whether the Bill mandates the seizure or expropriation of property.	Accepted
	• Subject each proposed power to a thorough practical, legal, and policy analysis prior to adoption.	Not yet implemented
	• Where such analysis is not possible before enactment, impose a sunset period of no more than 2 years on the proposed power.	Not yet implemented
Power to Override All Other Laws	• Clarify whether the Bill's purported override of other laws and legal rights affects collective agreements.	Not yet implemented
	• Insulate fundamental statutes from the Override	Not yet implemented
	• Reposition the Override to highlight its importance.	Not yet implemented
	• Review constitutional legitimacy of the Override.	Not yet implemented
The Information Override	• Clarify the scope of the government's power to compel the disclosure of information.	Not yet implemented
Declaration Standard	• Amend the standard applicable to the declaration of emergencies so as to rely on the reasonable perception of the decision-maker.	Accepted

Emergency Orders	• Amend the standard applicable to the making of emergency orders so as to rely on the reasonable perception of the decision-maker.	Accepted
Power to Implement Emergency Plans	• Ensure there is no unintended conferral of powers.	Not yet implemented
Access to Courts	• Provide for access to legal process during emergencies.	Not yet implemented
Basket Power	• Incorporate an objective reasonableness standard into the language governing the use of this power.	Not yet implemented
Occupational Health and Safety	• Require emergency plans to provide for advance consideration of potential OHS issues.	Not yet implemented
Concurrent Powers	• Provide that conferral of new emergency powers does not derogate from existing powers.	Accepted
Liability Shield	• Provide protection from liability for acts which are necessitated by an emergency and which are authorized by other statutes but not the EMA – and vice versa.	Not yet implemented