

# CHAPTER ONE

## The Commission's Mandate and Hindsight

---

The Commission's mandate was to investigate how the SARS virus came to Ontario, how it spread and how it was addressed, but to do so without making any findings of fact with respect to civil or criminal responsibility of any person or organization. The relevant sections of the Commission's Terms of Reference state:

1. The subject matter of the investigation shall be:
  - (a) how the SARS virus was introduced here and what measures, if any, could have been taken at points of entry to prevent its introduction;
  - (b) how the SARS virus spread;
  - (c) the extent to which information related to SARS was communicated among health care workers and institutions involved in dealing with the disease;
  - (d) whether health care workers and patients in health care treatment facilities and long-term care facilities were adequately protected from exposure to SARS, having regard for the knowledge and information available at the time;
  - (e) the extent of efforts taken to isolate and contain the virus and whether they were satisfactory or whether they could have been improved;
  - (f) existing legislative and regulatory provisions related to or that have implications for the isolation and containment of infectious diseases, including the quarantine of suspected carriers;
  - (g) any suggested improvements to provincial legislation or regulations, and any submissions that the Province of Ontario should make

concerning desirable amendments to federal legislation or regulations;  
and,

(h) all other relevant matters that Mr. Justice Campbell considers necessary to ensure that the health of Ontarians is protected and promoted and that the risks posed by SARS and other communicable diseases are effectively managed in the future.

—

5. Mr. Justice Campbell shall conduct the investigation and make his report without expressing any conclusion or recommendation regarding the civil or criminal responsibility of any person or organization, without interfering in any ongoing criminal, civil or other legal proceedings, and without making any findings of fact with respect to civil or criminal responsibility of any person or organization.

To fully understand what went right and what went wrong during SARS, it was important that all the witnesses testify in a complete and forthright manner in a confidential setting without the fear that their words might be used in civil or criminal proceedings. Without this kind of frank, in-depth testimony, the Commission's ability to fully consider all the issues and make appropriate findings and recommendations would have been seriously hampered. Other than the public hearings held in the fall of 2003, most proceedings of the Commission were conducted by way of confidential interviews.<sup>15</sup>

To effectively discharge its mandate, the Commission used the same fact-finding approach as accident safety investigations, accepting that full disclosure and prevention of future accidents required the trading of anonymity for candour. This was the approach of the Accident Investigation Board examining the *Columbia* space shuttle disaster of February 2003. It stated:

With a principal focus on identifying and correcting threats to safe operations, safety investigations place a premium on obtaining full and complete disclosure about every aspect of an accident, even if that information may prove damaging or embarrassing to particular individuals or

---

15. In most cases witnesses are quoted without personal attribution. In some cases witnesses agreed to be quoted by name.

organizations. However, individuals who have made mistakes, know of negligence by others, or suspect potential flaws in their organizations are often afraid of being fired or even prosecuted if they speak out. To allay these fears, which can prevent the emergence of information that could save lives in the future, many safety investigations, including those by NASA and by the Air Force and Navy Safety Centers, grant witnesses complete confidentiality, as do internal affairs investigations by agency Inspector Generals. This confidentiality, which courts recognize as “privileged communication,” allows witnesses to volunteer information that they would not otherwise provide and to speculate more openly about their organizations’ flaws than they would in a public forum.<sup>16</sup>

The Transportation Safety Board of Canada takes a similar approach:

The courts need accident investigations for both criminal and civil litigation purposes. In all of these, there is a necessary focus on who did something wrong. An agency like [the Transportation Safety Board of Canada] has no interest in determining blame or apportioning liability. We want to find out what happened, and why. The sole purpose of that information is so it can be used to reduce risk in the transportation system.

The probability of success is also enhanced by the independence of the safety investigator. The greater the separation from the regulators and from the courts, the greater the probability that those involved in accidents will speak freely and honestly to the investigators. The Canadian law includes protection against the release of witness statements, and it also contains restrictions against the use of the TSB-C’s information or conclusions in legal or disciplinary proceedings.<sup>17</sup>

Section 7 of the *Canadian Transportation Accident Investigation and Safety Board Act* states:

7. (1) The object of the Board is to advance transportation safety by
  - (a) conducting independent investigations, including, when necessary,

---

16. National Aeronautics and Space Administration, *Columbia Accident Investigation Board – Volume 1* (August 2003), pp. 232-233.

17. Transportation Safety Board of Canada, “The evolution of transportation safety investigation, a Canadian perspective,” [http://www.tsb.gc.ca/en/media/speeches/2000/billtucker\\_rome.asp](http://www.tsb.gc.ca/en/media/speeches/2000/billtucker_rome.asp).

public inquiries, into selected transportation occurrences in order to make findings as to their causes and contributing factors;

(b) identifying safety deficiencies as evidenced by transportation occurrences;

(c) making recommendations designed to eliminate or reduce any such safety deficiencies; and

(d) reporting publicly on its investigations and on the findings in relation thereto.

(2) In making its findings as to the causes and contributing factors of a transportation occurrence, it is not the function of the Board to assign fault or determine civil or criminal liability, but the Board shall not refrain from fully reporting on the causes and contributing factors merely because fault or liability might be inferred from the Board's findings.

(3) No finding of the Board shall be construed as assigning fault or determining civil or criminal liability.

(4) The findings of the Board are not binding on the parties to any legal, disciplinary or other proceedings.

Emphasizing fact-finding over assigning fault is also seen as playing an important role in promoting patient safety.

A study published in the *New England Journal of Medicine* stated:

In hospitals, staff members often fail to report incidents primarily because of time pressure, fear of punishment, and lack of perceived benefit. Among physicians, shame and fear of liability, loss of reputation, and peer disapproval are particularly strong disincentives. On the other hand, striking increases in internal reporting have been achieved recently in a few hospitals that implemented non-punitive and responsive reporting systems.<sup>18</sup>

---

18. Lucien J. Leape, "Reporting of adverse events," *New England Journal of Medicine*, 347, no. 20, (November 14, 2002): 1633.

A study in the *Canadian Medical Association Journal* states:

Health care organizations have historically focused on identifying and disciplining clinicians who were closest to incidents. However, experts suggest that the greatest gains in improving patient safety will come from modifying the work environment of health care professionals, creating better defenses for averting AEs [adverse events] and mitigating their effects.<sup>19</sup>

## The Use and Abuse of Hindsight

In discharging its mandate, the Commission has been keenly aware that it has reviewed the events with the benefit of hindsight. This is an ability that those who fought SARS did not have as they faced a new and unknown disease. Of course, it is easy with the benefit of what we now know to judge what happened during SARS. It is easy now to say which systems were inadequate and which decisions were mistaken. That is the great advantage of hindsight.

The Commission recognizes the skill and dedication of so many individuals who worked beyond the call of duty. Twenty-hour days were common. Health workers and volunteers worked tirelessly against a strange and deadly disease in an environment that changed from day to day. They did not have the luxury of hindsight to guide them. The Commission has approached the examination of the events connected with SARS with admiration and with a profound respect for those who gave above and beyond the call of duty to care for the ill and to fight against the spread of the disease. All Ontarians owe them a great debt of gratitude.

While it is not fair to use hindsight to judge behaviour, it can be helpful in the search for lessons to be learned. Hindsight can provide great assistance in determining what went wrong and what went right. It includes what has been learned post-SARS and it can point in a direction for avoiding the repetition of mistakes in the future.

It is essential in the investigation of a public emergency that the public interest be served by a full account of what occurred and a catalogue of the lessons to be learned. To do so thoroughly will, of necessity, require the application of hindsight. This is

---

19. Ross G. Baker et al. "The Canadian adverse events study: the incidence of adverse events among hospital patients in Canada," *Canadian Medical Association Journal* 170 (May 25, 2004): 1685.

unfair when speculation is entertained that someone “should have” or “might have” acted differently even though he or she did not have the knowledge that only became apparent after the event was over.

The Commission has sought to avoid the unfair use of hindsight in analyzing the events considered in this final report, and the reader is urged to do the same.