Long-Term Care Covid-19 Commission Mtg.

Meeting with Dr. Robert Kyle
on Friday, October 2, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 2nd day of October, 2020, 9:00 a.m. to 10:00 a.m.

BEFORE:

The Honourable Frank N. Marrocco, Lead Commissioner;
Angela Coke, Commissioner;
Dr. Jack Kitts, Commissioner.

PRESENTERS:

Dr. Robert Kyle, BSc, MD, MHSc, CCFP, FRCPC, FACPM
Commissioner & Medical Officer of Health Durham Region Health Department.

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat;
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat;
John Callaghan, Counsel, Long-Term Care Commission Secretariat;
Derek Lett, Policy Director, Long-Term Care Commission Secretariat;
Lynn Mahoney, Counsel to the Ministry of Health and Long-Term Care;

Dr. Pepi McTavish, Assistant Medical Officer of Health at the Durham Region Health Department;
Cindy Boyd, Solicitor Regional Municipality of Durham;
Arend Wakefield, Senior Solicitor Regional Municipality of Durham.

ALSO PRESENT:

McKaya McDonald, Stenographer/Transcriptionist.

-- Upon commencing at 9:06 a.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, we're now assembled. I think I've done the introductions as far as you're concerned.

Are you alone, or are you with somebody else?

DR. ROBERT KYLE: So, Commissioners, thank you for inviting us here.

So with me is my Assistant MOH Dr. Pepi McTavish. Good morning, Pepi.

COMMISSIONER FRANK MARROCCO (CHAIR): Good morning.

DR. ROBERT KYLE: And I think in the background, to save me from myself, are two legal counsel from the region.

Cindy Boyd, who really does yeoman's work with respect to helping us with respect to Public Health legal matters.

And her colleague Arend Wakeford who has done the same on this with respect to privacy matters.

So that's who's at our end, and for those Commissioners who are kind of unfamiliar with the structure of Public Health, I'm in a Public

Health unit that is embedded in a regional municipality.

So, Commissioner, I was briefed ahead of time as to some of the questions that the Commission may be interested in, so I've wrapped some bullet points under each of the headings.

And I'd be prepared to go through them, but my suggestion would be interrupt me at any time. I was just trying to collect my thoughts in an organized fashion.

And if I think I can capture some of the bullet points I've made in writing so that you can get into your questions, then I will indicate that, and you can let me know whether you want me to walk through it or just send it to you in writing.

COMMISSIONER FRANK MARROCCO (CHAIR): I think that --

DR. ROBERT KYLE: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): If I can -- since you invited me to interrupt, I will.

DR. ROBERT KYLE: Sure.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah. You know, Mr. Callaghan, who you may have

been speaking to, is our counsel. He reports to us. He takes his instructions from us.

So if there's something further in writing that you think should be forwarded to us, don't hesitate to send it to him, and he'll make sure that it gets to the three of us.

DR. ROBERT KYLE: Yeah, okay.

COMMISSIONER FRANK MARROCCO (CHAIR): And he's our counsel, and he doesn't have any other client.

Secondly, just so we're clear on what -- you know, Doctor, we find ourselves as a Commission in a bit of an odd situation. You were involved with SARS.

DR. ROBERT KYLE: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): And so you -- and Justice Campbell -- but, you know, typically a commission -- it looks back at something that happened and tries to explain what happened and analyzes it. The thing is over --

DR. ROBERT KYLE: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- and you're looking back at it. Of course, that is not our reality at all. And so we have tentatively concluded that we should try to make

some recommendations, some interim recommendations, as soon as we're in a position to do that --

DR. ROBERT KYLE: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- and then continue the exercise of looking back at Wave 1 and try to figure out --

That's the general thought we've had, and that's how we're kind of pursuing things, just so you understand where we're --

DR. ROBERT KYLE: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): -- coming from. So with that, we're in your hands.

DR. ROBERT KYLE: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): We will interrupt but just for the reason you mentioned, that that way we don't have to go back. We'll just ask questions at the time, and we look forward to your answers.

DR. ROBERT KYLE: Okay. And, Commissioner, can I ask, have you interviewed any other MOHs up to now? Because if not, there's a bit of context that I think probably is useful. But if you've heard it before, I'll just skip ahead.

COMMISSIONER FRANK MARROCCO (CHAIR): You know, I think the best way to go about this is if you think we need to hear something, then you tell us.

DR. ROBERT KYLE: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): And we'll tell you if we've kind of heard it before.

DR. ROBERT KYLE: Okay.

COMMISSIONER FRANK MARROCCO (CHAIR): And you won't need to spend too much time on it.

DR. ROBERT KYLE: Okay. So in terms of opening remarks, the only other thing I wanted to -- only other -- the two other things I wanted to mention is, first, I was on the frontlines not only with respect to SARS but with respect to the pandemic and influenza.

And I was explaining to John that, with respect to long-term care homes and retirement homes, at least I had skin in the game.

So I was the caregiver of two parents with dementia. And combined, my parents ended their years in long-term care homes. So for five years, I had a front row seat with respect to the care and treatment and the deterioration that I saw

during my parents residing in long-term care homes. So I would be the first to not criticize anybody in the system. They do the very best that they can.

And secondly, I can honestly say that if COVID-19 hit the home that my mother was in, I can't imagine that she would have survived. She was demented. She didn't know who I was. She wouldn't have understood masking. They would have to have restrained her to keep her in her room.

So it's a real issue for me. And I must say, as I was thinking through this and I was going through our experience in the first wave, in some ways, it hit home at a personal level. So if I get a tad emotional, I'm going to apologize ahead of time.

So I mentioned that we're one of the PHs embedded in a regional government. And in terms of what has our role been to date with respect to COVID-19, our main focus is on case contact and outbreak management.

We have done some surveillance and facilitated testing. We do data entry on cases and contacts, and we report out, and I'm very proud of our data tracker -- the link to it, I can send you offline.

But if you wanted to find out what was happening in our long-term care homes and retirement homes in real time, go to our data tracker, click on "Institutional Outbreaks." It's all there. And any information you want with respect to dates, times, and numbers of cases, it's all there.

COMMISSIONER FRANK MARROCCO (CHAIR): And that would be very helpful, actually, Doctor. If you could do that, that would be great.

DR. ROBERT KYLE: Yeah. So if somebody's taking notes, "durham.ca/covidcases," and it's pure gold.

Our role is with respect to Public Health messaging and communications. And, finally, we respond to inquiries, complaints, and we engage in progressive enforcement.

Since at least you, Chair, are a lawyer or a justice, sorry, in terms of the legal tools that we have used, we're heavily reliant on the HPPA and the regs thereunder.

And in particular, for long-term care homes, we have relied on Sections 13, 22, 29.2, and we have given thought to -- and not used in the long-term care home/retirement home sector --

Section 102, but we have used it. We also rely on the Ontario Public Health Standards, the protocols and the guidelines, which have legal authority.

I have issued instructions under regs 263/20 and 364/20 under, first, the Emergency Management and Civil Protection Act and now the Reopening Ontario Act.

And, of course, we are implementers at the local level, so we rely on directives, policies, guidelines from the Chief MOH, from the Ministry of Health, from the Ministry of Long-Term Care, from the Ministry For Seniors and Accessibility -- Seniors Affairs and Accessibility. And we're, of course, reliant on advice and lab support from PHO.

So one of the questions that I was asked, or we were asked, was what did we do with respect to this sector.

So our role up to now and currently has been with respect to outbreak management and prevention. We did surveillance of our long-term care homes and then took it upon ourselves to do surveillance of our retirement homes and group homes.

We have facilitated infection

prevention and control or, in the business, IPAC assessments.

We have managed test results both communicating out and interpreting positive and negative test results.

We have interpreted for many of our long-term care home retirement home stakeholders interpreting directives, testing, and clearance guidelines and so forth, and we've engaged in dialogue with, for example, i.e., doctors locally who may have questioned what was behind the issuance of these directives and documents.

I've issued two Section 29.2 orders under the HPPA. I believe you're familiar with Orchard Villa. So this provided legal authority for Lakeridge Health to take over and stabilize the management of an outbreak in Orchard Villa.

And I issued a Section 29.2 order with respect to -- I'm not sure how you classify it. I think we landed in quasi-retirement home, but it was a denominational René Goupil infirmary associated with a judge who had a retreat in Pickering, and I can tell you more about that.

I mentioned facilitating IPAC assessments. So in a couple of places, René Goupil

and another place in Durham Region, to ensure the implementation of IPAC assessments done by others, we issued two Section 13 orders.

And one of those orders has led to legal activity, as I understand it, and Cindy probably can weigh into that if that's of interest to the Commission.

We respond and continue to respond to inquiries and complaints regarding long-term care homes and retirement homes. As you probably are aware, MPPs are very interested in what's going on in their backyards, so we have held regular briefings with local MPPs, particularly in Wave 1, where they had homes in outbreak in their ridings.

Locally, a number of tables were set up to work collaboratively together particularly with respect to risk assessments which were then communicated upward to Ontario Health. And.

Dr. McTavish represented us on the Durham Cluster Table, and on that table included representatives from Lakeridge Health and the Central East LHIN.

We participated in a preparedness assessment at the behest of Ontario Health with respect to the long-term care homes.

Communications -- and you're probably going to hear an earful from affected families of affected homes. I was in the loop with respect to a number of families whose loved ones lived in Orchard Villa, so I did my best to respond to their inquiries.

I don't want to downplay our role with respect to René Goupil House, but I'm prepared to, of course, talk about that. And lastly --

COMMISSIONER FRANK MARROCCO (CHAIR): Doctor, if I could interrupt you for a minute.

Can you hear me okay?

DR. ROBERT KYLE: Oh, yeah, absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah. The order under 29.2, did you issue that order?

DR. ROBERT KYLE: I did.

COMMISSIONER FRANK MARROCCO (CHAIR): Are you forced to consult anyone, I mean, you're given your position? Or do you have the discretion to issue those orders as you see fit?

DR. ROBERT KYLE: Well, I have the discretion to do that. I do that in concert with my team and my legal counsel.

As you know, orders are appealable to

HSARB so you want to make sure that they are defensible as possible and you have reasonable and probably grounds.

In the case of Orchard Villa, you had two parties who were keen to have Lakeridge Health stabilize the situation. And I think for a whole variety of reasons, Orchard Villa was willing for them to come in. So the likelihood of the order being appealable was very unlikely because you had two willing partners.

But if your question is do I have to consult with my Board of Health, that sort of thing, no, I don't. And we turned around the order fairly quickly over the weekend.

And credit should go to Cindy who did most of the drafting and to make sure that it was complete and, as I said, defensible as possible.

She would have reached out to the Ministry of Health not for any permission but to make sure that we're using the right legal tool and to Lakeridge Health so that the provisions in the order were such that it allowed Public Health to carry out the duties embedded in the order that it thought was required of them to effectively stabilize the situation.

With respect to René Goupil House, so this is an infirmary very poorly designed, very -- it was outdated, and it has 24 or 25 beds and quite a number of deaths. I'm thinking four or five and many persons in outbreak -- I'm sorry, with COVID.

And we had a reluctant director of care who was not allowing us to do our job. So I put my foot down. I was quite concerned about that home. I issued that Section 29.2 order.

I would say to somebody at an institution that was less receptive than Lakeridge Health or Orchard Villa, I'm very proud of that. Community Health has stepped in, and it's cleaning up René Goupil. And the residents who were there were transferred to other facilities to allow that to happen, so I'm very pleased with that.

The last thing I was going to say, Commissioner, was that Hillsdale Terraces, which is a regional long-term care home, was, I believe, the first home in outbreak in Ontario.

So we weren't following (indiscernible), and there were a number of challenges that we had to deal with, a bit of ambiguity, with respect to the outbreak management.

It was early on in the days with

respect to Public Health measures that were strengthened as a result of Hillsdale Terraces -- communications, that kind of thing. So it was really a trial by fire.

So that's kind of a snapshot of what we did. I was asked how did we work with the Chief MOH and the Province?

It's a very, very complex landscape. A lot of players, a lot of moving parts, and all happening in real time as the first wave is getting higher and higher.

My view is I think we worked with the CMOH and province reasonably well. After fairly short order, if there were questions from the field, we would post them to the Emergency Operation Centre, and they were fairly quick at getting back to us. We had excellent support from, in particular, the physician leaders at Public Health Ontario.

Eventually the province got into the rhythm of two teleconferences per week, and after some storming and forming, they eventually normed and became quite effective.

There's been good communications from Ministry comms to our comms of folks, so that's

worked well. Partway through Wave 1, certain regional MOHs populated a "Public Health Measures" table, so this provides direct advice which is influenced, I guess, by the regional reps' local experiences with respect to Public Health advice to the chief medical officer of health.

I think we all would like there to be a quicker turnaround time, but I'm going to be critical of anyone. I can't imagine what it would be like working at the Ministry with multiple inputs to consider, multiple outputs to produce, dealing with multiple tables all in real time.

So I think everybody has done the best job that they can, but I do know that, at the local level, sometimes you wish the decision-making would be a bit quicker.

A new player which we're getting used to is Ontario Health. We belong to East Region. My sense is that Ontario Health is finding its legs.

I think that there is, perhaps, better alignment across the -- I think it's five regions, but to my mind, early on, there were some inconsistencies. So I'd get inputs from other MOHs, and then I would bring them over to our local

table that feeds up to the East Region table and thought that we were quite far behind.

We've established, as I mentioned, a local table. One of the good things, if I can call it that with respect to COVID-19, is that it has required us to get out of our silos and work with other players -- so hospitals, long-term care homes, the community, and so forth.

And who would have thought? Who would have thought -- at least in the early days when the economy was locked down, as was healthcare system -- that COVID-19 would end hallway medicine? But there you go.

I mentioned that we have been involved in surveillance and testing. Government, after it required us to do surveillance of long-term care homes -- so this is the testing of residents and staff in long-term care homes -- they turned testing over to Ontario Health. And it has been responsible for ongoing surveillance and testing of staff and retirement homes and the long-term care homes.

I think early on that the emperor had no clothes. I think that OH was kind of struggling to take on that mandate. It was certainly

invisible out our way, and I think some of our retirement homes and long-term care homes struggled to get assistance particularly with respect to surveillance testing if you were a retirement home, say, or a smaller long-term care home. It didn't have the same sort of infrastructure that others would have.

Eventually things normalized in Lakeridge Health, and its assessment centres were able to take on the testing responsibility. But there was a month period -- or that's my memory -- where it was a bit confusing about who did what. I do think --

COMMISSIONER FRANK MARROCCO (CHAIR): Doctor, in this one-month period, when did it first occur to you that there might be a problem in your region?

DR. ROBERT KYLE: You mean in terms of outbreaks, cases, and so forth?

COMMISSIONER FRANK MARROCCO (CHAIR): When it occurred to you that this virus could be a problem for you. Well, you know, whether it's an outbreak or -- but something that you would need to pay attention to.

DR. ROBERT KYLE: Well, I can tell you

that our first case was on February 29th because I was in Toronto driving home and sort of -- or taking the train home, actually, and trying to orchestrate a news release and so forth. So it hit home, I'm pretty sure, on February 29th.

We had been keeping a close eye on that since the beginning of the new year. And then, again, I don't have the dates in front of me, Commissioner, but Hillsdale Terraces was one of the first homes to be hit. So it was certainly real for us fairly early on sometime in March.

I'm thinking we had travel-related cases before then, and so we were experiencing the first wave pretty close to the beginning of March to late February. And certainly we were newsworthy with respect to the involvement of Hillsdale Terraces.

COMMISSIONER FRANK MARROCCO (CHAIR): You just mentioned keeping an eye on things since the beginning of -- or since early January?

DR. ROBERT KYLE: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): So what's the thinking when you first --

DR. ROBERT KYLE: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR):

-- wake up to the fact that there's this virus?

DR. ROBERT KYLE: So, Commissioner, what I can tell you is that the whole world, at least the Public Health community, was keeping a close eye on that.

We have an outbreak management plan, or I think it was a draft, but it was in pretty good shape. We had a -- or have a Health Department Emergency Master Plan. So we mobilized our plans. We set up our IMS structure, and we were keeping a close eye on the number of cases that were reported to us as they came in.

And I'm going by memory, but I think we activated our HIMG, so Health Incident Management Group, in February. I stand to be corrected. So we were already activated and kind of ready to go.

One of the questions posed to me was what have we learned. I would say within two or three weeks in March, we found that the HIMG and the whole IMS structure didn't work.

And we replaced that with daily updates by lead individuals, so a mix of directors and managers, and we've met daily pretty well since, I'm going to say, middle of March.

And we've had to set up tables that

deal with specific contingencies. So I mentioned long-term care home surveillance. So we were asked to do this, I'm thinking, late March/early April. I could be wrong. And we were given a few weeks to do surveillance of all of our long-term care homes, so we set up a table to kind of manage that file.

We decided, after we had done our long-term care homes, that it made sense for Public Health to focus on our vulnerable populations. So we did the same for all of our retirement homes and our group homes, and so we had this table set up to do it.

We have another table set up with respect to schools, and I imagine we may set up a table to deal with influenza.

So you need to be nimble. You need to be quick. You need to allow people to get on to do the work. And the more cumbersome an organization that you set up, which needs multiple feeds and so forth, the more time is taken to feed the beast than is taken to actually deal with the contingencies in front of you. So that is the huge kind of lesson learned for me.

If I can just finish, Commissioner, with how did we work with CMOH and province. Two

other points I wanted -- three other points I wanted to make.

The first is we're not funded by OH, and its communications to us, to my mind, has been abysmal. And we have one Public Health rep who sits at the East Region table, Vera Etches. She faithfully sends out her notes with respect to those tables.

Early on, the table that was set up did include Public Health, but largely, it now focusses on institutions, and we've been shut out.

So the communications, in my mind, from OH, has been abysmal. It may be -- it may be very robust for the key stakeholders more on institutional side, but for Public Health, from my judgement, it's been abysmal.

Secondly, in the first wave, the inspectors for the Ministry of Long-Term Care and the Retirement Home Regulatory Authority were invisible. I have no idea who they are, what they did. I understand that, to the extent they were engaged, they did it by phone. They have been completely invisible, and I have some thoughts about that when I get to recommendations.

Lastly, a big deal was made out of

hospitals doing IPAC assessments at long-term care homes, retirement homes. I'm sure -- well, I know all of the assessments were done very, very well. They're very robust. Excellent recommendations.

What happens if a home decides not to follow the advice received? There's absolutely no inspection or enforcement mechanism that I'm aware of. And as I say, in a couple of instances, we resorted to Section 13(2) orders to make sure that action was taken.

But you've got all these nice IPAC assessments out there, and I have no idea what's happened to any or all of them and have they been actioned? So it may have happened, but it's invisible to me, and it's certainly invisible to us if the inspectors from the Ministry of Long-Term Care or RHRA have had a role in play. And it may have happened when I'm out of the loop, but certainly it's been invisible to me.

COMMISSIONER FRANK MARROCCO (CHAIR): And, you know, I come at it from a different discipline, of course.

DR. ROBERT KYLE: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): But it does seem, listening to this, that there are

a lot of tables.

DR. ROBERT KYLE: Oh.

COMMISSIONER FRANK MARROCCO (CHAIR): Do you have the same impression or would that be --

DR. ROBERT KYLE: Well, this is healthcare. Lots of tables. Lots of acronyms. A whole lot of busy work. And you wonder -- and all of these tables need to be fed, right?

And I don't know about -- I think Dr. Kitts maybe can comment on this, although he's a commissioner, but one of the experiences that I've experienced is the death by dashboard.

There's so many friggin' dashboards out there, and I've already referred you to our data tracker which is the dashboard. But oh, my God. It really feels like a business school is running this stuff.

And, you know, is that good or bad? It is what it is. I mean, decision-makers -- I would commend government. I would commend key players in using any evidence to drive decision-making. But what I would say is if you set up a table, you have to care and feed it. And if you set up a dashboard, you have to care and feed it, and you shouldn't make those decisions lightly.

We set up tables to deal with contingencies. I'd like to say we whelmed them down once the job was done. So there you go. Healthcare, lots of tables, lots of acronyms, lots of dashboards, lots of data, and yeah. You kind of shake your head.

COMMISSIONER FRANK MARROCCO (CHAIR): Were there things that -- and I'm asking. I'm not trying to suggest.

Were there things that you wanted them to tell you to do that they either didn't tell you to do or waited so long to tell you to do it that it -- you know, it didn't -- the problem didn't matter anymore? Is it that kind of a thing?

DR. ROBERT KYLE: No, I don't think that that's the issue. I think the issue is you get a directive. You get a guideline. You know, I'll just -- testing and clearance. Testing, symptoms, that sort of thing.

And then you find out in the field that there are real-time consequences for implementing these guidelines. And if they're problematic, you would inform, say, the Province through EOC, and then you would wait, and then you would wait, and then you would wait.

And while you're waiting, of course, you're hearing complaints from the ID physicians who you see nightly on CBC news and, you know, all those other things. And, of course, that, then, feeds into kind of cynicism, concern, and so forth.

So that's what I would say. It would take a long time to change things to deal with real-life consequences on the ground. Eventually the fixes came in. They made sense. They helped deal with the situation.

And far be it for me to be critical because it takes time for multiple players to, you know, get their hands on this and so forth, but it does take time. You need to be patient, and you need to do the best that you can on the frontlines to deal with the uncertainties, the ambiguities, sometimes the problems that arise with respect to directives, policies, guidelines, and so forth.

So I don't think it's a lack of directives, policies, guidelines. I think it is the need for continual mid-course corrections as we learn more about the virus and as we learn more about the real-life consequences.

So that's a good segue, Commissioner, into the next question I was asked was what have we

learned to date.

So hopefully I've conveyed to you that the landscape we're dealing with is very complex. We're implementers, right? We're not decision-makers, although we are decision-makers on the ground in dealing with real-life situations -- Orchard Villa, René Goupil, a few others that come to mind.

And sometimes you can't wait, and sometimes you use the tools that you have at your disposal to deal with the contingency. I think everybody has been acting in good faith. And as long as you have reasonable, probable grounds, et cetera, et cetera and you can defend the actions that you're taking and live with the consequences and make the changes if you've made mistakes, then I think that's all that can be expected of us on the frontlines. But it is a very complex landscape -- multiple players, multiple inputs, multiple expectations.

Yesterday quite a number of guidelines were changed by the Ministry and sent out in a batch. So when I'm finished here, I'm going to have to go through them all, kind of digest them, and think "So what do we have to do about those,"

and think "What do we have to do to add this to our toolkit, change our script, change our processes to incorporate it the lightest change?"

So you have to be thoughtful about these things, but you have to be quick about these things because there are real-life consequences.

I talked about -- oh, what did we learn...

Oh, yeah. I was going to say so going back to my own experience and reflecting upon the long-term care home situation -- and I'm not going to be the right person to tell you this -- but this is not rocket science.

If a long-term care home has more money and it has newer facilities, then it stands a better chance of either stabilizing COVID-19 quicker or preventing it in the first place.

It's not rocket science. You have more money and more up-to-date facilities, you can pay your staff more so they're more likely to stay. You can hire more staff. And generally speaking -- and I'd be shocked if the evidence says otherwise -- I'd bet you that those homes -- and I'm thinking about, in our case, regional homes. I'm sure that they, at the end of the day, will

fare much better than those who are less well funded, those that have poor designs, and those that have more precarious workforces. So far be it for me to add to that, but that's certainly an observation I can make from the outside.

I was struggling with my wording, but I do think we need to be realistic about COVID-19 behaviour in long-term care homes. I think what we learned in Phase 1 is that once it takes hold, if you've got a whole lot of factors against you -- poor design, inability to cohort, high number of demented patients who haven't got a clue what's going on, and there's no snowball's chance in hell of cohorting them, of masking them, et cetera, et cetera, which would have been the case with my mother -- the best you can do is stabilize the situation.

And you stabilize the situation, by and large, by having enough staff there. And if you've got sick staff who are off self-isolating and afraid to come back to the home, the more likely it is that, you know, a home is not going to fare well. And I kind of think that's what happened at Orchard Villa and a couple other places, and I suspect that that is a risk that is being mitigated

as we go into second wave.

Carrying on, sorry.

I think that the legal tools that we have worked well. I do think, again, when I look at the -- I think it's the regs. I stand to be corrected. It could be in the statute itself, but I think in the regs under the Long-Term Care Homes Act and the Retirement Homes Act. There's a requirement for there to be an infection prevention and control program in place. That said, I do think there's some confusion about who enforces that.

Now, for the well-operating homes, you're going to -- they're going to say to you "Enough already. We have inspections up the gazoo."

But if you've got a home that either is underresourced, is paying lip service to having a bona fide program, and really needs it beefed up, who's going to enforce that particularly if you've got such homes and such observations awaiting the second wave?

Is it the Ministry of Long-Term Care inspectors? Did they have the tools they need to turn things around? Is it Public Health? We've

made the decision to at least intervene in a couple of places to ensure IPAC assessment recommendations are implemented. But who does what?

And if it is Public Health, are the tools adequate? Do they need to be strengthened? One of the benefits of the tools that we have is that we can get in there fairly quickly. And as long as there's due process, as long as we have reasonable and probable grounds to intervene, we can get in there quite quickly.

I think Dr. Kitts is from Ottawa. One of my colleagues indicated that a hospital needed to intervene in a couple of homes in Ottawa, and it was taking too long. She said "Can you give me your template?" I sent her a template, and I believe she intervened to make it happen while the Ministry was doing its thing.

And I'm not being critical of the Ministry, but when you set up these agreements, you have the dot the I's; you have to cross the Ts. I know all about it. You need to get the lawyers involved. You need to get the risk managers involved. It takes time.

Well, COVID-19 needs a situation stabilized immediately. You can't take time. So

if a hospital or other entity needs to move in to stabilize the situation, we need to be nimble and quick, and hopefully there's clarity around who does what and the clarity around the use of the appropriate tool.

But in my mind, there's a bit of confusion -- or maybe a bit of confusion about who really owns the enforcement piece with respect to long-term care homes and retirement homes.

I've learned that there needs to be clear, consistent messaging in whatever message you land on. Because if you're inconsistent, there's somebody who will tear you apart and say "Well, you said such and such to so-and-so back then," and so there needs to be quality communication.

COMMISSIONER FRANK MARROCCO (CHAIR): Can I just stop you for a second, Doctor?

DR. ROBERT KYLE: Absolutely.

COMMISSIONER FRANK MARROCCO (CHAIR): So you're local, and you make an order.

DR. ROBERT KYLE: Yeah.

COMMISSIONER FRANK MARROCCO (CHAIR): And they appeal your order to the review board or whatever it's called. Doesn't matter.

And so then do they go there with the

directives and say "Look, we were complying with the directives. He couldn't make the order"?

How do the directives and the policies and guidelines affect your ability at a local level to do what you think you need to do?

Because the statute -- that's what I'm -- how it plays itself out, that's what I'm trying to understand.

DR. ROBERT KYLE: Yeah. Well, you're going from the hypothetical, I think, to a specific situation.

So what I'm familiar with are the orders and the instructions that I've issued. So with respect to my orders, they're all appealable to HSARB. So I get legal advice. I rely on my staff. We make it as defensible as possible.

And in the case of Orchard Villa and Lakeridge Health, you had two kind of willing recipients. So the likelihood of it being appealed was minimal.

We have issued some Section 22 orders on individuals who were less than forthcoming with respect to names of contacts that we need to control COVID-19, and the same applies. As long as you have reasonable and probably grounds and meet

the requirements of the order, then you act in good faith and do what you can.

With respect to the instructions, they're rooted under, currently, the Reopening Ontario Act. And we think there is a solid legal foundation for that. And, of course, there are set fines under the Reopening Ontario Act.

So unlike the HPPA -- I was going to get into this with my recommendations. But unlike the HPPA and Section 22 orders where, if there's noncompliance with the virus that has a requirement of self-isolation for 14 days --

Time is of the essence if you need to ensure self-isolation and/or names and so forth. I'm not a provincial offences officer, so I have to resort to other sections of the Act -- in particular, Section 102 -- for remedies and penalties. It's not quick. It takes time. You really have to think that one through, and we have some experience with that.

So it's not the best tool to use to deal with noncompliance, but it is certainly very quick, and you can turn it around on a dime if you think you need to use it again depending on legal advice.

Where do directives, policies, guidelines sit? In my judgment, if you need to make the case for why you're intervening, the reasonable/probably grounds piece, you may want to rely on them, and we have relied on that.

With our Section 22 order, we make reference to the worldwide pandemic. We make reference to the states of emergencies being declared. So I view those types of statements, policy things, and so forth as grounds that you can use to claim reasonable and probable grounds.

I've probably gone as far as I can go, and I'm sure Cindy and Arend are probably cringing on this one. But my point was on the ground -- and I don't think there's confusion, but there may be confusion.

With respect to noncompliance -- and I'm talking about IPAC which is probably a shared responsibility between ourselves and the Ministry of Long-Term Care and the RHRA -- who trumps what, does that need to be clarified, and does Public Health have a stronger role to play in terms of IPAC assessment recommendation and enforcement at its current role which is, really, with respect to outbreak management.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke, did you want to ask a question?

Commissioner Coke, did you want to ask a question? I saw your hand moving. I wondered if --

No? Okay. Fine.

COMMISSIONER KITTS: I'll ask a question --

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

COMMISSIONER KITTS: -- if you don't mind. Dr. Kyle, you mentioned the IPAC assessments done by probably the hospital infectious diseases people.

And good assessments, well laid out, you have no idea whether they've been implemented or followed.

So my question for you is how many homes are you responsible for, and do you have the resources to be the overseer or oversight?

Because my look at -- you know, when you issue an order, you now have a hospital perhaps thinking they're in charge, long-term care thinking they may still be in charge of the long-term care

home, you've got IPAC insisting on things, and you've got Public Health.

Who is the person most accountable to ensure that the leadership is there to have these things done?

DR. ROBERT KYLE: So in terms of numbers, I can't tell you. I'm going to say -- well, I can't tell you. Ballpark, maybe 30 to 40 long-term care homes/retirement homes.

My order -- and it's a matter of public record, so you can read it -- it really had to do with Lakeridge Health carrying out a number of tasks. And I would characterize them not as, maybe, taking over the management of the home but stabilizing the outbreak. That was the intent.

And as important, there was a requirement for Orchard Villa to comply with the activities laid out in the order to be carried out by Lakeridge Health. So I think it was very clear Lakeridge Health was in charge of stabilizing the situation in the home.

I got two updates from Lakeridge Health to tell me -- really give me status reports as to how things were going. So I think it was fairly clear who was in charge of stabilizing the

situation and managing the outbreak. And I'm not aware that there are any issues there.

With respect to the two places that I referred to, René Goupil and a retirement home in north Durham, among the IPAC recommendations were some infrastructure changes and some important changes just beyond screening, IPAC, behaviour, that sort of thing.

And we felt because of the need for compliance and the role we could play in fostering that compliance, that it made sense to issue a Section 13 order. Cindy or Aaron can speak to this, but because of ongoing challenges with one of those homes, we are taking legal action.

So that's something that we can do that I don't believe Ministry of Long-Term Care or RHRA inspectors can do.

COMMISSIONER KITTS: Just a follow up. Is there anyone at the local level -- Public Health, hospital, IPAC, local long-term -- who is ultimately responsible, that as Wave 2 builds, that the IPAC measures are in place?

DR. ROBERT KYLE: Who is responsible? I don't know. You did ask me, by the way, do we have the resources? There are never enough

resources. But clearly if Public Health needs to get into the IPAC assessment game and actually be another pair of eyes for, I'm going to say, 20, 30, 40 homes, we obviously need the resources to do that. But I'm not here cap in hand. My advice is make a decision.

And we have tools at our disposal that allow us to get in there and to require acters to take action a lot quicker than other tools that are out there, so it is a resource worth considering as we enter the second wave.

But in considering it, and if that's the way you want to go, then I think you need to think through "Are there any legal impediments?" "Are there areas of confusion/ambiguity that need to be tightened up in the short term so that those barriers are mitigated for Public Health to do its job?" So the --

COMMISSIONER KITTS: You know, in an ideal world --

DR. ROBERT KYLE: Yeah.

COMMISSIONER KITTS: -- who would you tap on the shoulder? They have enough resources. Who should be most accountable and responsible for long-term care homes and --

DR. ROBERT KYLE: I --

COMMISSIONER KITTS: -- (indiscernible) IPAC measures?

DR. ROBERT KYLE: Yeah, I don't know. I need to do an environmental scan. I can tell you that, with respect to hospitals, Lakeridge Health did some; Ontario Shores did some; Unity Health did some.

So there were -- and I'm not sure about Markham Stouffville, but certainly three hospitals got into the IPAC assessment game in Durham Region, and I suspect that that's under consideration at tables far above me, perhaps at Ontario Health.

If I can just finish off, in the interest of time, Commissioner, in terms of lessons learned. I talked about clear, consist messaging.

I think you need to be -- you need to compartmentalize. Again, I go back to the IMS structure, fine in theory, not good in practice. And you need to be mobile and quick.

And you need to sunset tables that have accomplished their work because these tables tend to perpetuate. They need to be fed. They need to be cared or watered, and that's time taken from your day where you could do other things.

So I do think tables have their purpose, but we need to recognize it's an opportunity cost and that they do need to be sunset when they've served their purpose.

I think that multi-sectoral collaboration and partnerships are crucial. I do think COVID-19 did bring us together. I do think that OHTs are a work in progress. They're new players, and they're finding their feet. And I do think, however, that --

I don't know if we struck the right balance between decision-making and telling us what to do at the center versus enabling us to get the job done and letting us deal with the contingencies that arise on a day-to-day basis. I'm not sure that we've got that balance right.

And as you've seen by actions taken by some of my colleagues, most notably the MOH of Toronto, I think they're trying to tighten up Public Health measures beyond those taken essentially, and I think that will continue to exist.

Ontario's a big province, and I think we should embrace our diversity, and I think we should embrace allowing local acters to take

actions within a provincial framework to deal with the contingencies that are at hand, and hopefully they're driven as much my local epidemiology and evidence as they are the whims, if you will, of the individual who is in charge.

And I would say when I look at long-term care homes versus retirement homes -- as you know, retirement homes have a different legal framework. They have far less infrastructure.

We've had to help them out with respect to testing of residents and staff because some don't have a full-time medical director. Or I guess most don't have a full-time medical director. They just don't have the wherewithal.

And I think that the residents in retirement homes are as vulnerable to COVID-19 as long-term care homes, and I think that how the two sectors are regulated needs to be looked at by the commission.

So finally, I was asked about recommendations. And as a starting point -- and I really don't want to drill down in this forum, but -- how do I say this? -- I think that the independence of the local MOH and the tools that he or she needs to deal with the contingencies --

If you will, we're one of the foot soldiers on the ground, and we need to be equipped to do our jobs and to do it as independently as possible so that we put, first and foremost, the protection of the health of our communities first. I'm not saying that that is not the case, but I do think that needs to be preserved to be extent possible.

All I would say is there was a look at that in Volume IV of the Campbell commission, and, as part of that volume, there were some sound recommendations. I think some of those recommendations are alive today, and it's worth a read. And I expect that that is an input, and, perhaps, you have reflected upon at least parts of the report because that commission was established under Section 78 of the HPPA as this one is.

Secondly -- I'm not sure I'm the right person to address this, but I'd like to think that Sections 13, 22, 29.2, 67, and 102 of the HPPA are in good shape and give MOHs and their teams the proper legal duties and tools to get the job done to deal with the contingencies that arise on a day-to-day basis.

And I'm not sure anything can be done

in the short term to make that happen, but I do think that, to the extent there are barriers, therein place confusion.

Who's responsible for IPAC, I'm going to say, advancement, promotion, management in homes? Is it Ministry of Long-Term Care inspectors? Is it MOHs? Is it others?

Those sorts of things, I think, need to be clarified and could be clarified in the short term.

Likewise, again, I don't know if the IPAC provisions are under regulation or in statute in the Long-Term Care Homes Act and the Retirement Homes Act. But I don't know. They don't seem to be terribly effective, and I suspect you're going to get a litany of complaints from some of the families who have looked at the inspection records at some of the homes that have been in outbreak during COVID-19. So I'll let them speak to that.

The last thing I would say -- and this would just be a last opportunity. So under the HPPA, in order for an associate MOH to exercise his or her full duties, you need to be designated an associate MOH by the Minister.

So we've been waiting since January, so

I have to be absent from work in order for Dr. McTavish to carry out my duties and responsibilities.

Throughout the pandemic, I've reached out to MPP offices to inquire as to the status of the designation. My regional chair has written two letters to the Minister with respect to that designation, and I'm not alone. There are many associate -- I don't know about MOHs -- associate MOHs who are awaiting the Minister's designation so that they can carry out the full scope of their practices, and I think that would be a pretty quick and easy recommendation to make in the short term.

In the middle of the pandemic, waiting for this to happen -- and I'm not trying to be critical of the Minister in office. She's got a whole lot on her plate, and there may be reasons for this to not be occurring. So I'm not trying to be critical, but if this is due to just competing demands, then place it at a higher priority, and I would be sort of a happy man.

So those are my thoughts. I did mention, when I started out, that there are applicable protocols and guidelines that we follow with respect to our work with respect to long-term

care and retirement homes.

The protocols and standards tell us, Boards of Health, MOHs what we have to do, but the triggers are based on complaints and that sort of thing.

So in the longer term, if, in fact, there is a bigger role for Public Health to play with respect to IPAC practices in these places, for example, then I do think that you need to take a look at the protocols and guidelines.

And again, I'm not here with a cap in hand, but if you give us the responsibility -- and this is my plea. Give us the authority, and give us the resources to get the job done.

And I think I'll end there.

COMMISSIONER FRANK MARROCCO (CHAIR): I want to make sure I understand what you just said. It's a question of giving you the -- do I understand that, really, it's giving you the responsibility? You have the powers --

DR. ROBERT KYLE: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- to do what you need to do in the moment to stabilize?

DR. ROBERT KYLE: That's right.

COMMISSIONER FRANK MARROCCO (CHAIR): But you need the responsibility to act? Have I got that right?

DR. ROBERT KYLE: Yeah, that's right. So let me concretize it for you. So if the Ministry of Long -- and I must say, I'm speaking off the top of my head, and I really have not had any chance to dive deeply into the Long-Term Care Homes Act or the Retirement Homes Act.

This is the point I'm trying to make, and I think this will come up from families from, say, Orchard Villa. If the only sanction that a Ministry of Long-Term Care home inspector can use to enforce, say, noncompliance of an IPAC breech is somehow to pull a home's license, well, that's a very blank tool. And if you were to do that, then you would have to relocate all of the residents there. It's just not going to happen.

I'm not aware, but I stand to be corrected. Maybe they can take them -- maybe they can find them and that sort of thing. I don't know if they can. I can or our inspectors can, but we don't systemically do inspections of long-term care homes. We're not required to do that outside of our normal duties which focus more on food safety.

And, of course, we get involved in outbreaks, of course, in long-term care homes, and we follow provincial guidelines with respect to the long-term care homes.

Interestingly, usually we cross swords with LHINs during flu season because if, in fact, you have a home in outbreak and one of their residents, say, is in hospital and needs to be stabilized -- and I know Dr. Kitts may disagree with me -- we may say, "You know, what? You need to have that home out of outbreak before they can return home." Well, then, of course, that blocks a bed in the hospital. So we get involved in these things all the time, and we're just following provincial guidelines.

I digress, but my point is if it makes sense for Public Health to have a more prominent role with respect to, say, inspecting homes for IPAC breaches and using the tools at its disposal to deal with those breaches, then we would need a mandate to do that, and there would need to be resources attached to that.

So I think that was the point that I was trying to make, but we can actually rely on remedies and sanctions under the HPPA that,

perhaps, are more appropriate than those available to Ministry of Long-Term Care home inspectors or RHRA inspectors. I think that was the point I was trying to make, Commissioner.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you. All right. So, Doctor, if I understand you correctly, you've completed, but --

DR. ROBERT KYLE: So --

COMMISSIONER FRANK MARROCCO (CHAIR): -- then if not, carry on.

U/T DR. ROBERT KYLE: So those are the points that I was able to cobble together in the time that I had available yesterday to give some thought to this.

And I would be happy to undertake, when I can, to at least codify that in a set of bullets to send to commission, counsel, or staff. Happy to do that.

But what I've tried to do is give you some, at least, preliminary thoughts based on the questions that were posed to me in advance of this. So what did we do? How did we work with the CMOH and province? What have we learned? And what are some recommendations?

So hopefully I've been faithful to what

I was asked to do. And, Commissioners, the best that I could do given the time that I had and given that when we finish the call it's back to COVID-19.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, we don't want to take you away from that for too long a period of time.

But thank you, Doctor, for the presentation. We probably will be back to you.

DR. ROBERT KYLE: I'm happy to help you out any time bearing in mind that, for all of us, our reality is not the reality. It's a shared reality. But I've had a front row seat as an MOH for over 30 years, so I'd have a few thoughts.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I'm sure we'll be back to hear what they are. But thank you again, and thank you to the two --

I mean, you needed two lawyers with you to make sure you didn't get into any trouble, but it appears that they did their job too. So thank you, and we'll be in touch.

DR. ROBERT KYLE: Thank you very much, Commissioner.

COMMISSIONER COKE: Thank you.

DR. ROBERT KYLE: Have a great day, and take care and stay well.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

COMMISSIONER KITTS: Thank you.

DR. ROBERT KYLE: Bye-bye.

-- Adjourned at 10:15 a.m.

REPORTER'S CERTIFICATE

I, MCKAYA MCDONALD, CSR, Certified Shorthand Reporter, certify:

That the foregoing proceedings were taken before me at the time and place therein set forth;

That all remarks made at the time were recorded stenographically by me and were thereafter transcribed;

That the foregoing is a true and correct transcript of my shorthand notes so taken.

Dated this 2nd day of October, 2020.

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