CITATION: Welkoff v. Ontario (Health Professions Appeal Review Board), 2025 ONSC 4515
DIVISIONAL COURT FILE NO.: 525/24
DATE: 20250808

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

Backhouse, Lococo and Jensen JJ.

BETWEEN:	
ELAINE WELKOFF Applicant	Self-represented
– and –	
HEALTH PROFESSIONS APPEAL AND REVIEW BOARD, COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO, and DR. LEIGH SOLOMON Respondents	*Steven Bosnick* and *Roberto Walcott*, for the Respondent – Health Professions Appeal and Review Board *Ruth Ainsworth*, for the Respondent – College of Physicians and Surgeons of Ontario *Eric Pellegrino*, for the Respondent – Dr. Leigh Solomon
	HEARD at Toronto: June 26, 2025

Backhouse, J.

[1] The applicant Elaine Welkoff seeks judicial review of the decision of the Health Professions Appeal and Review Board (the "HPARB") dated August 8, 2024, reported at 2024 CanLII 74262 (the "Decision"). The HPARB upheld the decision of the screening committee, the Inquiries, Complaints and Reports Committee ("ICRC"), of the Royal College of Physicians and Surgeons (the "College") dated July 28, 2023, that resolved the complaint against Dr. Leigh Solomon (the "respondent doctor") by way of remedial agreement. The remedial agreement required the respondent doctor to self-study in the risk factors and management of personality disorders and persistent depressive disorders and discharge planning and submit a 2000-word report to be reviewed by the College.

[2] The applicant seeks to quash the Decision on the basis that the ICRC's investigation was inadequate, there was a denial of procedural fairness and the HPARB's decision was unreasonable.

[3] For the reasons set out below, the application is dismissed.

Factual Background

[4] The applicant attended the Emergency Department of the North York General Hospital on March 20, 2022. She expressed "wanting to commit suicide" and requested a medical assistance in dying procedure.

[5] The applicant had a history of mental health problems but had not required psychiatric treatment for a long time. She recently had some health issues and losses, she had moved, and was living on her own. She was affected by the COVID-19 pandemic and felt she needed help.

[6] The applicant was admitted on a voluntary basis to the psychiatry unit under care of the respondent doctor, who met with the applicant on March 21 and 22, 2022. The respondent doctor completed her initial consultation note on March 23, 2022. The respondent doctor's diagnostic impression was persistent depressive disorder with dependent and borderline personality features.

[7] The respondent doctor began to introduce discussion around a discharge date, potentially on Friday, March 25, 2022. During the admission, the respondent doctor prescribed Prozac, which the applicant declined, having previously tried the medication.

[8] The hospital notes and the applicant's complaint indicate the applicant was at times unhappy with the care she was receiving from the respondent doctor during the admission.

[9] The respondent doctor agreed to allow the applicant to stay through the weekend (March 26 and 27, 2022). The applicant understood that another psychiatrist would take over her care after the weekend. However, on Monday, March 28, 2022, the respondent doctor was on the unit and discharged the applicant. The applicant resisted and left the hospital accompanied by security guards.

[10] On August 25, 2022, the applicant lodged a complaint against the respondent doctor.

[11] As found by the ICRC, the applicant's overall complaint was that the respondent doctor did not properly assess or treat her. The applicant complained that the respondent doctor never really discussed her concerns with her and she felt the respondent doctor deemed the admission was illegitimate. The Complaint specified the applicant's concerns about the respondent doctor as:

- inappropriately told her that she should never have been admitted and that there was no help there for her;

- inappropriately profiled her;
- refused to offer outpatient supports;
- made untrue statements;
- instructed the social worker to only provide Oshawa Durham Region resources;
- had her forcibly removed from the hospital on a snowy day while she was in an active suicidal ideation state; and
- provided falsehoods in the discharge summary, which heightened her suicidal ideation state and affected subsequent care.

ICRC Decision: May 9, 2023

[12] While the Mental Health Panel of the ICRC did not uphold all of the complaints specified above, it had a number of concerns with respect to the respondent doctor's assessment and treatment of the applicant:

No support in the medical records for the respondent doctor's diagnosis

[13] The ICRC found that there was no support in the medical record as to why the respondent doctor diagnosed the applicant as having persistent depression disorder and borderline personality. It found:

> We are concerned that the Respondent's notes do not address any real diagnostic issues or suicidal risk factors in a patient who said she wished to die. In the Committee's opinion, the notes do not provide a sense that the Respondent understands the complexity or the arc of this patient's treatment and recent responses in the Complainant's previous hospitalization. We would expect a more thorough initial consultation note from a psychiatrist, in terms of attempting to understand a patient just met.[1]

The records suggest that respondent doctor's discharge of the applicant could be considered a premature discharge putting a patient at risk

[14] The ICRC found:

> Again, the Committee is concerned, overall, that while the Complainant did say she was suicidal, the Respondent's notes do not explore this in any detail except to indicate it was passive ideation. The Respondent states that the Complainant rejected treatment, but based on our review of the medical

[1] ICRC Decision, at p. 5, last para.

> record, it also appears there were difficulties in the parties' treating relationship itself.
>
> The records support that the Complainant clearly stated to different individuals involved in her care that she was not ready for discharge, and she felt not listened to. Notations in the chart from multidisciplinary team members document the Complainant's suicidal thoughts and intent, including on the day before her discharge.
>
> The Committee is concerned about the discharge plan in this clinical circumstance. The records suggest this could be considered a premature discharge.
>
> Sending a patient home with multiple (documented) adversities may put them at risk. In this case, the Complainant had experienced an acute decline in the context of numerous stressors, including the added isolation of the pandemic. An inpatient stay with discharge to the same set of circumstances would represent a challenge for a vulnerable patient. Also, the Committee notes that while outpatient programmes were coming back on board at the time in question, they were still overwhelmed.[2]

The respondent doctor discharged the applicant with inadequate discharge planning

[15] The ICRC found that "the discharge note was curt with respect to a patient who felt misunderstood." It found:

> The brief discharge notes also indicates inadequate discharge planning, in the short notation by the Respondent of the follow-up instructions, "Suggest follow up with FD [family doctor] and suggest mental health support.[3]

The respondent doctor bears responsibility for much of the shortcomings in the treating relationship

[16] The ICRC found:

> Notes show that on the day of discharge, when a nurse asked about the Complainant wishing to remain in hospital (prior to security being called), the Respondent indicated that, "the pt [patient] doesn't want to be helped." However, this is clearly not the case, as set out in many of the hospital progress notes (even despite that some notes also describe some resistance to help).[4]

---

[2] ICRC Decision, at p. 7, first 4 full paras.
[3] ICRC Decision, at p. 8, third bullet point.
[4] ICRC Decision, at p. 6, first 4 full paras.

> Notes show that the Complainant presented differently to different people, and different psychiatrists were able to interact with her.
>
> Overall, the record suggests to the Committee that the relationship between the parties was not optimal. In our view, the Respondent bears responsibility for much of this**.**
>
> As just noted above, the Respondent's notes are sparse, providing little insight into the dynamics of the treating relationship. The notes suggest the Complainant's "help rejecting" was not understood or appreciated within the context of her also help-seeking. The absence of a proper risk assessment in the face of the Complainant's recent decompensation and her risk factors suggests to the Committee that the Respondent did not take her concerns sufficiently seriously and was inappropriately dismissive or not "listening".[5]

The respondent doctor did not try a different antidepressant with the applicant if the respondent doctor thought the applicant had a persistent depressive disorder.

[17] The ICRC stated:

> The record does not address the medication issue, or an attempt to try an alternative medication, only that the Complainant rejected the prescribed medication.
>
> …
>
> We also question why the Respondent did not try a different antidepressant with the Complainant, if she thought the Complainant had a persistent depressive disorder." [6]

The respondent doctor should have been aware, that proper discharge is fundamental to proper treatment of patients with persistent depression and borderline pathology

[18] The ICRC found:

> The Committee is aware that the Respondent's history at the College includes a previous written caution around discharge of a patient without assessing the appropriateness of discharge planning.
>
> Considering this history, the Respondent should be aware that proper discharge is fundamental to proper treatment of patients with persistent

[5] ICRC Decision, at p.7.
[6] ICRC Decision, at p.8.

> depression and borderline pathology, if indeed that is what the Complainant has.[7]

[19] The ICRC concluded that the respondent doctor could benefit from further education to assist her in gaining a better understanding around the risk factors and management of personality disorders and persistent depressive disorders, and discharge planning.

[20] The ICRC highlighted that there was no information to suggest that the respondent doctor would be incapable of remediation. The respondent doctor acknowledged the ICRC's concerns and agreed to engage in the self-study. The ICRC accepted a Remedial Agreement from her with respect to her knowledge in the areas of concern.

HPARB Decision: August 8, 2023

[21] The applicant appealed the ICRC decision to the HPARB. It found that the ICRC's investigation was adequate, the ICRC's decision was reasonable and there was no procedural unfairness.

[22] The HPARB found that the Remedial Agreement addressed the concerns the ICRC had identified by including in the scope of study to be undertaken by the respondent doctor i) "risk factors and management of personality disorders and persistent depressive disorders" as well as ii) "discharge planning as a whole", which addressed the applicant's specific concerns about the basis for the discharge and community supports after discharge.

[23] The HPARB noted that the ICRC has the discretion to choose the appropriate outcome and there may be more than one reasonable outcome for a particular complaint. It noted that the HPARB's role is to assess whether the outcome that the ICRC imposed falls within this reasonable range, not whether the outcome is correct, nor whether it is the outcome that the HPARB would have chosen: *J.H. v. J.S.,* 2018 CanLII 95968 (ON HPARB), at para. 82.

[24] The HPARB found that the ICRC's decision to accept the Remedial Agreement addressed the issues raised in the Complaint and served to protect the public interest by providing guidance to the respondent doctor in her future practice.

[25] As such, the HPARB found the Remedial Agreement fell within the range of reasonable outcomes.

The Remedial Agreement

[26] The Remedial Agreement the respondent doctor entered into with the ICRC stated that she understood its concerns and agreed that she would benefit from remedial work with respect to her knowledge in the following areas: (i) Risk factors and management of personality disorders and persistent depressive disorders, and (ii) Discharge planning. She committed to participating in self-directed educational efforts to address these concerns. She agreed to

[7] ICRC Decision, at p.7, last 2 bullet points.

follow up by submitting a typed self-study report (approximately 2,000 words), complete with references of any material reviewed, to the College within four months of the date she signed the Remedial Agreement. The report was to include a description of the educational activities that she undertook to address the learning need, a summary of what she had learned, and an indication of how she has changed or plans to change her practice based upon this activity. The self-study report was to be reviewed by a staff member of the College, and if there were ongoing concerns as a result of that review, the matter was to be taken back to the ICRC for consideration.

[27] The ICRC found that there was no information before it to suggest that the respondent doctor was not capable of remediation of the identified concerns.

Court's Jurisdiction

[28] The Divisional Court has jurisdiction to hear judicial reviews under ss. 2 and 6(1) of the *Judicial Review Procedure Act*, R.S.O. 1990, c. J.1.

Standard of Review

[29] The presumptive standard of review upon judicial review of an administrative decision is reasonableness: *Canada (Minister of Citizenship and Immigration) v. Vavilov*, 2019 SCC 65, [2019] 4 S.C.R. 653. The reasonableness standard of review applies in this case.

[30] An administrative decision maker is required to conduct their proceedings fairly. The degree of procedural fairness required is determined by reference to all the circumstances of the case, including the factors set out in *Baker v. Canada (Minister of Citizenship and Immigration)*, [1999] 2 S.C.R. 817, at paras. 21-28; see also *Vavilov*, at para. 77.

Analysis

Issue 1: Was the HPARB's finding unreasonable that the ICRC's investigation was adequate?

[31] The applicant submitted that the ICRC's investigation was inadequate because: (i) no interviews were conducted to clarify facts, and (ii) the investigation did not include all the complaints that the applicant brought forward, including some that she characterized as the "most important" (i.e. that the respondent doctor "blatantly lied" in her response to the ICRC).

[32] In its Decision, the HPARB examined the adequacy of the ICRC's investigation. It noted that an adequate investigation need not be exhaustive. Rather, the ICRC must seek to obtain the essential information relevant to making an informed decision regarding the issues raised in the complaint.

[33] The HPARB held that s. 26(1) of the *Health Professions Procedural Code*[8] (the "*Code")* requires the ICRC to make "reasonable efforts" to consider the records and documents that it deems relevant to the complaint. The ICRC "is not required to examine all records and documents, conduct interviews, hear testimony, or make findings of credibility": *Torgerson v. Ontario (Health Professions Appeal and Review Board),* 2021 ONSC 7416 (Div. Ct.), at para. 45.

[34] The HPARB found that the ICRC provided the applicant with the respondent doctor's responses and an opportunity to reply and make additional comments. The ICRC spoke with the applicant three times (although the applicant states that these were simply requests by her for updates on the status of the complaint).

[35] The HPARB acknowledged the applicant's submissions regarding inaccuracies in the record. The HPARB found that the ICRC relied on the health records which did not contain compelling information to contradict the record. The HPARB found that the ICRC's Decision makes specific and frequent reference to the information in the Record to support its conclusions, and the conclusions were reasonable.

[36] The HPARB found that the investigation included the concerns that the applicant raised. It found that the ICRC's investigation covered the event in question, and that it obtained the essential information relevant to making an informed decision regarding the issues raised in the complaint.

[37] The HPARB found that the ICRC considered the applicant's allegations that the respondent doctor made inappropriate and untrue statements and profiled her. The HPARB found that the ICRC reviewed the medical records and while it was critical of the curtness of the respondent doctor's discharge note where the patient felt misunderstood, it did not find that there were untrue statements in it.

[38] The HPARB Decision outlines its reasons for finding the ICRC's investigation to be adequate and the HPARB's finding was reasonable.

Issue 2: Was the HPARB's decision procedurally fair?

[39] The applicant outlines 21 procedural fairness issues. For example:

- Hiding the respondent doctor's record with the College;
- Obscuring the main complaints;
- Omitting the College's emails from the record;
- Omitting relevant evidence from phone discussion notes;
- Refusing to provide the applicant with a copy of hospital records; and
- The investigator not interviewing the applicant.

[8] *Health Professions Procedural Code,* Schedule 2 to the *Regulated Health Professions Act, 1991*, S.O. 1991, c. 18.

[40] The applicant does not explain how these amount to breaches of procedural fairness, nor does she rely on any caselaw to support her arguments.

[41] Most of the applicant's allegations of procedural fairness relate to the ICRC Decision and were not raised before the HPARB.

[42] The issue of the respondent doctor's summary of her regulatory history with the College not being provided to the applicant was the subject of a motion before this court and the applicant did not pursue this issue. The ICRC and HPARB explicitly considered the respondent doctor's regulatory history in their decisions.

[43] The applicant's allegation that the respondent doctor was provided with the ICRC Decision in May 2023, two months before it was provided to the applicant, is incorrect. The respondent doctor engaged with the College on a possible Remedial Agreement in May 2023. The respondent doctor received the decision on the same day as the applicant, July 28, 2023.

[44] There is no justiciable issue of procedural fairness. The applicant was afforded the requisite procedural fairness.

Issue 3: Was the Decision unreasonable for upholding the ICRC's acceptance of a remedial agreement?

[45] The applicant submitted that the disposition was unreasonable because it did not address her main concerns that the respondent doctor committed deliberate falsehoods in the hospital records and in her responses to the College.

[46] The ICRC did not find that the respondent doctor committed falsehoods or violated the Code of Ethics. The HPARB found that the ICRC investigation covered the event in question and that it included the concerns that the applicant raised. It is not the role of the court to substitute its own factual findings for those of the ICRC.

[47] Deference is owed by the court to the disposition chosen by the ICRC and upheld by the HPARB. The Panel accepts that remediation requiring study and a report in the areas of concern found by the ICRC is a reasonable disposition in this case. However, given what appear to be the serious findings and the prior written caution in regard to similar issues, albeit dated, the Panel had a concern that the disposition of a remedial agreement was crafted for the purpose of avoiding public disclosure.

[48] Under the *Code* and the amendments thereto in the *Protecting Patients Act, 2017*, S.O. 2017, c. 11 (the "*PPA*"), remedial agreements are not required to be posted on the College's public website, while a disposition that requires a physician to take a remedial program is required to be posted and disclosed publicly: *Code*, s. 23(2)7.

[49] The reasonableness of the disposition from the perspective of protecting the public interest in the transparency of these proceedings as reflected in the *PPA* was not addressed at the

hearing or in the parties' factums. Accordingly, the Panel asked for written submissions from the parties.

[50] The applicant submits that the seriousness of the findings in this matter required protecting the public interest through public posting on the College's website. She submits that transparency was important both for public awareness by the public and to promote a better culture and behaviors by physicians.

[51] The respondent doctor submits that the remedial agreement should be found to be reasonable because, among other reasons, it was a negotiated resolution and the doctor completed the remedial program in 2023.

[52] The College submits that the legislature's choice to limit the types of outcomes that must be disclosed publicly reflects an understanding that some ICRC outcomes are more serious or address a greater risk than others.

[53] The College further submits that this court has repeatedly held that the fact that verbal cautions and specified continuing education or remediation programs ("SCERPS") are now public is irrelevant to a court's task in determining whether a disposition was reasonable.[9] It submits that transparency regarding the decision is the consequence of the decision, not a relevant consideration for the panel making the decision. However, it does not follow that if the disposition is being chosen to avoid public scrutiny, the court is not permitted to consider that to be a relevant factor in deciding whether the disposition was reasonable.

[54] The ICRC found that in this case, the respondent doctor prematurely discharged the applicant who had suicidal thoughts and intentions, including the day before she was discharged. The ICRC found that the applicant had made it clear that she was not ready for discharge and that discharging her without adequate planning where outpatient programs were still overwhelmed following Covid may have put her at risk. It is not apparent from the findings and the prior caution why this would not fall into the more serious or greater risk category requiring a disposition that must be disclosed publicly.

[55] There is nothing wrong with remedial agreements *per se* if the facts are not particularly serious. If dispositions are crafted for the purpose of avoiding the transparency provisions of the *Code* and the amendments thereto in the *PPA*, this will undermine the openness and public scrutiny of the College's regulation and governance of physicians which the legislation seeks to ensure and may result in the disposition being found to be unreasonable.

[56] Were this Panel to find that the disposition was unreasonable on this basis, the appropriate course of action would be to remit the matter to the HPARB. Given that the respondent doctor completed the remedial program in 2023, it is not sensible or necessary in this case, given the passage of time, to remit the matter to the HPARB. We raise this issue in case the practice becomes more widespread and is a systemic issue.

---

[9] *Dr. Rajiv Maini v. HPARB*, 2022 ONSC 3326, para.56.

Conclusion

[57] The application is dismissed. As agreed by the parties, there is no order of costs.

_____
Backhouse J.

_____
Lococo J.

_____
Jensen J.

Date: August 8, 2025

CITATION: Welkoff v. Ontario (Health Professions Appeal Review Board), 2025 ONSC 4515
DIVISIONAL COURT FILE NO.: 525/24
DATE: 20250808

ONTARIO

SUPERIOR COURT OF JUSTICE

DIVISIONAL COURT

Backhouse, Lococo and Jensen JJ.

BETWEEN:

ELAINE WELKOFF

Applicant

– and –

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD, COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO, and DR. LEIGH SOLOMON

Respondents

REASONS FOR JUDGMENT

BACKHOUSE J.

Date: August 8, 2025