September 25, 2023

E. coli and the *Public Health Act* (Alberta)

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Legislation commented on: *Public Health Act*, RSA 2000, c P-37; *Communicable Diseases Regulation*, Alta Reg 238/1985; *Food Regulation*, Alta Reg 31/2006

The beleaguered public health system in Alberta is back in the spotlight with the devastating *E. coli* outbreak in Calgary. As of September 19, there were 38 lab-confirmed cases connected to the outbreak, 8 of whom were receiving care in hospital, along with 27 cases of secondary transmission. The outbreak is believed to be linked to daycares that use a central kitchen, although a precise food source has not yet been identified. The kitchen suspected to be the source of the *E. coli* outbreak has previous public health violations and there are calls for a public inquiry. The particular strain of *E. coli* involved in this outbreak secretes a toxin that can lead to serious organ damage. Nine children connected with this outbreak have been diagnosed with hemolytic uremic syndrome, which can lead to kidney failure.

As occurred in the early days of the COVID-19 pandemic, the public is not getting a proper description from government officials on the legislative framework governing the outbreak. At recent media scrums, the Premier, the Minister of Health, and the Chief Medical Officer of Health (CMOH) have made statements that suggest new regulations governing centralized food kitchens may be needed, and that the CMOH does not have the authority to permanently close a food establishment (see "Alberta premier orders review of shared kitchens in Calgary as hundreds of kids sick with E. coli"). In this short post, we argue that new regulations are not needed and that the real takeaways here are:

(1) the obsession of many governments today (including Alberta) with cutting 'red tape' (aka regulations) poses significant risk to the public because it is so-called 'red tape' that holds together effective compliance and enforcement in a regulatory regime; and

(2) calls for a public inquiry should remind us that the role, function, and powers of a CMOH, and the relationship of that office with the political executive, is in desperate need of a review by the Legislature.

The *Public Health Act*, RSA 2000, c P-37 provides medical officers of health, including the CMOH, with powers to investigate the outbreak of a 'communicable disease' and implement measures to control its spread and protect those who are not infected. *E. coli* is a 'communicable disease,' defined in section 1(f) as "an illness in humans that is caused by an organism or micro-organism or its toxic products and is transmitted directly or indirectly from an infected person or animal or the environment." *E. coli* is also a 'notifiable' communicable disease pursuant to

Schedule 1 of the *Communicable Diseases Regulation*, Alta Reg 238/1985 (included as a 'foodborne illness') enacted pursuant to the Act.

A suspected case of a notifiable communicable disease, such as *E. coli*, receives special attention in the legislation. Sections 20 and 22 of the Act place unique obligations on persons infected with a notifiable communicable disease to promptly seek medical attention, and others responsible for those persons (e.g. health professionals) to notify a medical officer of health. Section 8 of the *Communicable Diseases Regulation* requires a medical officer of health to investigate all occurrences of *E. coli* – as a notifiable disease – to establish the cause, the mode of transmission, and the probable source, and to identify others who may be at risk. In relation to daycares specifically, section 9 of this Regulation gives a medical officer of health the power to require the operator of a daycare to notify the parents or guardians of other children attending the facility that their children may have been exposed to the communicable disease. Indeed, the Regulation includes many specific references to the outbreak of disease in daycares. Finally, section 29(2) of the Act gives the CMOH (or a medical officer of health) the general power take whatever steps the medical officer of health considers necessary to: (a) suppress the disease in those who may already have been infected with it; (b) protect those who have not already been exposed to the disease; (c) break the chain of transmission and prevent spread of the disease; and (d) remove the source of infection.

The *Food Regulation*, Alta Reg 31/2006, also enacted under the Act, is also relevant here because the suspected source of this *E. coli* outbreak is a kitchen. This Regulation applies to a 'food establishment' (defined as a place that handles food), and it requires a commercial food establishment to hold a valid permit (at section 3). This is a classic 'command and control' regulatory structure very common in our legal system, whereby regulated entities must apply for and hold a permit to operate, and the permit requires that prescribed standards of conduct are met. The application process provides regulatory officials with an opportunity to assess the ability of the applicant to meet regulatory requirements (at section 4). The prescribed standards of conduct can be set out as terms and conditions in the permit itself (at section 9) or in the legislation (at Part 2).

The permit also makes a regulated entity subject to a monitoring and compliance program designed to ensure these standards are met. A monitoring and compliance program may be established in terms and conditions set out in the permit or it can be legislated. For example, section 59 of the Act provides a medical officer of health with the power to enter a premises for the purpose of investigating suspected non-compliance with the Act or regulations. In cases of non-compliance with prescribed standards, enforcement measures can be implemented to achieve compliance and impose penalties as a deterrence on future non-compliance. For example, sections 11 and 12 of the *Food Regulation* provide authority to suspend or cancel a food establishment permit where there is an unsanitary condition or a breach of permit conditions or the legislation generally. Section 62 of the Act provides a medical officer of health with the power to close a place (e.g. a food establishment) regulated under the legislation.

This brief overview of the legislative framework is offered here simply to demonstrate that there is legislation that establishes a regulatory system governing a centralized food kitchen that serves daycares, and that legislation does provide the CMOH with broad, extensive powers to address an

E. coli outbreak, including the closure of facilities. In other words, this is not a case of missing regulations, as the Premier has suggested. Rather, this is more likely to be an implementation problem – as has been observed by public health experts who say more rigorous inspections of these establishments are needed. Interestingly, at a press conference on September 15, the CMOH stated that "under the *Public Health Act*, AHS does not have the ability to permanently close a food handling facility unless critical violations continue to exist." Given that the legislation makes no such reference to "critical violations", public health officials may fail to appreciate the breadth of their own powers and the distinction between regulatory and implementation problems. In short, the tools are there, but they were mostly left in the toolbox or forgotten about entirely.

The more robust monitoring and compliance program advocated by public health experts depends on having a government that is not obsessed with cutting 'red tape' and also provides the regulatory system with adequate resources to function properly. Legislative changes aimed at cutting red tape have occurred in a variety of sectors under the UCP, including child care, raising concerns with quality, safety, and a lack of oversight. The UCP government is clearly moving in the wrong direction on regulatory oversight and compliance. Take, for example, the direction given to the Minister of Service Alberta and Red Tape Reduction in July 2023 (available here):

> Refocusing red tape reduction efforts to measure, benchmark and reduce wait times for permit approvals across all ministries. Report on the feasibility of adopting an "automatic yes" policy that would assume a permit is approved within a reasonable and specific amount of time after an application, unless the ministry in question delivers a written rationale on why it should be rejected. (Mandate Letter at 2)

Consider for a moment what an 'automatic yes' policy would mean for issuing permits to operate under the *Food Regulation*.

Concerns with the handling of the *E. coli* outbreak, including the kitchen's history of past violations, a lack of timely communication from government, and the failure to identify a food source have prompted calls for a public inquiry. Although such inquiries can play an important role in uncovering the root causes of issues and prompting policy changes, the frequency with which they are currently proposed is suggestive of deeper problems with transparency and accountability in our executive branch of government. Query whether the public would be demanding an inquiry into *E. coli* if they trusted that a truly independent CMOH could investigate this outbreak and make the necessary changes. Not a CMOH who is appointed by the Minister of Health (as is currently the case in section 13 of the Act) and whose office has been exposed as far too intermingled with the political executive (for some discussion on this see here and here).

Many experts have long advocated for this more independent role for public health officials. For example, Ontario's SARS Commission concluded that "[t]he most important thing in a public health emergency is public confidence that medical decisions are made by a trusted independent medical leader such as the Chief Medical Officer of Health free from any bureaucratic or political pressures" (at 13). Instead of heeding these recommendations, politicians have sowed the seeds of distrust in public health officials by publicly critiquing and dismissing them when it suited their political interests, and by usurping their legal authority to make public health decisions during COVID-19.

This post may be cited as: Shaun Fluker & Lorian Hardcastle, "*E. coli* and the *Public Health Act* (Alberta)" (25 September 2023), online: ABlawg, http://ablawg.ca/wp-content/uploads/2023/09/Blog_SF_LH_E_Coli.pdf

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