A REVIEW OF BOARD OF HEALTH LIABILITY

For:

The Association of Local Public Health Agencies

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Introduction

Public health is paradoxical. Public health attracts little attention when the system is functioning well. It is only in situations where the public's health is compromised that society turns its attention to the role of the public health system and the actions of public health providers. Sensational public health events such as the Walkerton Water Tragedy in May 2000, the SARS outbreak in 2003, West Nile virus, Ebola virus and flu pandemic planning have prompted national and international attention to the role of public health and the actions of the public health providers.

In the course of the Walkerton Water Inquiry, other parties alleged fault on the part of the public health providers for decisions and actions taken in responding to the water crisis. Ultimately, the actions of the Bruce-Grey-Owen Sound Health Unit were exonerated and the steps taken by the Health Unit were in fact praised by Commissioner Dennis O'Connor in Part 1 of his Report of the Walkerton Inquiry. With respect to individual health concerns, in 2006, the City of Toronto faced legal action arising from allegedly negligent administration of hepatitis B vaccine to a social worker with the Parkdale Community Health Centre who received 2 inoculations from "The Works", a Toronto outreach program."[1] This claim was dismissed by the Ontario Superior Court in reasons released on November 27, 2006[2] and later upheld on appeal. In a 2010 decision, Canada, Ontario and the City of Toronto faced a lawsuit by a citizen who had contracted HIV from his spouse who was an immigrant to Canada[3]. The action alleged that the three levels of government (including the City by means of its "Public Health Department") had failed to protect him from this consequence but the claim was struck out as against the Province and the City[4].

Further, an action against the Province of Ontario with respect to West Nile Virus (representative of approximately 40 actions against the Government of Ontario in this regard) was also struck out by the Ontario Court of Appeal in November 2006. Actions against the Province in connection with the SARS crisis resulted in similar holdings by the Courts[5].

Nonetheless, Walkerton, the SARS crisis and ongoing matters of public health (such as flu pandemic planning) have raised questions regarding the liability of boards of health and individuals for actions taken in the course of carrying out their duties on behalf of the public health system.

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[1] See *Morgan v. Toronto* (2006), (Unreported: November 27, 2006) (Ont. S.C.J.) at para. 2; affirmed 2008 ONCA 603 (CanLII).
[2] *Ibid*.
[3] *Whiteman v. Iamkhong* 2010 ONSC 1456 (CanLII)
[4] *Ibid.*
[5] See for example *Abarquez v. Ontario* 2009 ONCA 374 (CanLII); *Laroza Estate v. Ontario*, 2009 ONCA 373; *Williams v. Ontario* 2009 ONCA 378 (CanLII), leave to appeal to the Supreme Court of Canada dismissed 2009 CanLII 71462 (S.C.C); *Jamal v. Scarborough General Hospital* 2009 ONCA 376 (CanLII); *Henry Estate v. Scarborough General Hospital* 2009 ONCA 375 (ONCA).

This paper addresses the topic of Board of Health liability in two main sections, each containing a number of interrelated topics:

I. GENERAL LIABILITIES OF DIRECTORS

1. **Prior to Accepting a Directorship**
2. **Statutory Liability**
3. **Determining Liability**
4. **Due Diligence**

II. SPECIFIC PUBLIC HEALTH LIABILITIES

1. **The Statutory Liability Exemption**
2. **Board Duties and Responsibilities**
3. **Board Governance**
4. **No Exemptions**
5. **Insurance**

Following the review of these main areas, I will conclude by providing a brief review of the case law noted above and outline the significance of these decisions in the context of public health liability.

I. GENERAL LIABILITIES OF DIRECTORS

1. Prior to Accepting a Directorship

It is virtually impossible to be aware of every obligation and liability imposed upon a director. However, a board member can limit his or her own potential individual liability as a director by conducting his or her own process of "due diligence" prior to accepting and undertaking the obligations of being a director.

At a minimum, due diligence should involve:

- Requesting and receiving a written job description detailing the specific responsibilities expected of a director and what committees you may be expected to sit on;

- Request and take the opportunity to review board and committee minutes of the past 2 or 3 years to give you an understanding of the issues with which the board has been dealing;

- Attend the orientation program for new board members. If one does not exist, request an orientation;

- Request and receive a report on the current areas of concern and focus for the board of directors;

- Inquire whether the board has formal policies for compliance with its regulatory requirements, including the ones reviewed above; and

- Request and receive confirmation that the board has indemnification by-laws and insurance for its directors.

2. Statutory Liability

Corporations in Ontario and their directors are subject to statutory obligations and requirements under the *Ontario Corporations Act* and related statutes.

Section 52 of the *Health Protection and Promotion Act* ("*HPPA*") sets out that "…every Board of Health is a corporation without share capital". Because of their legislated status as corporations, Boards of Health ordinarily would be subject to the *Corporations Act*. However, section 52 of the *HPPA* specifically exempts Boards of Health from the provisions of these statutes applicable to ordinary non-share capital corporate legislation. This section provides that "the *Corporations Act* and *Corporation Information Act* **do not** apply to a Board of Health" [**emphasis added**]. It is noted that in December, 2018, proposed amendments to the HPPA state that "on a date to be named subsection (2) is to be repealed and the following substituted:

> Non-application
> (2) The *Corporations Information Act* and the *Not-for-Profit Corporations Act, 2010* do not apply to a board of health except, in the case of the *Not-for-Profit Corporations Act, 2010*, as prescribed by regulation.

As this amendment has not been proclaimed as of December 2018, board members of a Board of Health remain being not subject to directors' liabilities arising under the *Corporations Act*, including the personal liability to pay wages.

This does not end the matter. There are a number of other statutes (both federal and provincial) that hold directors personally liable for the failure of a corporation to comply with its obligations under the particular statute.

Income Tax, Employment Insurance, Workplace Safety

Directors can be found personally liable for failure of the Board of Health to deduct and remit amounts required under the:

- the *Income Tax Act;*
- the *Canada Pension Plan;*
- *Employment Insurance Act* (employment insurance premiums); *and*
- *Workplace Safety and Insurance Act, 1997* (Workplace Safety and Insurance Board premiums).

For your protection, you must ensure that these remittances are submitted in accordance with the requirements of the particular statute. In addition to liability for the outstanding remittances, directors may also be subject to additional penalties designated in the particular statute.

Employment Standards Act

The *Employment Standards Act*, 2000 ("*ESA"*) creates a director's personal liability for the payment of up to six months of employees' unpaid wages and vacation pay[6]. However, this provision does not apply to members of a Board of Health -as section 80 of the *ESA* sets out that the liability of directors under the *ESA* does not apply to directors of corporations "*…that are carried on* ***without*** *the purpose of gain*" [**emphasis added**]. Therefore, board members of a Board of Health are not liable under the *ESA* for employee unpaid wages and vacation pay.

[6] See *ESA*, s.81.

Occupational Health and Safety

The Ontario *Occupational Health and Safety Act* ("*OHSA"*) establishes a comprehensive code of internal responsibility for health and safety within a workplace. This means that in addition to the employer as an entity, all individuals (from employees to directors) are responsible and liable for ensuring the health and safety of workers within a workplace, including a Public Health Unit.

Section 32 of the *OHSA* establishes the duties of directors and officers of a corporation. The section states that:

> Every director and every officer of a corporation shall take all reasonable care to ensure that the corporation complies with, (a) this Act and the Regulations; (b) orders and requirements of inspectors and directors; and (c) orders of the Minister.

In relevant circumstances, the Ministry of Labour pursues charges and prosecutes individuals connected with workplace accidents. The penalties for an individual (including a Director) who is convicted of an offence under the *OHSA* are:

- a fine of not more than $25,000: or
- imprisonment for a term of not more than 12 months; or
- both a fine and imprisonment[7].

Under the *Criminal Code of Canada* corporations and individuals can be charged with criminal negligence arising from a workplace accident. Such criminal charges would be in addition to a prosecution under the *OHSA*[8].

To comply with the duty to take reasonable care, directors must be found to have been involved with and to be overseeing the health and safety program in the Public Health Unit. At a minimum, this requires the Board of a Health Unit:

- to approve a health and safety policy;
- to ensure compliance with health and safety programs and training; and

[7] OHSA, s.66

[8] The first prosecution under the *Criminal Code* was initiated after a workplace fatality in April 2004 and resolved by way of a guilty plea to OHSA offences (with a withdrawal of the criminal charges) in March 2005. In 2010 individuals were charged in connection the death of four window washers on Christmas Eve 2009. A history of the prosecutions under the Bill C-45 amendments may be found at http://www.ccohs.ca/oshanswers/legisl/billc45.html

- to receive information on a regular basis regarding the health and safety activities of the Health Unit.

Human Rights Code

Section 5 of the *Ontario Human Rights Code* (*"HRC")* states:

> Every person has a right to equal treatment with respect to employment without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, record of offences, marital status, same sex partnership status, family status or disability.

The *HRC* contains a specific provision that a person who is an employee has a right to freedom from harassment in the workplace by the employer or agent of the employer or by another employee.

Individuals (including directors of an employer) can be named as a Respondent to a complaint of discrimination or harassment in employment. To avoid being named as a Respondent to such a complaint, board members must ensure that their Health Unit:

- has a policy stating that the employer upholds the principles of the *HRC*;
- has established a process for dealing with human rights complaints; and
- complies with the established complaint process.

3. Determining Liability

At law, a director may be found individually liable when that person's conduct falls short of the established standard of care. In many situations the standard is that of, "…*a reasonably prudent person*". However, for some persons the standard of care can be higher than that of the "*reasonably prudent person*". For those directors with expertise, the standard of care can be that "…*which may reasonably expected from a person of such knowledge and experience*", as the identified director. For example, a health care professional, accountant or lawyer is considered to have expertise. Under this higher standard, it is important that a director exercise due diligence

in accordance with his or her expertise to ensure that the Board and the organization is complying with its obligations.

4. Due Diligence

Most regulatory liability provisions allow a defence of "due diligence" for the corporation and for directors if potential liability extends to them. What constitutes "due diligence" depends on the regulatory statute, the corporation and the situation. However, some generalizations can be made. As a very general matter, "due diligence" involves:

- Putting in place a system for preventing non-compliance;
- Training employees in applying the system;
- Documentation;
- Monitoring and adjusting the system;
- Ensuring that adequate authority is given to the appropriate employees; and
- Planning remedial action in case the system fails at any point.

There is an increasing emphasis on the responsibility of directors to implement systems that provide them with the information they need to know to make decisions. Directors must ask questions and learn about the affairs and status of the corporation. They must monitor the workings of the corporation and make the decisions necessary to ensure that the corporation and its employees comply with the law.

To assist you in being able to comply with the due diligence required of a Board, I have included as Appendix "A" to this paper a questionnaire entitled, "*Potential Questions for Board Self-Evaluation*" This questionnaire will assist you in determining whether your Board is complying with its duties and obligations.

II. SPECIFIC PUBLIC HEALTH LIABILITIES

1. The Statutory Liability Exemption

The governmental responsibility for Public Health falls under the Ministry of Health and Long term Care. The *HPPA* sets out the statutory regime for the provision of public health duties, services, administration, and enforcement for the citizens of Ontario. The *HPPA* is divided into ten parts:

1. Interpretation
2. Health Programs and Services
3. Community Health Protection
4. Communicable Diseases
5. Rights of Entry and Appeals from Orders
6. Health Units and Boards of Health
7. Administration
8. Regulations
9. Enforcement

Section 95 of the *HPPA* deals with the issue of liability. The section provides for an exemption in regard to personal liability with respect to the carrying out of responsibilities under the *HPPA*. The section states:

> Protection from Personal Liability
>
> 95(1) No action or other proceeding for damages or otherwise shall be instituted against the Chief Medical Officer of Health or an Associate Chief Medical Officer of Health, 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 or an employee of a board of health who is working under the direction of a medical officer of health 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. **[emphasis added]**

This section provides a broad exemption/protection to individual members of a Board of Health and the specified other individuals with respect to carrying out their responsibilities, **where their actions are done in good faith.**

It is noted that subsection 95(2) of the *HPPA* does state that the above-noted protection from personal liability does not apply to:

- prevent an application for judicial review of an action or an order;
- prevent a proceeding that is specifically provided for in the HPPA.

Subsection 95(4) provides for protection from liability for reports. It states:

> 95(4) No action or other proceeding shall be instituted against a person for making a report in good faith in respect of a communicable disease or a "disease of public health significance" [9](formerly "reportable disease") in accordance with Part IV (Communicable Diseases). (quotations and explanation added)

However, these broad protections against individual liability under the *HPPA* do not end the matter. Subsection 95(3) reads:

> Board of Health not Relieved of Liability
>
> 95(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 **[emphasis added].**

"*Negligence*" may be defined as follows:

> …the failure to do something or to use such care as a reasonably prudent and careful person would use under similar circumstances, or alternatively, it is the doing of some act which a person of ordinary prudence would not have done under similar circumstances, or the failure to do what a person of ordinary prudence would have done under similar circumstances.

While subsection 95(1) provides protection to board members from personal liability in regard to alleged negligence or fault in the carrying out of any duty or power in good faith, subsection (3) makes the Board of Health corporately liable for damage caused by negligence, or action without authority, by one of the persons referred to in subsection (1). It is noted that subsection 95(1) is limited to the public health professionals that are named and does **not** include other public health professionals such as public health nurses.

[9] "disease of public health significance" was formerly referred to in the HPPA as a "reportable disease"

As well as the public health persons identified in section 95(1), other professionals of the Public Health Unit are protected by the 2-year time limitation for action stipulated in the *Limitations Act, 2002* ("*LA*"). Section 4 of the *LA* states:

> Unless this Act provides otherwise, a proceeding shall not be commenced in respect of a claim after the second anniversary of the day on which the claim was discovered.

While the statement of the 2-year limitation under section 4 of the *LA* seems relatively straightforward, the *LA* sets out fairly complicated rules for determining when a claim is "*discovered*" as a matter of practice (see section 5 thereof).

The proclamation of the *LA* repealed the existing protection given to health units as "public authorities" under the limitation stated in section 7 of the *Public Authorities Protection Act* ("*PAPA*").

2. Knowledge of Duties and Responsibilities

Given the limited protection from liability provided to members of a Board of Health under section 95, it is recommended that the first step to be taken to avoid claims of negligence and a finding of liability is that members of a Board of Health take the time to become familiar with their duties and responsibilities under the *HPPA*.

Part VI of the *HPPA* deals with the formation and functioning of health units and boards of health.

Sections 48 to 59 deal with the composition, administrative issues and functions of the board.

Sections 62 to 71 deal with the board's responsibilities with respect to the Medical Officer of Health and other staff hired by the local Public Health Unit.

Sections 72 to 77 deal with the issues of funding of the Board of Health by the municipality and the provincial Government. The legislation requires the Board of Health to submit written notice of the estimated expenses expected to be incurred in carrying out the functions and duties of the *HPPA* and any other Act. It is the duty of the Board of Health to set a budget that allows the

Board of Health to do what it is legally obligated to do. It is the obligation of the municipality to pay the expenses of the Board of Health.

Section 61 sets out the duty of a Board of Health in regard to the provision of public health services by the local Public Health Unit. This section states:

Duty of Board of Health

> 61. Every Board of Health **shall superintend and ensure the carrying out** of Parts II, III and IV and the Regulations relating to those parts in the health unit served by the Board of Health **[emphasis added]**.

Part II of the *HPPA* deals with Health Programs and Services.

The duties of the Board of Health with regards to health programs and services are set out in section 4. This section states:

> **Duty of Board of Health**
>
> 4. Every Board of Health:
>
> (a) shall superintend, provide or ensure the provision of the health programs and services required by this Act and the regulations to the persons who reside in the health unit served by the board; and
>
> (b) shall perform such other functions as are required by or under this **or any other act** [**emphasis added**]

The use of the word "*shall*" in subsection 4(a) makes the duty of the Board of Health to provide programs and services mandatory. Subsection 4(b) extends the obligation to perform public health functions required under any other act. A general computer search found a reference to the words "*Board of Health*" in 66 provincial Acts or regulations.

Section 5 of the *HPPA* sets out that health programs and services must be provided in the areas of: (1) community sanitation; (2) control of infectious diseases; (3) health promotion and health protection; (4) family health; and (5) homecare services ensured under the *Health Insurance Act.*

Section 6 deals with providing public health services to school pupils.

Section 7 states that the Minister may publish public health standards for the provision of mandatory health programs and services and every Board of Health **shall comply** with the published standards.

Section 8 qualifies the obligation to provide programs and services in that it states that a Board of Health is not required to provide or ensure the provision of a mandatory health program or service set out in Part II **except to the extent** and under the conditions prescribed by the regulations and the standards.

Section 9 states that a Board of Health **may** provide any other health program or service in any area in the health units served by the Board of Health if, (a) the Board of Health is of the opinion that the health program or service is necessary or desirable, having regard to the needs of persons in the area; and (b) the councils of the municipalities in the area approve the provision of the health program or service.

Part III of the *HPPA* deals with Community Health Protection. Part III establishes duties for the Medical Officer of Health and the professional staff of the local Public Health Unit with respect to conducting inspections for the purpose of preventing, eliminating and decreasing the effects of health hazards in the health unit; and dealing with complaints regarding a health hazard relating to occupational or environmental health.

Section 12 requires every Medical Officer of Health to keep him or herself informed in respect of matters related to occupational and environmental health.

Specific obligations are created in section 12(2) where it states that the Ministry of the Environment, the Ministry of Health, the Ministry of Labour or a municipality shall provide to a

Medical Officer of Health such information in respect of any matter related to occupational or environmental health as is requested by the Medical Officer of Health, is in the possession of the Ministry or the municipality, and the Ministry or municipality is not prohibited by law from disclosing.

Part III also deals with the issuing of orders by the Medical Officer of Health or Public Health Inspector regarding a health hazard, specific obligations regarding food premises and food items, and the power of Medical Officer of Health or a Public Health Inspector when of the opinion upon reasonable and probable grounds that a health hazard exists to seize, examine, return and/or destroy a substance, thing, plant or animal.

Section 13 of the *HPPA* gives broad powers to a Medical Officer of Health or a Public Health Inspector in regard to issuing orders in respect of a health hazard. This section states:

> Order by MOH or Public Health Inspector re Health Hazard
>
> 13(1) A medical officer of health or a public health inspector, in the circumstances mentioned in subsection (2), by a written order may require a person to take or to refrain from taking any action that is specified in the order in respect of a health hazard.
>
> Condition Precedent to Order
>
> (2) A medical officer of health or a public health inspector may make an order under this section where he or she is of the opinion, upon reasonable and probable grounds,
>
> (a) that a health hazard exists in the health unit served by him or her; and
>
> (b) that the requirements specified in the order are necessary in order to decrease the effect of, or to eliminate the health hazard.

Given the broad powers that are designated under this section, it is recommended that members of a board of familiarize themselves with the entire section 13 of the *HPPA*.

As discussed above, under section 61, the Board of Health has the mandatory responsibility to superintend and ensure the carrying out of the obligations in Part III of the Act.

Part IV of the *HPPA* deals with communicable diseases. This part of the Act deals with the powers that are designated to the Medical Officer of Health and her or his staff in dealing with

communicable diseases, many of which are defined in the Act. Part IV deals with the designated powers to a Medical Officer of Health to issue and seek the enforcement of orders and directions to prevent, respond to and control communicable diseases.

The *HPPA* formerly provided for a Medical Officer of Health to order blood samples in certain defined situations. Effective August 10, 2007, Section 22.1 of the *HPPA* was repealed and replaced by the *Mandatory Blood Testing Act, 2006***.** The *Mandatory Blood Testing Act, 2006* made three significant changes from the procedure in place under section 22.1[10]. These are as follows:

- the period during which a voluntary sample from the person (from whom blood is sought) may be pursued was shortened to 5 days (from the former 7 day period)

- the application formerly made under s.22.1(2) of the *HPPA* will no longer be directed to the local Medical Officer of Health but instead will be directed to the Ontario Consent and Capacity Board[11];

- the right of both an applicant for such an order or the respondent "other person" to appeal any decision made under the section (as formerly provided in s.22.1 (9)) was removed by Bill 28.[12]

In essence, the *Mandatory Blood Testing Act, 2006* continues the involvement of the local Medical Officer of Health in the process of seeking voluntary provision of blood samples. However, in situations where a request for a voluntary sample is refused or ignored, under the *Mandatory Blood Testing Act, 2006,* a local Medical Officer of Health is not called upon to make an order for a blood sample: the Consent and Capacity Board (Ontario) is given jurisdiction over making such findings under the new regime[13].

[10] Thanks to Dr. Rita Shahin who provided input on this section.
[11] For information on the Consent and Capacity Board, see www.ccboard.on.ca
[12] *Ibid.*
[13] See s.4 of the *Mandatory Blood Testing Act*, S.O. 2006, c.26.

It is recommended that members of Board of Health familiarize themselves with *the Mandatory Blood Testing Act*.[14]

Part IV of the HPPA also provides for appeals to the Health Services Appeal and Review Board and for applications to the courts in respect to orders and directions issued by the Medical Officer of Health.

Again, under section 61, the members of the Board of Health are responsible for superintending the actions of the Medical Officer of Health and staff of the local Public Health Unit under Part IV.

Safe Drinking Water Act

The *Safe Drinking Water Act, 2002*[15] ("*SDWA*") was introduced by the Ontario Government in response to the recommendations from the Walkerton Inquiry[16]. The *SDWA* establishes systems and obligations for the operators of water systems in the Province. The *SDWA* imposes a duty on persons:

- to report adverse water test results to the Ministry of the Environment and to the Medical Officer of Health;
- to consult with the local Medical Officer of Health in certain designated situations.

The *SDWA* also provides for the Medical Officer of Health to receive copies of orders from the Ministry of the Environment in regard to the operation and maintenance of water systems. The recipient Health Unit is obligated to respond to the communications in accordance with its mandate under the *HPPA*.

Under the *SDWA,* the Public Health Unit has direct oversight of five categories of water systems.

[14] The statute may be found at http://www.e-laws.gov.on.ca/html/statutes/english/elaws_statutes_06m26_e.htm
[15] S.O. 2002, c.32 (as amended).
[16] For background on the SDWA, see http://www.ene.gov.on.ca/envision/water/sdwa/index.htm

Under Ontario Regulation 252/05[17] Public Health Units are responsible for ensuring facilities such as churches, community halls, bed and breakfasts and tourist outfitters have safe drinking water. These provisions regulate systems serving non-residential and seasonal residential uses. This includes a risk-based, site-specific approach for all drinking water systems serving non-residential and seasonal uses. Health Units are required to evaluate risks at individual systems and develop a system-specific water protection plan to ensure compliance with provincial drinking water quality standards.

The protection from liability under section 95 of the *HPPA* applies to the carrying out of duties under the *SDWA.* That is, liability only accrues in the event that the Health Unit or individuals are found to have been negligent in regard to the prescribed obligations. As set out in section 95, a Health Unit and the persons identified cannot be held liable if the duties were carried out in good faith.

Clean Water Act, 2006

The *Clean Water Act, 2006*[18] ("*CWA*") came into force on July 3, 2007.

As described by the Government of Ontario Backgrounder on the legislation[19], under the *CWA*:

> For the first time, communities will be required to create and carry out a plan to protect the sources of their municipal drinking water supplies. The Clean Water Act will:
>
> - Require local communities to look at the existing and potential threats to their water and set out and implement the actions necessary to reduce or eliminate significant threats.
> - Empower communities to take action to prevent threats from becoming significant.

[17] The rather unwieldy title of this Regulation is "Non-residential and non-municipal seasonal residential systems that do not serve designated facilities."

[18] In November 2018 the government tabled *Bill 66, Restoring Ontario's Competitiveness Act*. The amendments to the *Planning Act* have been interpreted as allowing municipalities to pass "open-for-business planning by-laws" that do not have to comply with certain legislative provisions, including Section 39 of the *Clean Water Act* that deals with the requirement for developing plans for protecting water sources.

[19] http://news.ontario.ca/ene/en/2010/06/backgrounder-strong-protection-for-ontarios-drinking-water.html

- Require public participation on every local source protection plan. This means everyone in the community gets a chance to contribute to the planning process.
- Require that all plans and actions are based on sound science.[20]

Local boards of health (as "local boards" as defined in the *Municipal Affairs Act*[21]) may be called upon under the *CWA* to "*comply with any obligation that is imposed on it*…" pursuant to certain protection policies developed under the statute (see section 38). Boards of health may also be required to provide documents which relate "…*to the quality or quantity of any water that is or may be used as a source of drinking water*" including:

> (a) any technical or scientific studies undertaken by or on behalf of the person or body; and
>
> (b) any document or other record relating to a drinking water threat;

upon the request of a municipality, a provincial ministry or water protection authorities or committees which are to be created/authorized under the statute.[22]

Section 98(1) (c) of the *CWA* contains a provision protecting against liability for local boards such as Boards of Health. It reads:

> No cause of action arises as a direct or indirect result of:
>
> (c) anything done or not done by…a local board in accordance with Parts I, II or III.

Subsections (2) and (3) go further and preclude any remedy to any claimant with respect to anything done under section 98(1). Subsection (3) clarifies that any such proceeding is barred.

While a Board of Health's obligations under section 87 of the *CWA* fall in Part V (rather than Parts I through III which are protected under s.98), the ordinary protections of s.95 of the *HPPA* would apply to any duty under section 87 of the *CWA*. Nonetheless, section 99 of the *CWA* provides similar protections to "*employees or agents*….of local boards". Section 99(2) states that:

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[20] See http://www.ene.gov.on.ca/envision/news/2006/101801mb.htm
[21] Section 2 of the *CWA* imports the definition of "local board" from the *Municipal Affairs Act* which definition includes a "board of health" in section 1.
[22] See section 87.

> No action or other proceeding shall be instituted against a person referred to in subsection (1) for any act done in good faith in the execution or intended execution of any power or duty to which this section applies or for any alleged neglect or default in the execution in good faith of that power or duty.

The omission of statutory protection to local boards (and their members) seems to be a significant oversight in the *CWA*, particularly given that presumably the local board would authorize the disclosure of any document under s.87 by an employee or agent, yet the shield from liability in the statute (as currently drafted) applies only to the actor and presumably not to the board which would authorize such steps.

3. Board Governance

Given the obligations and responsibilities of the Board of Health, it is clear that in order to carry out its responsibilities and to avoid liability, members of the Board of Health must take an active role in assuring themselves that the Medical Officer of Health and staff are carrying out their duties in compliance with the *HPPA* and its regulations. This may call for a review of a Board of Health's governance policies, procedures and practices.

The Board of Health must be assured that the Medical Officer of Health and staff are providing the health programs and services prescribed in Part II of the *HPPA*. In regard to Parts III and IV, the Board of Health must be satisfied that the duties under these parts are being carried out in compliance with the *HPPA* and its regulations. This means being satisfied that proper policies and procedures for carrying out the responsibilities under the *HPPA* and creating records have been put into place by the Medical Officer of Health and have been communicated to the staff. A protocol should be in place that establishes the expectation that the Medical Officer of Health will advise the Board of Health or the Chair of the Board of Health of crisis situations and of situations where there has not been compliance with the Act and regulations.

At the Walkerton Inquiry, one of the issues that arose was in regard to the Health Unit's receipt and follow-up with respect to communications with the Ministry of the Environment. The Board of Health must be assured that procedures are in place to ensure that its staff receives pertinent information from outside sources and that follow-up information is provided, or received in order to complete the communications loop.

Under section 67 of the HPPA, a Medical Officer of Health is responsible for the employees and reporting to the Board of Health in relation to the delivery of public health programs or services and issues relating to public health concerns programs and services.

It is recommended that if a Board of Health has not already done so, that a standing item on the board's agenda should be the receipt of a report from the Medical Officer of Health on the status of compliance with required obligations under the HPPA.

At Appendix "B" is a sample "*Board of Director Duty of Care Report*". The report provided is from alPHa's executive director to the alpha Board. The report states that the statutory obligations of the organization have been met.

In Boards of Health where public health and administration duties are under the direction of separate individuals, a report from both of these persons regarding compliance in their areas of responsibility would be in order.

4. No Exceptions

It is posited that persons serving in public health, whether as staff or as a board member, have one of the most important and challenging roles in our society. Anyone who is aware of the history of the Province of Ontario knows that it is the contribution of public health that is responsible for the quality of health and standard of living that the citizens in our province enjoy.

I suggest that it is a particularly challenging responsibility to be a member of a Board of Health for municipal politicians. This is because municipal politicians are faced with many competing demands.

The political challenges faced by a Board of Health were described in an article commenting on the Krever Inquiry into the Blood Tragedy. In a section on politics and public health funding, the author writes:

> The final report states that public health has been chronically under funded, which contributed to the blood tragedy. I believe that public health has two characteristics that make its funding problematic.
>
> First, public health is least visible when it is working best. In the competition for public dollars and political priority, what is not visible may receive little attention. Preventative or protective functions are noticed most when they fail - as with Canada's blood supply.
>
> Public health is often in the position of justifying resource needs on the basis of problems successfully avoided, or of hypothetical future problems. Politicians rarely respond well to this kind of argument, particularly when faced with the public and professional pressure to put more money into the curative side of health. In many provinces, public health is less visible than ever as regionalization has pushed its operating side away from where major policy and resource decisions are made.
>
> Second, public health often has its highest political visibility when raising issues that politicians would just as soon avoid. Food and water safety, occupational and environmental health, alcohol and drugs, for example, provide many issues with significant political consequences that public health professionals champion. Often in the face of pressure from those with a vested interest in the status quo. Politicians rarely warm to those they believe are causing political problems, even when they are public health professionals simply doing their jobs.
>
> A concerted effort must be made to explain public health to the public, especially the preventative and protective functions that are seen only when they fail. At the same time, public health advocates must be careful not to generate a negative reaction in politicians and senior decision makers by how they approach their responsibilities. Politicians do listen to those with an understanding of the irresolvable dilemmas of modern politics, and to those who have a track record of not 'crying wolf', unless there really is one! [23]

These comments are also applicable to the Walkerton tragedy, SARS and to the challenges faced by Boards of Health in the last number of years, including planning for flu pandemics.

The author quoted above was writing about the political challenges for public health *vis-à-vis* politicians who are not members of a local Board of Health. I suggest that the political challenges relating to public health are heightened for councilors who are also members of the local Board of Health. The Walkerton tragedy in 2000 and the SARS epidemic in 2003 have served as stark reminders of the consequences if the public health system is weakened. These challenges are currently before members of Boards of Health in planning for a flu pandemic. Therefore, aside from the desire to avoid liability, the first duty of a member of a Board of Health is to ensure the integrity of the public health system. This is achieved by ensuring that

[23] Jan Skirrow: "Lessons from Krever - A Personal Perspective", Canadian HIV/AIDS Policy and Law Newsletter, Vol. 4, No. 2/3, Spring 1999.

the obligations under the *HPPA* are complied with, in order to protect the health of the citizens in the local health Unit.

Section 42 of the *HPPA* prohibits anyone from the obstruction of a public health professional from carrying out his or her duties. The section states:

> Obstruction
>
> 42.(1) No person shall hinder or obstruct an inspector appointed by the Minister, a Medical Officer of Health, a Public Health Inspector or a person acting under a direction of a Medical Officer of Health lawfully carrying out a power, duty or direction under this Act.

Notwithstanding the protection from liability under section 95 of the HPPA, an individual (including a board member) who is in violation of section 42 could be subject to being charged under the HPPA. While it is perhaps unlikely that a board member might face a charge under s.42 (as most, if not all, of a board member's actions in this regard would be official acts of the board itself as part of the directorship of the body corporate, i.e. supporting or opposing the board acting by way of motion or by-law), it is conceivable that an individual's actions in his or her personal capacity to hinder or obstruct the actions of the board or its employees might attract such a charge in appropriate circumstances.

Section 101(1) provides that every person who is guilty of an offence under this Act is liable on conviction to a fine of not more than $5,000 for every day or part of a day on which the offence occurs or continues.

A member of a Board of Health cannot let competing interests override the duty to protect the public's health.

5. Insurance

This paper has reviewed the responsibilities of a Board of Health and the ways in which a Board of Health can avoid being found liable for breaches of the duties and responsibilities under the HPPA. Nevertheless, despite this review, your Board of Health could still find itself one day subject to a claim for negligence.

As a final practical matter, your Board of Health should review its liability insurance coverage on a regular basis to ensure that its coverage is adequate.

CASELAW

In the 2006 decision in the case of *Morgan v. Toronto*[24] ("Morgan"), the defendant was the City of Toronto. The City faced a claim for damages from a social worker with Parkdale Community Health Centre ("Parkdale"), who received 2 inoculations in 1994 from "The Works", a social and medical assistance program operated by Toronto arising from allegedly negligent administrations of a hepatitis B vaccine. After she had started with Parkdale, the Plaintiff's supervisor suggested that because of her work with intravenous drug users, she should receive hepatitis B vaccinations. When Morgan objected to the $150 cost of the vaccinations, her supervisor arranged to have them administrated for free by "The Works". Morgan received 2 hepatitis B inoculations, which she claimed were done without her signing a consent form with respect to either administration. Morgan was later diagnosed with Chronic Fatigue Syndrome ("CFS") (which she attributed to the Hepatitis B vaccinations in view of her symptoms after both inoculations), which rendered her unable to work. She claimed damages against Toronto for, *inter alia*, loss of future earnings and loss of enjoyment of life arising from her CFS which she alleged were caused by these injections.

The Court dismissed the Plaintiff's claim. The Court was not unsympathetic to the Plaintiff's claim and essentially made a finding that the hepatitis B vaccinations she had received were the cause of her CFS[25]. However, the reasoning of the decision turned upon the Court's finding with

[24] *Supra*, note 4.
[25] *Ibid*. at para.392.

respect to the limited medical knowledge about the risks from the inoculations at the time the hepatitis B vaccinations were given in 1994. The Court found that given that in 1994, the administrations of the particular hepatitis B vaccine were presumed to be safe and were not suspected to be associated with long-term neurological damage, the City (through the Works) could not be found to have breached its standard of care to the Plaintiff in failing to warn her about possible serious side-effects in taking the vaccinations.[26] Given the increased medical knowledge concerning these inoculations in the years after 1994, the Court added:

> Given the developments since 1994…and the recurring expressions of concern in the medical literature, had [the Plaintiff's] inoculation taken place in 2006, and obviously dependent upon the specific evidence adduced, it might well be open to a Court to conclude [despite the lack of proof to scientific certainty] that inoculees should be advised of continuing expressions of concern in the medical literature about a possible link between the vaccine and serious sequelae, including serious neurological sequelae/CFS/demylination. It might be well open for a Court to find that these are known, "material" risks about which a reasonable patient would want to know before making a decision to undergo a vaccination….It might well be open for a Court to hold that failing to disclose that information would breach the requisite standard of care.[27]

In addition to the insight the decision provides with respect to how courts may handle allegations of negligence against public authorities (including Boards of Health), the *Morgan* decision is of interest to public health units because in the course of the trial, broader allegations were raised against, among others, public health authorities with respect to alleged suppression or concealment of hepatitis B vaccinations. The Court documented this at paragraph 4 of the decision as follows:

> "At trial, [the Plaintiff's] counsel alleged that the pharmaceutical companies, Health Canada, and other public health agencies have withheld and/or suppressed information concerning known dangers of the hepatitis B vaccine in order to promote widespread and therefore effective inoculation."[28]

[26] *Ibid* at para. 343.
[27] *Ibid*. at para. 353.
[28] *Ibid*., para. 4.

Despite these allegations, the Court confined its ruling to the issues between the parties, leaving these broader aspects largely unresolved, saying:

> While I agree that these broader issues are deserving of further consideration, and I have made some general observations at the end of these reasons, I have not made and would not make findings about the conduct of unrepresented persons. I have focused, as I must, on the issues between the parties.[29]

Toward the end of its reasons, the Court added comments which underscored the importance of public health activities (from a societal perspective) while acknowledging that the protection of the public from ongoing or emergent threats to public health often occurs in a context of scientific and factual uncertainty and debate, calling upon the Legislature to be proactive to create funds for compensation of those who may be injured in these circumstances.[30]

The *Morgan* decision demonstrates, in an individual context, the difficult challenge facing Boards of Health and officials: while allegations of negligence (and widespread attention) may follow compromises in public health (either on an individual or broader basis), public health endeavours to operate within the parameters of the specific medical and scientific context of its time and resources. This recognition by a court is somewhat comforting, but at the same time, highlights again the ongoing paradox of public health.

The difficult job faced by those who work in public health was also underscored by the Ontario Court of Appeal's decision in the case of *Eliopolous Estate v. Ontario (Ministry of Health and Long Term Care)*[31]. The matter involved a claim brought by the estate of a man who had been bitten by an infected mosquito and had contracted West Nile Virus ("WNV") in 2002[32]. He was treated in hospital and released. In 2003, however, he suffered a fall and died from the complications which ensued. His estate sued the Province of Ontario, claiming that it "*could have*" and "*should have*" prevented the outbreak of WNV.

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[29] *Ibid*. para. 10.
[30] *Ibid*. para. 417-446.
[31] *Supra*, note 3. While not specified to be a "class action" in the decision, the Court of Appeal mentions in paragraph 1 of its reasons that "*This action is one of approximately forty similar actions brought by Ontario residents who contracted WNV in 2002.*" An application for leave to appeal to the Supreme Court of Canada was filed by the plaintiff on December 29, 2006.

Faced with the claim, Ontario sought to strike the plaintiff's lawsuit on the grounds it disclosed no cause of action. Unsuccessful in both the motions Court and at the Ontario Divisional Court with this position, Ontario made a further appeal to the Ontario Court of Appeal. In the second paragraph of its decision in the case, the Court of Appeal summarized the central issue before it:

> The central issue is whether, on the facts that have been pleaded, Ontario owed [the plaintiff] a private law duty of care [so as to provide the plaintiff] with the necessary legal basis for a negligence action for damages. [33]

The plaintiff's contention was that Ontario owed a duty of care "*…to take reasonable steps to prevent the spread of WNV and that Ontario failed at the operational level to implement a plan it developed for the expected outbreak of WNV.*" Ontario countered by denying that it owed any private law duty of care to the plaintiff. However, it was the Province's secondary position on this appeal which had primary significance for Ontario boards of health:

> Ontario further submits that any liability for failure to implement measures to prevent WNV rests with local boards of health.

The Court of Appeal concluded (reciting the legal test used on a motion to strike a claim) that it was "*plain and obvious*" that the plaintiff's claim would not succeed. It allowed the appeal and struck the plaintiff's statement of claim. In so doing, however, it made somewhat startling and somewhat disconcerting statements concerning the responsibility of public boards of health for health crises such as WNV.

As noted above, the Court determined that the primary question before it was the proximity of the relationship between the plaintiff and defendant and whether under the circumstances, "*…it is just and fair having regard to that relationship to impose a duty of care on the defendant*."[34] In embarking upon its analysis of this question, the Court of Appeal held that this was a legal question which could be resolved, primarily by reference to the HPPA.[35] After reviewing the role of the Minister and Ministry of Health under the HPPA, the Court of Appeal found that the

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[32] As noted in the reasons, Mr. Eliopoulos was one of forty claimants re: WNV. All of the actions were at the same stage in litigation.
[33] *Supra*, para. 2.
[34] *Supra*, para. 11.
[35] Supra, para. 14-15.

Ministry/Minister of Health accrues "*discretionary powers*" under the HPPA which were insufficient to create a "*private duty*" of care to the plaintiff.[36]

Next, the Court of Appeal dealt with the plaintiff's argument that its issuance of "West Nile Virus: Surveillance and Prevention in Ontario 2001" ("the Plan") amounted to a policy decision "…*of the kind that would engage Ontario at the operational level*".[37] The Court rejected this argument for reasons including:

> …to the extent that the Plan amounted to a policy decision to act and created a duty of care, it is clear from the terms of the Plan itself and from the relevant legislation to which I will refer that any operational duties under the Plan resided with the local boards of health.[38]

On the issue of whether promulgation of the Plan by Ontario amounted to "*the adoption of a policy at the operational level*", the Court ruled that the Plan's impact was primarily informational and not practical, with the latter aspect falling to public health units:

> …the Plan represented an attempt by the Ministry to encourage and coordinate appropriate measures to reduce the risk of WNV by providing information to local authorities and the public. The Ministry undertook to do very little, if anything at all, beyond providing information and encouraging coordination. The implementation of specific measures was essentially left to the discretion of members of the public, local authorities and local boards of health.[39]

Finding that the operational aspects of the Plan (including the collection and reporting of dead birds; necessary liaison with hospitals and testing of mosquito pools) were "*left to local authorities*"[40], the Court of Appeal determined that the Plan fell "…*well short of the sort of policy decisions to do something about a particular risk that triggers a private law duty of care*."[41]

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[36] *Supra*, para. 17.
[37] *Supra*, para 21.
[38] *Supra*, para. 22
[39] *Supra*, para. 23
[40] *Supra*, para. 24
[41] *Supra*, para. 25.

The Court of Appeal returned to this aspect again, identifying that like the HPPA, the Plan outlines general duties of the Province, but by contrast delineates a specific, practical role for local health agencies:

> To the extent that the Plan may be read as identifying specific operations to be performed, those tasks are left to local health authorities and local boards of health. In this regard, the Plan mirrors the scheme of the HPPA, ss.4 and 5: responsibility for implementation of health policy, including superintending and carrying out health promotion, health protection, disease prevention, community health protection and control of infectious diseases and diseases of public health significance, rests with local boards of Health, not the Ministry.[42]

The Court did acknowledge however, that local boards could be directed by the Ministry:

> Local boards of health are subject to direction from the Minister (s.83 (1)), and in the event the local board of health fails to follow such direction, the Minister can act in its stead (s.84 (1)). However, this serves only to emphasize that under the HPPA, local boards of health, constituted as independent non-share capital corporations, bear primary operational responsibility for the implementation of health promotion and disease prevention policies.[43]

In concluding that it would "…*create an unreasonable and undesirable burden on Ontario that would interfere with sound decision-making in the realm of public health*" to impose a private law duty of care on Ontario with respect to the plaintiff, the Court of Appeal finished its reasons with some perhaps more comforting words for those working in the public health sector:

> "Public health priorities should be based upon the general public interest. Public health authorities should be left to decide where to focus their attention and resources without the fear or threat of lawsuits."[44]

The plaintiff's appeal to the Supreme Court of Canada was dismissed.

The thrust of the Court of Appeal's decision in *Eliopoulos* was that Ontario did not owe the plaintiff a duty of care with respect to WNV, the breach of which could give rise to an action for damages. The main rationale for this finding was that with respect to WNV specifically (and as a general matter under the HPPA), the Province has primarily an advisory rather than operational role with respect to matters of public health.

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[42] *Supra*, para. 27.
[43] *Supra*, para. 27.
[44] *Supra*, para. 33.

Unfortunately, the reasons of the Court of Appeal in *Eliopoulos*, in emphasizing the lack of proximity between Ontario and individual citizens with respect to operational matters of public health, perhaps overplays the legal responsibility of local public boards during any crisis in public health (such as WNV). It must be remembered that there is a difference between the existence of statutory duties to the public in this context and the breach of such duties: the case should not be misread as suggesting that losses attributable to crises in public health are necessarily recoverable from one or more local public boards of health (or their members). While certainly underplaying the importance of the Province's coordination of public health initiatives and operations in the face of public health crises, *Eliopoulos* does highlight that much of the hard work in responding to such health crises falls to the local units. It also acknowledges that under the structure of the HPPA, local units do have legal duties to citizens within their respective jurisdictions. At the same time, it must be remembered the fact that the Court of Appeal in *Eliopoulos* has identified that local units do have duties to members of the public with respect to public health crises (such as WNV) pursuant to the HPPA regime, it does not necessarily follow that any harm to a member of the public from such a crisis amounts to negligence on the part of a local public health unit (or any of its members) or to reasonably foreseeable damage.

In my view, the mere existence of duties of local health units to the citizens within their jurisdictions does not necessarily predicate that any loss from a public health crisis will give rise to a finding of liability against the health unit (or indeed any of its members). To show negligence, in addition to showing the existence of a duty, a plaintiff has to show:

- a breach of the duty of care by the defendant (i.e. less than the required standard of care);
- the breach of duty caused damages to the plaintiff which were reasonably foreseeable.

In these respects, individual members of local boards of health will still have the protection of s.95 of the HPPA for acts done in good faith in the "*execution or intended execution of any duty or power*" under the HPPA. Further, under the law of negligence, defendants are only responsible for reasonably foreseeable damages. The fact that loss occurs by virtue of a public health crisis does not mean that such damage was caused by a breach of duty by a local public

health authority or any of its members. In this context, it is submitted that the Court of Appeal's decision in *Eliopoulos* recognizes that, like so much in the public health realm, compromises of public health are reviewed retrospectively with the benefit of hindsight illuminating how the system could have worked better.

Courts considering the *Eliopoulos* decision have not seemed to focus on the responsibility of local public health agencies (or their members) in analyzing issues about duties to members of the public. The focus of the post- *Eliopoulos* decisions (particularly in respect to the SARS crisis) appear to have returned to a recognition of the inherent difficulty in making decisions in the context of emergencies –as the Court of Appeal stated, decisions about "*….where to focus their attention and resources*"[45] –and provide at least some deference to judgments made by local boards of health and their members in these trying contexts.

Decisions of Ontario courts subsequent to *Eliopoulos* (made in the context of the aftermath of the SARS crisis), appear to show a similar reluctance to impose a private law duty of care on health authorities as a result of a public health crisis. While there were many decisions arising out of the SARS crisis[46] (primarily seeking to strike out statements of claim at an early stage on the basis that they show no reasonable cause of action against public authorities), the Ontario Court of Appeal's decision in the case of *Williams v. Ontario*[47] ("Williams"), is perhaps the most expansive in its analysis of this issue.

Williams was heard along with 4 similar appeals which raised the issue of whether *"….Ontario can be held liable for damages by individuals who contracted SARS during the outbreak of that illness in 2003*."[48] In addressing a motion to strike by Ontario, the motions court had struck out portions of the claim, but not all of it, relying upon the Divisional Court's decision in *Eliopoulos* (which itself was later overruled by the Ontario Court of Appeal).

[45] *Supra*, note 44.
[46] *Supra*, note 9.
[47] *Ibid.*
[48] *Ibid*, para. 1.

Ontario appealed the decision with respect to the portions of the claim which survived the motion. In turn, the plaintiff appealed the motions court ruling in respect to those which had been struck out. The matter evolved into a proposed class action which came before the Ontario Court of Appeal. As in *Eliopoulos*, the Court of Appeal stated the issue in the matter plainly:

> The central issue on this appeal is whether, on the facts pleaded in the claim, it is arguable that Ontario owes a private law duty of care to the plaintiff sufficient to ground an action in negligence for damages.

The plaintiff tried to distinguish *Eliopoulos* on its facts, noting that the Directives issued by the Ontario Government during the SARS crisis created a relationship of proximity far closer than the situation than when the Province was facing the West Nile virus. In so arguing, the plaintiff was attempting to fit the facts before the Court within the test for the imposition of a legal duty of care.[49] In this analysis, the Court is first to look at whether the duty of care asserted by the plaintiff already exists in the law. If the facts do not fit within an existing situation where a duty of care has been recognized, the Court must do a two-step analysis involving two components:

- a consideration of whether the two parties are sufficiently proximate to justify the imposition of a duty of care; and
- whether there are residual policy considerations which militate against the imposition of a novel duty of care.

The plaintiff argued that the case fit squarely into an existing category: negligence causing physical harm to persons or property. The Court rejected this argument, focusing on the fact that the alleged negligence did not arise from creating the risk which caused the harm, but failing to adequately address it:

> …the proximity analysis cannot be short-circuited by focusing simply on the fact that the plaintiff has alleged that the defendant's negligence has resulted in physical harm to a plaintiff's person or property. This is especially so in cases where the defendant did not create the risk that actually caused the harm, and the alleged negligence consists of a failure to take adequate steps to prevent physical harm arising from the external or existing risk…

[49] *Anns v. Merton London Borough Council*, [1977] 2 All E.R. 492 as adopted by the Supreme Court of Canada in the case of n *Kamloops v. Nielsen*, 1984 CanLII 21 (S.C.C.), [1984] 2 S.C.R. 2, and *Cooper v. Hobart*, 2001 SCC 79 (CanLII), [2001] 3 S.C.R. 537

In moving to an analysis of the proximity between the plaintiff and Ontario, the Court looked at the statutory scheme under which SARS directives were made by Ontario's Chief Officer of Health ("COH"); the HPPA. In so doing, the Court summarized the finding in *Eliopoulos* that the powers given to the COH and MOH to take measures to protect the public in respect to outbreaks were to be exercised in the "*general public interest*" rather than being "…*aimed at or geared to the protection of the private interests of specific individuals*." In referencing *Eliopoulos*, the Court alluded to a similar finding by the Ontario Court of Appeal in the context of products liability, where individuals alleged negligence against the Federal Government in failing to test ban or recall certain breast implant products[50].

Despite the plaintiff's attempts to distinguish *Eliopoulos* by maintaining that the risk of exposure to SARS through a visit to a certain hospital was far more specific –and therefore proximate - than the risk of being bitten by a mosquito circulating among the public at large, the Court refused to distinguish the facts in *Eliopoulos* and declined to impose a duty of care on the Province to the plaintiff. In making this finding, the Court appeared to emphasize the highly "macro" nature of public health policy decision-making:

> When assessing how best to deal with the SARS outbreak, Ontario was required to address the interests of the public at large rather than focus on the particular interests of the plaintiff or other individuals in her situation. Decisions relating to the imposition, lifting or re-introduction of measures to combat SARS are clear examples of decisions that must be made on the basis of the general public interest rather than on the basis of the interests of a narrow class of individuals. Restrictions limiting access to hospitals or parts of hospitals may help combat the spread of disease, but such restrictions will also have an impact upon the interests of those who require access to the hospital for other heath care needs or those of relatives and friends. Similarly, a decision to lift restrictions may increase the risk of the disease spreading but may offer other advantages to the public at large including enhanced access to heath care facilities. The public officials charged with the responsibility for imposing and lifting such measures must weigh and balance the advantages and disadvantages and strive to act in a manner that best meets the overall interests of the public at large.

In its analysis of the second part of the test –whether there were any policy concerns which argued against the imposition of a duty of care on the Province to the Plaintiff re: SARS, the Court quoted *Eliopoulos* in saying that public health officials were called upon to "…*weigh and balance the many competing claims for the scarce resources available to promote and protect the health of its citizens.*" The Court agreed with its own earlier finding that to impose a duty on the Province to the Plaintiff re: SARS would impose "…*an unreasonable and undesirable burden on Ontario that would interfere with sound decision-making in the realm of public health*." In conclusion, the Court in *Williams* noted that the plaintiff was not without defendants to pursue: "*local health care facilities*" and "*health care professionals*" (without reference to local public health entities).

The *Williams* decision, while focusing on the duties of the Province, re: public health (and finding no liability against this level of health authority with respect to injuries suffered by citizens), essentially repeats the reasoning stated in *Eliopoulos* that there is both insufficient proximity and policy considerations which militate against imposing a private law duty of care on provincial health authorities for injuries suffered by citizens through outbreaks.

Apart from the many actions dealing with issues of liability in respect to the SARS outbreak, as noted above, a 2010 decision specifically addresses the legal distinction between an incorporated municipality and a local board of health operating within such jurisdiction.

In the matter of *Whiteman v. Iamkhong*[51], the plaintiff had contracted HIV from his spouse, who had immigrated to Canada from Thailand while HIV positive. The plaintiff brought an action against his former spouse, Canada (alleging among other things, negligence arising from a medical examination when the spouse sought permanent resident status), Ontario and the City of Toronto via its "Public Health Department". The lawsuit alleged that his former spouse had failed to disclose her HIV positive status to him. Against the three levels of government, the plaintiff alleged they had failed in their duty to protect him.

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[50] *Drady v. Canada (Minister of Health)* 2008 ONCA 659 (CanLII) leave to appeal to Supreme Court of Canada refused [2008 S.C.C.A. 492)

In his claim, the plaintiff had pleaded that "Toronto Public Health" was "….*the municipal entity responsible for educating, monitoring and investigating residents with reportable diseases pursuant to the Health Protection and Promotion Act."* The government defendants brought a motion to strike the plaintiff's claim as disclosing no reasonable cause of action among other reasons. The Court struck out the claim against Ontario based upon the reasoning in *Eliopoulos.*

In considering the motion by the City of Toronto, the Court made clear that the municipality was not the appropriate defendant to the action. Rather, the Court pointed to the independent corporate entity of Toronto's board of health, established pursuant to the *City of Toronto Act, 1997.* The Court similarly struck out the claim against the City observing that the municipality was not "…*the local "board of health" which may be held liable in some individual cases and, finally, any broad systemic failures alleged against Toronto in the public health field are not a proper basis for private law duties*".

The decision in Whiteman simply highlights that at the local level, it is the Board of Health, rather than the municipality itself, which is the independent entity responsible for health promotion and protection. The fact that the Court opined that perhaps a Board of Health might be held liable in certain circumstances (as more extensively described above) does not appear to detract from the *Eliopoulos* principle which resisted the imposition of duties on public health entities to individuals in public health emergencies.

CONCLUSION

Although there is statutory protection from liability for individuals and the Board of Health when carrying out responsibilities under the Health Protection and Promotion Act in good faith, the Board of Health remains potentially liable for harm caused by the negligence of an individual. Members of a Board of Health in order to avoid liability must be aware of the duties and activities of the employees of the Local Public Health Unit and be satisfied that the activities of health unit employees are being carried out in accordance with statutory requirements and in a professionally recognized manner. Board of Health members cannot allow for any exemptions

[51] *Whiteman v. Iamkhong* 2010 ONSC 1456 (CanLii)

from their public health obligations. Sufficient liability insurance should be purchased to ensure adequate coverage in the event a lawsuit is brought against the Board of Health.

APPENDIX A[52]

Potential Questions for Board Self-Evaluation

1. Does the BOH oversee the development of the strategic plan

2. Is the BOH as a governing body achieving its strategic outcomes?

3. Does the BOH get enough information of the right kind, at the right time, from the right members of management, including financial management, procurement policies and practice, risk management and human resources issues?

4. Does the BOH have an effective orientation and training program, both for new directors and for current directors?

5. Does the BOH have effective committees, composed of an appropriate number of directors to deal with such matters as audit, governance, nominations, human resource, program and other matters?

6. Are the committee members and chairs rotated at appropriate intervals?

7. Are the BOH meetings conducted effectively, with appropriate frequency and according to well-thought-out agendas and circulated in advance?

8. Do BOH members receive the necessary briefing material for BOH meetings in sufficient time to prepare?

9. Are BOH meetings characterized by open communication and diligent questions on the points discussed in a collegial manner?

10. Are the BOH's actions motivated by the furtherance of the objectives of the BOH and the HPPA and its regulations?

11. Does the BOH communicate regularly with its stakeholders?

[52] For a helpful general overview of this topic, I recommend *Directors' Duties in Canada: Managing Risk, 6th Edition* (2016), Margot Priest and Hartley R. Nathan, Q.C. CCH Canada Limited. I wish to thank Hartley Nathan for permission to use material from this book and to include the list of "Potential Questions for Board Self Evaluation".

12. Does the BOH establish goals for management and review their effectiveness and performance on at least an annual basis?

13. Does the BOH establish guidelines for managers that clearly specify their authority?

14. Does the BOH micromanage operations or, at the other extreme, does it ignore them and let management handle everything with little BOH oversight?

15. Has the BOH reviewed legal exposures and assessed legal compliance processes and records?

16. Does the BOH receive regular reports on compliance with applicable legislation, including compliance with the Income Tax Act and the Employment Standards Act and environmental statutes?

17. Does the BOH have an effective audit and financial oversight process?

18. Does the BOH have effective standards and procedures to minimize and disclose potential conflicts of interest by members or officers?

APPENDIX "B"

alPHa Board of Director Duty of Care Report

The following actions are being completed on behalf of the Board of Directors of the Association of Local Public Health Agencies:

1. The payroll functions are being completed by the Haliburton, Kawartha, and Pine Ridge District Health Unit (HKPR). Included in this is the payment of Canada Pension Plan contributions, Employment Insurance contributions, Ontario Municipal Employees Retirement Plan contributions to the appropriate sources and timely remuneration of Association staff. The current contract with HKPR expires March 31, 2018.

2. The Non-Profit Information Return (R1044) is filed within six months of March 31, (year end) of each year. Activities such as trades or business are not completed ensuring the Association maintains its non-profit status. The Association is exempt from Income Tax.

3. The General Sales Tax (GST) is reconciled and filed every three months. The Association is Provincial Sales Tax (PST) exempt.

4. Adequate Board of Directors' Liability Insurance is being maintained through the timely payment of its premiums.

5. All staff are operating under the alPHa Personnel Policies at all times when performing work for the Association.

6. No other information material to the financial operation of the Association has been withheld.