Long Term Care Covid-19 Commission Mtg.

Meeting with Dr. David Fisman and Dr. Ashleigh Tuite
on Thursday, November 12, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending remotely, on the 12th day of November, 2020, 1:00 p.m. to 1:43 p.m.

BEFORE:

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

PRESENTERS:

Dr. David Fisman, MD, FRCPC, Epidemiologist and Professor at the Dalla Lana School of Public Health and Institute for Pandemics, University of Toronto
Dr. Ashleigh Tuite, Assistant Professor at Dalla Lana School of Public Health, University of Toronto

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat
Jessica Franklin, Policy Lead, Long-Term Care Commission Secretariat
Sanjay Bahal, Team Lead for Operations, LTCC
Derek Lett, Policy Director, Long-Term Care Commission Secretariat

ALSO PRESENT:

Janet Belma, Stenographer/Transcriptionist

-- Upon commencing at 1:00 p.m.

COMMISSIONER FRANK MARROCCO (CHAIR): Hi, how are you? I'm Frank Marrocco, Commissioner Dr. Jack Kitts, who you may or may not know, and Commissioner, Angela Coke.

DAVID FISMAN: Hi. Nice to meet you.

COURT REPORTER: Good morning, sir. I'm Janet. I'm the court reporter today.

COMMISSIONER FRANK MARROCCO (CHAIR): Sorry, Janet. I left you out of that.

COURT REPORTER: That's okay. No worries.

DAVID FISMAN: I see Ashleigh is here as well.

COMMISSIONER FRANK MARROCCO (CHAIR): Right.

ASHLEIGH TUITE: Hi.

COMMISSIONER FRANK MARROCCO (CHAIR): Hello. I'm Commissioner Frank Marrocco, Commissioner Jack Kitts, Commissioner Angela Coke, Janet, from Neesons, who's taking the transcript. Are you waiting for anyone else?

DAVID FISMAN: I don't think we are.

COMMISSIONER FRANK MARROCCO (CHAIR): Neither are we, so we're ready to go when you are.

We will ask questions as we go along, if that's okay, rather than trying to go back?

ASHLEIGH TUITE: Yes. Sure.

DAVID FISMAN: Of course. I was just looking for some headphones, but I don't seem to have headphones that work with my computer, so...

COMMISSIONER FRANK MARROCCO (CHAIR) well, we've got -- we've got a minute if you want to take a second look for them.

DAVID FISMAN: If that's all right, it shouldn't be more than a moment.

COMMISSIONER FRANK MARROCCO (CHAIR): Sure.

DAVID FISMAN: They appear to have moved to another address. We had prepared some slides that I had hoped we could run through very quickly.

COMMISSIONER FRANK MARROCCO (CHAIR): Sure.

Janet, do you have the slides?

DAVID FISMAN: I haven't sent them, so you wouldn't have them yet.

COMMISSIONER FRANK MARROCCO (CHAIR): Oh. Oh, okay.

COURT REPORTER: I'm sorry. I don't

have the slides. If you want to email them to me or if you want to screenshare, you're absolutely able to do that right now.

DAVID FISMAN: That was my plan.

COURT REPORTER: Perfect.

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

DAVID FISMAN: And then I'll email them after.

COURT REPORTER: Thank you.

DAVID FISMAN: Sure. Let's see. Can you see that all right?

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, I can. I think we all can.

COMMISSIONER ANGELA COKE: Yes.

COMMISSIONER JACK KITTS: Yes. Yeah, that's good.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, we can all see.

DAVID FISMAN: All right. Well, I'll just launch right in, then. And I thought I'd begin with going back to March 2020 and ask the question, what we -- what we knew about COVID-19 at that time because I think it's a bit challenging with a process like this to put ourselves back and

in the same state of knowledge as we were in when this pandemic first got started.

I think we knew quite a bit. We knew that SARS coronavirus-2 infection had a very high case fatality in older individuals, and we already knew at that point that it had a propensity to cause outbreaks in care settings.

We had seen from February already in China that case fatality increased markedly with age. We knew that the virus almost seemed to target care settings. The initial recognition of community transmission in both Washington State and British Columbia was associated with high mortality outbreaks in long-term care.

We had had warnings from other countries, and we already knew that long-term care facilities were very vulnerable to outbreaks in communicable diseases. We see this frequently with influenza and other diseases.

In March 2020, we were working quite closely with colleagues in Korea who had reached out to us, had seen some of our modelling work, and we were sort of helping them with policy in Korea.

And Ashleigh and I got to know a very interesting fellow named Asaph Young Chun who's the

director of their Statistics Institute. And Asaph is very wise and very humane. And in March 2020, he was writing to us about their struggles with long-term care and COVID outbreaks in Korea. And he wrote: (as read)

> "Visitors and nursing persons in these group dwellings are more likely to be infected or infecting others as well, given the asymptomatic nature of COVID-19."

You know, that he regards that as established. This is March 22nd: (as read)

> "I add this COVID-19 virus is good at having humans to distrust each other, creating ungrounded fear and anxiety, and having us lose the precious elderly, the source of human wisdom. It attacks everyone yet discriminates against those weak and old by hitting them hard."

Then he has this lovely sentiment: (as read)

> "May I suggest Canadians, Koreans and others keep using Trust virus and Mutual Care vaccine to

defend against this ugly virus?"

This is from shortly thereafter. I just want to show this graphically, and I'm sorry it's such a small slide. This is an old picture that we had made to illustrate what happens to case fatality with age. So age groups are on the 'X' axis here, and non-long-term care populations, and in long-term care in Ontario, I would have made this around April, May, or so.

And what this is is it's a logistic regression model predicting mortality probability in a way that adjusts for gender and as well as comorbidities. And what you can see is that the predicted mortality for each individual rises very sharply with age going from well under 1% in kids and young adults up to, sort of, 20, 30, 40% range, both outside long-term care and inside long-term care. I'd note that case fatality in this range is what we see with viruses like Ebola.

We knew how to prevent death from long-term care in Canada as early as March of 2020. There are models for good practice from British Columbia. Dr. Michael Schwandt is a medical officer of health out there. He's a former student, and I've added a link to a marvelous

thread that he put on Twitter. He's subsequently written up a lot of this for the CMAJ, but I like what Michael said here: (as read)

> "If anyone tells you that massive and deadly COVID-19 outbreaks in long-term care are inevitable, please them otherwise. We've managed 17 long-term care outbreaks in Vancouver Coastal Health and have developed some useful measures which we think are life-saving."

And this is a very useful thread, but I note Michael's emphasis on using tests to identify -- using testing to identify risk before deaths start. He wrote: (as read)

> "When it comes to long-term care staff, monitor symptoms closely, test early, test broadly, and support workers from immediately staying off work for any compatible symptoms. It's well known that symptoms can be very low grade."

So this is knowledge that's been around in Canada, again, since March.

When I look back, and I must say more recently, my focus has been more on trying to forecast intensive care unit resources -- is they'll be, sort of, consumed by what seems to be a coming COVID wave. But when I look back on this time, March and April of 2020, I see at least nine fundamental errors that were made in Ontario that resulted in the tragedy that unfolded.

The first of these was denial of community transmission in Ontario in March 2020. The second was failure to acknowledge transmission by asymptomatic, presymptomatic, and minimally symptomatic individuals which I think is on ongoing problem in Ontario.

COMMISSIONER FRANK MARROCCO (CHAIR): Doctor, can I just stop you there for a minute?

DAVID FISMAN: Of course.

COMMISSIONER FRANK MARROCCO (CHAIR): Denial of community transmission, transmission by asymptomatic people, when you say an error, do you mean that's something that was known at the time --

DAVID FISMAN: Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- to be incorrect --

DAVID FISMAN: Yes. Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): -- or thought to be by --

DAVID FISMAN: Yes. Yes.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DAVID FISMAN: Absolutely, and I'll elaborate on that in a moment.

COMMISSIONER FRANK MARROCCO (CHAIR): Sure.

DAVID FISMAN: The application of influenza outbreak protocols including three tests and then no more testing to COVID-19 outbreaks in long-term care, I think that violates what ethicists call the rule of rescue. And, of course, COVID's very different from influenza in that we have no vaccine and no medications that can be used for prophylaxis.

There was failure to emulate successful strategies from B.C. in a timely manner. There was a failure to decouple our long-term care facility network by restricting staff to single facilities which resulted in this killer network.

We had failure to provide adequate PPE, personal protective equipment to long-term care staff, thus failure to create bidirectional

protection for staff and residents.

We know -- we understand this better now since the summer that aerosol transmission is probably important in long-term care, and I've got a link to a very important paper there for you.

Failure to create economic security and dignity for part-time workers at long-term care which would obviate the need to work at multiple facilities; failure to apply high throughput tests to identify presymptomatic infection in PSW and other workers, ongoing problem; and failure to apply the precautionary principle.

And this is a quote from my late teacher who was a pretty wonderful guy who taught me infectious disease epidemiology. Jonathan Freeman was very interested in understanding communicable diseases and how they spread, but as he used to teach us, your job is first and foremost to make it stop.

COMMISSIONER FRANK MARROCCO (CHAIR): M-hm.

DAVID FISMAN: And I -- I think the -- that's reflected in the precautionary principle that we can make errors of commission when we make good-faith efforts to stop epidemics and outbreaks.

This is an email that I sent on March the 24th when I was very angry about a press conference that Dr. Yaffe had given in which she -- again, this is March the 24th -- said that there was no community transmission of COVID in Toronto. And I apologize for the tone of this email, but I was very angry. I wrote: (as read).

> "Why is [Dr. Yaffe] doubling down on the community transmission stuff? Have you seen the poppycock she's been spouting in the Globe and Mail? [Name]..."

COMMISSIONER FRANK MARROCCO (CHAIR): You really didn't agree with her.

DAVID FISMAN: You know what, I -- and I wrote this email when we had six deaths in long-term care, you know, so about 2,000 left to go. I wrote: We're admitting people to the Toronto Western Hospital -- where I was working at that time: (as read)

> "-- whose exposures have been raves and Bay Street tax seminars, no travel.
>
> Our first -- the first man we intubated at the Toronto Western Hospital was a --

was a semiretired attorney who had a single outside-the-house exposure which was to a tax seminar on Bay Street. I wrote: (as read)

"What [Dr. Yaffe] is doing is awful. It undermines public health messaging and is patently false. We have a long-term care outbreak now -- "

This was connected to Michael Garron Hospital where I also worked: (as read)

"-- where staff worked with mild respiratory symptoms because it couldn't possibly be COVID. These personal support workers joked about it. But they haven't travelled, and they didn't know anyone with COVID, so according to [Dr. Yaffe] that’s unlikely COVID."

And I wrote: (as read)

"I am assuming you're all up to speed on what mortality of COVID looks like in long-term care...that is coming."

What I was incorrect about here is

I went on in the next paragraph to say: I think this will also saturate our ICU resources. And, of course, as it turned out, people were not moved from long-term care to intensive care units but largely died in the homes. This was some --

COMMISSIONER JACK KITTS: Can I just -- Dr. Fisman, can I ask a question about just the precautionary principle? I'd like to -- I'd like to hear your opinion on why -- why we wouldn't use the precautionary principle. Is it a fact that the nine -- or the eight fundamental errors led to not using the precautionary principle?

DAVID FISMAN: I can't answer your question because I don't understand it. I don't understand it at all. I think that repeatedly not just in long-term care but throughout this pandemic in Ontario, we've had arguments about things like masks, arguments about things like bunk houses and migratory workers where the precautionary principle would clearly state that if you're in doubt and if you're operating under uncertainty, you err on the side of caution.

And that's actually in the Health Protection and Promotion Act. That's been -- I think that's been validated by -- I'm trying to

remember -- Dr. Nesathurai's recent case that went before the Ontario Court of Appeals where the Court of Appeals noted that, you know, he was making a well-reasoned decision when he restricted occupancy of bunk houses even if there wasn't certainty. That -- you know, that -- we're supposed to do that. That's one of the lessons from the Naylor Commission in SARS is that we failed to use the precautionary principle last time.

So I think there have been numerous branch points over the course of this epidemic in Ontario where we haven't used the precautionary principle. And I think -- you know, I think I'm regarded by some of my colleagues as coming across as a bit of a hothead because I've been speaking out quite forcefully about this.

But if we set out a principle that's supposed to guide how we practice in a crisis and then we ignore it time and time again, you know, what is one to say?

This is a picture that I pulled out of an old email that I sent to several medical officers of health who are friends and colleagues of mine on April 11 when we first took a look at mortality in long-term care residents versus older

individuals outside long-term care and, sort of, saw this divergence in terms of death risk. We subsequently wrote this up. It's been published as a paper now. It came out over the summer.

But what we saw is that as of early April because of lockdowns, mortality outside long-term care and older adults was declining, and we saw this rapid takeoff happening in death risk in long-term care. And this is a model that was built based on 80 deaths in long-term care. So we'd gone from six on March the 24th to, I think, this analysis is April the 7th; now we have 80, and it was very clear what the trajectory of this was.

We also wrote -- I'm not sure if this is going to be particularly clear -- we also could see in the data from long-term care that what predicted death in residents were these yellow dots which are infections in staff. A relative risk of 1.0 is a null effect -- null effect, so for these blue dots, you have the confidence intervals mostly overlapping one.

So infections in residents did not predict deaths in residents. Infections in staff were highly predictive of deaths in residents, so you could actually, at this point, see

directionality, see how this was playing out, that it was infected staff who were in these homes infecting residents which I think for folks who know how -- who have been in the long-term care setting, know that many residents are -- many residents are less mobile and unlikely to be moving around and infecting one another. And in fact, they're connected by the movements of staff. So what you see here is directionality in transmission.

And this is what we wrote. This was a preprint draft. We posted this on April 14th. It come out on April 17th on a preprint server where it still sits. But we wrote this on April 14th: (as read)

> "In summary, we document that the rapid movement of COVID-19 through Ontario's long-term care system has resulted in a marked surge in mortality in that population, as compared to community-living elders.
>
> We find evidence that links mortality to infection in LTC staff, highlighting the urgent need for

improved infection control, more widespread testing, access to personal protective equipment, and economic protections and support for those who do this important work."

So, you know, I think -- I think much of -- much of what we're talking about now was visible and foreseeable in March and April.

And that ends my formal sort of slides, but I wanted to share that, and I will send those. I will send those.

COMMISSIONER FRANK MARROCCO (CHAIR): Do you think we're any better situated today than we were back in March and April?

DAVID FISMAN: I do. I do. I think -- I think that -- I think we're -- I think we're starting to get into trouble, and, you know, we -- I think as of yesterday, we had seen 200 deaths in long-term care since September attributable to COVID.

But when one looks at the pattern, and I -- you know, and I think -- I think the interim recommendations from this commission have helped a lot. When one looks at the pattern, it looks like linear growth in deaths, so it's a straight line

upwards which is very different from that concave upward shape that I showed you from April which is, sort of, that very explosive exponential increase in death risk.

So looking at the numbers, I don't regard them as positive or really even acceptable, but I regard them as a vast improvement on what happened to us in the spring.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

DAVID FISMAN: I want to turn this over to Ashleigh who has a lot to say. I tend to talk a lot, and --

COMMISSIONER JACK KITTS: Can I just -- can I just ask --

COMMISSIONER FRANK MARROCCO (CHAIR): Yeah, go ahead.

COMMISSIONER JACK KITTS: -- if you could -- if you could, would it be easy to put your second last slide up? Because I want to see what the contributing --

DAVID FISMAN: Of course.

COMMISSIONER JACK KITTS: -- factors were. Yeah, the one before that. Yeah.

DAVID FISMAN: Is this the one?

COMMISSIONER JACK KITTS: That's the one. So we know that in Wave 1 that there didn't seem to be enough PPE. We also knew that the IPAC preparation was -- could be better. We weren't doing widespread testing, so have we, in Wave 2, satisfied -- tell me how satisfied you are that we've improved significantly in those contributing factors for Wave 2.

DAVID FISMAN: Ashleigh, do you have a comment on that? Or --

ASHLEIGH TUITE: I mean, I don't work in long-term care. I don't work in that setting, so I don't feel qualified to talk about the preparations within the home. I think, you know, based on what we're seeing in terms of the epidemiology in terms of the average size of the outbreak, it looks like the outbreaks are smaller.

But, you know, having said that, it's still early days, so I don't -- I don't know that I can comment beyond that.

DAVID FISMAN: I think there's -- I think there's a different appreciation of how deadly this can be, and some of the things that we were seeing in the spring, for example, a colleague of mine, Janine McCready at Michael Garron, had a

situation where they had an individual hospitalized with COVID whose family members worked either in long-term care or as -- one of them worked in a meat-packing plant actually. And the difficulty that that person had was, you know, Janine's told to -- you have to isolate, and this individual's response was, well, if I isolate, I work at a long-term care facility; they'll fire me.

And Janine, you know, contacted that long-term care facility and sort of laid down the law a little bit there in terms of why this person can't come.

I don't -- I hope that the situation's improved with respect to some of that. I think there is more widespread use of testing in long-term care. I think there was that initial blitz in May where people really got a better handle on the epidemiology by doing widespread testing in long-term care. And it's my understanding that there is more aggressive testing of staff in long-term care now.

But as with Ashleigh, you know, I think -- I think the wave that I know best is the first wave which is, sort of, where we were very focused on this, and I think others have moved into

this area now; and I think a great person to talk to would be Nathan Stall who's our colleague from Mount Sinai who's really taken over -- you know, taken up the torch in terms of following long-term care epidemiology very closely, and I think Nathan is probably a better person to ask about what's better and what's not better.

THE COURT: Yeah, he was here this morning, Doctor.

DAVID FISMAN: Oh, excellent. He's great.

COMMISSIONER JACK KITTS: Thank you.

DAVID FISMAN: Sure.

COMMISSIONER FRANK MARROCCO (CHAIR): What -- in terms of the -- of the first wave, are there, from your perspective, institutional barriers that get in the way of appreciating some of the factors that you've identified, do you think?

DAVID FISMAN: I'm curious what Ashleigh has to say about this. Let me -- let me give you my perspective. I -- I'm a -- my background is an infectious disease physician. I've also worked in public health in Ontario. I was the Medical Officer of Health in Hamilton in

the early 2000s, and I got seconded to Toronto Public Health during SARS because they were shorthanded, so there's sort of a bit of compare and contrast.

The reason I'm back in Canada is I'd moved to the States and came back somewhat at the invitation of Dr. Don Low who was helping build the new Provincial Public Health Agency. And the idea in 2008, 2009 was we were going to build something that is arm's length and science-based, so I came back to join Public Health Ontario.

I didn't last there very long. I was gone by September 2009. I found Public Health Ontario to be extremely bureaucratic. There were issues around politics and the uses of data and saying the wrong thing, and it was not my speed. And a job came up at the University of Toronto, and I moved; and I've been there ever since, and I know a number of other scientific staff, some of whom I continue to collaborate with, also left Public Health Ontario.

So to me, you know -- and this is my -- this is certainly -- this is a bit of an egocentric world view here, but based on -- based on my experiences in Public Health in Ontario over 20

years, I think we do have cultural problems. I think -- I think we do tend to go with -- how shall I put this -- I think dogma over science. I think there's a resistance to new ideas. I think there is a tendency to not want to make hard decisions in real time.

And when I look at COVID in Ontario now and look back at SARS 20 years ago, you know, I don't -- I don't feel like much has changed. The public health -- the organization that was proposed which was supposed to look like -- something like the British Columbia CDC, was very rapidly -- I think by the time I left in 2009, it was already clear that this was simply becoming another, you know, adjunct Ontario Ministry of Health. And the science and creation of new knowledge and arm's length were not -- were not kind of concepts or principles that were going to be embraced, and so I left.

And I think -- I think a pandemic is a stress test for a public health system in terms of its ability to be nimble and be innovative and be brave because by definition, the challenges are new, you know. It's a new disease. That's what makes it challenging from a disease-dynamic point

of view. The newness means that the entire population's susceptible.

So that does a couple of different things. One is it makes the reproduction number very high because transmission is shut down by partial immunity in populations, right? So that's why we've had these very -- you know, these high rates of transmission.

The second is that older individuals in populations usually have early-life immune experience that protects them against death from infectious diseases because you've seen it before, and we saw that in 2009 with H1N1.

What you have here is a disease where you don't have that advantage which is why it's so lethal in older people. They don't have the advantage of a lifetime of immune experience.

You have a brand-new virus that also behaves in some funny ways. It's transmissible in people who don't have symptoms which makes it -- that's one of the hallmarks of a disease that's difficult to control.

You have a disease that you're, sort of, learning about in real time, and for each one of these things, you actually need to be up to

speed on what the science is in Canada and elsewhere. You need to be open-minded and not looking at things, like, you know, what we've always done for flu outbreaks and then applying that to this just because it's a respiratory virus. And you need to be able to roll with the punches a little bit and admit that you're wrong.

And I don't think -- I don't think the culture in Ontario welcomes any of those things. I think we saw that with masks over the summer. I think we're seeing it with masks still. You know, the idea that physicians have always had a certain dogma around droplet versus airborne, and even as we've had aerosol scientists come to us and say, you know, this is how aerosols work; what you've been teaching each other is incorrect. There's absolutely -- there's absolute reluctance to, sort of, let go of that dogma and say, we were wrong; we need to acknowledge that we were wrong, and we need to move on; we can't spend months learning about this because the pace of events doesn't allow it.

And I think culturally, we are not really equipped to deal with a novel rapidly evolving, rapidly changing, highly lethal public health threats in Ontario. We can't move fast

enough. Folks who are at the top of the totem pole don't want to acknowledge that they're wrong. And we simply don't have a -- kind of, a ruling caste in public health that is able to, kind of, keep up with new knowledge about a novel disease as it emerges. And I think that's been -- you know, I think that's at the core of our problem. It's not that the information wasn't available. It's not that you couldn't see what was coming. I mean, we're not particular genius epidemiologists, but this is, if you chose to look at the data, this was slap in the face obvious in March and April what was coming down the pike.

It's a matter of being prepared to pay attention, acknowledge you were wrong, and respond appropriately in a way that tries to protect, you know, the health and the lives of the population that you're supposed to be protecting.

And I'm just not sure what we need to do to bring about that kind of cultural change. You know, we -- I mean, the Naylor -- the Naylor Commission -- there were two other Post-SARS Commissions, they all sort of said the same thing, and it's one thing to say the words, and it's another thing to actually walk the talk.

That's a bit of a long-winded answer, but I think we have very deep-rooted problems in the culture of public health and medicine in this place.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Coke.

COMMISSIONER ANGELA COKE: So I'm just trying to understand when you gave some examples earlier how B.C. had seemed to have done a better job or seemed to be more on top of things, do you think that's because they have a different approach to the things you've just spoken about, or are there other factors that you think enable them to be somewhat more successful than Ontario?

DAVID FISMAN: I'm not sure. I've long regarded B.C. as the gold standard for, sort of, professionalism and competence and scientific orientation in public health practice in Canada. They've had the -- in the early 2000s, they started the British Columbia Centre For Disease Control which I've described to people as almost like a Russian nesting doll where you had this institution on the ground of some of the B.C. -- UBC teaching hospitals which was a public-health institution but which also served as sort of a clinic and as a

clinical-care hub for things like TB and sexually-transmitted infections.

And then within the institution, there was the University of British Columbia Centre For Disease Control which lived in the B.C. CDC and, for example, provided them with mathematical modelling and expertise. So you had these different pieces of a jigsaw puzzle that fit very well together.

You also had in Dr. Bob Brunham a scientist who had come to public health, and I think his orientation was and is -- I think Dr. Brunham is retired now, but his orientation was always very much on using good science to protect people and help people.

And I think, in Ontario, that's always been upside down. I think folks have tended to come through an institutional public health background, and the idea is, well, we could use science if you needed it. And I think that different orientation has set them up differently.

I mean, I don't agree with everything British Columbia has been doing as of late. I think they've also pushed back on masks. I have tremendous respect for Dr. Henry as a person and

as a friend -- I'd count her as a friend. I don't agree with everything that she has done.

But I think that ability to sort of roll with the punches and acknowledge your imperfections and communicate that to a population, I think, has served them very well, and I'll admit that I -- you know, I -- when I came back to Ontario, I thought working at Public Health Ontario was -- I had passed by an opportunity to work at B.C. CDC and always regretted it, so I'd sort of thought this was my mulligan that I'd get to work at a place like that. And it didn't work out that way, so I'm still puzzled why we can't get that to work here.

You know, I look at some of the things that we could do in Ontario. I look at the fact that, you know, the British Columbia -- the B.C. CDC lab has kept pace with the requirement for testing. You know, they haven't had these sort of boom-bust cycles of test collapse, test collapse as we've had in Ontario. They're using phylogenetics, which is genetic fingerprinting on the virus strains to identify their hotspots and where transmission's happening. We have that capability technically. We should have it in Ontario, but

we're not using it. Their infectious disease modellers have been integrated into, you know, their disease response from the get-go.

So, you know, it's sort of -- I think there's this willingness to use the tools that are in the toolbox, or rather than, I think, in Ontario, let things reach a point where it's a crisis and then say, oh, you know, we could maybe ask some scientists what to do in this situation. I think that integration is a very different model and has served them very well.

I should stop talking and let Ashleigh talk because I sure talk a lot.

COMMISSIONER FRANK MARROCCO (CHAIR): Ashleigh.

ASHLEIGH TUITE: I actually don't know that I have anything to add to what -- to what David said. I mean, I think, you know, in terms of the questions around institutional barriers, I mean, I don't have as long a history working in public health as David does, but I was around for H1N1. And, you know, a lot of the conversations that we have are the same conversations that we had then, you know, in terms of needing to update technology and have systems in place and be more

nimble. And, you know, there just doesn't seem to be -- you know, the crisis goes away, and things revert back to normal.

And I think the thing that's been surprising to me is the fact that, you know, you have so many people who are, you know, nominally outside of institutional public health, you know, people working at universities, people working -- you know, clinicians who are doing a lot of the heavy lifting here in terms of the science, in terms of, you know, trying to call -- call to arms in a sense, you know, the fact that we were publishing this -- these sorts of analyses on long-term care homes, and that wasn't coming from -- you know, within Public Health Ontario or within the Government. It's surprising to me given the fact that, you know, we have that capacity, and you know, that should be the, sort of, bread and butter type of analysis that's happening by our Government scientists. You know, they should be monitoring this and helping, you know, move the science forward.

COMMISSIONER FRANK MARROCCO (CHAIR): I have the -- I have the impression from some of what I've heard that there was a reluctance or is a

reluctance to access the expertise that's available in our hospitals.

Do you have a view about that? Either you or Ashleigh, but -- or both of you, but do you have a view about that?

DAVID FISMAN: I think -- I think that's interesting. Something that I suspect is going to evolve in the coming weeks is we've almost split off into -- you know, I like -- I suspect most in Ontario don't really know who makes the actual decisions, and I think that's a separate conversation is who is giving the thumbs up and the thumbs down to different policies.

I can speak more to what's happening in terms of advisory bodies, and I think there have been some very positive changes there that mostly I would lay at the feet of Steini Brown who's my boss at the School of Public Health and is -- again, has been a long-time personal friend but have sort of been lucky enough to get to work with him during this crisis.

And Steini actually established a Modelling Table. It's called the Modelling Consensus Table which I think is a bit jarring to anyone who does infectious disease epidemiology or

modelling. The idea is not consensus. The idea is figuring it out and identifying where the differences between different groups come from and digging down into that. But at any rate, that's what it was called.

Was -- there was a success over the summer and was followed by a science table that's now chaired by Peter Jüni, who's another really excellent colleague at St. Mike's table, and Beate Sander who took over the Modelling Table at this point, she's at the University Health Network. And I think both of those groups are doing very good work.

I think what you saw this past week or so with Ontario's new guidelines speaks to the limitations of that approach where I know from, you know, emails within the group with the Modelling Table, we were blindsided by Minister Elliot saying that the new -- the new benchmarks and guidelines had been based on advice from the Modelling Table, and I think she's walked that back now.

But there's been a lot of discomfort within the group and a lot of private conversations about whether it's ethical to continue in this vein if we are going to serve on science and modelling

tables that are not only advising the Government, but we really -- you know, are used more or less as window dressing, were used as a scientific fig leaf for bad policy decisions which we would never endorse. I think that's really problematic, and I think we could do more harm than good in that regard.

There's another table called the Public Health Measures Table. The Modelling Table -- the Science Table actually posts its guidance. We have a website, and the Modelling Table's now followed suit. We have websites where we post stuff, and the Public Health Measures Table is a completely different table that doesn't overlap and whose deliberations are not public.

And I think with this, sort of, walking back of whether or not the new guidance came from the Modelling Table now, it's been, sort of, laid at the feet of the Public Health Measures Table; and none of us can really comment on that.

So I think -- I think one difficulty that we're into in Ontario is you've sort of got this Byzantine structure where you have all these different groups and tables, and who knows how the information flows; or, you know, it also sets up

the opportunity of the divergent tables; you know, you can cherry-pick which one you listen to. And I think that's a problem.

So I think there's -- you know, I think the Modelling Table and the Science Table have been excellent developments that I would not have expected based on how things played out in the spring. But I think the difficulty is how is that -- how is that information used.

There, sort of, seems to be a little bit a separatist movement brewing at these tables now where folks are starting to talk about, you know, should we just split off and start a group like the SAGE -- the SAGE Group that they have in the UK that's totally independent of Government because there is -- there is tremendous frustration that we're, sort of, linked to Government and not only giving advice, but that advice is not necessarily, sort of, heated in any meaningful way.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, I don't have any further questions.

Dr. Kitts, did you?

COMMISSIONER JACK KITTS: No. Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR):

Commissioner Coke?

COMMISSIONER ANGELA COKE: No. That was good. Thank you.

DAVID FISMAN: Thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, thank you very much, Doctor. This is -- I certainly found it helpful, and I've been trying to sort out for myself what was known when and in order to avoid the evils of hindsight.

DAVID FISMAN: Right.

COMMISSIONER FRANK MARROCCO (CHAIR): I do appreciate the slide presentation for more reasons than that, but that in particular. And thank you for the effort. It's helpful to us, and we'll look forward to staying in communication with you as we go forward.

And we're kind of like -- we're kind of like -- we can't be -- you can't be cured from us. We don't go away. We just keep -- we just keep coming back in waves.

DAVID FISMAN: Well, I want to thank you for your work because, as I say, your preliminary inquiry recommendations, I think, were spot on, and I think there are people alive now who are alive thanks to those. So thank you for that.

And, you know, I can't speak for Ashleigh, but I'm certainly at your disposal moving forward.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you. It gives us a certain amount of renewed energy to hear something like that, so thank you very much. Good-bye now.

COMMISSIONER JACK KITTS: Thank you. Thank you both.

COMMISSIONER ANGELA COKE: Thank you.

COMMISSIONER JACK KITTS: Thank you.

-- Adjourned at 1:43 p.m.

REPORTER'S CERTIFICATE

I, JANET BELMA, 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 13th day of November, 2020.

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PER: JANET BELMA, CSR
CHARTERED SHORTHAND REPORTER

Page 32, line 1: “counter” should be “count her”.

Page 35, line 10: “turned” should be “took over”

Page 35, line 11: “be added to” should be “she’s at the”

Page 37, line 14: References to the “Sage” Group should be “SAGE” Group.

WORD INDEX