SUMMARY OF THE SECOND INTERIM REPORT OF THE SARS COMMISSION (CAMPBELL): SARS AND PUBLIC HEALTH LEGISLATION

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INTRODUCTION:

The Second Interim Report of the SARS commission deals with the legislative framework (both powers and structures) within which public health authorities carry out their duties. The analysis includes recommendations on leadership issues (independence and decision making powers); governance (local vs. central); reforms to the Health Protection and Promotion Act; response measures (quarantine, powers of entry, privacy protection); and public health resources.

As the Commission’s mandate is a response to how SARS was handled, there is little comment on aspects of public health that fall outside of infectious disease prevention and control and outbreak management. It does however make strong statements about strengthening the legal status of the existing public health programme guidelines, including health promotion functions.

The vision behind the recommendations appears to be enhancing the legal clarity and strength of the powers and duties of public health authorities (with assurances that every effort is made in advance to identify and account for any legal challenges to each where personal rights and freedoms are concerned) to ensure quick and effective responses to acute threats to community health. Adequate resources and freedom from political interference are identified as prerequisites to the success of such responses. Here is a selection of excerpts from the executive summary:

“*The test of the government’s commitment will come when the time arrives for the heavy expenditures required to bring our public health protection up to a reasonable standard (p.1).*”

“*Medical leadership that is free of bureaucratic and political pressure is what builds public confidence in the fight against deadly infectious diseases such as SARS (p.2).*”

“*The commission recommends five immediate measures required to strengthen public health governance and ensure a uniformly high standard of protection across the province: 1) Protect the local medical officer of health from bureaucratic encroachment; 2) Require by law the regular monitoring and auditing of local health units; 3) Change the public health programme guidelines to legally enforceable standards; 4) Increase provincial representation on local boards of health and set qualifications for board membership; and 5) Introduce a package of governance standards for local boards of health (p. 3).*”

“*Local boards of health must be strengthened to ensure that those who sit on them are committed to and interested in public health (p.4).*”

This summary is limited to the first 10 chapters, which cover the legislation that governs the day-to-day activities of Ontario’s public health system. The final chapter examines emergency legislation, whose requirements should certainly be well known but are only
invoked in extraordinary circumstances, i.e. where the measures recommended in the first 10 chapters have failed or are insufficient.

The full set of recommendations (including those for emergency legislation) is numbered and organized by chapter at the end of this document. Please note that the commission’s report does not number these recommendations. Referencing them by number will not be of much help if you are referring to the report itself.

CHAPTER 1: Medical Independence and Leadership

This section is based on the conviction that “management of infectious disease must be driven by medical expertise and not political expediency”. It therefore recommends that further operational and leadership powers be transferred to the Chief Medical Officer of Health (CMOH) and that parallel independence from political interests be entrenched for local medical officers of health (MOHs) under the Health Protection and Promotion Act (HPPA). Amendments to the HPPA to strengthen their authority to act and remove certain barriers to do so quickly and effectively (and in tandem where necessary) are recommended.

That said, the Commission also covers the accountability difficulties in separating the CMOH completely from government machinery. The argument is that the effectiveness of the office of the CMOH is enhanced by its direct relationship to the policy functions of government by way of the concurrent designation of Assistant Deputy Minister.

Also discussed are the difficulties in the personal discretion granted local medical officers of health without direct accountability to a central authority. One’s decision to quarantine and another’s decision not to quarantine in equal circumstances is given as an example. Local independence subject to central direction in certain circumstances is therefore suggested.

The specific difficulties of local medical officers of health reporting to the public on risks to health from within the machinery of local government are also addressed:

“Public health leadership and risk communication must be the clear domain of the local medical officer of health. The Health Protection and Promotion Act must authorize them to speak out on behalf of public health, without fear of adverse employment consequences.”

Finally, strong statements are made about the central role the CMOH and local MOHs must play in public health emergency preparedness and response. It is pointed out that the CMOH is in charge of none of the emergency committees established under the Ministry of Health and Long Term Care, and that the role of local MOHs in emergency plans is not defined at all. Measures to grant CMOH and MOH authority over public health emergency preparedness and response and streamline reporting relationships are recommended.
The concluding statement of this section states, “to avoid the problems that arose during SARS and to increase our protection against infectious disease, it is necessary to increase the independence of the Chief Medical Officer of Health and the local medical officers of health and consolidate public health leadership in the hands of the Chief Medical Officer of Health.”

CHAPTER 2: Local Governance

This section summarizes the drawbacks of the shared governance of public health by the province and the municipalities. It examines the current model of split governance and itemizes its advantages and drawbacks. Much of the ink is devoted to the latter, reporting the constant conflicts between public health and other interests at the local policy level, which stand in the way of fulfilling the public health mandate.

It points out that there while there remains significant debate over options to improve or replace the current model, there is strong agreement that immediate steps are required to strengthen public health’s ability to deliver its local programs and services.

Campbell recommends five measures for immediate implementation (reproduced in the Introduction above) while debate continues on split governance vs. 100% uploading to the province. The report reflects the differences within the public health community on this, acknowledging the pros and cons of each and stating that recommending either for the long term would be premature. It strongly states however that “measures must be taken to ensure that the financial priority given to public health, and accountability and authority of the medical officer of health are not diluted by difficulties with municipal bureaucracies (68).”

These difficulties are well illustrated with anecdotal information as well as the case study of the assessment and subsequent dissolution of the Muskoka Parry Sound Health Unit. In short, problems originate in boards of health that choose not to act in the best interests of community health or municipal councils that refuse their obligations to fund it. On the other hand, supportive boards and councils are important and effective political mechanisms for the advancement of public health issues.

At the same time, there are reasons given for discomfort with the idea of total provincial control, in essence that it would be difficult to maintain local decision-making authority in the absence of the funding to justify it.

The report then engages in the debate by asking a question: can the present system be fixed (i.e. can the political obstacles to effective local public health stewardship be removed) and at what cost in resources and focus? If this cannot be resolved by 2007, Campbell recommends 100% uploading as the only choice.
In the meantime, stronger legislative language is urged to support the authority of the local medical officer of health, as is more explicit legal weight to the Mandatory Programs and Services Guidelines. In addition, more meaningful and consistent central monitoring, auditing and enforcement functions are recommended in order to identify and root out the organizational impediments itemized in this section.

Given that the province is assuming a larger share of public health funding under the current split-governance model, Campbell does recommend that the proportion of provincially appointed board of health members reflect this. In addition, a commitment to the goals of the public health agenda should be a requirement of each member, as any other motivation amounts to dereliction of legal duty under the HPPA.

The concluding statement at the end of this section reads, “public health at the local level needs attention. The existing problems faced in some health units cannot be permitted to continue. The government, for the reasons given above, needs to make a clear decision by the end of the year 2007 whether to upload the financing and control of public health 100 per cent to the province and away from the municipalities.

“Although there is no consensus on the ultimate solution for the problems of split provincial/municipal governance, there is a consensus that improvements of the kind described above are required even within the existing system.

“Whatever the ultimate solution, the Health Protection and Promotion Act must be strengthened and enforced in the manner described above to ensure a uniform standard of protection across the province. Boards of health must likewise be strengthened to ensure that those who comprise the boards of health are committed to and interested in public health, that they clearly understand their primary focus is to be protection of the public’s health, and that they broadly represent the communities they serve.

The current state of affairs cannot continue. The cost of failing to fix will be to risk more disease and death.”

CHAPTER 3: HPPA Tuneup

This section introduces the HPPA, the Act governing public health as a complex and convoluted statute that requires general clarification and needs to have some important ambiguities addressed.

The first of these is ensuring that the powers and authority of public health officials are adequate and unambiguous to ensure early and effective intervention in a crisis, while making the limits of such powers to encroach on individual liberties clear. The HPPA does not succeed in its present form.

A major review of the Act was not undertaken, but four areas requiring immediate clarification were identified.
**Disease categories:** The four overlapping categories (infectious, communicable, reportable and virulent) must be clarified in order to ensure proper application of legally-defined requirements for actions to control them.

**Streams of power:** Campbell draws attention to the separation of parallel powers of intervention under Part III, S. 13 (Community Health Protection) and Part IV, S. 22 (Communicable Diseases). Each has different standards for application and the problems arise where the application of one over the other is not clear.

**Standards of Intervention:** Campbell calls for clarification and more thoughtful placement of “hard” (e.g. reasonable and probable grounds standard) and “soft” (e.g. opinion standard) legal triggers for exercise of powers under the Act.

**Section 22:** Needs to be clarified and strengthened, as it is clear that the decision to exercise of powers under this section is generally made when swift intervention is required.

The concluding statement at the end of this section reads, “the above highlights just a few examples of confusion in the Act. The Act must be clear and workable for those who use it to obtain their day to day authority to protect the public’s health. Otherwise, uncertainty and confusion will be the refuge for a noncompliant person or institution. Action that is necessary to protect the public may be delayed as public health officials and lawyers try to determine what they can do and when. If they are bold enough to act in the face of uncertainty, they risk legal challenges to their authority, which may in turn delay their ability to act effectively.

“The Health Protection and Promotion Act is a complex statute that has served the people of Ontario well since its inception. That being said, in the aftermath of SARS, it is time for the Ministry of Health and Long-Term Care to review the Act, in consultation with the Attorney General and those who work daily with the Act on the front lines of public health defence.”

**CHAPTER 4: Stronger Health Protection Powers**

This section calls for strengthening of the HPPA’s upstream powers of investigation, mitigation and risk management that are exercised daily to varying degrees to prevent public health crises. Access to information as well as resources, expertise and authority to investigate and intervene to minimize risks to health are identified as key areas of focus. These enhancements would ensure that the necessary range of powers is clear and contained in one Act.

As hospitals were significant factors in the spread of SARS, they are the arenas of choice to illustrate the impact of the recommendations made in this section. Stronger and more
convivial relationships are urged between them and health units, as an obvious mechanism for active monitoring of communities for infectious diseases.

They are also used as an example of custodians of information essential to effective public health monitoring and intervention, whose obligations to report it are not strongly defined.

Once information is in hand, public health requires sufficient authority to act on it to protect the public interest. The current standard of reasonable and probable grounds under S. 22 is given as an example of an obstacle to early intervention if a risk to public health is suspected but not defined.

The next section deals with case classification, illustrating the difficulties that arose from the lack of clarity on what qualified as a case of SARS (suspected or probable), and who was designated and / or qualified to make the call. Similar arguments are made in the following section about the issuing of directives in the absence of clear authority and legal triggers to do so. Recommendations are therefore made to ensure clarity of authority over and content of each.

The report then deals with powers of detention and entry. Each is couched in personal rights and freedoms issues, and therefore must be judiciously considered and clearly defined.

On the first subject, the HPPA allows detention for the purposes of treatment and isolation of a person carrying a virulent disease, but this may b subject to delays if court orders are needed. The HPPA does not provide for temporary detention of individuals or groups for the purposes of identification and contact tracing, or decontamination. Campbell makes separate recommendations for each of these three scenarios, for the purpose of ensuring that immediate health threats posed to communities by individuals can be dealt with.

On the second subject, the lack of clear authority to enter private dwellings to execute the above powers is identified as a serious obstacle to exercising the above powers. Amendments to the HPPA are thus suggested to provide this authority, subject to strict limitations that respect the fundamental legal protections of individuals from unreasonable intrusion by the state.

The concluding statement of this section reads, “as noted at the beginning of this chapter, the Health Protection and Promotion Act, which provides the legal machinery for our defence against infectious disease, needs to be stronger. It is the daily powers in the Health Protection and Promotion Act, powers of investigation, mitigation, and risk management that prevent public health emergencies from developing. It is these daily powers that require strengthening.
“Public health officials, to protect us from disease and to prevent small problems from growing into emergencies, require access to health risk information and the authority, resources, and expertise to investigate, intervene, and enforce.

The powers and safeguards recommended above are necessary to achieve these ends.”

**CHAPTER 5: Reporting Infectious Disease**

This section characterizes the legal obligation to report infectious diseases to public health authorities as a foundation for effective community health protection. Again using the hypothetical outbreak scenario, it points out that the inconsistencies and gaps in reporting requirements (subject to privacy legislation requirements) need to be clarified to ensure that the information required for an effective response is shared.

It reproduces the specific reporting requirements of the Act and then identifies shortcomings. These include references to the different disease categories (and different reporting requirements), inappropriately assigned reporting responsibilities (e.g. hospital administrators as opposed to ER physicians and staff), and differing levels of required detail in reported information.

It continues by illustrating the broad range of potential custodians of health information who by omission are not obliged to report it to public health (but are limited by the Personal Health Information Protection Act), and recommends an expansion of the categories of custodians with reporting obligations under the Act. Since this will not fill every gap, obligations to provide relevant information when requested by medical officers of health are also urged.

Timing and content of reports are then covered, underscoring the importance of timely and standardized reporting of specified information among clearly identified individuals, none of which is adequately defined in the HPPA. Some recent legal amendments have been made to address them, but some ambiguities and inconsistencies remain.

In order to make improvements effective, education and awareness of all identified individuals about their reporting obligations and the reasons for them are critical. This is especially true where there is any question of conflict with duties to protect personal health information. It must be clearly spelled out where duties to report override non-disclosure clauses in PHIPA.

It is also recommended that reporting requirements be imposed on public health authorities to disclose any information back to health care institutions that would help the latter control outbreaks within them.

The concluding statement in this section reads, “medical officers of health and the Chief Medical Officer of Health can only protect the public if they are aware of the existence of a threat to the health of the public. In respect of communicable diseases it is critical that
health care providers are aware of and vigilant in complying with their reporting obligations under the Act. This requires both education of health care workers and health care institutions as well as a collaborative effort between public health, health care providers and professional bodies to ensure, so much as possible, ease in complying with the reporting obligations under the Act. If the reporting structure or requirements are too onerous they will invite noncompliance. On the other hand, legal duties that are vague or un-enforced will similarly invite noncompliance. It could take only one failure to report the presence or suspected presence of a communicable disease to lead to a serious outbreak in a health care institution or in the community at large.

“The Chief Medical Officer of Health requires broad powers to compel information from health information custodians where necessary to protect the public from an infectious disease. The Act and its regulations cannot predict and provide for unknown diseases, such as SARS, which may come upon us suddenly and which require a strong and swift public health response.

There must also be an open exchange of information between health care professionals and public health with a common goal of investigating and preventing the spread of infectious disease.”

CHAPTER 6: Privacy and Disclosure

This section deals more specifically with required amendments to new privacy legislation to ensure that the vital flow of patient information required by public health authorities to deal with outbreaks is unimpeded. Clarity of disclosure requirements under the HPPA must be coupled with clarity of disclosure authorizations under PHIPA.

The first source of confusion is the lack of explicit differentiation between discretionary and mandatory disclosure of health information for the purposes of the HPPA. The natural tendency is to err on the side of non-disclosure if there is any question about the legal prerequisites for it, which is a serious barrier to the free flow of vital information about infectious diseases in the community.

The ability of medical officers of health to in turn disclose identifying personal health information where community health may be at risk is also addressed, arguing that the authority to disclose personal information is an important tool in some circumstances to prevent the spread of infectious disease.

Clarity is necessary in the requirements for handling of personal information, especially given the severe penalties imposed for their contravention. Ambiguity and confusion in the statutes that contain them must be removed. Where time is of the essence to protect the public good, the ability of legal experts to understand and interpret them is far less important than the ability of custodians of protected information to do so. An override clause is thus recommended, under which a liability-protected duty to provide information to a medical officer of health prevails.
Recommendations to fast track approvals for use of such information for research purposes and effective protection of personal health information received by public health authorities are also made.

The concluding statement of this section reads, “health professionals and public health professionals should not have to negotiate through lawyers to enable the disclosure of information required by law. There should be no avenue for delay. In an infectious disease outbreak, time is of the essence. Public health physicians and staff require access to personal health information to enable them to identify cases of disease and to investigate and manage an outbreak. Medical officers of health must be able to obtain the information they need to do their job, the disclosure of which is required by law.

“Confusion around complex privacy laws must not impede the vital flow of this legally required information. Simple amendments, which in no way affect the integrity of privacy legislation, are required to fix this problem.”

CHAPTER 7: Whistleblower Protection

Prompt reporting of public health risks by health care workers without fear of reprisal is essential to effective response to them. The commission points out that protections built in to the HPPA are too narrow, and gives examples of models for such protection from other pieces of legislation. It also points out that the purpose of expanded protections would be to ensure timely reporting for an effective response, and not enforcement and prosecution (for which other whistleblower protections are largely designed).

The recommendations for broader whistleblower protections under the HPPA include provisions for the types of information to be shared, risk-based triggers for sharing it and remedies for an employee whose employer violates them.

The concluding statement of this section reads, “any health care worker should be free to alert public health authorities to a situation that involves the risk of spreading an infectious disease, or a failure to comply with the Health Protection and Promotion Act.

“Public health officials do not have the resources to be present in every health care facility at every moment. While one would expect that a facility administrator, infection control specialist, or practitioner would report to public health officials situations or cases that might risk the public’s health, the cost of nonreporting or inaction is too high. In the event of such a failure to report, regardless of its cause, it is not enough to hope that public health officials will stumble across the problem eventually. SARS and other diseases clearly demonstrate the importance of timely reporting of a risk to public health. Health care workers can be the eyes and ears of public health and the front line protectors of the public’s health. They must be free to communicate with public health officials without fear of employment consequences or reprisals.”
CHAPTER 8: Quarantine

Quarantine and isolation are cited as important available defences against the progress of outbreaks. Their success depends heavily upon public cooperation, without which legal procedures are of little use. Such cooperation depends on confidence that comes from the perception that public health decisions are being made by credible and qualified people with the public’s best interests at heart, and who are forthcoming with information.

The individual consequences of quarantine are also covered, with a recommendation that legislation include basic mechanisms for compensation and job protection of individuals who must subject themselves to quarantine or isolation. A further amendment to the HPPA is also suggested, which would require local plans to ensure that basic supports are available to ensure individual compliance with quarantine or isolation (e.g. child care, delivery of food and medication, provision of information and follow-up).

The concluding statement of this section reads, “Quarantine and isolation are essential measures in the defence against infectious outbreaks. SARS could not have been so quickly contained in Toronto without the tremendous public cooperation and individual sacrifice of those who were quarantined. While public health officials require the power to isolate those who are infected, and to quarantine those who may have been exposed to infection and may be infectious to others, this power comes with the responsibility to provide information, support, and job protection.”

CHAPTER 9: Legal Access and Preparedness

This section calls for strengthening enforcement provisions in the HPPA, including clarifications of enforcement powers, procedures, jurisdiction and application, as well as elimination of time-consuming appeals process. The commission’s recommendations are made only in relation to compliance with orders made under the communicable disease control provisions of parts IV and VII of the HPPA, the strongest of which is urging unified court jurisdiction over all public health enforcement procedures and remedies.

Campbell points out that the powers of judicial enforcement are scattered throughout the HPPA without explicit and defendable procedures, which often require cross-referencing with other Acts governing legal enforcement (e.g. Provincial Offences Act) that were not drafted with considerations of the subtleties of public health emergencies. Recommendations are made to address these difficulties.

Finally, legal preparedness is identified as being a critical component of public health emergency preparedness. The ability to enforce them quickly and fairly requires the right laws being in place, competencies of those charged with their use and interpretation, and coordination of jurisdictions that cover them. Contingencies must be accounted for in advance to prevent legal obstacles to timely responses.
The concluding statement of this section reads, “confusion and uncertainty are the only common threads throughout the legal procedures now provided by the Health Protection and Promotion Act for public health enforcement and remedies. Uncertainty as to which court to use. Uncertainty as to when notice is required and how to dispense with it when necessary. Confusion as to the procedural authority for orders and their degree of permanence. Uncertainty as to the procedure to amend orders to suit the circumstances. Confusion as to the authority and the procedure to obtain an interim ex parte order (a temporary order made in the absence of the person against whom the order is sought, to be followed by a court hearing) and the duration of such an order. Uncertainty as to the process by which the exclusion of the public from a hearing may be challenged. “Public health officials and the lawyers who advise them require not only the clear authority to act in the face of public health risks, they require also a simple, rational, effective and fair set of procedures to enforce compliance and to provide legal remedies for those who challenge orders made against them. Delays in legal enforcement may cost lives. Delays in legal remedies may put individual liberty at risk. The above recommendations are necessary to secure effective access to enforcement and to remedies.”

CHAPTER 10: Public Health Resources

This chapter echoes the conclusions of other reports that followed the SARS outbreak in stating that until adequate resources are committed to Ontario’s public health system, the desired outcomes of the preceding recommendations cannot be realized. Some progress is acknowledged, but a sustained commitment is required to reverse decades of neglect, poor leadership and inadequate resources.

Campbell identifies laboratories, scientific advisory capacity, surge capacity, infectious disease and epidemiological expertise, information technology and general public health human resources among many areas that still require attention to prevent outbreaks. He cautions that steps already taken are just the beginning, and that it will take years to furnish a sustainable and effective public health system with the required resources, expertise and capacity.

The Central Public Health Laboratory is cited as a microcosm of the public health system as a whole, an agency whose functional and professional capacities cannot be created during a crisis, when these capacities are most important. It is also cited as an example of the difficulties of rebuilding a critical institution while finding short-term solutions to critical systemic problems.

The concluding statement of this section reads, “As the province moves into the latter stages of Operation Health Protection, stages when significant funding will be required, the challenge will be to provide the necessary resources to sustain the momentum for change despite the government’s other budgetary pressures.
“The point has to be made again and again that resources are essential to give effect to public health reform. Without additional resources, new leadership and new powers will do no good. To give the Chief Medical Officer of Health a new mandate without new resources is to make her powerless to effect the promised changes. As one thoughtful observer told the Commission:

The worst-case scenario is basically to get the obligation to do this and not get the resources to do it. Then the Chief Medical Officer of Health would have a legal duty that she can’t exercise.

“To arm the public health system with more powers and duties without the necessary resources is to mislead the public and to leave Ontario vulnerable to outbreaks like SARS.”
CHAPTER 1: Medical Independence and Leadership

1. The *Health Protection and Promotion Act* be amended to transfer the powers in ss. 82 through 85 (power over assessors) to the Chief Medical Officer of Health.

2. The Minister's power under s.79 of the *Health Protection and Promotion Act*, to establish and direct public health laboratory centres be transferred from the Minister to the Chief Medical Officer of Health, until such time as the establishment of the Ontario Health Protection and Promotion Agency and the transfer of power over the laboratories in accordance with the recommendations of the Walker Report.

3. The *Health Protection and Promotion Act* be amended to transfer the power in s. 102 (2) (enforcement powers) to the Chief Medical Officer of Health.

4. The *Health Protection and Promotion Act* be amended to remove from s. 102 (1) the Minister as a listed person who may exercise that power.

5. The *Health Protection and Promotion Act* be amended to transfer the powers in s. 80 (power over inspectors) to the Chief Medical Officer of Health.

6. The powers in s. 78 (appointment of inquiry) and in s. 87 (commandeering buildings for use as temporary isolation facilities) remain as they are, to be exercised by the Minister of Health and Long-term Care.

7. The *Health Protection and Promotion Act* be amended to provide for every local medical officer of health a degree of independence parallel to that of the Chief Medical Officer of Health. This would include:
   - Giving the local medical officers of health the same reporting duties and authority as the Chief Medical Officer of Health:
     - To report every year publicly on the state of public health in the unit. This report must be provided to the local board of health and the Chief Medical Officer of Health 30 days prior to it being made public: and
     - To make any other reports respecting the public’s health as he or she considers appropriate, and to present such a report to the public or any other person, at any time he or she considers appropriate.
   - Protecting the independence of the local medical officer of health by providing that no adverse employment action may be taken against any medical officer of health in respect of the good faith exercise of those reporting powers and duties.

8. The powers now assigned by law to the medical officer of health are assigned concurrently to the Chief Medical Officer of Health.

9. These concurrent powers shall be exercised by the medical officer of health in the local region, subject to the direction of the Chief Medical Officer of Health.

10. Public health emergency planning, preparedness, mitigation, management, recovery, coordination, and public health risk communication at the provincial level be put under the direct authority of the Chief Medical Officer of Health under the *Health Protection and Promotion Act*.

11. Public health emergency planning, preparedness, mitigation, management, recovery, coordination, and public health risk communication under the direction of the local
medical officer of health be added to the list of mandatory public health programmes and services required by s. 5 of the *Health Protection and Promotion Act.*

12. The Emergency Management Unit of the Ministry of Health and Long-Term Care be moved to the Public Health Division with its Director reporting directly to the Chief Medical Officer of Health.

13. The *Health Protection and Promotion Act* be amended to require that each local board of health and each medical officer of health provide to the Chief Medical Officer of Health a copy of their general public health emergency plan and any incident specific plans and ensure that the Chief Medical Officer of Health has, at any time, the most current version of those plans.

14. Section 95 (protection from personal liability) of the *Health Protection and Promotion Act* should be amended to extend its protection to everyone employed by or providing services to a public health board or to the provincial Public Health Division, everyone from the Chief Medical Officer of Health, to its expert advisors, to public health employees in the field.

**CHAPTER 2: Local Governance**

15. The province, by the end of the year 2007, after the implementation of the recommendations of the pending public health capacity review, decide whether the present system can be fixed with a reasonable outlay of resources. If not, funding and control of public health should be uploaded 100 percent to the province.

16. The Ministry of Health and Long-Term Care enforce the *Health Protection and Promotion Act* to ensure the protection of the medical officer of health from bureaucratic and political encroachment in the administration of public health resources and to ensure the administrative integrity of public health machinery under the executive direction of the medical officers of health. In particular, the Ministry of Health and Long-term Care should:
   - Amend and strengthen s. 67 of the *Health Protection and Promotion Act* to ensure that those whose duties relate to the delivery of public health services are directly accountable to, and under the authority of, the medical officers of health, and that their management cannot be delegated to municipal officials;
   - Take enforcement actions in respect of violations of s. 67
   - Amend the *Health Protection and Promotion Act* to clearly state that the medical officer of health is the chief executive officer of the board of health; and
   - Amend the *Health Protection and Promotion Act* to provide local medical officers of health a degree of independence parallel to that of the Chief Medical Officer of Health, as set out in Chapter 1 of this Report.

17. Section 7 of the *Health Protection and Promotion Act* be amended to provide that the Minister, on the advice of the Chief Medical Officer of Health shall publish standards for the provision of mandatory health programmes and services, and every board of health shall comply with the published standards that shall have the force of regulations.

18. The *Health Protection and Promotion Act* be amended to require by law the regular monitoring and auditing, including random spot auditing of local health units to ensure compliance with provincial standards. The results of any such audits should
be made public so citizens can keep abreast of the level of performance of their local health unit.

19. The *Health Protection and Promotion Act* be amended to ensure that the greater funding and influence of the province in health protection and promotion is reflected in provincial appointments to local boards of health. Also, to ensure that the qualifications required of members of boards of health include experience or interest in the goals of public health. In particular, the Ministry of Health and Long-term Care should:

- Appoint a majority of the members of each local board, to reflect the greater proportion of provincial public health funding and influence;
- Amend the *Health Protection and Promotion Act* to provide that where cabinet has not by Order in Council, the vacancy shall be filled by an appointment made directly by the Chief Medical Officer of Health;
- Amend the *Health Protection and Promotion Act* to require that those appointed to boards of health possess a demonstrated experience or interest in the goals of public health – to prevent the spread of disease and protect the health of the people of Ontario – and that they be broadly representative of the community to be served; and
- Consider an amendment to the *Health Protection and Promotion Act* to clarify the roles and priorities of health board members, the first priority being compliance with the *Health Protection and Promotion Act* and the mandatory public health standard.

20. The Ministry of Health and Long-term Care introduce a package of governance standards for local boards of health with reference to those sources referred to above, such as the Scott and Quigley governance framework.

**CHAPTER 3: HPPA Tuneup**

21. The four present categories of disease: infectious, communicable, reportable, and virulent, be simplified and reduced to two categories with clear boundaries and clear legal consequences.

22. The *Health Protection and Promotion Act* be amended to clarify whether the powers contained in the various parts of the Act apply outside of the Part of the Act in which the power is contained. For example, does s. 13 apply in the case of a communicable disease?

23. The Ministry of Health and Long-Term Care consider whether the definition of “health hazard” needs to be updated or expanded.

24. The Ministry of Health and Long-term Care review the numerous standards of intervention contained in the Act, examples of which are noted above, with a view to amending the Act to simplify and rationalize the apparently haphazard and overlapping standards for intervention, and to ensure that whether there is a hard trigger or a soft trigger, it should be rationally connected to the power being wielded.

25. Section 22 of the *Health Protection and Promotion Act* be amended to adjust the standard of intervention to provide that the medical officer of health can take necessary action without the criminal or quasi-criminal standard of objective proof on reasonable and probable grounds.
26. The Ministry of Health and Long-Term Care, in consultation with the public health community, examine the issue of any practical difficulties of administering s. 22, with a view to make it more effective for those who rely on its powers.

27. The *Health Protection and Promotion Act* be amended to provide that an order made under s. 22, in respect of a person infected with a communicable disease, is valid in any health unit in Ontario.

**CHAPTER 4: Stronger Health Protection Powers**

28. The role and authority of public health officials in relation to hospitals be clearly defined in the *Health Protection and Promotion Act* in accordance with the following principles:
   - The requirement that each public health unit have a presence in hospital infection control committees should be entrenched in the Act; and
   - The authority of the local medical officers of health and the Chief Medical Officer of Health in relation to institutional infectious disease surveillance and control should be enacted to include, without being limited to, the power to monitor, advise, investigate, require investigation by the hospital or an independent investigator, and intervene where necessary.

29. The Ministry of Health and Long-Term Care, in consultation with the provincial Infectious Diseases Advisory Committee, and the wider health care and public health communities, define a broad reporting trigger that would require reporting to public health where there is an infection control problem or an unexplained illness or cluster of illness.

30. Whether or not a workable trigger can be defined for compulsory reporting, a provision be added to the *Health Protection and Promotion Act*, to provide that a physician, infection control practitioner or hospital administrator may voluntarily report to public health officials the presence of any threat to the health of the population.

31. The *Health Protection and Promotion Act* be amended to include powers similar to those set out in Quebec’s Public Health Act, to allow for early intervention and investigation of situations, not limited to reportable or communicable diseases, that may pose a threat to the health of the public.

32. The *Health Protection and Promotion Act* be amended to clarify and regularize in a transparent system authorized by law, the respective roles of the Chief Medical Officer of Health and the medical officer of health, in deciding how a particular case should be classified.

33. The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health to issue directives to hospitals, medical clinics, long-term care facilities, and all other health care providers, private or public, in respect of precautions and procedures necessary to protect the public’s health. All directives should be issued under the signature of the Chief Medical Officer of Health alone.

34. The Ministry of Health and Long-Term Care appoint a working group of health care professionals from various institutions who are tasked, and paid, to translate the directives into a form that can be understood and applied by staff, without altering the content of the message. The Commission recommends further the development of an
educational programme to ensure that everyone affected by the directive knows how they work, what they mean and how they should be applied.

35. The Ministry of Health and Long-Term Care, in consultation with the affected health care communities, develop feedback machinery driven by health care workers in the field, to ensure the directives are clear and manageable from a practical point of view in the field.

36. The *Health Protection and Promotion Act* and the directives provide explicitly that they in no way diminish the procedures and precautions required by the circumstances that prevail in any particular institution, that they represent the floor, not the ceiling, of medical precaution, and do not relieve any institution of the obligation to take further precautions where medically indicated.

37. The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health or a medical officer of health to order temporarily detained for identification any person who refuses to provide their name, address and telephone contact information when required to do so for the purpose of identifying those who are leaving, or have been in a place of infection. The detained person unless immediately released, must be brought before a justice as soon as possible and in any event within 24 hours for a court hearing. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.

38. The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health or a medical officer of health to order the temporary detention of, for the purpose of a court hearing, any person suspected of having been exposed to a health hazard, and who refuses to consent to decontamination. The detained person must be bought before a justice as soon as possible and in any event within 24 hours. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.

39. The *Health Protection and Promotion Act* be amended to authorize the Chief Medical Officer of Health or a medical officer of health to order the temporary detention of anyone who there is reason to suspect is infected with an agent of a virulent disease, for the purposes of obtaining a judicial order authorizing the isolation, examination or treatment of the person, pursuant to s. 35 of the *Health Protection and Promotion Act*. The detained person must be brought before a justice as soon as possible and in any event within 24 hours. This power is to be backed up by the ultimate power of arrest with police assistance if necessary in the case of non-cooperation.

40. The *Health Protection and Promotion Act* be amended to provide for a court to authorize, by warrant, entry into a private dwelling, by a medical officer of health or specially designated public health official with police assistance for the purpose of enforcing an order under s. 35 of the Act.

41. The *Health Protection and Promotion Act* be amended to provide that a medical officer of health or specially designated public health official with police assistance may enter a dwelling-house for the purpose of apprehending a person where there are reasonable and probably grounds to believe that a basis for a s. 35 warrant exists and reasonable grounds to believe that the delay required to obtain such a warrant might endanger the public’s health. The detention
must be the subject to a court hearing as soon as possible and in any event within 24 hours.

CHAPTER 5: Reporting Infectious Disease

42. The Health Protection and Promotion Act be amended to repeal, in the duty of a physician to report to the medical officer of health, the distinction between hospital patients and non-hospital patients. This may be achieved by deleting from s. 25(1) the words “who is not a patient in or an out-patient of a hospital.”

43. The Ministry of Health and Long-Term Care require each hospital, long-term care facility, nursing home, home for the aged, community care access centre, private medical or health services clinic, and any health care institution, to establish an internal system to ensure compliance with the reporting obligation set out in the Health Protection and Promotion Act.

44. The definition of “practitioner” in the Health Protection and Promotion Act be amended to coincide with that set out in the Personal Health Information Protection Act.

45. The list of “institutions” as defined in s. 21(1) of the Health Protection and Promotion Act, be amended to coincide with that set out in the Personal Health Information Protection Act.

46. The Health Protection and Promotion Act be amended to ensure consistency between those who are defined as “health information custodians” under the Personal Health Information Protection Act and those who have reporting obligations under the Health Protection and Promotion Act.

47. The Health Protection and Promotion Act be amended to authorize the Minister of Health and Long-Term Care to amend the definition of “practitioner” or “institution” by regulation.

48. The Health Protection and Promotion Act be amended to include a provision similar to the provisions in Quebec’s Public Health Act, by which the Quebec public health director may order any person, any government department or any body to immediately communicate to the public health director or give the public health director immediate access to any document or any information in their possession, even if the information is personal information or the document or information is confidential.

49. The power should be broadly defined, to enable the Chief Medical Officer of Health to require any person, organization, institution, government department or other entity, to provide information, including personal health information, to the Chief Medical Officer of Health, for the purposes of investigating and preventing the spread of infectious disease.

50. The Health Protection and Promotion Act be amended to authorize the Chief Medical Officer of Health to order the 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 analysis from anyone, and to disclose the results of test analysis as the Chief Medical Officer of Health considers appropriate for the purpose of investigating and preventing the
spread of infectious disease. This power, however, should be subject to the following restrictions

- It should not include the power to take a bodily sample or specimen directly from a person without their consent or, absent consent, without court order. The power would only apply to specimens already taken;
- The collection should be limited to the purpose of investigating and preventing the spread of infectious disease. The specimen should be used only for this express purpose; and
- The power should not override any other provisions of the Act, which set out a specific process for the obtaining of samples.

51. The *Health Protection and Promotion Act* be amended to require that in the case of specific diseases, designated by regulation, information be reported “immediately” by telephone to the local medical officer of health, and that such report be followed up in writing within 24 hours;

52. The *Health Protection and Promotion Act* be amended to require that as in the case of those diseases not designated for immediate reporting, a written report must be provided to the local medical officer of health within 24 hours.

53. Subsection 1(2) of Regulation 569 be expanded to apply to any person who makes a report under the *Health Protection and Promotion Act*. Thus any person who gives information in accordance with a duty under the *Health Protection and Promotion Act*, shall, upon the request of the medical officer of health, give to the medical officer of health such additional information respecting the reportable disease or communicable disease, as the medical officer of health considers necessary.

54. The portion of regulation 569 (s. 1(2), additional information) be moved to the Act itself, to form an integral part of the reporting obligations set out in the Act and to ensure that the power is protected, absent legislative debate, from subsequent amendment.

55. Amendments to the *Health Protection and Promotion Act* and Regulations be preceded by consultation with the public health community who have to apply them in the field.

56. Local public health officials and the Public Health Division, in collaboration and consultation with hospitals, other health care institutions and professional organizations, develop a standardized form and means for reporting under the *Health Protection and Promotion Act*.

57. The standardized reporting include clarity around to whom the report must be made, and to clearly confirm that the changing of transmission goes from the hospital and health care facilities, to the local health units, to the province, so as to avoid multiple requests for information.

58. The Ministry of Health and Long-term Care, Public Health Division, in collaboration with local medical officers of health, health care facilities and professional organization, engage in broad-based education of reporting requirements under the *Health Protection and Promotion Act* and that such education be maintained on a regular basis.

59. The *Health Protection and Promotion Act* be amended to require public health authorities to report to a hospital or any other health care facility, including family
medical clinics, any information in the hands of public health that suggests a reportable disease may have been acquired through exposure at that site.

60. Section 39 (2) of the *Health Protection and Promotion Act* be amended to include an exception permitting public health officials to provide hospitals and other health care facilities, with the personal health information of persons about whom a report is made, where they are of the opinion that the information may reduce the risk of exposure or transmission to staff, patients or visitors.

**CHAPTER 6: Privacy and Disclosure**

61. Section 39 of the *Personal Health Information Protection Act* be amended to include:
- A health information custodian shall disclose personal health information about an individual, to the Chief Medical Officer of Health or a medical officer of health if the disclosure is required under the *Health Protection and Promotion Act*.

62. Subsection 39(2) of the *Health Protection and Promotion Act* be amended to allow an exception to s. 39(1) to permit the disclosure of the name of or any information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, by the Chief Medical Officer of Health or a medical officer of health to any person where it is necessary to investigate or prevent the spread of a communicable disease.

63. Subsection 39(2) of the *Health Protection and Promotion Act* be amended to allow an exception to s. 39(1) to permit the disclosure of the name of or any information that will or is likely to identify a person in respect of whom an application, order, certificate or report is made in respect of a communicable disease, by the Chief Medical Officer of Health or a medical officer of health to a public health authority as described in s 39(2)(b) of the *Personal Health Information Protection Act*.

64. The *Personal Health Information Protection Act* be amended to provide that nothing in the Act prevents a health information custodian from providing personal health information to the Chief Medical Officer of Health or a medical officer of health, pursuant to the *Personal Health Information Protection Act*.

65. The *Health Protection and Promotion Act* and the *Personal Health Information Protection Act* be amended to state that in the event of any conflict between the two statutes, the duties in the *Health Protection and Promotion Act* prevail.

66. The *Personal Health Information Protection Act* be amended to provide that where a good faith disclosure is made to the Chief Medical Officer of Health or a medical officer of health, in reliance on the *Health Protection and Promotion Act*, the health information custodian will be exempt from liability.

67. The Ministry of Health and Long-Term Care, in consultation with the appropriate community, establish procedures for the fast-tracking of approval of access to personal health information for the purposes of urgently required research, to enable health care custodians to provide access to data in a timely manner, without fear of violation privacy legislation.

68. The Chief Medical Officer of Health review, and if necessary strengthen, the internal protocols and procedures now in place to ensure effective privacy safeguards for personal health information received by public health authority.
CHAPTER 7: Whistleblower Protection

69. The *Health Protection and Promotion Act* be amended to provide health care workers whistleblower protection in accordance with the following principles:
   - It applies to every health care worker in Ontario and to everyone in Ontario who employs or engages the services of a health care worker;
   - It enables disclosure to a medical officer of health (including the Chief Medical Officer of Health);
   - It includes disclosure to the medical officer of health (including the Chief Medical Officer of Health) of confidential personal health information;
   - It applies to the risk of spread of an infectious disease and to failures to conform to the *Health Protection and Promotion Act*;
   - It prohibits any form of reprisal, retaliation or adverse employment consequences direct or indirect;
   - It requires only good faith on the part of the employee; and
   - It not only punishes the violating employer but also provides a remedy for the employee

CHAPTER 8: Quarantine

70. 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.

71. The *Health Protection and Promotion Act* be amended to provide that it is a mandatory public health standard for each local medical officer of health to develop under the guidance of the Chief Medical Officer of Health a local plan in consultation with employers, educators, community groups, businesses, emergency responders, and health care facilities to ensure that plans are in place to ensure that those quarantined in the future have timely and adequate information, and the support necessary to encourage and enable them to comply with quarantine.

72. The *Health Protection and Promotion Act* be amended to add a provision similar to s. 6(1) of the *SARS Assistance and Recovery Strategy Act*, to apply to infectious diseases as identified by the Chief Medical Officer of Health. The amendment should provide, in respect of such a disease, that a person is entitled to a leave of absence without pay where he or she is unable to work as a result of investigation or treatment related to the disease, or because he or she is subject to quarantine or isolation. The amendment should also protect those who are unable to work because they are needed to provide care or assistance to a spouse, child, grandparent, sibling or relative who is dependent on the employee for care and assistance.

73. Section 22(5.0.1) be amended to provide that the power to order and enforce the isolation of a group must, wherever practicable, be preceded by such degree of consultation with the group as is feasible in the circumstances.

74. Section 106 of the *Health Protection and Promotion Act* be amended to provide that in the case of a class order made under s. 5.0.2, service is effective when notice of the
class order is posted and the order may be enforced as soon as it is brought to the actual attention of the person affected.

75. The word “quarantine” be introduced into the Health Protection and Promotion Act as a defined legal term to correspond to the universal popular understanding of that word as used during SARS.

CHAPTER 9: Legal Access and Preparedness

76. The Health Protection and Promotion Act be amended to eliminate the complex appeal process, rife with delay, in respect of an appeal by the subject of an order from a decision of the Health Services Appeal and Review Board, and provide an appeal as of right directly to the Court of Appeal with no prior requirement to secure leave to appeal.

77. The Ministry of Health and Long-Term Care consider whether the Health Services Appeal and Review Board is a necessary step in the complex hearing and review process in the Health Protection and Promotion Act or whether some other system should be enacted.

78. The Health Protection and Promotion Act be amended to simplify the complex and restrictive appeal process in respect of appeals from provincial court to the Superior Court and then to the Court of Appeal but only if a judge of the Court of Appeal grants leave to appeal on special grounds on a question of law alone. This process could be simplified by eliminating the intermediate appeal to the Superior Court and the restricted leave to appeal to the Court of Appeal or both.

79. The multiplicity of procedures in respect of the enforcement of Orders made under Part IV (communicable diseases) and Part VII (administration) of the Health Protection and Promotion Act, be replaced by a single, simple, codified procedure in the Superior Court.

80. The Health Protection and Promotion Act be amended to provide the Superior Court, when ordering compliance with a public health obligation, with a full range of remedial power, including the power to make mandatory orders.

81. The Health Protection and Promotion Act be amended to consolidate and codify all provisions in respect of court enforcement and access to judicial remedies in respect of communicable disease into one seamless system or powers and procedures.

82. The Health Protection and Promotion Act be amended to include special procedures such as ex parte procedures for interim and temporary orders, video and audio hearings, and other measures to prevent the court process from becoming a vector of infection.

83. The Rules of Civil Procedure be amended to include a clear, self-contained and complete code of procedure for public health enforcement and remedies in respect of communicable diseases.

84. A consequential amendment to the Courts of Justice Act provide that proceedings in respect of the Health Protection and Promotion Act enforcement and remedies in respect of communicable diseases shall be heard at the earliest opportunity.

85. The Health Protection and Promotion Act be amended to provide that an order under s. 35 may be directed to any police service in Ontario where the person may be found,
and the police service shall do all things reasonably able to be done to locate, apprehend, and deliver the person in accordance with the order.

86. The judiciary be asked to establish court access protocols in consultation with the public health legal community.

87. The *Health Protection and Promotion Act* be amended to provide that an order under s. 35 may be directed to any police service in Ontario where the person may be found, and the police service shall do all things reasonably able to be done to locate, apprehend, and deliver the person in accordance with the order.

88. The Ministry of Community Safety and Correctional Services and the Ministry of the Attorney General, together with public health officials, establish protocols and plans for the enforcement of orders under the *Health Protection and Promotion Act* and the involvement of police officers in that process.

89. Legal preparedness be an integral component of all public health emergency plans.

**CHAPTER 10: Public Health Resources**

No specific recommendations are made in this chapter. It refers to other reports (e.g. Walker, Naylor and the First Interim Report of the SARS Commission), and makes broad statements about resource requirements to ensure that the recommendations made in the preceding 9 chapters are meaningful.

**CHAPTER 11: Emergency Legislation**

90. 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.

91. 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.

92. 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.

93. 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.

94. 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.
95. 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 an emergency.

96. 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.

97. 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.

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

99. 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.

100. 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.

101. 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.

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

103. 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, the Legislative Assembly Act, the Human Rights Code, the Elections Act, and the Courts of Justice Act against emergency override.
104. 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.

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

106. 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.

107. The structure and content of the limitations 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.

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

109. 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 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.

110. 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.

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

112. 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.

113. 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 that 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.