Emergency Legislation

Introduction

The first goal of public health emergency management is to stop emergencies before they start by preventing the spread of disease. If a small outbreak is prevented or contained, the draconian legal powers available to fight a full-blown emergency will not be needed.

This is why the Commission in the previous 10 chapters has gone into such detail about strengthening the *Health Protection and Promotion Act* with workable daily powers that can prevent emergencies.

Preparedness and prevention backed up by enhanced daily public health powers are the best protection against public health emergencies.

Legal powers by themselves are false hopes in times of public crisis.[314] In the face of impending disaster no law will work without public cooperation and individual sacrifice of the kind demonstrated by so many during SARS. Without machinery to support public cooperation, emergency powers will be of little use.

Some emergencies, however, will require extraordinary action beyond ordinary government intervention and ordinary government power. Emergencies will come upon us suddenly and without warning, no matter how prepared and vigilant we may be. Any emergency, once it gets going, may overwhelm the protection provided by existing legal powers.

Ontario got through SARS without any explicit emergency legal powers. Ontario's *Emergency Management Act*, then as now, conferred no special powers to be used in any kind of emergency. SARS showed that explicit emergency powers are required to protect the public from even more catastrophic public health disasters such as the next influenza pandemic, thought by some scientists to be overdue.

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314. Paraphrased from Mr. Justice Learned Hand's 1944 address *The Spirit of Liberty.*

Such a colossal epidemic would require strong explicit emergency powers of the kind that were not legally available during SARS.

Another reason why explicit emergency powers would be required for pandemic influenza is the uncertainty about the legal extent of existing emergency powers. Many of the actions taken to fight SARS were done without explicit statutory authority. The legal authority for every governmental action taken during SARS may be legally defended on a generous reading of existing inherent and statutory powers, but the extent of our present legal emergency authority is far from clear. Many who complied willingly with emergency directives during SARS have since then, on reflection, expressed concern that they might not do so again unless the power to issue directives and orders is spelled out clearly in some form of explicit emergency legislation.

The Commission has recommended strengthening the *Health Protection and Promotion Act* with daily powers that can be exercised with or without a declared emergency. These recommended powers include warrantless entry of dwelling houses in urgent situations but subject to a later court hearing, and subject also to court hearing, temporary detention and decontamination of people exposed to infectious agents such as anthrax or weaponized smallpox.

The special powers advocated for public health emergencies such as pandemic influenza include such measures as mass compulsory vaccination, compulsory requisition of supplies such as vaccines and respirators, compulsory closing of hospitals and other institutions, involuntary transfer of patients, and a wide range of general powers such as evacuation and rationing. These emergency powers cannot be met by the *Health Protection and Promotion Act*. Explicit emergency powers are required in addition to the daily powers now available under the *Health Protection and Promotion Act* and the further daily powers recommended by the Commission.

Public health emergencies are in many ways unique and unlike typical disasters like floods, fires, power blackouts, or ice storms. In floods and power losses people can take certain protective actions on their own. However, they have few personal defences against an invisible virus that can kill them. They must turn to trusted medical leadership.

The most important thing in a public health emergency is public confidence that medical decisions are made by a trusted independent medical leader such as the Chief Medical Officer of Health, free from any bureaucratic or political pressures. This is particularly true of public communication of health risk. People trust their health to

doctors, not to politicians or government managers. It is essential that the public get from the Chief Medical Officer of Health the facts about infectious risks to the public health and the degree that precautions are needed and advice on how they can avoid infection. It is essential when public precautions are relaxed, like the removal of protective N95 respirators in hospitals, the re-opening of hospitals or the declaration that it is business as usual in the health system, that these decisions are made and are seen to be made by and on the advice of the independent Chief Medical Officer of Health. In a public health emergency, or the public health aspects of an emergency such as flood-borne disease, the Chief Medical Officer of Health should be the public face of public communication from the government.

It is artificial to try to distinguish between public health emergencies and general emergencies. Indeed there is no such thing as a pure public health emergency. Every big public health emergency creates problems beyond the realm of public health. Schools, jails, homeless shelters, tourism, travel restrictions, and the economy are not typically within the expertise of medical advisors. If medical predictions are correct, the next influenza pandemic will start as a public health emergency, and rapidly snowball into a general emergency.

Conversely there is no such thing as a pure general emergency. Big general emergencies that arise outside the field of public health will usually have a public health component. A major flood might bring disease through infected water. The breakdown of sanitation would soon involve public health, as would a power blackout that spoiled restaurant food.

Because there is no clear line between public health emergencies and general emergencies it would be wrong to introduce separate, freestanding, parallel emergency regimes, one for public health emergencies and the other for all other big emergencies. The existence of two parallel regimes would bring nothing but legal confusion and administrative disorder, two things no one wants in any emergency.

The government has expressed its intention to proceed with general emergency legislation along the lines suggested in Bill 138, an Act to amend the *Emergency Management Act* and the *Employment Standards Act, 2000*, which received first reading on November 1, 2004 as a private member's bill produced by the Standing Committee on Justice Policy after public hearings.

The Commission's mandate does not cover general emergency legislation for war, famine, flood, ice storms and power blackouts and the government decision to proceed with Bill 138 is not within the Commission's terms of reference. Because the

government has chosen Bill 138 as the vehicle for all emergency legislation including public health emergency legislation, the Commission must say something about Bill 138 as a vehicle for public health emergency powers.

Bill 138 gives government officials unrestricted authority to override virtually every other Ontario law that gets in the way of any power they consider necessary to exercise in an emergency. It represents a profound change in our legal structure and raises issues that must be addressed whenever a statute is proposed that so fundamentally alters our system of government by law.

Every emergency power, once conferred, "lies about like a loaded weapon ready for the hand of any authority that can bring forward a plausible claim of an urgent need."[315] This danger of overreaction is accompanied by the danger of underreaction, not doing enough in the face of an uncertain and ambiguous new disease threat.

This report is interim, not final. It is written now to respond to current government plans to amend the *Health Protection and Promotion Act* and the *Emergency Management Act*. Because of its interim nature the report takes no final position on every issue around emergency powers. This chapter identifies issues such as compulsory mass immunization where further examination of the evidence may be required before the right balance can be achieved between public protection and personal rights. It also identifies issues that have not been fully confronted.

On Bill 138's impacts on public health emergencies, the Commission in this chapter notes the need for:

- A fundamental legal and constitutional overhaul of the proposed legislation by the Attorney General who has indicated he is fully engaged in reviewing Bill 138 to ensure that it meets necessary legal and constitutional requirements;

- Specific provisions to ensure Chief Medical Officer of Health leadership in every public health aspect of every emergency;

- A process to ensure that the general powers of Bill 138 cover all authority needed for public health aspects of emergencies; and

315. Mr. Justice Jackson, dissenting, in *Korematsu vs. United States*, 323 U.S. 214 (1944) in respect of the race-based internment of Japanese Americans during WW II.

- A fundamental review to cover all these legal and operational aspects, a review of the kind exemplified in the Commission's analysis of compulsory mass immunization.

The various aspects of emergency legislation examined by the Commission in this chapter are found under the following headings:

- Voluntary Compliance
- Prevention, Preparedness and Cooperation
- Who's in Charge?
- Types of Emergencies
- Emergency Legislation: Two Models
- Emergency Response: Inherent Dangers
- Role of the Chief Medical Officer of Health
- Specific Public Health Emergency Powers
- Compulsory Mass Immunization: a Paradigm
- Bill 138
    - Power to Override Ontario Laws
    - Trigger, Criteria and Limitations
    - Power to Implement Emergency Plans
    - Basket Clause
    - Occupational Health and Safety
    - The Problem of Concurrent Powers
- Summary of Recommendations

Voluntary Compliance

Voluntary compliance is the bedrock of any emergency response. Even the most exquisite emergency powers will never work unless the public cooperates.

Legal powers are false hopes during a public crisis.[316] No law will work during a disaster without the public cooperation and individual sacrifice shown during SARS. Nor will any law work without the machinery that supports and compensates those who sacrifice for the greater good of public health.

Voluntary compliance also depends on public trust in those managing the emergency and public confidence that medical decisions are made on medical evidence, not on grounds of political expediency or bureaucratic convenience. The latter issue is addressed below in the context of the emergency role of the Chief Medical Officer of Health.

It is essential in any emergency to compensate those who suffer an unfair burden of personal cost for cooperating in public health measures like quarantine.

While Ontario enjoyed high levels of quarantine compliance during SARS, it is vital that this not lead to complacency. SARS revealed obstacles to compliance that may, if not adequately addressed, hamper the response to future public health emergencies. In its interviews, telephone polls and focus groups, the U.S. study on the elements of voluntary compliance referred to above identified these impediments to compliance:

- Fear of loss of income;
- Poor logistical support;
- Psychological stress;
- Spotty monitoring of compliance;
- Inconsistencies in the application of quarantine measures between various jurisdictions; and

316. Paraphrased from Mr. Justice Learned Hand's 1944 address *The Spirit of Liberty.*

- Problems with public communications.[317]

Fear of loss of income topped the list of concerns:

> Fear of loss of income was of paramount importance. It was especially significant, according to our interviews, focus groups, and Healthcare Workers Survey, for people who were unconvinced that their quarantine was necessary. This fear was the most common reason given to us for noncompliance or non-self-quarantine among people who were advised that they met quarantine criteria. And the fear was justified. Although some employers assured their employees at the outset that their pay would continue while they were in quarantine, others said it would not. The situation was even more disconcerting for those whose income came from part-time work, casual work, or self-employment.[318]

Despite criticism that it took too long to bring forward an appropriate SARS compensation package, some observers suggest that the compensation system once in place was largely responsible for the success of the voluntary quarantine programme. Dr. James Young said:

> During SARS, we were using quarantine for the first time in 50 years. One of the important things in using quarantine was getting people to abide by it. One of the important ways of getting people to abide by it was by offering financial compensation so they would in fact abide by it and stay in quarantine if and when they were ordered by the medical officer of health. We got approval from the Ontario government to institute a quarantine program and to pay people for that. That resulted in us being able to manage the quarantine in an effective manner.[319]

A lesson from SARS is that advance planning for health emergency compensation is vital. It is impossible to predict in advance the precise form and amount of compensation necessary and affordable for every conceivable emergency. It is possible to require

317. DiGiovanni, Clete, Conley, Jerome, Chiu, Daniel and Zaborski, Jason, "Factors Influencing Compliance with Quarantine in Toronto During the 2003 SARS Outbreak." Published in Biosecurity and Bioterrorism: Biodefense Strategy, Practice and Science, Volume 2, Number 4, 2004, pp. 267-70.
318. *Ibid*, pp. 267-68.
319. Justice Policy Committee, Public Hearings, August 3, 2004, p. 10.

by legislation that every government emergency plan include a basic blueprint for the most predictable type of compensation packages.

Recommendation

The Commission therefore recommends that:

- **Emergency legislation require that every government emergency plan provide a basic blueprint for the most predictable types of compensation packages and that they be ready for use, with appropriate tailoring, immediately following any declaration of emergency.**

Prevention, Preparedness and Cooperation

Without preparedness, emergency powers are of little use. Systems that prevent little problems from becoming big emergencies are much more important than the legal details of the emergency powers. If put in place before an emergency arises, they reduce the need to use draconian emergency powers. These systems ensure adequate planning and training and include coordinated incident management, secure sources of supply for medical and protective equipment and effective public communications.

The importance of public health emergency planning is stressed in the above chapter on medical leadership. It is essential as recommended above that the Chief Medical Officer of Health be in charge of provincial public health emergency planning; the medical officer of health on the local emergency planning level. These responsibilities should be crystallized in mandatory standards under the *Health Promotion and Protection Act*. Legal preparedness should be an essential part of every emergency plan, as should public health risk communication by the Chief Medical Officer of Health and the local medical officer of health.

It is not enough to be prepared generally or to develop "one size fits all" general emergency plans. An emergency plan for an ice storm will be of no use in an influenza pandemic. An influenza pandemic plan will be of no use in an ice storm. Specific emergency plans are required for specific threats. Generic plans are not enough.

Dr. James Young told the Justice Policy Committee that specific plans are needed to address specific risks:

> … we have come to learn that preparedness and response alone will not do it. As SARS illustrated … when an emergency happens, I can only deal with the system that's already built. I have to make that system work. I have to design other infrastructure around it, and other ways of managing. That means, then, that we're going to have bigger calamities and more problems if we start doing it at that point in time. The real work needs to be done in advance so that we can minimize the effect.
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> We've come to recognize that a generic set of plans, a single binderful that will manage every emergency in Ontario, is not the way to go. We have to do risk-based plans. We have to figure out what the risks are in communities and to provincial ministries, and then we have to do specific planning for those risks.[320]

Measures resulting from advance planning require resources of people and equipment. Examples are surge capacity for human resources and medical equipment such as N95 respirators, gloves, gowns, visors and other protective equipment, and a secure source of supply and an effective logistical system to distribute them.

Every emergency power, such as the power to ration food, vaccines and antiviral medicines, should be supported by such systems.

The provincial response to emergencies in Ontario is structured on the incident management system, an approach pioneered by forest fire managers in California in the 1970s that has become widely accepted in Canada and the United States.

> The Incident Management System (IMS) is an international emergency protocol adopted by Emergency Measures Ontario as the operational framework for emergency management for government, and is being introduced at the local level. To ensure consistency, MOHLTC has adopted the IMS system, which will be activated once a health emergency is declared.[321]

The Johns Hopkins and Red Cross-Red Crescent Public Health Guide for Emergencies details the history of the incident management system:

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320. *Ibid*, p. 9

321. See *Ministry of Health and Long-Term Care Emergency Plan* at http://www.health.gov.on.ca/english/providers/program/emu/emerg_prep/emerg_plan.html.

In the 1970s, after a severe wildfire season, fire managers in California (on the west coast of the United States) realized they needed a new approach to emergency response. In incident after incident, they ran into the same overall problem – poor inter-agency co-ordination. Most agencies are experienced in responding to routine or small-scale incidents. This usually involves only a few agencies and the demand for resources is limited. As disasters intensify, more agencies arrive on the scene. This brings further communication, logistical, and co-ordination problems, as listed below:

1. Having uncommon radio frequencies, signals, and codes – this leads to poor interagency communication.

2. Lack of common terms – when agencies did talk, they often misunderstood each other.

3. No effective or functional command system – each agency operated on the luck and personality of its leaders. In some situations, the operational effectiveness depended on which leader or chief was working that day.

4. Insufficient methods for giving out resources effectively.

5. Poorly defined ways of responding to disasters – there were no standard guidelines. How each response related to other functions depended upon individual interpretation.

A group of aircraft engineers agreed to help the fire managers develop a disaster management strategy for co-ordinating all agencies responding to large-scale emergencies such as wild-land fires. As a result, the modern Incident Command System (ICS) was developed. It was based on the "*systems approach*" common to the defence and aerospace industries.

Over the next two decades, ICS teams were only organized for wild-land fire fighting. Later, people in other emergency response sectors began to think that if ICS teams could handle a major wild-land fire, they should also be able to apply ICS to any type of emergency or disaster, ranging from natural disasters, technological disasters, terrorism, or complex humanitarian emergencies.

> As a result, ICS terminology and management aspects were revised and the ICS concept was broadened to an "all-hazards" approach. The Incident Command System (ICS) became the Incident Management System (IMS) – an all-risk, all agencies, coordinated system … [322]

The incident management system is intended to bring an orderly, consistent and flexible chain of command and control within an emergency response. Dr. Young told the Justice Policy Committee:

> One of the hallmarks of what we're trying to do with response is to bring in an incident command system, so whether it's the police, fire, ambulance, the municipalities or the province, we're all organized the same way and we all use the same system. When we're sitting in the middle of an emergency, we're speaking the same language and we're managing it in the same way.[323]

In the event of an infectious disease emergency and the incident management system is activated, Dr. Sheela Basrur, Chief Medical Officer of Health, indicated that she would assume the role of incident commander and oversee the response to the emergency. She said:

> … there will be many other impacts right across the city, whether it be, "Is it safe to go on the subway system?" or "Should non-essential people stay home because we need the roads clear for the ambulances?" …
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> So in the incident management system, if I or my designate is the incident commander, there would be a whole series of operational responses, public health responses and conceivably other responses as well. They would all be planned and carried out under a public health lead to the extent that infectious disease is the thing we're trying to get control over.[324]

The question of management and clarity arose again and again in the concerns of those who helped pull the province through SARS and who want to make sure that

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322. The Johns Hopkins and Red Cross /Red Crescent Public Health Guide for Emergencies, (Johns Hopkins University, Baltimore, MD: 2000) pp. 10-3.
323. Justice Policy Committee, Public Hearings, August 3, 2004, p. 9.
324. Justice Policy Committee, Public Hearings, August 18, 2004, p. 143.

the lessons so painfully learned are not forgotten and that something is done to ensure that the problems of emergency management are addressed.

Two common themes ran through many submissions to the Commission in respect of emergency management. The first was the need for clear lines of authority (who's in charge) and for clarity around roles and responsibilities (who does what). The second was the need to integrate emergency plans, for instance any provincial public health emergency plan, any local public health emergency plan, any hospital plan, and indeed every emergency plan with a public health component.

The best way to present these ideas is through the thoughtful words of those who struggled with SARS and came to realize what must be done to prepare for the next emergency.

On the question of who's in charge and who does what, the following recommendations were made to the Commission:

> Specifically there is a need for clearly defined levels of authority during an emergency health situation, such as SARS. Lack of coordination and contradicting messages between the Public Health Authority, the Ministry of Health and Long-Term Care, Ministry of Labour, and Health Canada made it very difficult to function confidently during the SARS outbreak. Clearly defining the over-riding authority in such situations would decrease confusion and allow health care workers to respond quickly and confidently.

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> We require clear legal powers and lines of authority to respond to an infectious disease or biological threat, including a need for quarantines or restrictions to travel and balanced against the need to respect individual rights …
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> … The wording of the Act addresses the responsibilities of municipalities and Ministries, but not those of the agencies that are subordinate to Ministries, such as hospitals or health departments.

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> During a declared Provincial Emergency, a single authority should be designated for the purpose of issuing guidance to healthcare organiza-

tions. Each action communicated to healthcare organizations by this authority should be clearly labeled as to whether the action is mandatory, recommended or discretionary.

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The introduction of health emergency legislation would provide an opportunity for each of the participants to have a clear understanding of their role and to engage in the appropriate planning process. While the lack of such legislation did not prevent hospitals from responding to the SARS outbreak, we believe that the introduction of such legislation would enhance the system's ability to respond and provide greater clarity to hospitals and health care workers, which will assist them in responding to future outbreaks.

From a system-wide perspective, it is the Hospital's view that the essential components of special health emergency legislation include:

1. Clear designation of areas of responsibility as between the Provincial Ministry of Health, public health authorities, public hospitals, ambulance services and individual physicians and other health care providers;

2. Provision of authority to those so designated under item 1, so that they are able to carry out their particular responsibilities, giving particular attention to clarify hierarchical and centralized decision making powers;

3. A definition of the criteria under which the legislative enactments conferring such responsibility and the authority are to apply, and a mechanism for determining when the health emergency is over and normal operations may be resumed …

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Based on our experience during the SARS crisis, the key areas that need to be addressed, in terms of legislation for an emergency situation such as SARS, are:

- The current structure of who is ultimately accountable and authorized

to manage an emergency …

… Our suggestions for improvement in these areas are:

- To legislate the creation of an emergency plan/framework that has a single point of accountability and authority to manage an emergency, i.e. one person with emergency powers to create/manage a system-wide response to the emergency. This would ensure consistency in officials' directions and messages to health providers and greater cooperation between organizations.

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The Act [the *Emergency Management Act*] does define the powers of the Premier, which may be delegated to another Minister, but little else. The lack of clear roles and a designated authority structure created confusion during the SARS outbreak and should be outlined explicitly in the Act.

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Scope – It is recognized that legislation cannot provide for, nor address in any detailed manner, all conceivable emergencies, but nonetheless legislation should, in a comprehensive manner, provide for the key components of emergency management – i.e. lines of communication, containment of risk; provision of expertise and human resources; establishment of a clear chain of command.

Systemic coordination – During the SARS experience, hospitals continued to function as individual entities, yet there are system requirements that need to be coordinated in response to province-wide emergencies. Legislation must therefore clearly identify who or what entity has the authority to direct hospitals and other health care facilities and providers during an emergency; what the facilities responsibility is to this authority and who is accountable for actions taken, or conversely, for failure to act. We would further suggest that in this regard, the relationship and respective powers of the Public Health Branch and the Healthcare Programs Branch of the Ministry of Health and Long-Term Care during a provincial emergency be clearly articulated.

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> Clarity of role, leadership, funding envelopes, and accountability needs to be struck for all aspects of emergency planning, response, and recovery programs put in place in Ontario. Not only is it unclear who is responsible during an outbreak or emergency, but also how this authority and power is shifted when an emergency is declared (shifting from the non-emergency to emergency state). Clearly defined roles and responsibilities need to be made during the transfer …
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> … [We] once again re-emphasize the need for clear authority and a collaborative working relationship between all parties during an outbreak: the *EMA* does not illustrate this or emphasizes its utility. The Act sets out a generic framework. It makes no mention of specific roles for agencies and individuals. It empowers the control group to take actions within the law to control the emergency, but it does not go the further step to establish a functioning relationship between the parties. This is a key principle, especially when the health emergency is health related. The *EMA* deals with non-health related emergencies, and as witnessed in SARS (2003), it is poor in dealing with health emergencies.
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> A lack of a clear delineation of authority and responsibility between jurisdictions resulted in disjointed communication, information overload, and mixed messages to clinicians.

On the question of integrating emergency plans, the following recommendations were made to the Commission:

> … no outbreak follows political boundaries. This said it has to be noted that there is little if any room in the current legislation to deal with cross boundary issues (inter-provincial, and inter-jurisdictional issues within Canada let alone International issues) that may arise during an outbreak. A prime example of this can be found in the current experience with the Pandemic Influenza planning process underway in Ontario. Jurisdictional and political "turf wars" are guiding this process, more than the betterment and protection of "the public" in general. Coupled with this issue, is the lack of acknowledgement of the differing circumstances in the rural versus urban centres in Ontario. Generic planning for "Ontario" diminishes the complexity of Ontario's society and culture – including Native issues, the multi-cultural nature of the province, global

communications, and the rural urban divide, which clearly exists in the province.

Repeatedly, it has been stated that what will work for Toronto, will not necessarily be sustainable or practical outside of Toronto, and this needs to be acknowledged in reforming the system. To date, there have been no clear indications that this is being done. There is a continuing lack of clarity between the activation and response functions of different levels of government. This is particularly true in counties, as distinct from regions in Ontario. In these sites, a small lower tier municipality (town or township) has an emergency program (plan, education, exercises). More recently, the upper tier county level of government has been mandated to develop an emergency program. The coordination of lower tier vs. upper tier responses is not well characterized in legislation. Healthcare providers, facilities and municipalities need practical, applied simulation exercises (e.g. table top exercises) without the need to develop these independently in all areas …

… Currently townships, counties, and hospitals design, prepare and run simulations, and fund their emergency planning process through their own budgets. There is collaboration on many fronts with these various levels of governance, but emergency planning is very much an independent process. The *Emergency Management Act* does not clearly delineate what happens to this independence during an emergency and if the control of the process remains at the local/hospital level or if it is subsumed by the Chief Medical Officer of Health or provincial emergency management unit. Some greater clarification of this process needs to be developed including taking into consideration the 'health' aspects of the emergency.

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In future, we believe the province requires a centralized command-and-control structure on a "civil defence model" for emergency situations where there is integration of federal, provincial and municipal legislation and plans. This would require strengthening and altering the *Emergency Management Act*. Lines of authority should be clearly integrated and defined across federal, provincial and municipal jurisdictions. Individual health facility emergency plans also need to be standardized and integrated into municipal plans. Training should be provided to all those in

> the lines of authority to ensure that the scope of their authority and responsibilities are clear, feasible and understood. We would recommend one designated lead authority and spokesperson working with subgroups in future vs. multiple leads, as was the case in 2003. Multiple leads sometimes conveyed conflicting messages at press conferences and in private consultations.
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> The wording of the Act [the *Emergency Management Act*] should provide a legal mandate and requirement for agencies which are subordinate to the Ministries, such as hospitals, to formally coordinate their planning and related activities with those of the communities in which they are located.
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> … we agree with the need for all levels of government to review their respective legislative instruments in light of the lessons learned from SARS. Moreover, we have to ensure, collectively, that the provincial/territorial and the federal legislation complement each other so as to improve the public health protection offered to Canadians.

Because these views come from organizations who worked in the front lines during SARS they are entitled to great weight and careful consideration.

The Commission therefore recommends that Bill 138 provide explicitly for a process to ensure the integration of all emergency plans and the requirement that every emergency plan specify clearly who is in charge and who does what.

SARS not only underlined the importance of having an effective emergency management structure, it also emphasized the need to have sufficient quantities of medical supplies, secure supply chains and the means to distribute the supplies. While more will be said in the final report about these issues, it is relevant in this interim report for the Commission to examine certain legal questions related to public health emergency supply chain matters.

Many who worked through SARS told the Commission about their frustration with persistent supply chain problems.

Karen Sullivan, Executive of the Ontario Long-Term Care Association, said at the SARS Commission Public Hearings:

> Supply chain issues across the system led to shortages of equipment, N-95 masks, et cetera, that are not part of typical infection control management supplies. Coordination to ensure – to assure system-wide distribution of key emergency supplies is an important lesson.[325]

David McKinnon, past president of the Ontario Hospital Association, noted at the SARS Commission Public Hearings that supply chain management is lacking. He said major studies suggest that there should only be one supply chain management for all systems – "for all hospitals and that the technologies which underline that system should be fully contemporary so that the availability of supplies and equipment is transparent to everyone and so that we are not caught with fundamental information blockages at time of emergencies."[326]

Dr. Yoal Abells, Chair of the Family Physicians of Toronto, said at the SARS Commission Public Hearings:

> In terms of supplies and equipment, a reliable source of equipment – supplies and equipment is necessary. The just-in-time delivery system did us in. It may have looked good to the financial gurus and our hospital bean counters but it simply took too long to get supplies and equipment to the front line care worker – providers because there was a shortage of supplies and equipment. We need a reliable materials management system with immediate surge capacity.
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> Supplies and equipment are useless without an effective distribution system.[327]

Getting enough supplies of N95 respirators was a wide-spread problem. An article in the *Lancet Infectious Diseases* by officials from Toronto's University Health Network describes the particular challenge of getting enough masks:

> … submicron filtering masks (e.g., N95 masks) were in variable supply, because before SARS such masks were used only for patients with

325. SARS Commission, Public Hearings, October 1, 2003, p. 56.
326. *Ibid*, p. 109.
327. *Ibid.*

> airborne infections and hence most facilities would have only kept a limited supply. With 211 hospitals in Ontario alone requiring these supplies, Canadian suppliers rapidly ran out of stock. There was no pre-existing supply stockpile, and our mask supplies were obtained from foreign manufacturers. Because SARS was a worldwide threat, there was great difficulty in acquiring masks from other countries, since foreign governments understandably wanted to keep such supplies for their own citizens.[328]

The Commission heard from many nurses and other health care workers, whose story will be told in the final report, about the problems they encountered with insufficient supplies such as respirators.

The importance of having emergency supplies and a secure supply chain is an important lesson as we prepare for the possibility of future public health emergencies, like pandemic influenza.

Dr. Young testified at the Commission's public hearings:

> We clearly learned lessons out of this about inventory control on the future and maintaining supplies of infectious control materials, but that, again, in the world we lived in, in those days, did not exist and we had to create those systems and create those systems for delivering supplies to doctors' offices. Those systems were simply not in place.[329]

The Walker interim report said:

> SARS thus revealed clear provincial and national weaknesses around both production and distribution of emergency supplies. The Panel is aware of work at the provincial and federal levels to upgrade stockpiles and formalize distribution networks.[330]

In January 2005, the province announced an investment of $13.5 million on emergency medical equipment. It said:

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328. Sue Lim, Tom Closson, Gillian Howard, and Michael Gardam. "Collateral damage: the unforeseen effects of emergency outbreak policies. Lancet Infectious Dis. 2004; 4(11): 697-703."
329. SARS Commission, Public Hearings, September 29, 2003, p. 133.
330. Walker Interim Report, p. 123.

The $13.5 million investment aims to build preparedness for chemical, biological, radiological and nuclear (CBRN) emergencies, such as nuclear-related illnesses and train derailments. It is the first investment of its kind in Ontario's history. The investment will be used to:

- Purchase one portable, self-contained decontamination tent for every hospital emergency department. Tents ensure decontamination of any patients exposed to chemical, biological, radiological or nuclear (CBRN) agents occurs outside of the hospital, reducing risk to other patients and staff. Tents contain an area for stretchers, shower facilities, and can store potentially contaminated grey water from shower runoff.

- Build emergency stockpiles of equipment and supplies to assist hospitals in dealing with a CBRN event. These stockpiles will include:

    - gloves, masks, goggles

    - protective suits

    - hand sanitizer

    - spill control products

    - radiological/nuclear monitoring systems and air samplers

- Train hospital staff for all types of emergencies, including CBRN events.

- Enable hospitals to conduct emergency exercises in conjunction with Ontario's Emergency Medical Assistance Team and in partnership with community first responders.

- This investment will bring a consistent level of emergency preparedness across the hospital sector.[331]

331. Canada News Wire, Operation Health Protection' Giving Hospitals Improved Training And Emergency Supplies, January 13, 2005.

Despite these important and commendable efforts and others to prepare for an emergency, one can imagine the heightened demand on emergency stockpiles and supply-chains in the event of an influenza pandemic.

The Justice Policy Committee's report recommended that hospitals be designated to receive key medical and other supplies during an emergency:

> … the government designate hospitals as priority services in municipal emergency plans to ensure priority access to water supplies, fuel, and telecommunications during an emergency.[332]

The Commission endorses this recommendation and recommends that, in the event of a public health emergency, it be extended to all front-line components of the public health response.

During a public health emergency like an influenza pandemic, the demands on medical and other necessary supplies might require strong measures to secure necessary supplies and ration them appropriately.

Public health emergencies require legislation to address the supply chain problems addressed above. Those jurisdictions with separate public health emergency statutes address the problem specifically in terms of medical supplies. Bill 138, because it is general legislation designed to cover all emergencies, addresses the problem in general terms.

Section 7.0.2 (4) of Bill 138 contains the following emergency supply-chain powers:

> 7. The use of any necessary goods, services and resources within any part of Ontario.
>
> 8. The procurement of necessary goods, services and resources, the distribution, availability and use of necessary goods, services and resources and the establishment of centres for their distribution.
>
> 9. The fixing of prices for necessary goods, services and resources and the prohibition against charging higher prices in respect of necessary goods,

332. Justice Policy Committee, "Report on the Review of Emergency Management Law in Ontario," (Toronto: November 2004), p. 5.

> services and resources than the fair market value of the necessary goods, services or resources immediately before the emergency.

These powers are unclear. They do not provide that goods and services and resources may be used or procured without consent. Words like use, procure, fix, and requisition do not necessarily imply any element of compulsory taking. They do not authorize expropriation or compulsory seizure. Other emergency statutes do make such provision.[333]

The Commission therefore recommends that Bill 138 be examined to determine and clarify whether the supply chain powers in s. 7.0.2 (4) 7, 8, and 9 are intended to authorize compulsory seizure and expropriation of property and, if explicitly compulsory, what provisions should be made for compensation, administrative procedures, or other safeguards.

This particular example of lack of legal clarity in Bill 138 raises a general concern about its proposed powers. Is their purpose clear, and do they achieve their purpose, or do they on close examination reveal ambiguity as to their purpose and effect. The Commission therefore recommends that all the powers proposed in Bill 138 be reviewed by the Attorney General to ensure that there is no doubt as to their intended purpose and their legal effect.

Recommendations

The Commission therefore recommends that:

- **Bill 138 provide explicitly for a process to ensure the integration of all emergency plans and the requirement that every emergency plan specify clearly who is in charge and who does what.**

- **Bill 138 be examined to determine and clarify whether the supply chain powers in s. 7.0.2(4) 7, 8, and 9 are intended to authorize compulsory seizure and expropriation of property and, if explicitly compulsory, what provisions should be made for compensation, administrative procedures, or other safeguards.**

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333. See, for example, New Brunswick, *Emergency Measures Act*, S.N.B. 1978, c. E-7.1, s. 13(b); Nova Scotia *Emergency Measures Act*, S.N.S. 1990, c. 8, s. 14(b); Prince Edward Island *Emergency Measures Act*, S.P.E.I., c. E-6.1, s. 11(b).

- **All powers proposed in Bill 138 be examined to remove ambiguity of the sort that appears in s. 7.0.2(4) 7, 8 and 9 to ensure there is no lack of clarity as to the intended purpose and legal effect of any proposed power.**

Who's in Charge?

In times of emergency it is essential to know who is in charge. As Dr. Basrur noted in her appearance before the Justice Policy Committee:

> The point is that someone has to be in charge; people have to know where the buck stops, where decisions are made and where they can be unmade, and who the go-to person is.[334]

This interim report addresses the question of who was in charge at the public service level, not the political level.[335]

The leadership confusion and lack of clarity during SARS was at the operational and managerial level. There was no system in place to ensure one person was in charge of the overall management of the crisis and one expert medical leader to be in charge of medical issues. Lines of authority and accountability were unclear. These problems presented at the top, middle, and front line of the operational response to SARS. They resonated negatively throughout the response to SARS in the form of blurred chains of command, ambiguous reporting relationships and confusing directives and orders.

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334. Justice Policy Committee, Public Hearings, August 18, 2004, p. 142.

335. The Commission, as noted in the first interim report, continues to investigate the question whether public health decisions were influenced by political considerations. The Interim Report stated: "The Commission on the evidence examined thus far has found no evidence of political interference with public health decisions during the SARS crisis. There is, however, a perception among many who worked in the crisis that politics were at work in some of the public health decisions. Whatever the ultimate finding may be once the investigation is completed, the perception of political independence is equally important. A public health system must ensure public confidence that public health decisions during an outbreak are free from political motivation. The public must be assured that if there is a public health hazard the Chief Medical Officer of Health will be able to tell the public about it without going through a political filter. Visible safeguards to ensure the independence of the Chief Medical Officer of Health were absent during SARS. Machinery must be put in place to ensure the actual and apparent independence of the Chief Medical Officer of Health in decisions around outbreak management and his or her ability, when necessary, to communicate directly with the public."

At the top it was unclear who was in charge: Dr. James Young, the then Commissioner of Public Safety and Security (a position now called the Commissioner of Emergency Management), or Dr. Colin D'Cunha, the then Chief Medical Officer of Health. One medical leader put it this way:

> I think that if you asked me who was in charge of the SARS outbreak at a provincial level, I would have a very difficult time telling you who.

This confusion was highlighted by a submission to the Naylor committee signed by the chief executives of nine major health care groups:

> During a crisis or emergency, the public will quickly begin to look for a trusted and consistent source of information. However, during the early days of the SARS crisis, in Toronto, there were occasions when several different public health officials were being quoted and had titles attributed to them that appeared to indicate they were responding in an acting capacity only and not as an 'official.' This had the potential to leave an impression with the public that no one with any authority was in control.[336]

As noted in the Commission's first 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. Compounding the problem, in the view of some observers, was that branches of the Ministry of Health and Long-Term Care appeared to function on their own. As the Naylor report said:

> … the dual leadership structure was less than ideal, and one person should have been in charge. Matters were further complicated as other branches of the MOHLTC helped to manage the interactions with hospitals, long-term care facilities, physicians, and various elements of the health service system. A number of physicians involved in caring for SARS patients began actively discussing whether and how the management of the outbreak could be handed over to a single "SARS czar".[337]

336. Naylor Report, p. 32.
337. *Ibid*, p. 31.

The disastrous news conference on May 23, 2003 to announce a major SARS outbreak at North York General reinforces the point that one person needs to be in charge of public communication of health risk and that the Chief Medical Officer of Health, armed with the independence recommended by the Commission and accepted by the government, should be that person.

During the news conference, a reporter initially asked Dr. D'Cunha about the situation at North York General. Dr. D'Cunha answered:

> There are a couple of people under investigation.

Then, he turned the floor over to Dr. Low, who dropped what one reporter called "a bit of a bombshell" and announced the new outbreak:

> It's been a rough day at North York. I don't have all the answers for you tonight but what we've essentially identified is a cluster of cases that occurred on one ward at North York General … That there has been a likely transmission to health care workers. That there has been transmission to family members. And that there's probably been transmission to other patients.

After Dr. Low suggested that this cluster numbered "in the 20s," an incredulous reporter asked with justifiable heat:

> In the twenties. Okay. Why did you just go through this whole presentation for 20 minutes and we had to get it in a question? Why didn't you tell us at the start?

As noted in the Commission's first interim report, the confusion that marked the May 23 press conference exemplified the lack of any coherent communication strategy and the lack of any clear lines of accountability for the communication to the public of vital news about the status of the outbreak

Dr. Low, who had worked diligently all day to get to the bottom of a new troubling outbreak, was placed in the uncomfortable and unfair position of answering for systemic deficiencies in the uncoordinated flow of information.

The confusion that marked the May 23 press conference exemplified the lack of any coherent communications strategy and the lack of any clear lines of accountability

for the communication to the public of vital news about the status of the outbreak.[338]

Tom Closson, President and CEO of the University Health Network, made this point at the Commission's public hearings:

> … during SARS, was the fact that, there wasn't enough attention given to unified communication. We would see infectious diseases specialists being interviewed as being part of the POC. We'd see them being interviewed as representing their hospitals. We'd see them as being interviewed as, maybe, representing themselves and there's a lot of conflicting information going around.
>
> … Fighting it out in public is not really the best way to instill confidence. I'll tell you, our staff were quite frightened during SARS because they heard different things from different people and unified communication was necessary…[339]

It is essential during an emergency that the public and those fighting the emergency know who is in charge. As noted below it is essential that the Chief Medical Officer of Health be in charge of medical decisions, medical advice, and public communication about health risk and health safety, that the Commissioner of Emergency Management be in charge of all other matters, and that their respective roles be clear. Machinery to secure clear lines of authority is discussed below.

Types of Emergencies

The introduction to this chapter notes the uniqueness of public health emergencies. An infectious disease emergency like SARS can unfold over a much longer time frame than other emergencies. It is usually characterized by unknowns and intangi-

338. Some officials in the Ministry of Health and Long-Term Care think that the Chief Medical Officer of Health should not be clearly in charge. They think it is more comforting to the public to see a small group of government officials, each talking about the crisis from their own individual perspective. The Commission rejects this perspective. If any one incident rebuts this perspective, it is the May 23 press conference, the consequent loss of confidence that anyone was really in charge, and the loss of confidence that the public was being told the whole story.

339. SARS Public Hearings, October 1, 2003, p. 200.

bles. It evokes sustained responses of fear, both reasonable and unreasonable. It generates heightened stress. And it has the potential to strain severely, over time, personal and community bonds.

With a train derailment, a tornado or the 9/11 tragedy, one knows quite clearly in the early stages of the event's unfolding that a terrible catastrophe has occurred. Public health emergencies like SARS may involve a new illness, or one radically different from known disease strains. The new illness may not even have a name. It may present symptoms quite similar to other diseases. Its lethal nature and long-term effects may be completely unknown. And, while the outbreak gathers momentum, there may be no fool-proof means of diagnosing it or identifying its victims.

Again, as noted in the introduction to this chapter, it is artificial to speak of public health emergencies as if they are distinct from general emergencies. There are no pure public health emergencies. Although pandemic influenza might start as a public health emergency, it would rapidly snowball into a general emergency. Big general emergencies that arise outside the field of public health will usually have a public health component, such as flood-borne water infection.

Public health emergencies are different because unlike forest fires, floods or tornadoes, the underlying cause of an infectious disease emergency and its progress defies efforts to locate its core, its expanding perimeter and its agents of transmission.

In short, an infectious disease emergency is not easily traceable in real time. A public health emergency can unfold over a long, complex time frame. If there is a readily discernable beginning, it may not be identifiable until well into the outbreak. In all likelihood, as occurred with SARS, there may be no easily identifiable end. To declare an end to a public health emergency is fraught with danger. Declare it over too soon and hidden reservoirs of the disease may still linger, waiting for opportunities to re-emerge.

Dr. James Young told the SARS Commission hearings:

> … it's not like a forest fire which, in and by itself, can be difficult enough to control, but if I want to know the size of a forest fire, I can get above the forest fire, see where it is and build a barrier so that the forest fire does not jump over that barrier and even if it does, I may be able to have a series of smaller fires I can put out.
>
> The theory in controlling something like SARS is the same but the difficulty and the problem is, I have no idea where it is. I only know where it

> was 10 days ago and I have to not only catch up that 10 days, I must get further ahead.[340]

This means that accountability and governance requirements may have to be different in a public health emergency than, say, a power outage. The uncertain time frame of a public health emergency means that the feasibility and dynamics of accountability and governance require modification from those expected in other types of emergencies.

Dr. Young has said:

> I firmly believe there must be accountability and that's the way you have to operate, but I also think you have to be careful that you don't trip over your accountability. In the middle of an emergency, there is an awful lot going on and there are a lot of ends, so if your accountability time frames are either too rigid or too short, you're going to stop what you're doing and lose focus on what you're doing just so you can go back and account. Then you're going to be accounting for why you lost your focus and why people died because you were busy producing a report to go to a Legislature or somewhere else. So I think the accountability has to be at a point in time when you have the ability and the luxury to do it and do it well and to stop and consider it. It should be on an ongoing basis but it shouldn't be so tight that it interferes with the actual management of the emergency. …
>
> I would have been quite happy in the power blackout – you know, two weeks after we're in pretty good shape and we can start to account for it. In SARS, after two weeks we were still at the height of it, and being accountable two weeks into it would have been a very major burden.
>
> The other thing, from a personal point of view, is that after you're over it, for the people who are involved in it, there's a certain level of fatigue that sets in at that point and you'll get a better accounting a little bit later, when you've had a couple of days off once in a while.
>
> The problem with accountability – and I don't know the solution; I can't give you the answer – is that it does vary to some extent. If it's an ongoing

340. SARS Public Hearings, September 30, 2003, p. 35-6.

> process and an ongoing emergency like SARS, the accountability needs to be further out; if it's a shorter thing, then the accountability can be sooner.[341]

Further distinguishing public health emergencies are the tools and resources required to resolve the crisis. Where other kinds of emergency responses may require heavy-equipment operators and electrical experts, resolving public health emergencies is in the hands of a relatively small cadre of skilled professionals and agencies. Containment efforts rely on the resources and capabilities of medical specialties, like infection control and epidemiology, focused on disease prevention and containment in the population. Cutting-edge epidemiological and scientific direction and advice is vital to timely containment.

The key institutions and agencies at the forefront of containing a public health emergency tend to be publicly-funded and regulated. Although there was some spread in households and doctors' offices, and a limited element of community spread, SARS was largely a hospital-spread infection. Of the 247 probable cases in Ontario 190, or 77 per cent, were either health care workers, people who sought care at health care facilities or visitors. Health care workers were the predominant group: 108 were probable cases, a full 43 per cent of all probable cases.

Public health emergencies thus engage Ontario's complex, fragmented, unwieldy health care system, with all the challenges that entails. The Toronto Public Health unit, for example, has 22 hospital corporations within its jurisdiction. Some, however, also have sites outside the City of Toronto. The Rouge Valley Health System has two sites in Toronto and three outside the city.[342]

As Dr. Bonnie Henry, formerly of Toronto Public Health, has said:

> If we are doing things differently in two different health units, that can be very difficult for a hospital.
>
> It's the same if we look at our mental health system, our community care access centres, our district health councils, our long-term-care facilities. They are all, if you want, regionalized or organized on different geographical and jurisdictional boundaries. That can create massive difficul-

341. Justice Policy Committee, Public Hearings, August 26, 2004, p. 320.
342. Justice Policy Committee, Public Hearings, August 18, 2004, p. 153.

> ties in dealing with an emergency, and it's not limited to the health sector. It's similar in many other parts of our organization as well. For example, one health unit may actually involve several different municipal police services plus the OPP.[343]

This is not to say that public health professionals are only involved in infectious disease emergencies. As noted below by Dr. Basrur they also play important albeit less directing roles in responding to emergencies where public health capabilities, expertise and resources are not the main factors in the response.

Filling the legal gaps identified by SARS requires consideration of both the primary and secondary roles of public health in crises that are not public health emergencies.

An Ontario expert whose public health experience in emergency management began in the 1970s told the Commission that there is a clear distinction between the primary and secondary emergency roles of public health professionals and agencies:

> If a nuclear plant goes down, that's a much different kind of situation. There's a health component to it immediately for anybody injured – for evacuation of people out of the area. But you're not dealing with major medical [event] on a broad scale. Just those people that were injured at the initial site or whatever – if it was a train derailment or a bomb, or whatever. That's different from a communicable disease kind of outbreak, because we're not looking at putting out a fire, or repairing a facility or cleaning a bio-hazardous material from the area – that is something that is spread through communicable disease. That's probably where it divides.

Public health emergencies have unique aspects that require expert independent medical leadership from the Chief Medical Officer of Health as described in the next section of this chapter.

As noted by one professional association:

> Prefacing this section, it must be stated that a health emergency is fundamentally different than an emergency caused by a natural disaster, or other human-initiated emergency that may have some health implications. Specific health emergency legislation is needed to draw together

343. *Ibid.*

> expertise, resources, and establish a hierarchical transfer of authority to those in the healthcare system who will have the responsibility to make informed evidence based decisions to protect the public.
>
> There is a clear and present need for special emergency health legislation in Ontario. Coupled with this, there is a need for clarification of the ownership of the health hazard and risk assessment (s 5.1.2 of the EMA) and the accountability of provincial authorities concerning CBRN, bioterrorism, infectious disease, etc. Embedded in this there are implications for the new *Personal Health Information Protection Act* that need to be explored.
>
> Very clear roles, responsibilities, linkages, and inter-relationships for the health agencies, facilities and professionals involved in the health emergency need to be demarcated in this legislation, as well the role of the CMOH and the local MOH in the declaration of the emergency and the roles once the declaration has been made need to be determined.

The Missouri State Emergency Management Agency describes this difference in the following terms:

> Public health emergencies can occur as primary events by themselves, or they may be secondary to another disaster or emergency, such as tornado, flood, or hazardous material incident.[344]

In her appearance before the Justice Policy Committee, Dr. Sheela Basrur made a similar observation, suggesting that in infectious disease outbreaks, the Chief Medical Officer of Health needs to lead the provincial response, but may take a more supporting role in other kinds of emergencies:

> For other emergencies, whether it's a toxic release or a radiation accident or a major flood, there may well be health implications attached to those, but it's not as clear to me that the Ministry of Health and the public health division is the lead agency for the care and control of the incident. They are absolutely going to be main supporters of the response, but not necessarily the lead. That's the distinction I would make.

344. State of Missouri Emergency Management Agency, *Missouri Hazard Analysis*, (Jefferson, City, Missouri: September 2003), p. P-1.

> We can probably have a long debate, till the end of the day, about what's a public health emergency where you might have a mixture. They talk about the spectre of, let's say, a dirty bomb. A dirty bomb might be an explosive device that contains either nuclear or radioactive material, or it may have some real or perceived infectious pathogens in it. You're going to have mixed responsibilities, mixed jurisdictions. You'd have to deal with that on a case-by-case basis, and everyone is going to have to work together extremely closely anyway.[345]

At the same time, it must be kept in mind that certain emergencies can begin without a public health focus but can, depending on how events unfold, become public health emergencies. Response to an outbreak of avian flu could start with efforts to cull infected birds, protect the health and safety of workers involving in the culling and dispose of the carcasses in a manner that does not contaminate the environment. But if any humans get infected, it could become a public health emergency. If someone infected with avian flu also happened to be carrying another human virus at the same time, it could lead to the creation of a new virus that may have the ability to pass from one person to another.

As Dr. Young has warned:

> So the great risk with an avian flu is that it could turn into the new Spanish flu. We think that's how the Spanish flu started in 1918-19. Between 20 million and 50 million died of the Spanish flu at that time.[346]

Emergencies in the real world do not separate themselves into pigeonholes like general emergencies, public health emergencies, serious emergencies and catastrophic emergencies. Emergencies, by their unexpected nature and their ability to change direction suddenly, defy precise legal classification.

The argument against distinct and separate statutory regimes for different levels and types of emergencies was put very clearly by Dr. Young to the Justice Policy Committee;

> Mr. Arthurs: Could the application, the inclusion in legislation of these extraordinary powers, be in distinct legislation?

345. Justice Policy Committee, Public Hearings, August 18, 2004, p. 142.
346. Justice Policy Committee Hearings, August 3, 2004, p. 12.

> Dr. Young: I would recommend against it. I think when you separate it out, you're making it – it makes more sense to me that it's part and parcel of an emergency, and I don't think it's an accident that it sits within other acts as well and not as a separate and distinct thing. If you start putting it outside and putting it separately, then you're saying, "We've got about five levels of emergencies," and I think it's very confusing.
>
> If we start and we have a provincial emergency and then on the third day I need an extraordinary power, we announce we've bumped it up and we're using an extraordinary power, and two days later I say, "We've still got an emergency, but we've bumped it down one level of emergency," what you get is the weariness and the problems the United States is having with the coding system: What does it mean and how do you manage and do I not have to pay attention now because the extraordinary powers are out? I think it just becomes potentially a management issue in running the emergency, because you've got so many levels that people are going to be arguing with you, "Well, yesterday I had to follow your direction; today I don't." So I think there are issues around it.[347]

It is simply too confusing to enact separate legislative regimes for separate and distinct levels and categories of emergencies.

Because public health emergencies do not confine themselves to public health problems, and because general emergencies invariably involve some component of public health emergency, and because Ontario has chosen Bill 138 as the primary legal vehicle to carry emergency action, it would not be helpful to enact a separate definition of public health emergency. Although legislation in many American jurisdictions and some other Canadian provinces[348] refers specifically to public health emergencies as distinct from other emergencies, Ontario's SARS experience suggests strongly that it is better to have one single seamless emergency response without artificial legal barriers to inter-agency cooperation. To have a separate definition and separate legal regimes for public health emergencies and other emergencies would create two separate systems when SARS showed us that it is difficult enough to coordinate a single emergency system.

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347. Justice Policy Committee, Public Hearings, August 26, 2004, p. 319.

348. See Alberta's *Public Health Act*, R.S.A. 2000, c. P-37, s. 1(hh.1); Saskatchewan's *Public Health Act, 1994*, S.S. 1994, c. P-37.1, s.2(jj.1); Manitoba's *Public Health Act*, C.C.S.M. c. P.210, ss.22.1ff; Quebec's *Public Health Act*, R.S.Q. c. S-2.2, s.118.

The Commission's view is shared by the Ministry of Health, as indicated in a letter from the Minister to the Commission received on March 14:

> We understand that the upcoming report will focus mainly on public health and proposed amendments to the *Health Protection and Promotion Act* (*HPPA*). In addition to amendments to the *HPPA*, you have referred to powers of the Chief Medical Officer of Health in the course of a "public health emergency." While we are committed to ensuring that the Chief Medical Officer of Health has the necessary powers under HPPA to address issues as they arise under that legislation, including powers available in any emergency, and we will continue to look at how best this can be achieved, we do not feel that a separate definition of "public health emergency" per se achieves this goal in a clear manner.
>
> I, the Minister of Health and Long-Term Care, have sought the advice of the Chief Medical Officer of Health and she has expressed to me her reservations on this point, including the risk of potential confusion that could arise with dual definitions of emergency. In our view, it would be difficult to imagine an emergency that does not have some public health component or risk. Therefore, while the concept of clear roles for a CMOH in an emergency is clearly one we agree with, the manner in which this is achieved requires careful examination. We therefore look forward to reviewing your report in full and particularly your detailed comments on this matter.

For the reasons set out above and the reasons advanced by the Minister, the Commission recommends against the enactment of separate public health emergency legislation. For the same reasons the Commission recommends that Bill 138 make it clear that the special powers available in an emergency are in addition to the powers in the *Health Protection and Promotion Act* and the declaration of an emergency does not prevent the continuing use of the *Health Protection and Promotion Act's* health protection powers.

While SARS showed us that there should be only one emergency response system, it showed us also that medical aspects of emergency response should be directed by the Chief Medical Officer of Health for all the reasons referred to above, including medical expertise, independence, public trust, and the unique nature of the health care and public health systems. This special requirement, discussed below, will not necessitate a separate definition of public health emergency. It will however require some statutory language to ensure clarity in the respective roles of the Chief Medical

Officer of Health and the Commissioner of Emergency Management. The best way to provide clarity is to give words their ordinary day to day meaning. The drafting of amendments to Bill 138 is a job for Legislative Counsel and the Crown law officers. All the Commission can do is to offer some general suggestions for elements they may wish to consider when drafting those provisions of Bill 138 that deal with the role of the Chief Medical Officer of Health in public health emergencies and the public health aspects of larger emergencies:

> "Public health" in the expressions "public health emergency" and "public health aspect of any emergency" includes any matter touching on the protection of the health of the people of Ontario from infectious disease or any other health risk including, without restricting the generality of the foregoing, public communication of health risk and safety.

This approach avoids a definition of public health emergency that creates an artificial distinction between public health emergencies and other emergencies. This approach ensures clarity as to the role of the Chief Medical Officer of Health in the public health aspects of any emergency.

Recommendation

- **For the reasons set out above and the reasons advanced by the Minister, the Commission recommends against the enactment of separate public health emergency legislation. For the same reasons the Commission recommends that Bill 138 make it clear that the special powers available in an emergency are in addition to the powers in the *Health Protection and Promotion Act* and the declaration of an emergency does not prevent the continuing use of the *Health Protection and Promotion Act* health protection powers.**

Emergency Legislation: Two Models

Of the many models for emergency legislation two systems are relevant for Ontario at this time.

The first is the present model which involves three elements:

1. Specific statutory powers to deal with specific emergencies such as forest fires.

2. Inherent powers,[349] not set out in legislation, such as the power used to evacuate 218,000 Mississauga residents after the 1979 chlorine gas train derailment.

3. An *Emergency Management Act* which provides no additional emergency powers but concentrates existing powers for effective emergency deployment and provides for emergency plans.

The second is the model represented by Bill 138 which enacts broad emergency powers to make orders which override existing laws.

The case for the existing model without any special emergency powers was made in a 1981 discussion paper prepared by Solicitor General Roy McMurtry who had managed the Mississauga derailment within the framework of the existing law without any special emergency powers:

> Some persons feel that the draft Bill should grant special powers, for example, authorizing the entry of private property and the commandeering of property in an emergency. The draft Bill does not adopt this recommendation. It is felt that existing powers are adequate to deal with emergencies, both large and small. The responsible officials have the same powers when one building is threatened by fire as when one hundred buildings are threatened by fire.
>
> ———
>
> It is infinitely better that the courts should decide as each case arises, whether having regard to the necessities of the case the safeguards required in the public interest, the police are under legal duty in the particular circumstances."

Deputy Commissioner Maurice Pilon of the Ontario Provincial Police noted before the Justice Policy Committee that the existence of these inherent powers gives the police the authority to evacuate neighbourhoods without additional powers of the kind proposed in Bill 138. But he noted, very significantly, that it would make the work of the police easier in an emergency if their authority was set out in more legally explicit terms:

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349. It may be more technically correct to refer to these powers as ancillary powers because they are necessarily incidental to statutory powers such as those contained in the *Police Services Act*.

> … on the issue of evacuation during emergencies, it's my opinion that we need not create additional powers since they exist and can be locally exercised, thereby respecting the notion of the lowest competent level of response. Having said that, in practical terms in the absence of legislation that specifically authorizes evacuation, and forcible evacuation if necessary, it sometimes becomes a very difficult issue in dealing with the residents who choose for their own personal reasons not to leave a facility or a residence. You'll find that the elderly in particular do not wish to leave. They become confused and so on.
>
> So I would say that while we have the authority, it could be very much tested in law. It would be much easier if the law did specify that that authority existed.[350]

Before turning to the arguments for and against these two principal models, this is a convenient place to note a suggestion that there may be a third model which involves a significant judicial presence in emergency management. The *Toronto Star* in a thoughtful editorial[351] said this:

> One way to ensure the government is held to account would be to immediately refer any emergency declaration to a court to assess its legitimacy. The government could then make emergency orders pending the court's decision, but in the knowledge that its actions were being reviewed.

It is difficult in the absence of a more fully developed model to comment on the merits of this suggestion. Nothing in the experience of judges or the process of the courts suggests they are particularly well qualified to provide a speedy approval process for governmental emergency action. One difficulty is that courts will be obliged to hear individual applications to enforce public health statutes and emergency orders as well as challenges against emergency declarations and emergency orders. The courts' prior involvement in the process of oversight and review of such orders could make it difficult to provide a detached and independent forum for the adjudication of applications to enforce such orders and challenges against such orders.

Turning back to the two principal models under discussion, two major changes since 1981 suggest, to those who advocate the Bill 138 model, that the inherent powers

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350. Justice Policy Committee, Public Hearings, August 16, 2004, p. 78. See also the remarks by Mr. Alan Borovoy, general counsel of the Canadian Civil Liberties Association, before the Justice Policy Committee on October 14, 2004, at p. 347.

351. Toronto Star, Editorial, November 3, 2004.

model is no longer sufficient to protect against emergencies.

The first major change was the advent in 1982 of the *Canadian Charter of Rights and Freedoms*. It revolutionized our legal system by a new emphasis on individual rights and increased scrutiny of governmental action by way of judicial review. Although the Charter did not sweep away the existing inherent powers discussed above it became infinitely more important for governments, in defending their actions, to rely on explicit sources of power supported by rational arguments marshalled in advance of the exercise of the power.[352]

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352. It was acknowledged during the Justice Policy Committee hearings that there are arguments for and against the sufficiency of inherent powers and the need for explicit emergency powers. The following exchange took place on August 19, 2004 between Mr. Kormos and Mr. Twohig of the Attorney General's Department:

Mr. Twohig: Certainly, if you go back to the white paper of 1981, we had the Mississauga train derailment, we have Mr McMurtry-and it's right in the paper. They say, "We consider the need for special powers," and we say no. We say . . .

Mr Kormos: And McMurtry is a pretty smart guy.

Mr Twohig: Well, and he says, "We'll leave it to the common law." That was 1983 or 1981. When you look at the other provincial statutes-and we were discussing it this morning-of the other nine provinces and the federal government, seven of those jurisdictions, post-charter, have passed legislation with these wide, sweeping powers. They thought it was necessary. Presumably they read the McMurtry paper and disagreed. But that question, whether there's a need or not, I can't carry that. I was asked to assume that there was a need, and if we asked you to construct the powers with appropriate checks, what would it look like?

Mr Kormos: Fair enough. But now, because we talked about that just a little bit here in the committee, because we've got that McMurtry white paper, the 1981 paper, and all of us-I think it's pages 26, 27, 28, and boom, right to that special powers, you'll see it. It's not the same politics as mine, but I knew him as a smart guy when he was justice minister and I consider him a pretty smart guy now. Maybe he's changed his mind, but do you dispute the conclusion he reached as a lawyer?

Having said that, because we also tried to reflect on what changed from 1981, the only thing we could think of was the charter, right? So I suppose I'd ask you to tell us what about the charter would change or impact on the conclusions that Minister McMurtry, as he was then, reached in his report of 1981.

Mr Twohig: I absolutely take no issue with the fact that there is an argument. That's the threshold question: Is there a need for change? Did the charter in fact make McMurtry's argument even stronger? I appreciate that that's an argument, but to address that argument, I never got to that. I was asked to assume that there was a need, and if there was a need, the direction was, "Have something ready. We don't want to be caught. If it turns out that people aren't following directives, if it turns out that the evacuation of people needs to take place and someone says, 'Well, wait a minute; you don't have the authority to do it,' what would those powers look like?" That's what I did. But your question is certainly the critical threshold question.

The second major change is the increasingly serious and complex nature of the threats that might require emergency action, a terrorist attack of an unforeseen nature or an influenza pandemic to take two examples only. The argument that broad and explicit emergency powers are required to combat these new threats was made by Dr. James Young in his letter to the Premier dated June 21, 2004:

> Although we have made significant advancements in the Province's state of emergency preparedness, the risk situation from a number of factors including terrorism, global warming, interconnected and aging infrastructure, and pandemics is greater today than at any point in the province's history. We continue to address these issues at all levels of government and are making steady progress in our ability to respond.
>
> Clearly, one of the best ways to guide our preparation is to learn from our past experiences. With this goal in mind, I would like to specifically comment on some deficiencies in our emergency legislation. The 1998 ice storm and particularly the 2003 SARS and power blackout emergencies, have demonstrated limits in our current legislation.
>
> In the event of a declared provincial emergency, the *Emergency Management Act* concentrates existing legislative power in your hands, but does not add any additional powers to manage the unique issues that arise during an emergency. For example, it is not clear if you could force an evacuation or control the distribution or price of vital supplies such as gas, electricity or medical protective equipment. In concert with other ministries, we have been looking at a range of potential powers and comparing our proposed approach with existing legislation in other provinces. Currently, Ontario has the weakest legislation in the country. The additional powers we have considered appear in other provincial or federal legislation and most of the legislation describes these powers in similar ways. Any additional powers, of course, must be used carefully in an emergency and an accountability mechanism should be built into their use. The overriding principle, however, is that these powers are necessary to protect public safety in an emergency situation.
>
> I believe that our research and analysis has evolved to a point where we can offer constructive and comprehensive advice to you concerning necessary legislative amendments to the *Emergency Management Act*.

> For your information, I am attaching to this letter a jurisdictional analysis of emergency powers legislation in other provinces.

Dr. Young's letter was supported by a chart showing that the federal government and every province except Ontario had enacted emergency legislation along the general model represented by Bill 138.

Correspondence between the Commission and the Ministry of Health and Long-Term Care in Appendix H makes it clear that the government is committed to the second model represented by Bill 138. The Commission has no mandate in respect of emergency legislation generally or the particular model the government chooses to use for all emergencies including public health emergencies.

The model chosen raises natural concerns by reason of its extremely open-ended and vague powers to make emergency orders, coupled with the awesome power to override existing laws whenever the government considers it necessary. There are however three arguments in favour of an explicit powers model that may make it difficult to oppose at least in some modified form after a major legal overhaul by the Attorney General.

The first argument is that every other jurisdiction in Canada has adopted some form of explicit emergency power regime of the kind generally represented by Bill 138, putting a burden of persuasion on those who argue that Ontario should choose a radically different model such as an inherent power model.

The second argument is that you can never in this day and age foresee exactly what form an emergency may take and therefore you can never legislate in advance the precise limits of all the powers that may be necessary to protect the public.

The third argument is based on evidence of increasing concern about legal liability and legal authority. Many who stepped up to the plate during SARS, and complied unquestioningly with directives rather than challenging their legal authority, suggest that they might not do so again in the absence of explicit legal authority because of concern about their own legal obligations and potential liability.

Emergency Response: Two Inherent Dangers

Emergency powers are inherently dangerous. They carry the twin dangers of overreaction and underreaction.

The first danger is overreaction. As noted above every emergency power, once conferred, "lies about like a loaded weapon ready for the hand of any authority that can bring forward a plausible claim of an urgent need."[353] To a hammer, everything looks like a nail. To some emergency managers, every problem may look like an opportunity to invoke emergency powers.

The second danger is underreaction. In face of a deadly new disease with an uncertain incubation period, ambiguous symptoms, no diagnostic tests, uncertainty as to its infectiveness and mechanisms of transmission, and no idea where in the province it may be simmering, decisive action may be necessary that turns out in hindsight to have been excessive.

The problems of overreaction are familiar to the legal system. Lawyers and legislators and courts and judges have become adept over the years at preventing the problems of overreaction by means of legislative safeguards. These legislative safeguards will be addressed below in the discussion of Bill 138.

The legal system is not designed to prevent the problems of underreaction. Although a public body might be sued after the fact for failing to prevent a problem such as an attack by a known sexual predator, these lawsuits are complex and they do nothing to prevent the problem in the first place. All the legal system can do is ensure that the emergency managers are not hamstrung by legislative requirements that prevent them from acting unless and until they can prove objectively that emergency action is necessary. Such objective standards may prevent emergency managers from acting until it is too late.

The precautionary principle addresses the problem of underreaction by pointing out that in the face of a grave risk it is better to be safe than sorry:

> The absence of full scientific certainty shall not be used as a reason for postponing decisions where there is a risk of serious or irreversible harm.[354]

Mr. Justice Krever emphasized this principle in the Commission of Inquiry on the Blood System in Canada:

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353. Mr. Justice Jackson, dissenting, in *Korematsu vs. United States*, 323 U.S. 214 (1944) in respect of the race-based internment of Japanese Americans during WW II.

354. Privy Council of Canada, *A Framework for the Application of Precaution in Science-based Decision Making About Risk* (Ottawa: 2003), p. 2.

> 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.[355]

Suggestions that the authorities overreacted during SARS, and suggestions that the authorities underreacted during SARS, are questions for the Commission's final report. It is enough to say now that the precautionary principle may require emergency managers to overreact in order to avert a threat of unknown proportions. Dr. James Young addressed this issue in the hearings of both the SARS Commission and the Justice Policy Committee:

> And so, in my view, the only way of combatting something like this, is to go after it very hard and very fast and attempt to get far enough ahead that, in fact, if we have any breakout it's very limited. Areas that did not do this at the beginning, such as Beijing, ended up with a much bigger outbreak because, in fact, that was the only way of getting in front of it.[356]

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> Unfortunately, the safest and the best way when you're thinking about emergencies and potential emergencies is to overreact and then cut back rather than under-react. If you play catch-up and you under-react and you make mistakes, you'll spend much longer trying to repair the damage and the human or economic loss will be much greater.[357]

The only legal solution to the problem of underreaction is to permit the application of the precautionary principle by ensuring first that the emergency managers have all the necessary legal tools and legal powers they require, and second that they are not unduly hampered by objective standards that require too high a level of proof before sensible precautions can be imposed.

The central task of emergency legislation is to guard against overreaction by providing safeguards and to guard against underreaction by avoiding legal restrictions that prevent the application of the precautionary principle.

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355. *Commission of Inquiry on the Blood System in Canada*. Final Report at page 295, see also pp. 989-994.
356. SARS Commission Public Hearings, September 30, 2003, p. 36.
357. Justice Policy Committee, Public Hearings, August 3, 2004, p. 12.

Role of Chief Medical Officer of Health

The most important thing in a public health emergency is public confidence that medical decisions are made by a trusted independent medical leader such as the Chief Medical Officer of Health, free from any bureaucratic or political pressures. This is particularly true of public communication of health risk. People trust their health to doctors, not to politicians or government managers. It is essential that the public get from the Chief Medical Officer of Health the facts about infectious risks to the public health and the degree that precautions are needed and advice on how they can avoid infection. It is essential when public precautions are relaxed, like the removal of protective respirators in hospitals, the re-opening of hospitals or the declaration that it is business as usual in the health system, that these decisions are made and are seen to be made by and on the advice of the independent Chief Medical Officer of Health. It is essential in a public health emergency, or the public health aspects of an emergency such as flood-borne disease, that the Chief Medical Officer of Health be the public face of public communication from the government.

Health Minister George Smitherman highlighted the vital role of the Chief Medical Officer of Health when he introduced amendments in October 2004 to the *Health Protection and Promotion Act*[358] enhancing the independence of the Chief Medical Officer of Health. He told the Ontario legislature:

> The position of chief medical officer of health is probably not one that most Ontarians think about very often. After all, you don't generally think about your doctor until you have a health problem. The chief medical officer of health, or CMOH, is, in a very real sense, the top doctor for 12 million Ontarians. So it's only when there is a public health problem that has the potential to affect anyone and everyone that this position suddenly takes on its extremely important public profile.
>
> When there is a health crisis and politicians speak, some people listen. But when there is a health crisis and the chief medical officer of health speaks, everybody listens. It is at those times, times when diseases like SARS or West Nile are a real threat, that the chief medical officer of health must be there for his or her patients, all 12 million of them. It is at

358. The amendments were introduced in Bill 124, which was passed by the Ontario legislature on December 15, 2004, and received Royal Assent one day later.

> times like those that the chief medical officer of health must be able to interact with his or her patients without worrying about what the Minister of Health might think, what the effect might be on the government or what the opposition might say. We learned that lesson as a province during Walkerton, West Nile and SARS. We learned that what Ontarians wanted, what they needed, from their chief doctor was his or her undivided attention.[359]

The government, as noted above, has started to strengthen the independence of the Chief Medical Officer of Health and the Commission has recommended the completion of this task together with a parallel measure of independence for the local medical officer of health. These additional measures are necessary to ensure that these trusted medical figures have the actual independence and the perceived independence necessary to secure public confidence that whatever they do and whatever they say in a public health emergency is for the public's health and not for some political or bureaucratic expediency.

The importance of the independence and leadership of the Chief Medical Officer of Heath and medical officers of health during an emergency was emphasized by one professional association:

> The provincial Chief and local Medical Officers of Health should be granted authority in managing the health aspects of any emergency and possess full authority delegated by the Provincial Commissioner of Emergency Management or municipal Chief of Emergency Management in managing a health emergency. This should be addressed in the Emergency Management Act itself.
>
> There is also a clear conflict of interest that may develop during an emergency if the "political will" of the government of the day stands in the way of actions that need to be taken by the Chief Medical Officer of Health to protect the health of the public. This is to say, that there may be clear variance from a government's policy directions in the choices made by the Chief Medical Officer of Health in order to protect the public. The Chief Medical Officer of Health needs to be given the authority to act and protected in the EMA from recourse of such choices.

359. Legislative Assembly of Ontario, October 14, 2004, p. 3388.

> Further to this, it remains unclear whether the HPPA or the EMA is the more powerful, and hence presiding legislation, during health emergencies. When the emergency is declared it is clear that the EMA is the dominant legislative authority, however as mentioned above, the EMA does not deal with health emergencies, and therefore the linkages between the players in the system. Where the control lies, either with the CMOH or MOH, and the role of each in decision-making and the custodianship of emergency planning, management, and recovery plans needs to be more clearly defined.

The emergency role of the Chief Medical Officer of Health and medical officer of health should, as recommended above, include the fullest direct authority for public health emergency planning. While the medical officers will, of course, consult other agencies in the development of public health emergency plans, there should be no mistake as to who is in charge of the public health emergency planning process. It is for instance unacceptable, for the reasons noted above, that provincial public health emergency planning not be under the authority of the Chief Medical Officer of Health.

To give the Chief Medical Officer of Health special authority in public health emergencies and the public health aspects of more general emergencies is to provoke the excellent question: who's in charge? How can you have the Commissioner of Emergency Management in charge of the emergency and the Chief Medical Officer of Health in charge of its public health aspects? Does that not invite the SARS problem of unclear authority? The rhetorical answer is to ask "in charge of what?" There should be no difficulty, when lines of authority are clear and a good working relationship is ensured in advance by consultation, protocols, and drills, in an incident management system where the Chief Medical Officer of Health is in charge of the medical aspects and the Commissioner of Emergency Management is in charge of everything else. The inevitable boundaries issues can be solved by cooperation, advance planning, and, above all common sense. All that is required is for the Commissioner of Emergency Management and the Chief Medical Officer of Health, whoever may succeed to those jobs from time to time, to park their egos outside the door of the incident room and get on together with the job of managing the emergency. Both require not only confidence in their authority but also a clear acceptance of their mutual roles and limitations.

Key members of the Ontario SARS Scientific Advisory Committee recommend the following:

> At the provincial level, the Commissioner of Emergency Management should have the power and authority to manage all provincial emergencies and be accountable directly to the Premier. Where an emergency principally involves health, this authority should be delegated to the Chief Medical Officer of Health with coordination, support and authority to manage all the non-health aspects of the emergency remaining with the Commissioner of Health Management.
>
> ———
>
> If the Chief Medical Officer of Health is the incident commander during a health emergency, it follows therefore that all other health sectors are accountable to the Chief Medical Officer of Health. This was the premise during the SARS outbreak and worked to the extent that proper command and control structures were exercised, and now the Emergency Management Unit of the Ministry of Health and Long-Term Care is the coordinating structure by which provincial health care providers and organizations would report to the Chief Medical Officer of Health during an emergency and this should be recognized in legislation. During the SARS outbreak there was duplication of information and efforts from within the MOHLTC. One central Emergency Management Unit reporting to the Chief Medical Officer of Health will avoid duplication and confusion.

This means that, during a public health emergency, the Chief Medical Officer of Health must be an integral part of every emergency committee, from the highest level down, that is relevant to containing the emergency, even if it is a committee whose meetings normally would only be open to the Commissioner of Emergency Management. Otherwise, the independent accountability of the Chief Medical Officer of Health for public health risk communication and the Chief Medical Officer of Health's exclusive authority over medical decisions are nullified.

Dr. Sheela Basrur described her public health emergency role during testimony to the Justice Policy Committee:

> The point is that someone has to be in charge; people have to know where the buck stops, where decisions are made and where they can be unmade, and who the go-to person is. For infectious diseases, I think it needs to be the chief MOH. For other emergencies, whether it's a toxic release or a radiation accident or a major flood, there may well be health

> implications attached to those, but it's not as clear to me that the Ministry of Health and the public health division is the lead agency for the care and control of the incident. They are absolutely going to be main supporters of the response, but not necessarily the lead. That's the distinction I would make.
>
> We can probably have a long debate, till the end of the day, about what's a public health emergency where you might have a mixture. They talk about the spectre of, let's say, a dirty bomb. A dirty bomb might be an explosive device that contains either nuclear or radioactive material, or it may have some real or perceived infectious pathogens in it. You're going to have mixed responsibilities, mixed jurisdictions. You'd have to deal with that on a case-by-case basis, and everyone is going to have to work together extremely closely anyway.[360]

To meet the problem of divided leadership during SARS, Dr. Basrur suggested that the Chief Medical Officer of Health be the one issuing directives in a public health emergency:

> During SARS, as you are aware, there were a multitude of directives issued under the authority of the two commissioners – the Commissioner of Emergency Management and the Commissioner of Public Health – and many comments back that people were unsure who was in charge because there were two signatories; there were always two people who had to be consulted. I would say that if you have a public health emergency, which means primarily that you have an infectious disease emergency for which public health is clearly the lead agency, it is wise, in my opinion, for those directives to be issued under the authority of the chief MOH. That's not to say that the chief MOH wouldn't check in with a whole lot of people: Dr. Stuart – honorary doctor; lucky you – as the director of the emergency management unit; obviously with the deputy minister; with Dr. Young over where he is, and so on. I'm sorry; the acronym escapes me.[361]

Dr. Donald Low told the Justice Policy Committee:

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360. Justice Policy Committee, Public Hearings, August 18, 2004, p. 142.
361. *Ibid*, p. 142.

> Let me just, again, put my focus on a couple of these issues that I thought were particularly important. One was critical: the identification of somebody who is really in charge. During this outbreak, that didn't happen, and I really would support that we identify who that person should be. Obviously, in medical emergencies, it should be the chief medical officer of health, and not only that that person has the authority, but also the authority to appoint individuals to assist with the investigation and managing of the outbreak.[362]

The Commission therefore recommends that emergency legislation provide that the Chief Medical Officer of Health has clear primary authority in respect of the public health aspects of every provincial emergency including:

- Public communication of health risk, necessary precautions, regular situation updates;
- Advice to the government as to whether an emergency should be declared, if the emergency presents at first as a public health problem;
- Strategic advice to the government in the management of the emergency;
- Advice to the government as to whether an emergency should be declared to be over, and emergency orders lifted, in respect of the public health measures taken to fight the emergency;
- Advice to the government in respect of emergency orders of a public health nature and emergency orders that affect public health e.g. ensuring that gasoline rationing does not deprive hospitals of emergency supplies;
- Delegated authority in respect of emergency orders of a public health nature; and
- Such further and other authority, of a nature consistent with the authority referred to above, in respect of the public health aspects of any emergency.

362. *Ibid*, p. 146.

This primary emergency authority carries with it the duty to consult with the Commissioner of Emergency Management and other necessary agencies. Although this is just basic common sense, it would be well to make the duty of consultation explicit as a public signpost enshrined in legislation. This public signpost would ensure that the problems never happen again that arose during SARS in respect of the office of Chief Medical Officer of Health. The office of the Chief Medical Officer of Health must never, no matter who succeeds to the office from time to time, become a separate silo as it sometimes appeared to others during SARS, jealous of its own authority and reluctant to cooperate and share that authority with other agencies.

The Commission therefore recommends that emergency legislation provide that the Chief Medical Officer of Health shall exercise his or her authority, so far as reasonably possible, in consultation with the Commissioner of Emergency Management and other necessary agencies. Conversely, the Commission recommends that emergency legislation provide that the Commissioner of Emergency Management, on any matter affecting public health, shall exercise his or her authority so far as reasonably possible in consultation with the Chief Medical Officer of Health.

The details of the consultation and cooperation between the Commissioner of Emergency Management and the Chief Medical Officer of Health need not be reduced to legislative form. It is not, for instance, necessary to specify in legislation whether emergency directives to hospitals be cosigned by the Chief Medical Officer of Health and the Commissioner of Emergency Management as they were during SARS. This kind of detail should be worked out in advance between them in a protocol or memorandum of agreement that is flexible enough to allow for the unexpected and clear enough to point the holders of both offices, and those with whom they work, along a simple path of cooperation.

Recommendations

The Commission therefore recommends that:

- **Emergency legislation provide that the Chief Medical Officer of Health has clear primary authority in respect of the public health aspects of every provincial emergency including:**
    - **Public health emergency planning;**

- **Public communication of health risk, necessary precautions, regular situation updates;**

- **Advice to the government as to whether an emergency should be declared, if the emergency presents at first as a public health problem;**

- **Strategic advice to the government in the management of the emergency;**

- **Advice to the government as to whether an emergency should be declared to be over, and emergency orders lifted, in respect of the public health measures taken to fight the emergency;**

- **Advice to the government in respect of emergency orders of a public health nature and emergency orders that affect public health e.g. ensuring that gasoline rationing does not deprive hospitals of emergency supplies;**

- **Delegated authority in respect of emergency orders of a public health nature; and**

- **Such further and other authority, of a nature consistent with the authority referred to above, in respect of the public health aspects of any emergency.**

- **Emergency legislation provide that the Chief Medical Officer of Health shall exercise his or her authority, so far as reasonably possible, in consultation with the Commissioner of Emergency Management and other necessary agencies. Conversely, the Commission recommends that emergency legislation provide that the Commissioner of Emergency Management, on any matter affecting public health, shall exercise his or her authority so far as reasonably possible in consultation with the Chief Medical Officer of Health.**

Specific Public Health Emergency Powers

The first line of public health emergency defence, as noted above, is to stop emergencies before they start by arming the Chief and local medical officers of health through the *Health Protection and Promotion Act* with stronger daily powers to prevent the

spread of infection. The measures recommended above will provide a strong shield against the onslaught of public health emergencies.

But public health emergencies will arise despite the greatest vigilance of public health authorities and the most vigorous exercise of their daily powers.

The quintessential public health emergency is an outbreak of infectious disease that overwhelms the capacity of the public health system. The most serious predictable public health emergency is pandemic influenza which would overwhelm not only the public health and hospital and medical systems but also the other systems that keep the province going. Pandemic influenza exemplifies the need for strong emergency powers.

Three times in the last century radical new influenza strains have emerged to cause global pandemics.[363] The worst was in 1918-19 when 20 to 50 million people died worldwide, including an estimated 30,000 to 50,000 people in Canada. Leading experts agree a flu pandemic that could kill millions around the world[364] is inevitable and overdue.[365]

The Ontario Health Pandemic Influenza Plan, which suggests that a flu pandemic in

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363. Pandemic is defined as "An epidemic occurring worldwide, or over a wide area, crossing international boundaries, and usually affecting a large number of people." Source: Last, John M., ed., *A Dictionary of Epidemiology* (Oxford, U.K.: 2001), p. 131.

364. "Even in the best case scenarios of the next pandemic, 2 to 7 million people would die and tens of millions would require medical attention. If the next pandemic virus is a very virulent strain, deaths could be dramatically higher." (Source: WHO, "Estimating the impact of the next influenza pandemic," December 8, 2004.) Also note that Peter Sandman and Jody Lanard, American experts in risk communication, have said: "Estimates of how many people a flu pandemic will kill are basically informed guesses. Nobody knows how virulent the influenza strain that launches the pandemic will be, or how that strain will attenuate or intensify once it starts to spread; nobody knows what percentage of the world's population will be infected or what percentage of those infected will die; nobody knows how soon a vaccine will be mass-produced and distributed; nobody knows how well the vaccine will work or how successful "social distance" strategies will be in the meantime." (Source: Lanard, Jody and Sandman, Peter, "Pandemic Influenza Risk Communication: The Teachable Moment.")

365. Some experts like Sandman and Lanard have questioned whether there is sufficient evidence to believe pandemics are cyclical: "If there are really reasons for thinking flu pandemics are cyclic (for example, if going decades without a pandemic makes the human population more vulnerable to a novel strain) then this makes sense. But we haven't seen it argued as a scientific proposition … If pandemics are random events, then each year's odds are the same, regardless of what happened the year before," See: Lanard, Jody and Sandman, Peter, "Pandemic Influenza Risk Communication: The Teachable Moment."

the province could result in as many as 52 thousand hospitalizations, 2.25 million outpatient visits, and 12 thousand deaths,[366] said:

> Although no one can predict when the next influenza pandemic will hit, public health officials have warned that a global influenza pandemic is overdue.[367]

A study by experts at the Institute of Medicine of the National Academies in the U.S. said:

> All influenza virologists agree that a new pandemic is imminent.[368]

Health Canada said:

> A pandemic can occur at any time, with the potential to cause serious illness, death and colossal social and economic disruption throughout the world.[369]

The WHO has identified three prerequisites for the start of a pandemic:

1. A novel virus subtype must emerge to which the general population will have no or little immunity.

2. The new virus must be able to replicate in humans and cause serious illness.

3. The new virus must be efficiently transmitted from one human to another; efficient human-to-human transmission is expressed as sustained chains of transmission causing community-wide outbreaks.[370]

The WHO believes that the H5N1 virus, which has caused unprecedented outbreaks of highly pathogenic avian influenza in large parts of Asia, has met the first two prerequisites:

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366. Ministry of Health and Long-Term Care, *Ontario Health Pandemic Influenza Plan* (Toronto: May 2004) p. 6.
367. *Ibid*, p. 10.
368. Institute of Medicine of the National Academies, *Microbial Threats to Health* (Washington: 2003), p. 146.
369. Health Canada, *Canadian Pandemic Influenza Plan* (Ottawa: February 2004), p. 17.
370. WHO, "Avian influenza: Assessing the pandemic threat," (Geneva: January 2005), p.11.

> All prerequisites for the start of a pandemic had been met save one, namely the onset of efficient human-to-human transmission. Should the virus improve its transmissibility, everyone in the world would be vulnerable to infection by a pathogen – passed along by a cough or a sneeze – entirely foreign to the human immune system.[371]

Concludes the WHO:

> During 2004, the world moved closer to a further pandemic than it has been at any time since 1968.[372]

Dr. Julie Gerberding, director of the CDC, believes H5N1 represents the "most important threat we are facing right now."[373]

Raising the level of concern over H5N1 are reports that create doubts about the reliability of laboratory tests in some affected areas of Asia, raising the possibility that the virus's progress may have been underestimated.[374]

Some experts, however, question whether the next pandemic will be triggered by the H5N1 virus. They question whether there is sufficient scientific evidence to point definitely to H5N1 as the cause of the next pandemic. Some skeptics even go so far as to suggest that the fear factor is good business for agencies and industries with a vested interest in directing public attention and public funds to emergency preparedness.[375]

It would of course be unwise to accept at face value, without critical analysis, every portent of disaster. History has not been kind to Cassandra or Chicken Little. Those who warn of disasters have been accused throughout history of simply trying to scare people. Whether the next pandemic will be caused by H5N1 or another novel disease, or whether fears about H5N1 may, in hindsight, turn out to be exaggerated, it would be reckless not to prepare for the next pandemic. As the U.K. Ministry of Defence's Chief Scientist has said:

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371. *Ibid,* p.11.
372. *Ibid*, p.3.
373. Macleans, "Bracing for bird flu," March 16, 2005.
374. Los Angeles Times, "Many scientists fear bird flu cases exceed data," March 16, 2005.
375. CBC News Online, "H5N1: A string of numbers and letters that has the World Health Organization deeply concerned," March 8, 2005; Macleans, "Bracing for bird flu," March 16, 2005.

> Although it sounds alarmist, the balanced view is that we are overdue a major pandemic.[376]

Prudence and precaution require that effective planning and preparedness for an influenza pandemic be undertaken.

Although Ontario got through SARS without any special emergency powers, the prospect of pandemic influenza brings home the need for such powers. Even if all the emergency measures taken during SARS were explicitly enshrined in emergency legislation, those measures would be hopelessly inadequate in the face of a much larger infectious attack such as pandemic influenza.

SARS infected hundreds of people and killed 44 in Ontario. While one death from infectious disease is one death too many, the overall burden of disease from SARS was much less than the 1918 Spanish flu pandemic and the prospect of future emergencies like an influenza pandemic.

The prospect of pandemic influenza or indeed any outbreak more serious even than SARS requires the enactment of emergency powers stronger than those available during SARS and available now.

It is impossible, as noted above, to draw a bright line between public health emergencies and other emergencies. It is therefore almost a misnomer to refer to "public health emergency powers" as if they were distinct from other powers required when an emergency like pandemic influenza overwhelms the public health system and the ordinary machinery of public safety. It is however convenient as a practical matter to refer to public health emergency powers when discussing those emergency powers that are particularly relevant to the public health aspects of any emergency.

The Commission asked the Ministry of Health and Long-Term Care for its position on powers required in the event of a public health emergency and the then Deputy Ministry of Health Mr. Phil Hassen, in a reply dated August 4, 2004, reproduced in Appendix H, made the following recommendations:

> … [W]ithin the framework of broader emergency response powers, we have been considering enhancements that may be required in our legislation to address specific program issues as they arise in (or prior to or

376. The Guardian, "Bird flu could put Britain in quarantine, warns scientist," March 27, 2005.

after) any emergency. For example, we will be considering various ways of clarifying the authority to issue directives prior to, during, or after an emergency. This could be achieved by including a general provision in the *Ministry of Health and Long-Term Act,* or provisions in program specific legislation (i.e., legislation governing public hospitals, laboratories, long-term care facilities, etc.).

There is also the possibility of enhancing the ability of the Chief Medical Officer of Health to take action or provide directions as required in any circumstance relating to a public health emergency. A further complementary amendment is to provide a mechanism to expedite the registration of health care professionals in an emergency, and possibly before or after an emergency, to ensure that professionals registered in other jurisdictions could come to Ontario and practice on short notice. This would require amendments under the *Regulated Health Professions Act* and related legislation.

In addition to these potential changes, specific amendments to the *Health Protection and Promotion Act* are discussed in more detail below.

Health Protection and Promotion Act

The current *Health Protection and Promotion Act* ("HPPA") provides extensive powers to address public health issues throughout Ontario. As you know, over the coming year we would initiate changes that will enhance the role of the Chief Medical Officer of Health ("CMOH"), increasing the independence of that office through mandatory reports to the public and increasing the transparency of the appointment process. We hope to proceed with those amendments this fall.

In addition to those changes, we have identified a range of amendments that would work within the framework of broad emergency powers under the *EMA*. The key to the exercise of these powers would be the necessity of a declaration of an emergency under the *EMA* and any exercise of the powers would be subject to the constitutional safeguards under the *EMA*. The main goal of these amendments is to ensure that public health officials have the necessary, extraordinary powers under the *Health Protection and Promotion Act* to address a public health emergency if and when one is declared under the *EMA*. With those parameters in mind, we believe that the following amendments should be considered:

- Authorizing the CMOH to take such action as he or she considers appropriate to decrease the risk presented by the public health emergency.

- Adding new Order provisions to provide for:

  - Mass immunization of individuals or populations, or requiring the isolation of persons where medical contraindications warrant exception from the required immunization;

  - Decontamination in emergency situations, where such action is considered appropriate (decontamination orders are not currently found under the Act, but such procedures may be required for individuals or large groups in the event of a nuclear disaster); and

  - Such other 'orders as may be necessary in an emergency.

- Authorizing medical officers of health to enter any premises, including a private residence, without a warrant, where the medical officer has reasonable and probable grounds to believe there is a risk to health due to a health hazard or an infectious disease.

- Authorizing the Chief Medical Officer of Health to order collection, analysis, and retention of any laboratory specimen from any person, animal, plant, or anything the Chief Medical Officer of Health specifies, and to acquire previously collected specimens and test analyses from anyone, and to disclose the results of test analyses as the Chief Medical Officer of Health considers appropriate.

- Authorizing the Chief Medical Officer of Health to require any person, organization, government agency or other entity to report information to the Chief Medical Officer of Health as she or he considers necessary, to reduce prevent or eliminate the risk of the emergency.

- Requiring physicians and other regulated health professionals, hospital administrators and operators of other health care institutions to report such information as the medical officer of health considers necessary in the circumstances (at present, physicians and other regulated health professionals are required to report "such additional information" about a reportable or communicable disease case as the

medical officer of health considers necessary, under section 1(2) of Regulation 569 – Reports).

- Adding the Chief Medical Officer of Health to those currently protected from exposure to liability under the Act, such as medical officers of health and members of boards of health. (But note that this proposal would not be restricted to emergency situations.)

The Commission has taken the following approach to the powers sought in the Deputy Minister's letter, and referred to in Dr. Basrur's presentation to the Justice Policy Committee on August 18, 2004:

- As for directives, the Commission has recommended that the *Health Protection and Promotion Act* be amended to provide clear day to day authority to issue directives to health care facilities. Because of the government decision to pour provincial emergency powers into the general vehicle of Bill 138, the Commission recommends that Bill 138's provisions be scrutinized to ensure that it includes the power to issue emergency directives of the kind here requested, particularly if the directive overrides some provision in program specific legislation of the kind noted (i.e., legislation governing public hospitals, laboratories, long-term care facilities, etc.).

- As for the "basket clause," the Commission cannot in light of the powers now in the *Health Protection and Promotion Act* (see, for instance, s. 86) and those recommended in this report, recommend without further evidence a "basket clause" in the *Health Protection and Promotion Act* authorizing the Chief Medical Officer of Health to take such action as he or she considers appropriate to decrease the risk presented by the public health emergency. In the first place, the powers in s. 86 are already very wide. In the second place, the power requested is not restricted to matters similar to those already within the jurisdiction of the Chief Medical Officer of Health and is therefore a power without limits. In the third place, the government's decision to proceed with Bill 138 suggests that any emergency "basket power" belongs in s. 7.0.2(3)12 of Bill 138.

- The power of registration and licensure is apparently addressed in s. 7.0.2(3)10 of Bill 138 which should be scrutinized to determine whether it provides the authority contemplated by the Ministry of

Health and Long-Term care. The licensure and registration for health professionals qualified to practice outside Ontario was identified to the Commission by a number of professional groups and health care institutions.

- As for compulsory mass immunization, the Commission suggests below that further analysis and evidence is required before this power is ripe for enactment as a permanent feature of our laws.

- Decontamination is addressed in the Commission's recommendations above. The position of the Commission is that the powers associated with decontamination should be available without a declaration of emergency. If hundreds of people are covered with white powder that appears to be weaponized anthrax, immediate action is required without waiting for a provincial declaration of emergency.

- Powers of entry to a private dwelling without warrant are addressed in the Commission's recommendations above as daily powers in the *Health Protection and Promotion Act* with the safeguards associated with the Supreme Court of Canada judgment in *Feeney*. If additional powers of entry are required in an emergency they should be addressed in Bill 138, which presently contains no such powers.

- The collection of laboratory samples is addressed in the Commission's recommendations for daily *Health Protection and Promotion Act* powers. These powers apply only to samples already collected because any power to take bodily samples from a person without consent and without court order engages serious issues under the *Charter of Rights*. No such power is proposed in Bill 138.

- The disclosure of personal health information to the Chief Medical Officer of Health and medical officers of health is addressed in the Commission's recommendations for increased daily powers in the *Health Protection and Promotion Act*. Emergency disclosure of personal health information is addressed in s. 7.0.2 (4) 11 of Bill 138 and also in s. 7.0.2 (9) and s. 7.0.2 (10) of Bill 138.

- Liability protection for the Chief Medical Officer of Health is addressed in the Commission's recommendations under the *Health Protection and Promotion Act*.

This completes the list of public health emergency powers suggested by the Ministry of Health in the Deputy Minister's letter of August 4, 2004, and referred to by Dr. Basrur in her appearance before the Justice Policy Committee on August 18, 2004.

Because the government has chosen the Bill 138 general power approach, it would be helpful to test the Bill 138 powers to ensure that they cover not only the matters addressed above but also the matters addressed specifically in the emergency public health legislation from other jurisdictions. The following list, which is non-exhaustive and overlaps some of the issues discussed above, is drawn from the Model State Emergency Health Powers Act in the U.S., the statutes of American jurisdictions and other Canadian provinces and from suggestions by those involved in the public health response to SARS:

Examples of Temporary Compulsory Powers

- Powers of the kind presently authorized under the *Health Protection and Promotion Act* for daily use, that are wider than those authorized for daily use.
- Compulsory procurement of facilities, supplies and materials.
- Power to ration medical supplies.
- Power to issue directives throughout the health care system that override existing legal provisions, e.g., patient transfer.
- Power to require services from facilities, institutions, and individuals.
- Power to take over and manage facilities.
- Power to destroy livestock.
- Power to evacuate buildings and neighbourhoods.
- Power for the safe disposal of human remains including any necessary override of related statutes such as the *Coroner's Act*.
- Power for the safe disposal of infectious waste.
- Power to detain or to enter premises including dwelling places beyond that

authorized by *Health Protection and Promotion Act*.

- Power to obtain personal health information beyond that authorized by the *Health Protection and Protection Act*.

- Power to override licensure requirements for health professionals and others.

- Power to support volunteers through compensation and insurance.

- Power to support those quarantined and isolated through compensation and other forms of assistance.

- Power to expand existing compensation schemes (e.g. OHIP,) to provide for emergency services.

- Power to protect, from personal liability, individuals who act reasonably and in good faith, without denying existing rights of legal recourse against institutional employers.[377]

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377. For a good example of effective liability protection see *Health Protection and Promotion Act* s. 95 which now provides:

> 95. (1) No action or other proceeding for damages or otherwise shall be instituted against a member of a board of health, a medical officer of health, an associate medical officer of health of a board of health, an acting medical officer of health of a board of health or a public health inspector for any act done in good faith in the execution or the intended execution of any duty or power under this Act or for any alleged neglect or default in the execution in good faith of any such duty or power. R.S.O. 1990, c. H.7, s. 95 (1).
>
> Exception
>
> (2) Subsection (1) does not apply to prevent an application for judicial review or a proceeding that is specifically provided for in this Act. R.S.O. 1990, c. H.7, s. 95 (2).
>
> Board of health not relieved of liability
>
> (3) Subsection (1) does not relieve a board of health from liability for damage caused by negligence of or action without authority by a person referred to in subsection (1), and a board of health is liable for such damage in the same manner as if subsection (1) had not been enacted. R.S.O. 1990, c. H.7, s. 95 (3).

Compare and contrast this provision with the liability protection in the Attorney General's Draft Bill which provides:

Recommendation

The Commission therefore recommends that:

- **Bill 138 be subjected to a fundamental legal and constitutional overhaul by the Attorney General who has indicated he is fully engaged in reviewing Bill 138 to ensure that it meets necessary legal and constitutional requirements.**

- **The government in its review of Bill 138 consider whether it adequately addresses the public health emergency powers referred to above.**

Compulsory Mass Immunization: A Paradigm

The power of compulsory mass immunization is a paradigm for public health emergency powers. Compulsory mass immunization exemplifies the legal, policy and practical problems that must be addressed in every analysis of every proposed public health emergency power and any proposed general emergency power. The issue is addressed at greater length than other proposed public health emergency powers for two reasons. First, because it has attracted less policy analysis and discussion than other proposed powers such as the power to ration medical supplies. Second, because

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> 11. (1) No action or other proceeding lies or shall be instituted against a person designated in subsection (3) for doing any act or neglecting to do any act under this Act or under any order under this Act.
>
> (2) Despite subsection (1), a person described in subsection (3) is liable where a claim of gross negligence is proven in the carrying out of an act or in neglecting to carry out an act under this Act.

and the contrasting provision in Bill 138 which provides:

> 11. (1) No person designated under subsection (3) is liable for any act done in good faith in the exercise or performance or the intended exercise or performance of any power or duty under this Act or under an order made under this Act or for any neglect or default in the exercise or performance in good faith of such power or duty.
>
> (2) Despite subsection (1), a person described in sub-section (3) is liable for an act done in the exercise or performance or the intended exercise or performance of any power or duty under this Act or under an order made under this Act or for any neglect or default in the exercise or performance of such power or duty where a claim of bad faith or gross negligence is proven.

it bristles with legal issues that typify any emergency proposal to interfere with individual liberties for the sake of the greater public good. The purpose of this section is not only to demonstrate that the power of mass compulsory immunization is not yet ripe for enactment, but also to demonstrate the type of legal, practical, and policy analysis that should be taken in respect of every proposed emergency power before it is enacted.

Mass immunization by order is a hot-button issue. It engages serious issues that require careful consideration.

Ontario officials seek the power to order mass immunization in a widespread public health emergency such as an influenza pandemic[378] and to isolate those who cannot or will not be immunized.[379] Mass immunization by order, particularly if refusal invites isolation or suspension from health care work or jail, is very different from voluntary immunization.

The question to be confronted is whether the evidence to support the power to order mass immunization, and the accompanying power to isolate or refuse work to those who decline, has been presented in any comprehensive fashion. It may be that a case for mass immunization by order can be made that adequately addresses the fundamental issues noted below. Until the evidence in support of such a case has been presented in a comprehensive fashion, it is difficult to say that this power, as opposed

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378. Other potentials for mass immunization by order include bioterrorism attacks involving anthrax or weaponized smallpox.

379. Deputy Minister of Health Phil Hassen in his letter to the Commission of August 4, 2004 recommended the enactment, within the context of a broad emergency statute, of power to order:

> Mass immunization of individuals or populations, or requiring the isolation of persons where medical contraindications warrant exception from the required immunization.

Chief Medical Officer of Health Sheela Basrur made the same point in her evidence before the Justice Policy Committee on August 18, 2004:

> Additional authorities that probably will be necessary before we have such things as pandemic influenza would be an ability of the chief medical officer of health to make orders regarding mass immunization of individuals or populations. Right now, from SARS we had the experience that we needed to issue an order against classes of people, but there was no vaccine. What if there had been a vaccine? I would have had to order, maybe, vaccination one at a time. I'm not sure I have the authority to order vaccination even one at a time, much less against a class of people. If we think about a vaccine-preventable disease emergency, we need to have those provisions in place so we can take action pretty quickly to protect the healthy people from becoming sick.

to a purely voluntary immunization programme with effective public education, is ripe for enactment at this time as a permanent feature of Ontario's law.

A prominent feature of the *Model State Emergency Health Powers Act*[380], the power of

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380. This American model statute has provoked some controversy because of its coercive powers. Initially released on October 2001, it was amended in December of that year.

An article in the New England Journal of Medicine stated:

> On December 21, 2001, in response to criticisms of the model act … a revised version was released. No one any longer considers the act a "model." Instead, it is now labeled a "draft for discussion." The new version does "not represent the official policy, endorsement, or views" of anyone, including the authors themselves and the CDC. (Source: Annas, George J., Bioterrorism, Public Health and Civil Liberties. New England Journal of Medicine, Volume 346:1337-1342, April 25, 2002).

An article in Medical Student JAMA stated:

> The MSEHPA has been criticized for vesting enormous powers in the nation's governors; for allowing governmental authorities to seize and control private property during a public health emergency and not be held liable in case of their damage or destruction; for allowing the arrest, imprisonment, and forcible examination, vaccination, or medication of individuals without their consent and not be held liable in case of any injury or death; and for being vague in what defines a public health emergency. (Source: Joseph, George D, Uses of *Jacobson v Massachusetts* in the Age of Bioterrorism, Medical Student JAMA, November 5, 2003).

The principal drafters of the *Model State Emergency Health Powers Act* concede that coercive measures like compulsory immunization are controversial, but may nevertheless be needed. In a commentary on the Act, they stated:

> *Managing Property and Protecting Persons*. Authorization for the use of coercive powers is the most controversial aspect of public health laws. Nevertheless, their use may be necessary to manage property or protect persons in a public health emergency … There may also be a need to exercise powers over individuals to avert significant threats to the public's health. Vaccination, testing, physical examination, treatment, isolation, and quarantine each may help contain the spread of infectious diseases. Although most people will comply with these programs during emergencies for the same reason they comply during non-emergencies (i.e., because it is in their own interests or desirable for the common welfare), compulsory powers may be needed for those who will not comply and whose conduct poses risks to others or the public health. These people may be required to yield some of their autonomy or liberty to protect the health and security of the community. (Source: Gostin, Lawrence O., James G. Hodge, Jr. *The Model State Emergency Health Powers Act – Brief Commentary*, Seattle, WA: Turning Point National Program Office at the University of Washington, September 2002, pp. 11-2.)

The Model Act provides as follows: Section 603 Vaccination and Treatment. During a state of public health emergency the public health authority may exercise the following emergency powers over persons as necessary to address the public health emergency-

mass immunization by order is strikingly absent[381] from Ontario proposals in Bill 138 and the staff discussion draft presented to the Justice Policy Committee on August 19, 2004 by counsel for the Attorney General's Department.[382]

Although vaccination statutes do not typically use words like "forced" or "compulsory", immunization is not voluntary if refusal invites forced isolation, loss of employment or jail or suspension from school.[383] Some immunization statutes provide forced vaccination by court order.[384] Any kind of forced medical treatment attracts serious

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(a) Vaccination To vaccinate persons as protection against infectious disease and to prevent the spread of contagious or possibly contagious disease.

(1) Vaccination may be performed by any qualified person authorized to do so by the public health authority.

(2) A vaccine to be administered must not be such as is reasonably likely to lead to serious harm to the affected individual

(3) To prevent the spread of contagious or possibly contagious disease, the public health authority may isolate or quarantine, pursuant to section 604, persons who are unable or unwilling for reasons of health, religion, or conscience to undergo vaccination pursuant to this section.

381. Although enthusiasts might argue that mass immunization and every other conceivable emergency power is covered by the basket clauses that authorize "such other actions that may be necessary," such arguments stretch the legal imagination.
382. As Mr. John Twohig told the Committee: "The central piece of material I want to give to you is a piece of draft legislation that we worked on, the so-called contingent legislation should an emergency occur—fortunately it did not occur—during the winter of 2004 …" See Justice Policy Committee, Public Hearings, August 19, 2004, p. 74.
383. See the *Model State Emergency Health Powers Act*, above, the Ontario ambulance paramedic regulations in the *Kotsopoulos* case, below, and Ontario's *Immunization of School Pupils Act* R.S.O. 1990, c. I-1.
384. Under s. 38(1)(c) of Alberta's *Public Health Act*, R.S.A. 2000, c. P-37:

38(1) Where the Lieutenant Governor in Council is satisfied that a communicable disease referred to in section 20(1) has become or may become epidemic or that a public health emergency exists, the Lieutenant Governor in Council may do any or all of the following:

a) order the closure of any public place;

b) subject to the Legislative Assembly Act and the Senatorial Selection Act, order the postponement of any intended election for a period not exceeding 3 months;

c) in the case of a communicable disease order the immunization or re-immunization of persons who are not then immunized against the disease or who do not have sufficient other evidence of immunity to the disease.

legal issues[385] even in the absence of extreme measures like those used in Boston during the smallpox epidemic at the turn of the last century. A disproportionate degree of vaccination was forced on immigrants, blacks, and homeless people.[386]

> Every imaginable threat from civil suits to cold-blooded murder when they got an opportunity to commit it, was made by the writhing, cursing, struggling tramps who were operated upon, and a lot of them had to be held down in their cots, one big policeman sitting on their legs and another on their heads, while the third held their arms, bared for the doctor.

Scientific evidence in favour of immunization is powerful[387] and most pandemic

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Amongst the orders available under Quebec's *Public Health Act,* R.S.Q., c. S-2.2, s.123 provides as follows:

> Notwithstanding any provision to the contrary, while the public health emergency is in effect, the Government or the Minister, if he or she has been so empowered, may, without delay and without further formality, to protect the health of the population,
>
> 1) order compulsory vaccination of the entire population or any part of it against smallpox or any other contagious disease seriously threatening the health of the population and, if necessary, prepare a list of persons or groups who require priority vaccination; …

Section 126 provides as follows:

> If a person fails to submit to a vaccination ordered under section 123, a judge of the Court of Québec or of the municipal courts of the cities of Montréal, Laval or Québec having jurisdiction in the locality where the person is to be found may order the person to submit to the vaccination.

In addition, the judge may, if satisfied on reasonable grounds that the person will not submit to the vaccination and if of the opinion that the protection of public health warrants it, order that the person be taken to a specific place to be vaccinated.

385. See the references below to cases in Ontario, Manitoba, and Alberta.
386. This graphic picture of forced vaccination is provided in Albert MR, Ostheimer KG, Bremen JG *The last smallpox epidemic in Boston and the vaccination controversy*, 1901-1902 N Engl J Med 2001: 344: 375-9, quoted in James J. Misrahi, Gene W. Matthew, and Richard E. Hoffman *Legal Authorities for Interventions During Public Health Emergencies* The Law and Core Public Health Functions Chief Medical Officer of Health. 10, p. 195.
387. See, for instance, Elizabeth Rea and Ross Upshur, *Semmelweiss Revisited; the ethics of infection prevention among health care workers* CMAJ May 15 2001; Richard E. Schabas, *Mass Influenza Vaccination in Ontario: A Sensible Move* CMAJ 2001:161 (1):36-37; Dr. Schabas adds a note of caution when he says, after noting the arguments in favour of mass immunization, "There are admittedly many uncertainties in this argument. There is because, of course, universal immunization has never before been seriously attempted on this scale."

influenza plans provide for its use as a primary means of containing an outbreak.[388]

A strong body of scientific evidence establishes that immunization carries very little risk.

> Vaccines are among the safest tools of modern medicine. Serious side effects are rare. For example, severe allergic reactions can occur, but they very rarely do. In Canada, this kind of reaction has occurred less than once in every one million doses of vaccine, and there are effective treatments for this condition. The dangers of vaccine-preventable diseases are many times greater than the risk of serious adverse reaction to the vaccine.[389]

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388. The Ontario Health Pandemic Influenza Plan states:

> Vaccination is the primary means to prevent disease and death from influenza during an epidemic or pandemic. (Source: Ontario Health Pandemic Influenza Plan, May 2004, p. 37.)

The Canadian Pandemic Influenza Plan states:

> In a pandemic, the current aim is to vaccinate the whole Canadian population over a period of four months on a continuous prioritized basis after receipt of the pandemic seed strain. This would require a minimum of 32 million monovalent doses (8 million doses per month) …
>
> For vaccine program planning purposes it is important to be prepared to immunize 100% of the population; however the actual proportion of the population that will voluntarily seek vaccination will depend on public perception of risk and severity of the disease. Therefore the demand, manifest as clinic attendance, will likely vary between jurisdictions and within each jurisdiction as the pandemic evolves. Previous experience with outbreak related immunization clinics indicates that it would be prudent to prepare for an initial demand of 75% of the target population. It is recommended that planning activities also focus on delivering a two-dose program to ensure that the public health response is ready to deal with this possibility. (Source: Canadian Pandemic Influenza Plan, February 2004, p. 33.)

389. Health Canada, *Canadian Immunization Guide*, *6th Edition,* (Ottawa: 2002), p. 46.

As for Guillain-Barré syndrome, the *Canadian Immunization Guide*, *6th Edition* – 2002, p. 125, stated:

> Guillain-Barré syndrome (GBS) associated with influenza immunization has been observed in a minority of influenza seasons over the last two decades. Apart from the 1976-1977 swine flu season, the risk of GBS associated with influenza immunization is small. In a retrospective study of the 1992-93 and 1993-94 seasons in four U.S. states, the relative risk of GBS occurring within 6 weeks after influenza immunization, adjusted for age and sex, was 1.7 (95% confidence interval 1.0-2.8, $p = 0.04$), suggesting slightly more than one additional case of GBS per million

Notwithstanding the long history of scientific evidence that vaccination is safe, there is an equally long history of opposition. *The English Vaccination Act* of 1853 provoked violent riots.[390] Closer to home, Montrealers rioted all night against vaccination during the 1885 smallpox epidemic. Even today there is an element of skepticism.[391] Some people doubt that every new vaccine is necessarily safe. They decline vaccination on grounds of conscience, medical risk[392] or simply

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people vaccinated against influenza. In comparison, the morbidity and mortality associated with influenza are much greater.

Dr. Richard Schabas stated:

> Despite these problems, the influenza vaccine works, and works well. In healthy adults its efficacy is between 70% and 90%. Serious side effects are very rare. Guillain-Barré syndrome, for example, is only a complication of the vaccine in a minority of influenza seasons, and even it occurs at a rate of about one in a million doses. (Schabas R.E., *Mass influenza vaccination in Ontario: A sensible move*. CMAJ. 2001 Jan 9; 164(1):36-7.)

Richard E. Schabas, *Mass Influenza Vaccination in Ontario: A Sensible Move*,CMAJ 2001:161 (1):36-37, citing *Canadian Immunization Guide* 5th ed. Ottawa: Health Canada; 1998 p. 103-10 and Lasky T, Terracciano D. O., Magder L, Koski C. L. Ballesteros M.S., Nash D, et al *The Guillan Barre Syndrome and the 1992-1993 and 1993-1994 Influenza vaccines* N Engl J Med 1998: 339: 1797-802.

390. See Robert M Wolfe & Lisa K Sharp, *Anti-vaccionists past and present*, BMJ 2002; 325: 430.
391. For contemporary scepticism about mass immunization see the National Post op ed piece of November 22, 2004 by David Dehaas, Editor of M.D. Canada Magazine.
392. The existence of medical risk is recognized by s. 38 of Ontario's *Health Protection and Promotion Act* which requires adverse vaccination reactions to be reported. The risk is evidenced in court cases where governments have been sued for rare yet devastating medical catastrophes following childhood vaccination. See *Jacques Lapierre v. Attorney General for Quebec* [1985] 1 S.C.R. 241. In the late 1980's a catastrophic vaccination reaction was alleged and supported by significant scientific evidence but the causal connection between vaccination and injury was not ultimately proven in *Rothwell v. Raes* (1988), 66 O.R. (2d) 449 (H.C.J.), affd. (1990) 2 O.R. (3d) 332 (C.A.), application for leave to appeal dismissed (1991), 49 O.A.C. 398 n (S.C.C.), a case of post-pertussis vaccine encephalopathy involving severe brain damage and tragic retardation. Osler J. noted (at 515) that some jurisdictions have statutory compensation schemes for persons suffering neurological damage in close temporal association with vaccine administration and agreed with the comments of Krever J. in *Ferguson v. Hamilton Civic Hospitals* (1983), 40 O.R. (2d) 577 at 618-19: "I confess to a feeling of discomfort over a state of affairs, in an enlightened and compassionate society, in which a patient, who undergoes a necessary procedure and who cannot afford to bear the entire loss, through no fault of his and reposing full confidence in our system of medical care, suffers catastrophic disability but is not entitled to be compensated because of the absence of fault on the part of those involved in his care. While it may be that there is no remedy for this unfortunate and brave plaintiff and that this shortcoming should not be corrected judicially, there is, in my view, an urgent need for correction."

    It is on the basis of tragic cases like this that any immunization plan should provide a no-fault compensation system for vaccine-injured patients.

because they object. These objections raise serious legal[393] and moral considerations.

Ontario law[394] required Bill Kotospoulos, a North Bay ambulance paramedic, to submit himself to influenza vaccination on pain of suspension without pay if he refused. The rationale for the compulsory law was:

> … widespread concerns that health care workers, during the course of their work, have the potential for acquiring and transmitting influenza to those under their care.[395]

Mr. Kotsopoulos objected to compulsory vaccination because:

> I have the ultimate right to give or withhold consent to an injection which invades my bodily and psychological integrity.

Section 7 of the *Canadian Charter of Rights and Freedoms* provides:

> Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Because Mr. Kotsopoulos refused to be vaccinated the hospital suspended him without pay and he sought a temporary court order to restore his job.

Mr. Justice Norman M. Karam on the basis of the evidence before him assumed that the compulsory immunization regulation was for the public good and that it would damage the public interest to interfere with it.

> ¶ 20 There was extensive evidence provided with respect to the public benefit flowing from influenza vaccination. Influenza is a viral infection that causes serious illness and can be fatal. Statistics provided by the respondents are that it leads to the hospitalization of approximately

393. For an excellent review of these issues see *Legal Issues and Controversies – Exemptions To Mandatory Vaccinations* http://www.cdc.gov/nip/policies/vacc_mandates_chptr13.htm.

394. *Ambulance Act, R.S.O. 1990, c. A.19* and its Regulations, *Ambulance Act, Regulation 257/00*, and the Ministry of Health's *Ambulance Service Communicable Disease Standards*.

395. Rationale For Influenza Surveillance Protocol, quoted in *Kotsopoulos v. North Bay General Hospital,* [2002] O.J. no. 715 (S.C.J.) at para 24.

> 75,000 people and results in the deaths of 6,500 in Canada annually. It is particularly dangerous to the elderly, often resulting in complications such as pneumonia and exacerbating heart and respiratory disease. The strength and strain of the virus varies from year to year, and as a result the genetic makeup of each year's vaccine is different, in order to deal with the particular virus prevalent that year. Further evidence was provided that the immunization of health care workers is a necessary step in controlling the spread of the virus, and therefore the death and illness of patients exposed to them.
>
> ¶ 21 I am satisfied on the basis of the evidence provided to me, that influenza is an extremely infectious disease, often leading to hospitalization and death. It is particularly dangerous to the elderly. There is no question that paramedics in the course of their duties are often confronted with health situations involving the elderly. This regulation is clearly designed for no other purpose than to control the disease by taking steps to control its spread. Influenza vaccine is the primary defence in preventing its spread. Immunizing health care workers is one step in that direction. As earlier indicated, this Court, for the purpose of interlocutory proceedings, must therefore assume that the legislation is for the public good, and that any interference would damage the public interest.

The court on the other hand held that Mr. Kotsopoulos raised an important issue, whether his *Charter* rights were violated by the requirement that he submit to immunization on pain of job loss. He argued that immunization would create a risk to his health and a violation of his rights unjustified by any greater public good:

> ¶ 22 The applicant, who has never taken a flu shot, did adduce evidence that there is a risk to his health by immunization for influenza. Opinions were provided that there is a possibility of contracting various diseases through the flu vaccine. While the respondents disputed these allegations and offered evidence that such exposure creates very slight risk, there was an acknowledgement that some risk, however minuscule, does exist. The real issue is whether the applicant should be required, against his wishes, to expose himself to immunization, in the interests of what the Province sees as the necessity to protect the public. Whether the legislation can be justified on the basis that it intrudes upon the rights of an individual not to have substances introduced into his body against his will is a very important issue, but not one that can properly be dealt with

> on an interlocutory application, in the absence of a complete constitutional review of all of the evidence available.

Mr. Kotsopoulos's main argument was that reinstatement to his paramedic job would create no health risk to others:

> ¶ 23 The main argument raised by the applicant, for the purposes of this application, is that his temporary reinstatement is unlikely to increase the risk of influenza. Although there are province-wide protocols for hospitals and long-term facilities that recommend inoculations against influenza for all caregivers, only paramedics are required to be immunized. No other medical, emergency or critical care personnel are required by statute to obtain a flu shot. The evidence of the applicant is that up to one-third of all of the health care workers in the region have not been immunized against influenza. In addition, in that respect, is the exemption permitted for those paramedics providing a medical certificate establishing that they are medically contra-indicated. In this instance, there are three other paramedics exempted for that reason, at least two of whom are presently on the job, and another who is not working for an unrelated reason. The applicant argues therefore, that in light of these circumstances, his temporary reinstatement would not significantly increase the risk involved. In fact, Dr. Erika Abraham, whose affidavit has been filed on behalf of the respondents, acknowledged as much, when cross-examined for the purposes of this motion. She stated that permitting those paramedics who are contra-indicated to work, without being immunized, constituted an acceptable and minimal risk. Clearly, it follows that there is little difference should there be four instead of three or three instead of two.

The judge reviewed the Ministry of Health policy for gradual universal influenza immunization coupled with education of health care workers. Because the desired level of health care worker immunization had not been reached, the Ministry was exploring various policy and legislative solutions.

> ¶ 24 However, the evidence also indicates that the approach taken by the Ministry of Health has been to proceed gradually with a public program of universal influenza immunization, while at the same time recognizing the importance of the immunization of health care workers. The Rationale For Influenza Surveillance Protocol provides: "This protocol was developed in response to widespread concerns that health care

> workers, during the course of their work, have the potential for acquiring and transmitting influenza to those under their care." In a published report summarizing the 1998/99 flu season, Dr. Abraham stated:
>
> > "The main strategy of promoting the use of influenza vaccine among health care workers is health promotion and education. Despite the successes of these methods in some settings, the desired level of immunization has not been achieved in health care staff in institutions. In order to reach the targeted level of coverage of above 70%, several working groups of the Ministry of Health, medical officers of health and various professional associations are exploring policy and legislative solutions."
>
> For that purpose, it would appear that health care workers with the greatest high-risk exposure to patients have been targeted. I can only assume, on the evidence before me, that the requirement for immunization against influenza does not yet extend to all caregivers, such as nurses for example, or even to all paramedics, because at this stage, that is the Province's overall strategy. Presumably this is due to the fact, as Dr. Abraham indicated in her cross-examination, that paramedics create the greatest risk to the spread of the disease, because their duties are not confined to a single health facility, but exposes them to many or all of them.

Mr. Justice Karam refused Mr. Kosopolous's application for reinstatement because it raised serious issues that required more evidence than was available at the interim hearing.[396]

This case did not even touch upon the big question of mass immunization. It addressed only the very limited power to immunize health workers on pain of job loss

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396. An arbitration board in *Re St. Peter's Health Systems and Canadian Union of Public Employees, Local 778* (2001), 106 L.A.C. (4th) 170 (Charney), February 7, 2002 dealt with a chronic care geriatric facility public hospital dealing with old and frail inmates. It had 130 full time staff. A hospital regulation directed that if there is a flu outbreak, every staff member would either have a flu shot or Amantadine treatment or would be suspended from work without pay until the outbreak subsides. Fifteen grievors challenged the regulation. The board held that in the absence of a statutory requirement enforced vaccination like any other form of enforced medical treatment, was an assault, relying on the Supreme Court of Canada decision in *Rodriguez v. British Columbia (Attorney General),* [1993] 3 S.C.R. The opposite result was reached in *Re Carewest and Alberta Union of Provincial Employees* (2001), 104 L.A.C. (4th) 240 (Smith)." where the arbitration board found that the employers policy of enforced vaccination was reasonable. a. "."

if they refuse. Even this limited power is controversial. Some health workers find it singular and heavy-handed. One nurse said:

> And it is imperative that all preventative measures be emphasized vis-à-vis the singular and heavy handed emphasis on mandatory immunization of staff.

Immunization is an integral part of our public health system[397] which has the benefit of distinguished scientific advice.[398] Ontario leads the way in annual voluntary adult influenza vaccination[399] and its universal influenza vaccination plan has been hailed as a model for the world:[400]

> If a country cannot cope with interpandemic influenza, it is likely that the pandemic, when it does occur, will cause massive societal disruption … The steps needed to deal effectively with interpandemic influenza can

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397. Section 5 of the Health Protection and Promotion Act, provides:

> 5. Every board of health shall superintend, provide or ensure the provision of health programs and services in the following areas:
>
> 1. Community sanitation, to ensure the maintenance of sanitary conditions and the prevention or elimination of health hazards.
>
> 2. Control of infectious diseases and reportable diseases, including provision of immunization services to children and adults …

See Ontario's Immunization of *School Pupils Act*, R.S.O. 1990, c. I.1

398. The Ministry of Health and Long-Term Care established the Provincial Infectious Diseases Advisory Committee (PIDAC) to provide a single standing source of expert advice to the Chief Medical Officer of Health on infectious diseases for Ontario. PIDAC's immunization subcommittee is chaired by Dr. Ian Gemmill, the Medical Officer of Health for the Kingston, Frontenac and Lennox and Addington Health Unit.
399. Ontario is the only jurisdiction in North America to make the influenza vaccine available free to all residents. Ontario's universal influenza vaccination programme was announced on July 25, 2000. The province acquired 5.5 million doses of the vaccine for the 2004-5 flu season. According to "The Ontario Experience with Universal Vaccination," a presentation by Dr. Karim Kurji, Associate CMOH, to the National Influenza Summit, Atlanta, Georgia, on April 2004, the programme appears to be increasing immunization rates in priority groups, including health care workers. The presentation stated that before the advent of the universal vaccination program, 20 per cent of hospital staff was immunized. By the 2003-4 flu season, this had risen to 55 per cent.
400. Institute of Medicine of the National Academies, *Microbial Threats to Health: Emergence, Detection and Response*, (Washington, D.C.: 2003), p. 147

> also help in preparing for an influenza pandemic. The new initiative promoting universal influenza vaccination in Ontario, Canada, can serve as a model for the world. If demonstrated to be effective, it should be expanded to other areas.

Despite this international acclaim, Ontario has not yet solved the limited problem of health worker immunization by order,[401] let alone the bigger problems of mass immunization by order.

Health care workers are the first priority for immunization in every Canadian pandemic plan.[402] If Ontario has not solved the limited problem of health worker immunization by order, is it ready to enact a sweeping power to immunize by order the entire population of 12 million? It is one thing to prove that compulsory vaccination of paramedics is a reasonable limit in a free and democratic society.[403] It is a

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401. Ontario is still struggling with the immunization of health workers. A report by Dr. Abraham on the 1998/99 flu season, introduced into evidence in the Kotospoulos case, noted that the desired level of immunization, a target of over 70%, had not been achieved in health care institutions. Recent influenza vaccine coverage data for staff and residents in Ontario hospitals and long term care facilities for 2003/2004 shows that 55% of hospital staff are covered while 84% of long term care staff are covered. (Source: Dr. Karim Kurji, Associate Chief Medical Officer of Health for Ontario, *The Ontario Experience with Universal Vaccination* National Influenza Vaccine Summit, Atlanta, April, 2004.)

402. The Ontario plan provides in part:

PRIORITY GROUP	ESTIMATED NUMBER	RATIONALE	SUBGROUPS
1. Health care workers, emergency medical services, public health workers	140,000 RNs/RPNs, 25,000 physicians, 7,000 public health workers	The health care and public health sectors are the first line of defense in a pandemic. An effective response depends on maintaining these services.	Health care workers in: • acute care hospitals • long term care facilities/nursing homes • private physicians' offices • home care and other community care facilities • public health offices • ambulance and paramedic services • pharmacies • laboratories

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403. *Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.) 1982, c. 11* provides as follows:

> 1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

quantum leap to prove that compulsory vaccination of Ontario's entire population of 12 million is a reasonable limit. If a case for the smaller power has not yet been established, can a case be made out for the much bigger power? Can the Attorney General give the government a legal opinion that any proposal for mass immunization by order complies with the *Canadian Charter of Rights and Freedoms*?

As Dr. Schabas notes above, universal immunization has never before been attempted even on a voluntary basis on the scale currently under way in Ontario. In the event of an influenza pandemic, it raises a host of issues. Will there be enough vaccine?[404] Will every new vaccine be safe? How can safety be ensured?[405] Who gets vaccinated first?[406] Can people who are low on the priority list go to court and argue their equality rights are infringed because they are deprived of a benefit given to others?[407] What do you do with people who refuse vaccination; can you legally isolate them or jail them or suspend them from their jobs as health care workers? This last question engages the unresolved legal issues noted above. Any proposal for mass immunization by order must be very explicit about the legal consequences of refusal.

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404. The objective of the Canadian Influenza Pandemic Plan is to "vaccinate the whole Canadian population over a period of four months on a continuous prioritized basis after receipt of the pandemic seed strain. This would require a minimum of 32 million monovalent doses (8 million doses per month)." For supply line difficulties caused by contamination at a vaccine manufacturing facility in Liverpool producing vaccine for the Chiron Corporation see John Treanor, M.D. Weathering the Influenza Vaccine Crisis N Engl J. Med 351:20 November 11, 2004.

405. "Mass immunization campaigns pose specific safety challenges, due to their objective of immunizing large populations over a short period of time and often being conducted outside the normal healthcare setting. Two of the most notable challenges are injection safety and adverse events following immunization (AEFI)": Safety of Mass Immunization Campaigns Immunization Safety Priority Project, Department of Vaccines and Biologicals, W.H.O. As the Canadian Immunization Guide states: "No one in the field of public health takes the safety of vaccines for granted. Vaccine safety is an international concern. Information on possible safety concerns is communicated very rapidly among different countries. This careful monitoring ensures that public health authorities can act quickly to address concerns." Canadian Immunization Guide 6th ed 2002 p. 46.

406. One dilemma was posed by Gregory Poland, chief of the vaccine research group at the Mayo clinic: "Long term care facilities are saying, 'we have 100 residents and 60 health-care workers. We have 100 doses of vaccine. Who should get them?' There's no clear-cut answer." Marilynn Larkin, *Flu Vaccine: Will Scarcity Improve Compliance in USA?* The Lancet Infectious Diseases v. 4 December 2004.

407. Vaccine shortage or apprehended crisis creates demand for immunization. The recent shortage of American influenza vaccine in October of 2004 "…unleashed a veritable frenzy… 'Medical tourism' has been one creative response to the vaccine shortage: Americans are paying U.S. $105 to take the high-speed ferry from Seattle, Washington, to Victoria, British Columbia, or are crossing other borders into Canada to get influenza vaccines." (Source: European Molecular Biology Organization, Reports v. 6 no. 1 2005 p. 13.) The Journal of the American Medical Association Dec. 1 2004 v. 292 No. 21 p. 2582 noted: "Publicity surrounding the shortage has created demand even among lower-risk adults, further threatening the supply for those who need it most."

This is not to say that every question must be completely resolved before proceeding. It is simply to say that as soon as any element of compulsion is introduced through an order for immunization, with a consequence like isolation or job suspension for those who refuse, the practical and policy and legal implications must be fully confronted before proceeding.

As for penalty, mass immunization by order is not set out as a power in any Ontario law[408] and disobedience to such an order would attract no penalty. This chapter has referred repeatedly to consequences of refusal such as isolation or, for a health care worker, job suspension. But if mass immunization by order were enacted in Bill 138, the proposed emergencies bill now before the Legislative Assembly, failure to obey an immunization order would be punishable by a fine of up to $100,000.00 and imprisonment for up to one year. If mass immunization by order is enacted as part of a general emergency statute that carries a penalty for noncompliance, it ups the legal ante and requires very careful attention to the exemption procedures.

The most important question of all is whether mass immunization by order is enforceable.[409] If even a small proportion of Ontario's 12 million people decline vaccination, can the government realistically enforce the mass isolation of all those who refuse? Because the success of mass immunization depends on voluntary compliance and public confidence, public education is infinitely more important than legal compulsion.[410]

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408. Although a legal argument might be made that a generous reading of the general powers in the *Health Protection and Promotion Act* could support such an order, that argument would be a real stretch. An argument might also be made that mass immunization by order is authorized under the doctrine of inherent or common law powers discussed below.

409. The standard enforcement pattern for involuntary medical treatment in the *Health Protection and Promotion Act* requires an individual court hearing for each individual who it is sought to treat. Any proposal for mass immunization by order would have to be very clear as to the exact machinery of enforcement, its efficacy if there were thousands of refusals, and its viability in face of a legal challenge under the *Charter of Rights.*

410. Gregory Poland, chief of the vaccine research group at the Mayo clinic said of flu vaccine education "Despite 60 years of data on the efficacy and safety of the vaccine, ignorance – no inconvenience or cost – is what keeps health-care workers from being vaccinated…. We can't continue to let fears and misperceptions prevent us from doing the right thing for our patients." Marilynn Larkin, *Flu Vaccine: Will Scarcity Improve Compliance in USA?* The Lancet Infectious Diseases v. 4 December 2004. See also Carolyn S. Markey, R.N., *Healthcare Worker Influenza Vaccination* Home Healthcare Nurse v. 22 no. 9 September 2004: "Why aren't more of our colleagues being immunized against flu? Reasons for not receiving influenza vaccine cited in several studies include: concern about side effects or vaccine safety, including the misperception that the injectable vaccine could cause the flu; perception of a low personal risk of contracting influenza; inconvenience; ignorance of the CDC recommendations; and dislike of needles…."

The World Health Organization identifies compulsory immunization as a difficult legal issue that requires a legal framework based on a transparent assessment and justification of the measures under consideration.[411]

What is required in any proposal for mass immunization by order, and indeed any other emergency power is an appropriate balance between the public interest in protecting the community from disease and the personal liberty of every individual to refuse state compulsion when fundamental freedoms are engaged.

It may be that a case for mass immunization by order can be made that adequately addresses the fundamental issues noted above. It may be that evidence is available to satisfy the Charter requirement that the measure is reasonably justified in a free and democratic society.[412] It may be that evidence is available to satisfy the WHO requirement that the measure is based on transparent assessment and justification.

Until such evidence has been presented in a comprehensive fashion, it is difficult to say that mass immunization by order, as opposed to a purely voluntary programme, is ripe for enactment at this time as a permanent feature of Ontario's law. Although a purely voluntary scheme would not raise the same issues, proposals for mass immunization by order involve some element of compulsion in the form of a consequence for refusal such as isolation or jail or suspension from work.

It must be emphasized again that every question need not be resolved completely before proceeding with legislation. It is simply to say that as soon as any element of compulsion is introduced through an order for immunization, with a consequence like isolation or jail or job suspension for those who refuse, the practical and policy and legal implications must be fully confronted before entrenching compulsory mass immunization as a permanent feature of our law.

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411. "During a pandemic, it may be necessary to overrule existing legislation or (individual) human rights. Examples are the enforcement of quarantine (overruling individual freedom of movement), use of privately owned buildings for hospitals, off-license use of drugs, compulsory vaccination or implementation of emergency shifts in essential services. These decisions need a legal framework to ensure transparent assessment and justification of the measures that are being considered and to ensure coherence with international legislation (like the revised International Health Regulations)." (Source: W.H.O., "Influenza Pandemic Preparedness Checklist," (Geneva: November 2004), p. 12.)
412. For convenience, section one of the Charter is repeated below:

> 1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

If the government thinks that the power to order mass immunization instead of a purely voluntary programme is required in the interests of public safety, its obligation is to bring forward as soon as possible a detailed plan and body of evidence that will enable the Attorney General to give an opinion on the constitutional validity of such a power and to enable the Legislative Assembly and the public to assess its necessity.

If pandemic influenza threatens suddenly, pending the development of such a case, it is open to the government to bring forward an urgent statute with an early sunset clause to get through any immediate threat. There is however no justification to delay the production and presentation of the case for mass immunization by order. As the Justice Policy Committee was advised:

> The time to consider emergencies is when you don't have one.[413]

Recommendations

The Commission therefore recommends that:

- **The power of mass compulsory immunization not be enacted as a permanent feature of Ontario's law until the evidence has been presented in a comprehensive fashion.**

- **Every proposed emergency power, before its enactment, be thoroughly subjected to the legal, practical, and policy analysis exemplified by the above analysis of compulsory mass immunization and that the evidence in support of each power be presented in a comprehensive fashion before enactment.**

- **If the government decides it is necessary to enact any emergency power before there is time to subject it thoroughly to the legal, practical, and policy analysis exemplified by this analysis of compulsory mass immunization, that the government sunset any such provision for a period not to exceed two years in order to provide time for the required scrutiny.**

413. John Twohig counsel from the policy branch of the Attorney General's Department, in testimony to Justice Policy Committee, August 19, 2004 on August 19 2004, p. 181.

Bill 138

The government, as noted above, has expressed its intention to proceed with general emergency legislation along the lines suggested in Bill 138, *An Act to Amend the Emergency Management Act and the Employment Standards Act, 2000*, which received first reading on November 1, 2004 as a private member's bill produced by the Standing Committee on Justice Policy after public hearings.

As noted above the Commission's mandate does not cover general emergency legislation for war, famine, flood, ice storms and power blackouts and the government decision to proceed with Bill 138 is not within the Commission's terms of reference. Because the government has chosen Bill 138 as the vehicle for all emergency legislation including public health emergency legislation the Commission must say something about Bill 138 as a vehicle for public health emergency powers and the government has invited the Commission to do so.[414]

The thoughtful work of the Justice Policy Committee in its hearings and its production of its report and Bill 138 is a matter of public record. It need not be recounted here except to note that the people of Ontario owe a significant debt of gratitude to those members of the Legislative Assembly who worked so hard and to all of those who assisted them.

The strengths of the Committee process are obvious to anyone who has had an opportunity to review its proceedings. Certain legal concerns, flowing largely from the unusual process imposed on the Committee, are addressed in correspondence between the Commission and the government set out in Appendix H. The essence of the Commission's concern is that the unusual process of proceeding to a draft bill of such profound legal importance, without prior policy and operational analysis by departments of government and without prior legal and constitutional scrutiny by the Attorney General deprived the Bill of the solid underpinnings that ordinarily precede the development of any important piece of legislation.

The work initiated by the Justice Policy Committee when they took the discussion draft bill from the Attorney General's Department and considered it in light of the

414. Letter to the Commission from the Minister of Health and Long Term Care and the Minister of Community Safety and Correctional Services, received March 14, 2005 and reproduced in Appendix H.

Committee's public hearings must now be completed. A sober second thought is now required. That sober second thought must be informed by the regular processes that the government skipped in its decision to proceed as it did.

As noted above, the first big question about Bill 138 is legal. Does it conform to the Charter and it is clear and workable from a legal point of view? The Commission has no mandate to give legal advice or opinions on the constitutionality of Bill 138 or any of its provisions. These legal questions can only be answered by the Attorney General whose exclusive authority on these questions is set out below.

Ontario's emergency legislation will probably be challenged in court. A lot will be at stake in any court challenge. It will be a major blow to the integrity of the legislation should a court strike down as unconstitutional any part of the statute or any emergency order made under the statute. A successful court challenge in the middle of an emergency could have disastrous effects on the emergency response. A successful court challenge at any time would produce a cloud of uncertainty that might not disperse for years. The first delay in resolving the uncertainty could be the time it takes for a challenge to wend its way from the trial court to the Supreme Court of Canada. The second delay could come from the lengthy cycle that so often ensues when legislation is struck down on Charter grounds, sometimes referred to as a dialogue between the courts and the legislature. The courts strike it down, the legislature makes amendments to conform to the Charter, and then the whole cycle could start again with a new court challenge to the amendments.

It is therefore essential to ensure as much as possible that the legislation conforms with the *Canadian Charter of Rights and Freedoms*.

This job is at the heart of the responsibilities of the Attorney General and his Crown Law Officers. Firstly, because it is the responsibility of counsel for the Attorney General to defend any challenge to the legislation or the emergency order. Secondly, the common law and the *Constitution Act, 1867*[415] impose these duties, also set out in the *Ministry of the Attorney General Act*,[416] exclusively on the Attorney General.

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415. *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c.3, (formerly know as the *British North America Act*).
416. Ministry of the Attorney General Act R.S.O. 1990, c. M-17 s. 5:

> The Attorney General,
>
> (a) is the Law Officer of the Executive Council;

While the work of the Justice Policy Committee was impressive within the limits of the resources available to it, Bill 138 still requires fundamental review by the Attorney General before it can get a clean bill of health, legally and constitutionally. As noted above, the Attorney General has indicated that he is fully engaged in reviewing Bill 138 to ensure that it meets necessary legal and constitutional requirements. See the letter to the Commission of March 14, 2005 from the Minister of Health and Long-Term Care and the Minister of Community Safety and Correctional Services.

The job of the Attorney General is never an easy one because of the independent quasi-judicial duties associated with that office, and the independent constitutional obligation to ensure that both government legislation and government action are conducted according to law. This can bring the holder of that office into conflict with the political agenda of the government.[417] Fortunately this province has a strong

> (b) shall see that the administration of public affairs is in accordance with the law;
>
> (c) shall superintend all matters connected with the administration of justice in Ontario;
>
> (d) shall perform the duties and have the powers that belong to the Attorney General and Solicitor General of England by law or usage, so far as those duties and powers are applicable to Ontario, and also shall perform the duties and have the powers that, until the *Constitution Act, 1867* came into effect, belonged to the offices of the Attorney General and Solicitor General in the provinces of Canada and Upper Canada and which, under the provisions of that Act, are within the scope of the powers of the Legislature;
>
> (e) shall advise the Government upon all matters of law connected with legislative enactments and upon all matters of law referred to him or her by the Government;
>
> (f) shall advise the Government upon all matters of a legislative nature and superintend all Government measures of a legislative nature;
>
> (g) shall advise the heads of the ministries and agencies of Government upon all matters of law connected with such ministries and agencies;
>
> (h) shall conduct and regulate all litigation for and against the Crown or any ministry or agency of Government in respect of any subject within the authority or jurisdiction of the Legislature;
>
> (i) shall superintend all matters connected with judicial offices;
>
> (j) shall perform such other functions as are assigned to him or her by the Legislature or by the Lieutenant Governor in Council. R.S.O. 1990, c. M.17, s. 5.

417. This is one reason why Sir Patrick Hastings, a former Attorney General for the United Kingdom said "Being an Attorney General as it was in those days is my idea of hell." Sir Patrick Hastings. *The Autobiography of Sir Patrick Hastings*, London, William Heinemann 1948 at p. 236. The first lesson learned by every new Attorney General is the cautionary tale of Hastings, a rising political star and

tradition that the Attorney General stands up for what is legally right whether or not it is politically expedient and that the government takes the Attorney General's advice on matters having to do with the legal and constitutional integrity of government legislation and government action. No Cabinet can be reminded too often that any government that ignores the Attorney General's advice does so at its peril.

That is why the Attorney General's review of Bill 138 is so fundamentally necessary in order to give the members of the Legislative Assembly and the public the assurance of legal and constitutional integrity.

The second big question about Bill 138 is whether it covers all the powers that might reasonably be required in a public health emergency or the public health aspects of a wider emergency. Does Bill 138 provide adequate legal authority for the operational measures that may reasonably become necessary in an emergency? The operational aspects of these questions can only be answered by those government departments that have to make the legislation work in the field when an emergency strikes. The legal aspects of these questions, once more, can only be answered by the Attorney General.

Because it would be unwise for the reasons noted above to have one set of laws for public health emergencies and a different set of laws for all other emergencies, and because the government has chosen Bill 138 as the vehicle for emergency laws, Bill 138 requires examination to ensure that it contains all the authority necessary to deal with public health emergencies. These specific public health emergency powers, listed above, must be reviewed operationally within government to see if they are necessary and to see if further specific powers are required. Once the government has decided what powers are required for public health emergencies, the Attorney General must examine the powers in Bill 138 to see if they cover what is needed or if they require expansion to deal with the identified needs of public health emergencies.

One example of the many issues that require legal and policy analysis is the problem of legal liability from lawsuits arising out of emergency action.

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brilliant lawyer whose political career ended in ruins in 1924 when the government fell because he allegedly took political advice from the government about the conduct of a criminal prosecution As a later Attorney General put it: "The truth of the allegations remains disputed but this case has long served as a warning to later Law Officers and to governments." As Dingle Foot, Solicitor General during the Wilson administration put it quite simply: 'The Campbell case should have taught governments not to interfere with the Law Officers.' *Politics, Public Interest and Prosecutions – A View by the Attorney General* 13th Annual Tom Sargent Memorial Lecture: An address by the Right Hon. The Lord Goldsmith, Q.C., Her Majesty's Attorney General, London, 20 November 2001.

The problem of personal liability under the *Health Protection and Promotion Act* is addressed above, in Chapter 1, in respect of extending to the Chief Medical Officer of Health and all professional advisers and public health workers the same personal protection now afforded to the medical officer of health by s. 95 of the *Health Protection and Promotion Act*. The differences between this form of liability protection, the liability protection suggested in the discussion draft bill from the Attorney General's Department, and the liability protection suggested in Bill 138 are noted above. While these issues are legally complicated, people and organizations who help out in an emergency either voluntarily or by responding to an emergency order are entitled to know where they stand. Concerns about liability were put to the Commission by a number of organizations:

> … it would be most helpful to have legislation that limits claims brought forward as a result of actions taken by employers at the direction of the defined authority in emergency situations.
>
> ———
>
> Protection from liability for health care sector providers and government authorities with respect to acts performed in good faith in responding to the emergency, and in implementing health emergency plans.
>
> ———
>
> If nurses are expected to follow specific government, hospital or other orders during an emergency, they should be provided immunity from disciplinary, civil and other legal proceedings. We recommend that nurses be provided such immunity where their conduct constitutes a good faith attempt to carry out an order in an emergency.

The issue of liability during an emergency was also raised by Dr. Bonnie Henry, in her submissions before the Justice Policy Committee:

> If I could make a comment on that, I think one of the things we learn over and over again in a crisis is that you can never do just enough. If you stop the outbreak, you've done way too much and you overreacted; if you don't stop the outbreak, you clearly didn't do enough. I don't think there's any way to legislate the ability to do things in good faith. It's a really difficult situation that we're put into. We're now dealing with at least three class-action lawsuits, none of which, thankfully, has been certified

> yet and all of which name the city of Toronto for doing too much. I'm actually quite proud of doing too much, the perception that we did too much. I think we did what we needed to do under very trying circumstances, and understanding that the need to protect people from lawsuits for doing what they feel is right and what is supported as right or – I'm not being very articulate – what is being done to the best of their ability and knowledge to try and control a situation that's extremely dangerous, needs to be enshrined in legislation. People who are asked by the government to help, to provide advice, whether their advice is taken or not, need to be protected from liability. I don't think the Good Samaritan Act is the same concept. I think the Good Samaritan Act is pretty good, for what it does. It protects people for different situations.[418]

Whatever competing model the government decides to take in respect of protection against liability from lawsuits, concerns such as those expressed above must be addressed one way or the other. Whatever the government's choice, those who express these concerns are entitled to know exactly where they stand.

All the Commission can do, lacking any mandate in respect of general emergency legislation like Bill 138, is to point to some problems with Bill 138 as a vehicle for public health emergency problems and to identify some areas where the Bill 138 powers may not provide all the authority necessary.

Bill 138: Power to Override Ontario Laws

Bill 138 provides, with one exception,[419] that emergency orders prevail over every other Ontario law. Subsection 7.0.6 (1) provides:

> In the event of a conflict between an order made under section 7.4 and any statute, regulation, rule, by-law or order, the order under section 7.4 prevails.

This power is awesome. One provincial official described it, accurately, as grandiose. An emergency order could override laws such as the *Habeas Corpus Act*,[420] the

418. Justice Policy Committee, Public Hearings, August 18, 2004, p. 158.
419. The sole exception is the *Occupational Health and Safety Act*, R.S.O. 1990, c. O-1 discussed below.
420. R.S.O. 1990, c. H-1.

Legislative Assemby Act,[421] the *Human Rights Code,*[422] the *Elections Act,*[423] and the *Courts of Justice Act.*[424] An emergency order could override any law that promotes the public good or protects individual rights. Any such proposal requires the most searching scrutiny.[425]

The override power in Bill 138 is not only awesome but it also differs significantly from the approach in other emergency statutes.[426]

Not all provincial emergency statutes contain clear override provisions. See for instance Saskatchewan's *Emergency Planning Act*[427] and New Brunswick's *Emergency Measures Act.*[428] It would be helpful to be provided with a full legal analysis by the Attorney General of the extent to which the emergency legislation of other provinces contains override provisions and how such provisions compare with those in Bill 138.

To take one example of the kind of analysis required, the override provisions in the emergency legislation of Manitoba and Alberta, by explicit language, limit the overrides to other legislation of the provincial legislature.

Manitoba's *Emergency Measures Act,*[429] provides that where there is a conflict between an emergency order of the minister and "a provision of, or an order made under, any other Act of the Legislature," the minister's order prevails. Alberta's *Disaster Services Act,*[430] is particularly notable in that s. 18(5) first confines the override to other provincial statutes, and then excludes certain of those statutes from the override:

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421. R.S.O. 1990, c. L-10.
422. R.S.O. 1990, c. H-19.
423. R.S.O. 1990, c. E-6.
424. R.S.O. 1990, c. C-43.
425. In Robert Bolt's play "A Man for All Seasons" Sir Thomas More makes a famous plea for the protection of laws as a shelter for the nation and its people:

    "This country's planted thick with laws from coast to coast … and if you cut them down …d'you really think you could stand upright in the winds that would blow then?"

426. This is a convenient place to note that Ontario's existing emergency management act contains a limited power for the government to override temporarily laws that set limits for compensation and benefits, in order to provide more services, benefits, or compensation to victims of an emergency than the limits ordinarily imposed in non-emergency situations. *Emergency Management Act* R.S.O. 1990, c. E-9, s. 7.1 (7).
427. S.S. 1989-90, c. E-8.1.
428. S.N.B. 1978, c. E-7.1.
429. C.C.S.M. c. E-80, s. 21(2).
430. R.S.A. 2000, c. D-13.

> 18(5) Unless otherwise provided for in the order for a declaration of a state of emergency, where
>
> (a) an order for a declaration of a state of emergency is made, and
>
> (b) there is a conflict between this Act or a regulation made under this Act and any other Act or regulation, other than the *Alberta Bill of Rights* or the *Human Rights, Citizenship and Multiculturalism Act* or a regulation made under either of those Acts,
>
> this Act and the regulations made under this Act, during the time that the order is in effect, shall prevail in Alberta or that part of Alberta in respect of which the order was made.

The override power in Bill 138 is less clear. Does the word "rule" in s. 7.0.6(1) reflect an intention to override rules of common law? If not, this should be made clear. Does the word "order" in s. 7.0.6(1) reflect an intention to override the order of a court or labour tribunal or Human Rights tribunal or of the Legislative Assembly? If not, this should be made clear.

Another issue is the extent of the double override in Bill 138 in respect of the power to compel from any person any information that is thought by the government to be necessary for emergency management. Bill 138 provides that emergency orders may be made in respect of such compulsory disclosure:

> 7.0.2(4) 11. Subject to subsection (9), the requirement that any person disclose information that in the opinion of the Lieutenant Governor in Council may be necessary in order to prevent, respond to or alleviate the effects of the emergency.
>
> …
>
> 7.0.2(9) The following rules apply with respect to an order under paragraph 11 of subsection (4):
>
> 1. An order prevails over any other Act or regulation.
>
> 2. Information that is subject to the order must be used to prevent, respond to or alleviate the effects of the emergency and for no other purpose.

3. Information that is subject to the order that is personal information within the meaning of the *Freedom of Information and Protection of Privacy Act* shall be destroyed as soon as is practicable after the emergency is terminated.

This power to compel anyone to disclose any information demanded by the government raises two concerns.

One concern is technical. It is unclear why the power to compel information inserts a limited override (s. 7.0.2 (9) 1.) into a wider override (7.0.6 (1)). It is doubly unclear to the point of confusion why the two overrides are different. The information override prevails over any other Act or regulation. The wider override prevails over any statute, regulation, rule, by-law or order. It is a mystery why the language of the two overrides is different. It is unclear whether they work together or which one prevails in case of conflict.

The more important concern is the extent of the power to compel anyone to disclose any information demanded by the government. On its face it would apply to the confidential sources of journalists and to confidential information entrusted to lawyers by their clients. It may be argued on the basis of general legal principles that the power does not override any common law privilege against disclosure. But Bill 138 does not say so. If Bill 138 does not compel disclosure of confidential journalistic sources or solicitor client confidences, either Bill 138 should say so or the Attorney General should say so. It is essential before Bill 138 is enacted that people know whether they may refuse to disclose confidential information or the identity of its source or whether, if they refuse to disclose it, they will be liable to the penalty provided by Bill 138, a fine of up to $100,000 and a term of imprisonment for up to a year for every day on which the refusal continues.[431]

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431. Subsection 7.0.12(1) provides:

> (1) Every person who fails to comply with an order under subsection 7.0.2(4) or who interferes with or obstructs any person in the exercise of a power or the performance of a duty conferred by an order under that subsection is guilty of an offence and is liable on conviction,
>
> (a) in the case of an individual, subject to clause (b), to a fine of not more than $100,000 and for a term of imprisonment of not more than one year;
>
> (b) in the case of an individual who is a director or officer of a corporation, to a fine of not more than $500,000 and for a term of imprisonment of not more than one year; and
>
> (c) in the case of a corporation, to a fine of not more than $10,000,000.

It seems reasonable to provide some kind of override. If you have to empty out a hospital to make room for SARS cases and send some patients immediately to long-term care facilities, it makes sense to override temporarily the patients' right to consider and ponder and choose which long-term care facility they prefer.

Specific examples of the need for such override were brought to the Commission's attention in a series of submissions from organizations who addressed the question in light of the lessons they learned in SARS. Concerns about any power to override collective agreements and safety regulations are addressed specifically below. What this list provides is evidence that those who will have to respond to a future emergency need clarity in respect of any override provision:

> Specific legislation that clearly defines which act supersedes another in given situations will be important. For example, does the need to access personal health information during outbreak conditions supersede the Privacy Legislation?
>
> ———
>
> The relevant pieces of legislation need to make clear which legislation takes precedence, for example Occupational Health and Safety versus Privacy versus Emergency measures.
>
> ———
>
> Clear indications of when and how provisions of the emergency health legislation would trump other legislation enactments that apply to the health care sector in non-emergency situations …
>
> … we consider it particularly important that health emergency legislation consider how the legal duties of public hospitals and other health

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Separate offence

(2) A person is guilty of a separate offence on each day that an offence under subsection (1) occurs or continues.

Increased penalty

(3) Despite the maximum fines set out in subsection (1), the court that convicts a person of an offence may increase a fine imposed on the person by an amount equal to the financial benefit that was acquired by or that accrued to the person as a result of the commission of the offence.

providers, as provided for in other legislation, will be temporarily suspended during the emergency. Any change in "normal" legal duties must be made with a view to facilitating the most efficient, objective, and scientifically supported response to the emergency. Particular statutes of importance to the hospital sector that must be considered include, among others:

1. Public Hospitals Act and its regulations, especially the Hospital Management Regulation;

2. Various employment-related statutes, such as the *Occupational Health and Safety Act*;

3. Commitment to the Future of Medicare Act, 2004 (Bill 8);

4. *Personal Health Information Protection Act, 2004*, sections 1 - 72 of which come into force on November 1, 2004;

5. Regulated Health Professsionals Act, 1991 and related professions Acts; and

6. Health Protection and Promotion Act.

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Legislative power should be integrated for the duration of the emergency to enable directives at all jurisdictional levels at the declaration of a state of emergency by the federal parliament or provincial legislature. Such legislation needs to suspend the responsibilities of health care facility Boards of Directors under, for example, the Corporations Act and collective agreements, for the duration of the emergency.

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Suspension of legislative/regulatory requirements – Any emergency legislation must clearly provide for the suspension of existing legislative and regulatory requirements, where appropriate. For example, during SARS, the challenge of discharging patients to long-term care facilities was exacerbated by regulatory requirements that stipulate that transfers could not be made to facilities that were not on the patient's list of preferred facilities.

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> Legislation should specifically provide that the declaration of a provincial emergency and/or special health emergency does not suspend collective agreements. The parties to collective agreements should be required to comply with them, subject to terms that are specifically negotiated under an emergency plan …
>
> ———
>
> … There should be specific provisions stating that the declaration of an emergency and/or special health emergency does not permit the circumvention of occupational health and safety obligations and legislation.
>
> ———
>
> Legislation should specifically provide that the declaration of a provincial emergency and/or special health emergency does not abrogate any legal rights, except those expressly identified. While the declaration of an emergency does not currently suspend collective agreements or otherwise limit employees' rights, hospitals took that position during the SARS crisis and, accordingly, a specific legislative provision is required …
>
> … It should be specifically provided that the declaration of an emergency and/or special health emergency does not permit the circumvention of occupational health and safety obligations and legislation.

This is a convenient place to note that Bill 138 makes no reference to collective agreements. The draft discussion bill provided to the Justice Policy Committee by the Attorney General's Department contained an explicit provision that emergency orders would override collective agreements.[432] That power is strikingly absent from Bill 138.[433] Bill 138 neither expressly overrides collective agreements in the manner

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432. Section 7.4(10) provides: "No contract, collective agreement, lease, license or other non-legislative instrument shall be interpreted so as to prevent the carrying out of an order under this section."

433. The Justice Policy Committee may have addressed the issue indirectly when it said in its Report: "In a declared emergency … it is necessary to ensure that help is available, while at the same time acknowledging: (i) statutory and contractual employment, labour and occupational health and safety standards …." … "The Committee recommends that the government seek to facilitate the development of protocols under which management and employees can deal with the extraordinary circumstances of an emergency." See: Standing Committee on Justice Policy, *Report on the Review of Emergency Management Law in Ontario*, (November 2004), p.7.

proposed in the draft discussion bill, nor expressly preserves them from the general override in s. 7.0.6(1) as it does with occupational health and safety laws. It may be that Bill 138 leaves collective agreements in limbo. It is a legal question, whether or not the present override in Bill 138 would override collective agreements through the power to override statutes that provide for collective bargaining rights. This is an issue too important to leave to legal debate once an emergency arises. It must be clear to employers and employees whether or not emergency orders override collective agreements. This is another legal area that requires clarification from the Attorney General.

The Commission therefore recommends that the Attorney General, in the review of Bill 138, clarify whether or not the override power in s. 7.0.6(1) affects collective agreements.

In one particular respect the override power is deficient and dangerous. It is not reasonable to override the foundational laws that underpin Ontario's democratic legal system including laws such as the *Habeas Corpus Act*,[434] the *Legislative Assembly Act*,[435] the *Human Rights Code*,[436] the *Elections Act*,[437] and the *Courts of Justice Act*.[438] The line might not be perfectly clear in respect of every statute. The *Elections Act*[439] is a good example. Alberta provides a power to delay an election for up to three months in face of a disease epidemic or other public health emergency.[440] It is a political ques-

434. R.S.O. 1990, c. H-1.
435. R.S.O. 1990 c. L-10.
436. R.S.O. 1990 c. H-19.
437. R.S.O. 1990, c. E-6.
438. R.S.O. 1990, c. C-43.
439. R.S.O. 1990, c. E-6.
440. *Public Health Act*, R.S.A. 2000, c. P-37, s. 38(1)(b).

> 38 (1) Where the Lieutenant Governor in Council is satisfied that a communicable disease referred to in section 20(1) has become or may become epidemic or that a public health emergency exists, the Lieutenant Governor in Council may do any or all of the following:
>
> (a) order the closure of any public place;
>
> (b) subject to the Legislative Assembly Act and the Senatorial Selection Act, order the postponement of any intended election for a period not exceeding 3 months;
>
> (c) in the case of a communicable disease order the immunization or re-immunization of persons who are not then immunized against the disease or who do not have sufficient other evidence of immunity to the disease.
>
> (2) Where an election is postponed under subsection (1), the order shall name a date for holding the

tion for the government and the Legislative Assembly exactly how far the override should intrude into foundational legal statutes such as the *Elections Act*. The Commission recommends thorough scrutiny and amendment of the override provision to protect our foundational legal statutes against emergency override.

The override goes to the essential character of the powers themselves and should be tightly connected with them through its position in the statute. It should not be necessary to comb through the statute to find this extraordinary power, now relegated to an obscure position in the statute some 20 provisions after the grant of power. The Commission recommends that this override power be given a more prominent place in the statute by putting right after the enumerated powers.

The Commission recommends that the Attorney General review Bill 138 to ensure that the extent of the override, combined with the vague and open ended nature of the powers including the basket clause, does not constitute a constitutionally impermissible delegation of legislative power to public officials.[441]

Recommendations

The Commission therefore recommends that:

- **The Attorney General in the review of Bill 138 clarify whether or not the override power in s. 7.0.6(1) affects collective agreements.**

- **The Attorney General undertake a thorough scrutiny and amendment of the override provision to protect our foundational legal statutes such as the *Habeas Corpus Act*,[442] the *Legislative Assembly Act*,[443] the *Human Rights***

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nominations or polling, or both of them, and nothing in the order adversely affects or invalidates anything done or the status of any person during the period of time between the date of the order and the completion of the election.

(3) Where a person refuses to be immunized pursuant to an order of the Lieutenant Governor in Council, the person shall be subject to this Part with respect to the disease concerned as if the person were proven to be infected with that disease.

441. For vagueness, see for instance Gonthier J. in *R. v. Nova Scotia Pharmaceutical Society* [1992] 2 S.C.R. 606 at para 69. For delegation of plenary discretion, see for instance *Irwin Toy Ltd. v. Quebec (A.G.)* [1989] 1 S.C.R. 927 at para 63.
442. R.S.O. 1990, c. H-1.
443. R.S.O. 1990, c. L-10.

***Code*,[444] the *Elections Act*,[445] and the *Courts of Justice Act*[446] against emergency override.**

- **It be made clear whether a journalist or lawyer who refuses to disclose confidential information or the identity of its source is liable to the penalty provided by Bill 138, a fine of up to $100,000 and a term of imprisonment for up to a year for every day on which the refusal continues.**

- **The override power be given a more prominent place in the statute by putting right after the enumerated powers.**

- **The Attorney General review Bill 138 to ensure that the extent of the override, combined with the vague and open ended nature of the powers including the basket clause, does not constitute a constitutionally impermissible delegation of legislative power to public officials.**

Bill 138: Trigger, Criteria and Limitations

Bill 138 provides for the making of a declaration of emergency, and for the exercise of emergency powers contingent on such a declaration. Both the declaration of emergency, the "trigger", and the ensuing power to make orders are hedged around with conditions and requirements.

The trigger conditions which are set out in s.7.0.1(3):

> Declaration of emergency
>
> 7.0.1 (1) Subject to subsection (3), the Lieutenant Governor in Council or the Premier, if in the Premier's opinion the urgency of the situation requires that an order be made immediately, may by order declare that an emergency exists throughout Ontario or in any part of Ontario.
>
> ———
>
> Criteria for declaration

444. R.S.O. 1990, c. H-19.
445. R.S.O. 1990, c. E-6.
446. R.S.O. 1990, c. C-43.

> (3) An order declaring that an emergency exists throughout Ontario or any part of it may be made under this section if there is an emergency that is such that,
>
> (a) it requires immediate action to prevent, reduce or mitigate a danger of major proportions that could result in serious harm to persons or substantial damage to property; and
>
> (b) the action cannot be undertaken using the resources normally available to a ministry of the Government of Ontario or an agency, board or commission or other branch of the government.

These provisions represent a clear intention to place reasonable limits on the exercise of emergency powers. What is not so clear is why the author chose these particular legal drafting techniques. As a Yale law professor noted,

> Drafting these provisions is a tricky business.[447]

What is most striking about the trigger provisions is the way in which they combine subjective and objective conditions. On the one hand, subsection (1) requires subjective condition that the decision-maker be of the "opinion" that a situation is sufficiently urgent to require a declaration of emergency. On the other hand, subsection (3) then imposes two objective "criteria": the emergency must be such that "immediate action" is required, *and* it must be such that action cannot be taken using the resources normally available. In other words, before an emergency can be declared, the decision-maker must not only be satisfied that an emergency exits, he or she must also attempt to establish both that the threat is such as to require immediate action, and that the action "cannot be undertaken using the resources normally available," whatever may be meant by that ambiguous phrase.

The trigger provision used in Bill 138 can be contrasted with the trigger provisions found in other emergency statutes. For example, Alberta's *Disaster Services Act*[448] simply requires (at s. 18(1)) that the Lieutenant Governor be "satisfied" that an emergency exists or may exist before a declaration to that effect can be made. A simi-

447. Bruce Ackerman, Sterling Professor of Law and Political Science, Yale University, The Emergency Constitution (2004) 113 Yale Law Journal 1029 at p. 1058.
448. R.S.A. 2000, c. D-13.

lar approach is adopted in British Columbia's *Emergency Program Act*.[449] Subsection 9(1) provides that once the Minister or Lieutenant Governor in Council is "satisfied" that an emergency exists, a declaration of emergency can be made.

The objective criteria surrounding the trigger power in Bill 138 are not only unusual, they are also problematic. Not only will valuable time be lost in attempting to satisfy the criteria, it will probably be lost in a pointless exercise. Even if the decision-maker had the luxury of time, would it always be possible, before the fact, to determine that "immediate action" is indeed required to prevent "a danger of major proportions"?

> These problems noted above reappear when one turns from the emergency trigger to the emergency powers. The conditions surrounding the exercise of the principal powers are set out in s. 7.0.2(2):
>
> Criteria for emergency orders
>
> 7.0.2 (2) If an emergency is declared under section 7.0.1, the Lieutenant Governor in Council may make such orders as the Lieutenant Governor in Council considers necessary and essential in the circumstances to prevent, reduce or mitigate serious harm to persons or substantial damage to property,
>
> (a) if the harm or damage will be alleviated by the order; and
>
> (b) if there is no reasonable alternative to the order.
>
> Limitations on emergency order
>
> (3) Orders made under this section are subject to the following limitations:
>
> 1. The actions authorized by an order shall be exercised in a manner which limits their intrusiveness. …

Two features of these provisions are worth noting. First, s. 7.0.2(2) effectively establishes a second set of barriers to the making of an emergency order. In other words, before making an emergency order, the Lieutenant Governor must not only satisfy

449 .R.S.B.C. 1996, c. 111.

the conditions attaching to the declarations of an emergency as set out in s. 7.0.1(3), he or she must also satisfy the conditions which attach to the making of emergency orders as set out in s. 7.0.2(2).

Second, the conditions imposed on the making of an emergency order use a mixture of subjective and objective standards. In this connection two observations may be made:

- The exercise of the power itself is purely subjective ("considers necessary and essential") with no requirement of objective reasonableness (such as "on reasonable grounds") or even subjective reasonableness (such as "he considers reasonable"); and

- The limitations on the power are objective and very strict. They require not that the orders be based on reasonable grounds, but that they be objectively correct in the sense that it must be objectively proven that the harm or damage will in fact be alleviated by the order and it must be objectively proven that there is no reasonable alternative to the order.

The strategy adopted in Bill 138 can be contrasted to the strategy used in other jurisdictions.

As has been noted, Alberta's *Disaster Services Act*[450] requires (at s. 18(1)) that the Lieutenant Governor be "satisfied" that an emergency exists or may exist. However, once the subjective condition surrounding the declaration has been satisfied, and the declaration has been made, no further conditions are imposed on the making of emergency orders. The power to make orders is conferred on the designated Minister, and s. 19(1) provides that he or she "may do all acts and take all necessary proceedings including the following …."

Again, as has been noted, British Columbia's *Emergency Program Act*[451] requires (at s. 9(1)) that once the Minister or Lieutenant Governor in Council is "satisfied" that an emergency exists before a declaration to that effect can be made. Thereafter the Minister is free (pursuant to s. 10(1)) to make an emergency order at his or her discretion; no further conditions need be satisfied.

450. R.S.A. 2000, c. D-13.
451. R.S.B.C. 1996, c. 111.

The approach adopted in these jurisdictions ensures that once the decision-maker meets the precondition to the making of a declaration of emergency, he or she is then free to respond in the manner dictated by the circumstances of that emergency, without first ensuring that a further set of conditions is met.

The approach adopted in the emergency portion of Saskatchewan's *Public Health Act*[452] is more structured. The Minister is empowered to issue a remedial order where he or she "believes, on reasonable grounds" both that a serious public health threat exists, and that the order is necessary to remedy the threat.

The strategy adopted in Ontario's Bill 138 is different yet again. In one respect it is closer to that adopted in Saskatchewan's *Public Health Act 1994,* than to that adopted in Alberta's *Disaster Services Act* or British Columbia's *Emergency Program Act*: having declared an emergency, Ontario's Lieutenant Governor in Council must then satisfy further conditions before making an emergency order. However, unlike Saskatchewan's statute the conditions imposed employ not only subjective, but also, as noted above, objective requirements. Therein lies the problem. This approach will make it difficult, in some cases impossible, to say whether or not any given order is legal. Because of course it is impossible to tell in advance whether, to use the language of s. 7.0.2(2), the harm will be "alleviated," or whether there is "no reasonable alternative."

The objective requirements imposed by s. 7.0.2(2)(a) and (b) require perfect prescience on the part of the emergency decision-maker. Although hindsight may be 20-20, it will be impossible for any Premier or cabinet minister to be sure in advance that he or she is perfectly right in what they propose to do. And this is likely to be especially true in the circumstances in which the decision to invoke the power will be made. In the heat of an emergency, like the fog of war, things are not always clear. Is the virus spreading? Do a cluster of patients have SARS or something else? Is it necessary or reasonable to close a hospital even though the extent of simmering undiagnosed disease is yet unclear? What are the risks if the disease spreads into the community because the hospital remains open? Emergencies present risks of unknown proportion and solutions of uncertain success. To require objective correctness is to require the impossible and to straitjacket emergency officials who may need to act very quickly in face of a threat of unknown proportions. No lawyer and no judge would be able to say whether or not any particular emergency order under Bill

452. S.S. 1994, P-37.1.

138 is or is not legal within the strict limits of its strict criteria.

Similar problem flows from the requirements set out in s. 7.02 (3) 1 and 2. The former provides that actions authorized by an order "shall be exercised in a manner which limits their intrusiveness." Not only is this requirement objective, it is also ambiguous. The latter provides that an order shall only apply to the areas of the Province "where it is necessary." Once more the standard is objective and therefore impossible to implement. An order that appears reasonable and necessary in the face of an unknown threat may prove, after the fact, to have been unnecessary. It is not fair to judge emergency actions solely on the basis of hindsight.

The problems with objective standards of this sort are apparent. They not only require great powers of prescience but they also ignore the practical realities of emergency management. As noted above, the precautionary principle and the hard earned lessons of the past tell us that it may be necessary to overreact in face of a threat that turns out later to be less serious than anyone thought at the time.

The application of an objective standard not only hinders emergency response but it also invites lawsuits based on hindsight that unfairly judges the emergency responder not on what he or she did at the time, but on what turned up later, after the dust had settled.

To enact an objective trigger for an emergency declaration, and objective limitations for the exercise of emergency authority is to ignore the problem of hindsight. Objective standards require courts, when judging the legality of emergency action afterwards, to examine the declaration and the orders in hindsight on the basis of what proved later to be actually necessary rather than judging them on the basis of how things reasonably appeared at the time. In the fog of emergency, like the fog of war, objective standards do not work. As one military historian noted:

> Once a dramatic event takes place, it always appears to have been predictable because hindsight tells the historian which clues were vital, which insignificant, and which false. The unfortunate general who must act without the benefit of hindsight is much more likely to err.[453]

To take an example closer to home, Dr. Young at the SARS Commission public hearings addressed the problem that an emergency may require decisive action in the face of many unknown facts:

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453. Steven E. Woodworth, *How Good a General Was Sherman?* North and South v. 7 no. 2, March 2004.

> … when we called the provincial emergency, we were dealing with an outbreak where we did not know for sure that it was a virus, we did not know for certainty what virus it was, we did not know what symptoms and what order of symptoms SARS presented with. We had a vague idea that some of the symptoms might include fever and cough. We did not, for example, for some period of time, realize that about 30 per cent of patients also could present with diarrhea. We did not know how long it incubated for. We did not know with certainty whether it was droplet spread or whether it was airborne. We did not know when it was infectious. We did not have a diagnostic test for it and still do not have an accurate diagnostic test. We had no way of preventing it, we had no vaccine and we had no treatment. What we had was an illness with many unknowns and virtually no knowns.[454]

Objective standards of the kind imposed by Bill 138, as noted above, prevent the application of the precautionary principle, so vital to public protection and so strongly relevant to public health emergencies:

> The absence of full scientific certainty shall not be used as a reason for postponing decisions where there is a risk of serious or irreversible harm.[455]

———

> 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.[456]

This is not to suggest that conditions should not be imposed on the use of emergency powers. Conditions will however be more realistic if, as in the case of Saskatchewan's *Public Health Act*, they have a subjective focus on what the decision-maker might reasonably be expected to know or understand in the circumstances. When a community defends itself against an apparently deadly threat of unknown proportions it cannot be expected to weigh its response with precision.

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454. SARS Commission, Public Hearings, September 30, 2003, p. 34.
455. Privy Council of Canada, *A Framework for the Application of Precaution in Science-based Decision Making About Risk* (Ottawa: 2003), p.2
456. *Commission of Inquiry on the Blood System in Canada*. Final Report at page 295, see also pp. 989-994.

A helpful analogy can be drawn to the traditional direction given to juries in cases of self defence:

> … a person defending himself cannot weigh to a nicety the exact measure of his necessary defensive action. If a jury thought that in a moment of unexpected anguish a person attacked had only done what he honestly and reasonably thought was necessary that would be the most potent evidence that only reasonable defensive action had been taken.[457]

Again and again judges have told juries in cases of self defence that it is not fair to judge defensive action by objective standards alone. Words like the following have been used:

> None of us can measure with any precision what degree of force is excessive or what degree of force we have to use to protect ourselves or someone else. It all depends on what is happening at the time and what we reasonably think is happening. An American Chief Justice said that detached reflection cannot be demanded in the face of an uplifted knife. An English Chief Justice said that one does not use jeweller's scales to measure reasonable force. As our own Supreme Court says, a person who reasonably feels threatened with serious bodily harm or death cannot be expected to weight with nicety the exact measure of responsive force.

The actions of public officials who defend us against emergencies should be judged by no harsher standards than the actions of those who defend themselves against personal aggression.

The test should not be whether an emergency action turns out in hindsight to have been necessary. The test should be whether the emergency action was taken in the honest and reasonable belief that it was necessary in the circumstances as they appeared at the time.

With respect to the precise content of the suggested standard, some guidance can be found in the legal concept of "reasonable apprehension," a concept which has stood the test of time. It is the underlying principle that governs the extent of police powers.

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457. J. C. Smith, *Justification and Excuse in the Criminal Law,* Hamlyn Trust 1989 p. 108; quoting Lord Morris of Borth Y Gest in Palmer [1971] 1 All E.R. 1077 at 1088.

In an often quoted passage setting out the extent of police power to take action to protect the public, it was described in the following terms:

> The first duty of a constable is always to prevent the commission of a crime if a constable reasonably apprehends that the action of any person may result in a breach of the peace, it is his duty to prevent that action. It is his general duty to protect life and property, and the general function of controlling traffic on the roads is derived from this duty.[458]

Although closely connected to the concept of reasonable and probable grounds, the test of reasonable apprehension focuses more on the reasonableness of the officer's belief than the existence of objective proof that his belief is in fact correct. See, for instance, Schroeder J.A. in *R. v. Joseph Advent* [1957] O.J. no. 442:

> One of the principal duties of a police officer is to prevent breaches of the peace which he reasonably apprehends and the important question in this case is whether or not there were reasonable and probable grounds for the police to entertain the belief that the accused and those with whom he was associated were about to commit a breach of the peace or that there was danger of their committing an assault on the drivers of the approaching trucks if their conduct was not controlled.

Recommendation

The Commission therefore recommends that:

- **The structure and content of the limitations and criteria for the declaration of emergency and the exercise of emergency powers be reviewed with a view to the development of a standard based on the decision-maker's reasonable apprehension that the exercise of the power is necessary in the circumstances.**

458. *Halsbury's Laws of England*, 3rd ed., vol. 30 p. 129. This passage has been quoted in countless cases including *R. v. Waterfield et al.,* [1964] 1 Q.B. 164, per Lord Widgery at p. 188. The latter was, for years, the leading English case on police powers and is to this day invoked regularly in Canada. See *R. v. Clayton* [2005] O.J. No. 1078, (C.A.), per Doherty J.A. at para 35.

Bill 138: Power to Implement Emergency Plans

The power in s. 7.0.2 (4) 1. to "implement emergency plans"[459] is at best ambiguous and at worst lacking in transparency. A close examination suggests that it may confer powers intended by no one.

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459. "The implementation of any emergency plans formulated under section 3, 6, 8 or 8.1." incorporates by reference the contents of the plans formulated under sections 3, 6, 8, or 8.1. Section 3 (1) provides that "Every municipality shall formulate an emergency plan governing the provision of necessary services during an emergency and the procedures under and the manner in which employees of the municipality and other persons will respond to the emergency and the council of the municipality shall by by-law adopt the emergency plan." Section 6 which provides that every Cabinet Minister and every agency head shall formulate an emergency plan "governing the provision of necessary services during an emergency and the procedures under and the manner in which Crown employees and other persons will respond to the emergency. Section 8, the nuclear emergency section provides that Cabinet shall "formulate an emergency plan respecting emergencies arising in connection with nuclear facilities." Section 8.1 provides a wide power in the Solicitor General to "formulate emergency plans" in respect of non-nuclear emergencies. All of these powers to "formulate emergency plans" come home to roost in the acutal details of what gets written into these plans. Section 9 provides what a plan may provide:

9. An emergency plan formulated under section 3, 6 or 8 shall,

(a) in the case of a municipality, authorize employees of the municipality or, in the case of a plan formulated under section 6 or 8, authorize Crown employees to take action under the emergency plan where an emergency exists but has not yet been declared to exist;

(b) specify procedures to be taken for the safety or evacuation of persons in an emergency area;

(c) in the case of a municipality, designate one or more members of council who may exercise the powers and perform the duties of the head of council under this Act or the emergency plan during the absence of the head of council or during his or her inability to act;

(d) establish committees and designate employees to be responsible for reviewing the emergency plan, training employees in their functions and implementing the emergency plan during an emergency;

(e) provide for obtaining and distributing materials, equipment and supplies during an emergency;

(e.1) provide for any other matter required by the standards for emergency plans set under section 14; and

(f) provide for such other matters as are considered necessary or advisable for the implementation of the emergency plan during an emergency. R.S.O. 1990, c. E.9, s. 9; 2002, c. 14, s. 13.

The section provides:

> (3) the Lieutenant Governor in Council may make orders in respect of the following:
>
> 1. The implementation of any emergency plans formulated under section 3, 6, 8 or 8.1.

Although it is true that emergency statutes commonly contain a provision such as this, a plain reading raises the question as to what exact power it confers. The words of the section convey no picture of what is intended or what is legally authorized. On its face the provision seems innocuous, a sensible form of words that attracts deference to some reasonable, pre-planned administrative arrangements. But the devil is in the details. Arguably what the provision really provides, through the opaque technique of incorporation by reference, is a series of blank cheques which authorize public officials to do anything they see fit so long as it is written down in some plan. The plans referred to in this provision contain:

- procedures to be taken for safety or evacuation;
- procedures to obtain and distribute materials, equipment, and supplies ;
- any other matter required by emergency plan standards under s. 14;[460]
- such other matters as are considered necessary or advisable for the implementation of the emergency plan during an emergency.

It does not stretch the imagination to envisage the wide fields of power opened up by this provision. Arrest, confiscation, conscription, forced medical treatment, indeed any power imaginable could be written into any of these plans with the stroke of a pen. This would enable public officials to exercise any power they wished so long as they wrote it down beforehand.

460. Section 14 provides a blank cheque within a blank cheque. It provides that "The Solicitor General may make regulations setting standards for the development and implementation of emergency management programs under sections 2.1 and 5.1 and for the formulation and implementation of emergency plans under sections 3 and 6." This represents a further delegation of power to the Minister of Public Safety to write into emergency plans whatever powers he may see fit from time to time, without limitation.

It is at first sight difficult to see why such a power is necessary or appropriate in an emergency powers statute. It adds a wild card to the entire list of enumerated powers that follow it in s. 7.0.2(4) of Bill 138. Through the technique of incorporation by reference it delegates a limitless range of unspecified powers to government officials. It lacks transparency.

It may be that this provision is an historical artifact that harkens back to the Premier's power under the *Emergency Management Act* to implement emergency plans. That section, which would be repealed under the new emergency statute, provides:

> 7. (1) The Premier of Ontario may declare that an emergency exists throughout Ontario or in any part thereof and may take such action and make such orders as he or she considers necessary and are **not contrary to law** to implement the emergency plans formulated under section 6 or 8 and to protect property and the health, safety and welfare of the inhabitants of the emergency area. R.S.O. 1990, c. E.9, s. 7 (1). [emphasis added]

Absent from the proposed power to implement emergency plans is the safeguard that restricts emergency response to actions that are not contrary to any existing law. The omission of this safeguard exacerbates the blank cheque nature of proposed s. 7.0.2(4)1. That said, even if this safeguard were restored by an amendment to the power in s. 7.0.2(4)1 to implement emergency plans, the lack of transparency would remain.

Recommendations

The Commission therefore recommends that:

- **The power to implement emergency plans be amended to ensure that it confers no powers other than those explicitly set out in Bill 138.**

- **Bill 138 be amended to provide that every emergency plan requires protocols for safe and speedy court access developed in consultation with the judiciary, and that the Courts of Justice Act be amended to ensure an early hearing for any proceeding under or in respect of emergency legislation or any action taken under it.**

- **The Attorney General's Department scrutinize Bill 138 intensely for trans-**

> **parency to ensure that it confers no hidden powers and that all powers conferred are clearly set out on the face of the statute.**

Bill 138: Basket Clause

At the end of its list of emergency powers, Bill 138 provides a "basket clause" to catch and include any power similar to those expressly provided, that may prove necessary:

> 7.0.2 (3), the Lieutenant Governor in Council may make orders in respect of the following:
>
> …
>
> 12. Consistent with the powers authorized in this subsection, the taking of such other actions or implementing such other measures as the Lieutenant Governor in Council considers necessary in order to prevent, respond to or alleviate the effects of the emergency.

Most emergency statutes contain such a clause. In some cases it is appended as an introduction to the list of conferred powers.[461] For example, s.10(1) of British Columbia's *Emergency Program Act* begins by providing that after a declaration of emergency,

> … the minister may do all acts and implement all procedures that the minister considers necessary to prevent, respond to or alleviate the effects of an emergency or a disaster, including any or all of the following….

In other cases it appears at the end of the list as free-standing power. For example, s. 18(1) of Saskatchewan's *Emergency Planning Act*[462]sets out a list of powers to be exercised by the Minister in the event of a declaration of emergency. The last of these is as follows:

> … do all acts and take all proceedings that are reasonably necessary to meet the emergency.

461. R.S.B.C. 1996, c. 111.
462. S.S. 1989-90, c. E-8.1.

Bill 138 uses an approach similar to that followed in the Saskatchewan legislation but with one crucial difference, Bill 138 does not impose any reasonableness standard. Indeed the requirement of reasonable grounds is strikingly absent from Bill 138 as a whole. It is true, as has been noted, that the power to make emergency orders is conferred by s. 7.0.2(2)[463] is made conditional on the requirement that the decision-maker must first determine that there is no "reasonable alternative" to the order. However, it is suggested that this is an inadequate alternative. As noted in the section on "Trigger, Criteria and Limitations," not only does it require inordinate powers of prescience, but it also represents an unusual departure from the ordinary language of "reasonable grounds" or "reasonable apprehension" that is so familiar and well-tested in our law.

Recommendation

The Commission therefore recommends that:

- **The basket clause s. 7.0.2(4)12 be reviewed on the same basis as that recommended above for the trigger and criteria and limitations, the basis of reasonable apprehension.**

Bill 138: Occupational Health and Safety

Bill 138 exempts occupational health and safety laws from the override power. The emergency powers trump every Ontario law except health and safety laws:

> 7.0.6 (1) In the event of a conflict between an order made under section 7.0.2 and any statute, regulation, rule, by-law or order, the order under section 7.0.2 prevails.

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463. Criteria for emergency orders

> 7.0.2(2) If an emergency is declared under section 7.0.1, the Lieutenant Governor in Council may make such orders as the Lieutenant Governor in Council considers necessary and essential in the circumstances to prevent, reduce or mitigate serious harm to persons or substantial damage to property,
>
> (a) if the harm or damage will be alleviated by the order; and
>
> (b) if there is no reasonable alternative to the order.

> . . .
>
> Preservation of duties and rights
>
> (4) Despite subsection (1), nothing in this Act or in an order made under it abrogates any duties that are imposed and rights that are provided under the *Occupational Health and Safety Act*.

The discussion draft statute from the Attorney General's Department did not contain this provision that preserves every occupational health and safety regulation from the force of every emergency order. The exemption was added by the Justice Policy Committee when it drafted Bill 138. The Justice Policy Committee had heard strong arguments that safety regulations should remain in force during an emergency and should not be overriden by emergency orders.

Marcelle Goldenberg, a lawyer with the Service Employees International Union, told the Justice Policy Committee:

> Until the Ontario government can guarantee the health and safety of workers, it cannot force them to perform emergency work of an unknown nature. SEIU believes the province should not legislate a statutory provision empowering the Lieutenant Governor to direct any person or member of a class of persons to render services of a type that the person may reasonably be qualified to perform in emergency situations.[464]
>
> ———
>
> Until health care workers are assured that they will receive the proper training and personal protective equipment for the infectious diseases they must encounter, they cannot be ordered by any authority to put their lives on the line.[465]

Risa Pancer, a lawyer with the Canadian Union of Public Employees, told the Justice Policy Committee:

> We are also, though, putting in it how we're going to deal with occupational health and safety concerns, that the act will apply and every-

464. Justice Policy Committee, Public Hearings, October 14, 2004, p. 360.
465. *Ibid,* p. 361.

> one will have the right to raise concerns during an emergency and feel no fear of retaliation.[466]

Leah Casselman, president of the Ontario Public Services Employees Union, referred in her testimony to recommendations her union has made to the Commission on,

- the need to protect employees' rights and collective agreements during emergencies.

- avoiding the circumvention of employers' occupational health and safety obligations.[467]

These powerful arguments reflect the concerns of front line health care workers who were exposed to risk during SARS. They lack confidence in existing occupational and health safeguards. They lack confidence in the operation of the machinery of enforcement in place during SARS. In light of these concerns they cannot accept any legislative measure that appears to erode whatever safety protection they now have, inadequate though it may be.

These concerns, as noted above, are a major part of the Commission's ongoing investigation and will be addressed in the Commission's final report. It is enough to say at this time that nothing in the evidence examined so far suggests to the Commission that it would be wise to enact a complete emergency override of occupational health and safety laws.

The health and safety of emergency workers is a fundamental element of every emergency response. One of the strongest lessons from SARS is that the health and safety of health care workers and other first responders is paramount in a public health emergency. SARS demonstrated that emergency response can be seriously hampered by high levels of illness or quarantine among health care workers. As Dr. Young has said:

> Certainly one of my priorities is occupational health and safety of the first responders, whether they are hospital workers or whether they're fire or police, or farm workers in the case of avian flu.[468]

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466. Justice Policy Committee, October 14, 2004, p. 364.
467. *Ibid*, p. 356.
468. Justice Policy Committee, Public Hearings, August 3, 2004, p. 17.

Those who favour a limited override of some safety regulations point out that they may contain minor technical provisions that do not directly protect workers, provisions that might be overridden in an emergency without affecting worker safety.

If such provisions exist, and if they would unreasonably impair emergency response, and if it would not endanger workers to override these provisions, the burden of persuasion is on those who would argue that some safety provisions may be safely overridden.

The solution, to any concern that occupational health and safety laws might impede emergency response, is not to enact a blunt override of those laws. Emergency orders will not work if they leave workers deep concern for their personal health and safety. The deepest concern of workers in an infectious outbreak is not their own safety but the safety of their families and those they may infect if not properly protected.

Emergency orders that do not meet these concerns cannot be enforced.

To override occupational health and safety laws would eliminate even the restricted rights of first-responders to refuse unsafe work at a time when other protective measures might also be weakened. In such a hazardous environment, such a draconian measure would be impossible to enforce. Health care workers and other front-line responders may decide in future emergencies, as so many did so heroically during SARS, to accept heightened levels of personal risk voluntarily. But no one, no matter how dedicated and conscientious, should or can be legally coerced to work in an unsafe work environment that they believe will harm themselves and their families. And as a practical matter such legal coercion would be impossible to enforce.

Doris Grinspun, executive director of the Registered Nurses Association of Ontario, has stated:

> … you cannot really mandate people to work. Yes, you can put the legislation, all right, but people can call and say, "I am sick" – one way or another … When some refused [during SARS], they were afraid of the protection. So, again, let's be prepared for how we protect not only our nurses but doctors and others, and we will have fewer and fewer refusals.[469]

469. Justice Policy Committee, Public Hearings, August 26, 2004, p. 272.

The Justice Policy Committee, in its *Report on the Review of Emergency Management Law in Ontario*, stated:

> Emergencies put special stress on workers and employers where work is temporarily interrupted, or otherwise affected by the emergency. In a declared emergency under the *Emergency Management Act* it is necessary to ensure that help is available, while at the same time acknowledging (i) statutory and contractual employment, labour, and occupational health and safety standards, and (ii) issues under the *Human Rights Code*.
>
> 12. The Committee recommends that the government seek to facilitate the development of protocols under which management and employees can deal with the extraordinary circumstance of an emergency.
>
> 13. The Committee recommends that the government review labour and employment legislation with a view to ensuring that the tools needed to respond adequately to a provincial emergency are available.[470]

The Commission agrees that it is important to have mechanisms in place to deal with any health and safety workplace issues that may arise during a future public health emergency in order to:

- Prevent situations from developing that would leave health care and other front-line workers with no choice but to seriously consider refusing work; and

- Develop effective means for workplace parties to work out thorny issues that might arise during an emergency.

These points were made by both management and labour.

Janet Beed, the chief operating officer of the Ontario Hospital Association, has stated:

> Labour issues will always be contentious, but if you have a health crisis, labour issues need to have been considered long before the crisis occurs.

470. Justice Policy Committee, *Report on the Review of Emergency Management Law in Ontario* (Toronto: November 1, 2004), p. 13.

> You can appreciate that there are many issues. What we learned from SARS is that what is needed is a process to bring together the various partners – union, management, government, ministries, associations – to address these very complex systemic and legal issues, but we need to do that long before the crisis hits. When the crisis hits, we need timely action; we don't need bringing a group together that hasn't worked together before or has only worked in distant relationships. Bringing that group together in anticipation and setting up a set of ideologies and legislative requirements will help.[471]

One union in a written submission to the Commission, recommended:

> 1. The Public Hospitals Act should be amended to provide that each hospital should have in place a health emergency plan in advance of any emergency. Where the hospital is unionized, the health emergency plans should be negotiated with unions through collective bargaining to address issues affecting the employment conditions of health care workers. Issues to be bargained and included in the health emergency plan should include:
>
> a. deployment of staff during an emergency;
>
> b. scheduling and hours of work for health care workers during an emergency;
>
> c. pay for health care workers during an emergency, including any entitlement to emergency premiums and protection from financial disadvantage caused by the emergency;
>
> d. plans for staffing an emergency, including whether staffing should occur on a voluntary basis and whether those who volunteer should be entitled to premium pay;
>
> e. training health care workers for the implementation of emergency plans, both in advance of any emergency and during the emergency;
>
> f. training health care workers for additional health and safety issues arising during an emergency;

471. Justice Policy Committee, Public Hearings, August 18, 2004, p. 147.

> g. management of health care worker stress during an emergency;
>
> h. protection of occupational health and safety standards during an emergency;
>
> i. impact of restrictions on health care worker employment during an emergency (e.g. restrictions placed on those who work in more than one facility);
>
> j. impact on health care workers caused by the shut-down of facilities, including in terms of compensation;
>
> k. workers requiring particular accommodation during an emergency, for example, pregnant workers or immunosuppressed workers;
>
> l. workers required to be placed in quarantine during an emergency;
>
> m. long-term impact on health care workers caused by the emergency; and
>
> n. vacation entitlement during an emergency.
>
> Some of the above issues, such as those dealing with compensation, should be bargained between central parties, while other issues, for example scheduling and hours of work, should be bargained locally according to principles determined by the central parties.

Another union in a submission to the Commission said this:

> … early in SARS, an ad hoc committee to address issues arising out of SARS workplaces was established by the MOHLTC. It was comprised of representatives of the MOHLTC, the Ministry of Labour, the Workplace Safety and Insurance Board (WSIB), the OHA, various affected hospitals and most of the health-care unions, including [the union] …
>
> The committee met once or twice a week, either in person or by teleconference, between April 1, and June 2003. It discussed such issues as staffing, health and safety, movement of staff between facilities and compensation. The committee did have serious limitations. It did not

> know about, or approve, the enhancements given to staff by hospitals. In addition, it did not solve many of the communication problems that existed during SARS. [Union] representatives were frustrated that many of their questions were not answered and that crucial information was not available to them, in spite of committee meetings.
>
> However, on the positive side, the committee did discuss and approve creative staffing solutions to the SARS crisis. For instance, rather than enhancing pay, it concluded that it was preferable to shorten working hours for nurses working in SARS units with no reduction in pay. In addition, the committee worked out the details of a government initiated Compassionate Assistance Program that provided compensation to nurses who suffered financial loss due to the impact of SARS …
>
> During a health emergency a provincial ad hoc committee, similar to the one operating during SARS, should be struck to deal with ongoing issues. The committee should include representation from all unions with affected members. Each hospital should also strike an ad hoc committee that has union representation. This committee should also include representation from the public health sector to facilitate the integration and coordination of response between hospitals and public health services.

As noted above it is the position of the Commission that the onus is on those who favor the power to suspend occupational health and safety protections during an emergency to prove their case. Thus far, they have not done so. What is needed during an emergency, instead of a blunt override of occupational health and safety protections, is a pre-planned, pre-existing process to sort out quickly any workplace issues that touch on occupational health and safety.

Recommendation

The Commission therefore recommends that:

- **Every emergency plan provide for a process to facilitate advance planning to address potential workplace health and safety issues and to work out those issues when they arise.**

Bill 138: The Problem of Concurrent Powers

It is important to ensure that Bill 138, in conferring new emergency powers, does not take away any existing powers that might be used in an emergency such as the powers in the *Health Protection and Promotion Act*, the *Police Services Act* and other Ontario statutes, and ancillary and inherent powers such as those used to evacuate 218,000 Mississauga residents after the 1979 chlorine gas train derailment.

The Commission recommends that Bill 138 explicitly provide that it does not derogate from any of these existing powers that might be used in an emergency.

The continuing existence of these separate and concurrent streams of power should not become a trap for the emergency responder faced with a choice of powers to accomplish the same end. What is needed is a way to prevent the two different streams of authority from forcing an emergency responder, who must act in a hurry, to stop and wait for lawyers to debate which power is more appropriate. So long as the emergency response is justified by law it should not matter which overlapping stream of authority was chosen.

For instance the existence of concurrent powers under the *Health Protection and Promotion Act* and Bill 138 may create uncertainty about the preferable choice of power and may force emergency responders to ponder which power to use. If I use the wrong power, will my action be invalid? Will I suffer consequences? Do I use the *Health Protection and Promotion Act's* s. 87 to seize the motel as a temporary isolation facility, or do I use the powers in Bill 138 (assuming they have been amended to make them compulsory)? What are the legal consequences of each choice? These are questions that emergency responders should not have to ask themselves.

The responder should not have to scratch his head and take legal advice as to the precise differences between these overlapping powers. So long as the action is authorized by one statute or the other, the responder should be able to go ahead with confidence and just do it. And the responder should be able to avoid legal challenges based on legalistic pigeonholes. Emergency responders should not have to spend hours under cross examination in a later court challenge answering questions like: Did you do it under the *Health Protection and Promotion Act*? If so, did you dot this i and cross this t? Did you do it under Bill 138? If so, did you dot these other i's and cross these other t's? The way to avoid these problems down the line is to provide that the emergency action is valid so long as it is authorized by law, no matter which legal pigeonhole it might best fit.

Recommendations

The Commission therefore recommends that:

- **Bill 138 be amended to provide:**

- **That Bill 138 does not derogate from the powers authorized by any Ontario Statute or any ancillary or inherent authority;**

  - **That no order made or action purportedly taken under Bill 138 shall be set aside on grounds it is not authorized by the Act if the order or action is authorized by some other Ontario statute or inherent or ancillary power; and**

  - **That no order made or action taken in response to a declared emergency under the purported authority of any Ontario statute or inherent or ancillary power shall be set aside for lack of legal authority if the order or action is authorized under Bill 138.**

Conclusion and Summary of Recommendations

For the reasons above, the Commission recommends that:

- **Emergency legislation require that every government emergency plan provide a basic blueprint for the most predictable types of compensation packages and that they be ready for use, with appropriate tailoring, immediately following any declaration of emergency.**

- **Bill 138 provide explicitly for a process to ensure the integration of all emergency plans and the requirement that every emergency plan specify clearly who is in charge and who does what.**

- **Bill 138 be examined to determine and clarify whether the supply chain powers in s. 7.0.2(4) 7, 8, and 9 are intended to authorize compulsory seizure and expropriation of property and, if explicitly compulsory, what provisions should be made for compensation, administrative procedures, or other safeguards.**

- **All powers proposed in Bill 138 be examined to remove ambiguity of the sort that appears in s. 7.0.2(4) 7, 8 and 9 to ensure there is no lack of clarity as to the intended purpose and legal effect of any proposed power.**

- **For the reasons set out above and the reasons advanced by the Minister, the Commission recommends against the enactment of separate public health emergency legislation. For the same reasons the Commission recommends that Bill 138 make it clear that the special powers available in an emergency are in addition to the powers in the *Health Protection and Promotion Act* and the declaration of an emergency does not prevent the continuing use of the *Health Protection and Promotion Act* health protection powers.**

- **Emergency legislation provide that the Chief Medical Officer of Health has clear primary authority in respect of the public health aspects of every provincial emergency including:**

  - **Public health emergency planning;**

  - **Public communication of health risk, necessary precautions, regular situation updates;**

  - **Advice to the government as to whether an emergency should be declared, if the emergency presents at first as a public health problem;**

  - **Strategic advice to the government in the management of the emergency;**

  - **Advice to the government as to whether an emergency should be declared to be over, and emergency orders lifted, in respect of the public health measures taken to fight the emergency;**

  - **Advice to the government in respect of emergency orders of a public health nature and emergency orders that affect public health e.g. ensuring that gasoline rationing does not deprive hospitals of emergency supplies;**

  - **Delegated authority in respect of emergency orders of a public health nature; and**

  - **Such further and other authority, of a nature consistent with the author-**

ity referred to above, in respect of the public health aspects of any emergency.

- **Emergency legislation provide that the Chief Medical Officer of Health shall exercise his or her authority, so far as reasonably possible, in consultation with the Commissioner of Emergency Management and other necessary agencies. Conversely, the Commission recommends that emergency legislation provide that the Commissioner of Emergency Management, on any matter affecting public health, shall exercise his or her authority so far as reasonably possible in consultation with the Chief Medical Officer of Health.**

- **Bill 138 be subjected to a fundamental legal and constitutional overhaul by the Attorney General who has indicated he is fully engaged in reviewing Bill 138 to ensure that it meets necessary legal and constitutional requirements.**

- **The government in its review of Bill 138 consider whether it adequately addresses the public health emergency powers referred to above.**

- **The power of mass compulsory immunization not be enacted as a permanent feature of Ontario's law until the evidence has been presented in a comprehensive fashion.**

- **Every proposed emergency power, before its enactment, be thoroughly subjected to the legal, practical, and policy analysis exemplified by the above analysis of compulsory mass immunization and that the evidence in support of each power be presented in a comprehensive fashion before enactment.**

- **If the government decides it is necessary to enact any emergency power before there is time to subject it thoroughly to the legal, practical, and policy analysis exemplified by this analysis of compulsory mass immunization, that the government sunset any such provision for a period not to exceed two years in order to provide time for the required scrutiny.**

- **The Attorney General in the review of Bill 138 clarify whether the override power in s. 7.0.6(1) affects collective agreements.**

- **The Attorney General undertake a thorough scrutiny and amendment of the override provision to protect our foundational legal statutes such as the**

***Habeas Corpus Act*,[472] the *Legislative Assembly Act*,[473] the *Human Rights Code*,[474] the *Elections Act*,[475] and the *Courts of Justice Act*[476] against emergency override.**

- **It be made clear whether a journalist or lawyer who refuses to disclose confidential information or the identity of its source is liable to the penalty provided by Bill 138, a fine of up to $100,000 and a term of imprisonment for up to a year for every day on which the refusal continues.**

- **The override power be given a more prominent place in the statute by putting it right after the enumerated powers.**

- **The Attorney General review Bill 138 to ensure that the extent of the override, combined with the vague and open ended nature of the powers including the basket clause, does not constitute a constitutionally impermissible delegation of legislative power to public officials.[477]**

- **The structure and content of the limitations and criteria for the declaration of emergency and the exercise of emergency powers be reviewed with a view to the development of a standard based on the decision-maker's reasonable apprehension that the exercise of the power is necessary in the circumstances;.**

- **The power to implement emergency plans be amended to ensure that it confers no powers other than those explicitly set out in Bill 138.**

- **Bill 138 be amended to provide that every emergency plan requires protocols for safe and speedy court access developed in consultation with the judiciary, and that the Courts of Justice Act be amended to ensure an early hearing for any proceeding under or in respect of emergency legislation or any action taken under it.**

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472. R.S.O. 1990, c. H-1.
473. R.S.O. 1990, c. L-10.
474. R.S.O. 1990, c. H-19.
475. R.S.O. 1990, c. E-6.
476. R.S.O. 1990, c. C-43.
477. For vagueness, see for instance Gonthier J. in *R. v. Nova Scotia Pharmaceutical Society* [1992] 2 S.C.R. 606 at para 69. For delegation of plenary discretion, see for instance *Irwin Toy Ltd. v. Quebec (A.G.)* [1989] 1 S.C.R. 927 at para 63.

- **The Attorney General's Department scrutinize Bill 138 intensely for transparency to ensure that it confers no hidden powers and that all powers conferred are clearly set out on the face of the statute.**

- **The basket clause s. 7.0.2(4)12 be reviewed on the same basis as that recommended above for the trigger and criteria and limitations, the basis of reasonable apprehension.**

- **Every emergency plan provide for a process to facilitate advance planning to address potential workplace health and safety issues and to work out those issues when they arise.**

- **Bill 138 be amended to provide:**

  - **That Bill 138 does not derogate from the powers authorized by any Ontario Statute or any ancillary or inherent authority.**

  - **That no order made or action purportedly taken under Bill 138 shall be set aside on grounds it is not authorized by the Act if the order or action is authorized by some other Ontario statute or inherent or ancillary power.**

  - **That no order made or action taken in response to a declared emergency under the purported authority of any Ontario statute or inherent or ancillary power shall be set aside for lack of legal authority if the order or action is authorized under Bill 138.**