

Long Term Care Covid-19 Commission Mtg.

Dr. Turnbull
on Wednesday, December 16, 2020



77 King Street West, Suite 2020
Toronto, Ontario M5K 1A1

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7	MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION
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14	--- Held via Zoom Videoconferencing, with all
15	participants attending remotely, on the 16th day of
16	December, 2020, 9:00 a.m. to 10:00 a.m.
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1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

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7 PRESENTERS:

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9 OTTAWA INNER CITY HEALTH INC.:

10 Dr. Jeff Turnbull, Medical Director of Ottawa

11 Inner City Health

12

13 PARTICIPANTS:

14

15 Alison Drummond, Assistant Deputy Minister,

16 Long-Term Care Commission Secretariat

17 Ida Bianchi, Counsel, Long-Term Care Commission

18 Secretariat

19 Kate McGrann, Counsel, Long-Term Care Commission

20 Secretariat

21 John Callaghan, Counsel, Long-Term Care Commission

22 Secretariat

23 Lynn Mahoney, Counsel, Long-Term Care Commission

24 Secretariat

25 Derek Lett, Policy Director, Long-Term Care

1 Commission Secretariat

2 Dawn Palin Rokosh, Director, Operations, Long-Term
3 Care Commission Secretariat

4 Jessica Franklin, Policy Lead, Long-Term Care
5 Commission Secretariat

6 Adriana Diaz Choconta, Senior Policy Analyst,
7 Long-Term Care Commission Secretariat

8

9 ALSO PRESENT:

10 Deana Santedicola, Stenographer/Transcriptionist

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1 -- Upon commencing at 9:00 a.m.

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3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 I think you probably know basically the
5 way we are conducting this. We will have a
6 transcript which we will post on the website in a
7 few days.

8 We tend to ask questions as we go
9 along, if that is okay.

10 DR. JEFF TURNBULL: Absolutely.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 And I don't know that there is anything
13 else. I think we are ready to go when you are,
14 Doctor.

15 DR. JEFF TURNBULL: Then I'll begin. I
16 understood that we have about an hour. If that is
17 still acceptable, then --

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 Yes.

20 DR. JEFF TURNBULL: What I thought I
21 would do is present to you our recommendations
22 through the Royal Society of Canada. Now, I'll
23 explain that a little bit.

24 The Royal Society of Canada is an
25 academic organization of experts right across the

1 country, and they were taken by the impact of
2 COVID, and they turned to people who are caring for
3 different vulnerable populations, and they said,
4 Would you mind writing a report?

5 And I know that there has been one
6 co-authored by Sharon Straus that dealt with
7 long-term care.

8 Ours deals with how we deal with COVID
9 within the context of another conjugate setting,
10 and that is in the homeless environment.

11 And so what I thought I would do is
12 present -- use that as a focus, the recommendations
13 that we provided, and first tell you a little bit
14 about homelessness so you understand some of the
15 challenges that we face, and then tell you about
16 some of the recommendations that we have
17 implemented right across the country, actually, to
18 try and minimize the impact of COVID-19 on this
19 very vulnerable population.

20 And I think that you will see, as we go
21 along, that there are some very direct parallels to
22 the long-term care environment.

23 So that is what I thought I would do,
24 but first let me begin by talking about the issue
25 of homelessness and so that you can see the

1 challenge that we face when we have a pandemic such
2 as COVID or any other respiratory contagion,
3 whether it be H1N1, influenza or other issues.

4 So if we could move to the next slide.
5 So, first thing, let's dial back before we started
6 COVID, and I will explain to you what homelessness
7 is like, and then we'll talk about the advent of
8 COVID.

9 So homelessness in Canada, there are
10 tonight, at any one night, about 35,000 people who
11 will be in an emergency shelter. Ottawa, that is
12 1,000 people last night. It is cold now, so by
13 around 4 o'clock we would have met all of our full
14 capacity in our regular shelter beds, and we'll be
15 rolling out cots in the chapel and common areas.
16 And so we will try and get people in out of the
17 cold by around 4:00 or 5:00, get them some food and
18 into their respective beds or on the cots.

19 And so you have to understand that --
20 first of all, the circumstances. We have massive
21 over-crowding. So people are, you know, really
22 cheek by jowl. We have one room at the Shepherds
23 of Good Hope that has 70 beds. These are
24 three-bunk beds, three bunks high, right
25 throughout, about 30 of these beds. So that is

1 just one room in our shelter that is housing a
2 thousand people throughout the city.

3 We have acute men and women's shelters,
4 five of them, and that will house the 1,000 to
5 1,200 people every night. So a lot of crowding.

6 At the same time, you'll line up with
7 about 200 other people for your meals. There is
8 one washroom per floor, and so hygiene is a
9 challenge. And at the same time, think about the
10 individuals. They are very vulnerable, their
11 age-adjusted mortality rate is about 20 years older
12 than their stated age. So if you are 50, you are
13 really 70. The likelihood of getting to the age of
14 70 in a shelter is only 20 percent. So these are
15 sick people. They have chronic obstructive
16 pulmonary disease. They have all sorts of issues
17 related to mental health and addictions and the
18 complications of all of that and the violence of
19 living in a shelter. So these are the chronically
20 homeless.

21 And so we have a population of very
22 vulnerable people, vulnerable in terms of their
23 physical and mental health, not particularly
24 compliant with anything that you might want to ask
25 them to do, such as wear masks, et cetera, sleeping

1 in very, very congested conjugate settings.

2 And we thought that when COVID was --
3 there was a discussion about COVID. We thought we
4 were going to be overrun. We could just see that
5 when COVID got into this population that there
6 would be absolutely no way that we were going to be
7 able to restrict its growth and development, and it
8 would have a huge impact.

9 So that was the circumstances that we
10 were facing with.

11 At the same time as COVID was starting,
12 many of the care providers withdrew their services
13 from the homeless setting because of the risk of
14 contagion. Mental health support and other care
15 providers, social services, et cetera, stopped
16 providing services in the shelters and said, Oh, we
17 can do that at a distance with FaceTime or whatever
18 that might be.

19 Well, this is not a population that
20 deals well with FaceTime. They don't walk around
21 with their cell phones, and they don't walk around
22 with -- or their encounters, they lack trust in the
23 best of times and then their encounters on a
24 regular basis are infrequent. So it's a challenge.

25 So you can imagine, as I was thinking

1 about COVID, I was thinking, well, this is going to
2 not be good for our community. It is not going to
3 be good for other conjugate settings. It won't be
4 good for people on reserves, et cetera.

5 But we knew that we had a massive
6 problem on our hands, and we had to respond
7 dramatically.

8 So if we could go to the next slide,
9 please. These are a series of recommendations, and
10 I am going to speak to each one. They are not that
11 sort of relevant, per se, but it is more the
12 discussion. So feel free to ask me questions about
13 them.

14 But as I go through them -- there is
15 eight or so, and then I am going to tell you about
16 just what happened in the end and were we able to
17 contain COVID within this environment and then why.

18 So the first one, it became immediately
19 clear that in our environment, as opposed to
20 long-term care, this is -- long-term care is
21 housing and health. Homelessness is homeless. It
22 is housing, with very little emphasis on health.
23 There were no regulations on IPAC that applied to
24 homelessness. There was a mass of different people
25 who are playing different roles. Just think about

1 it. We have the shelters, we have social services,
2 we have the municipality, we have Public Health, we
3 have care providers, all with their finger in the
4 pie, but nobody really running things and nobody
5 coordinating a COVID response.

6 And if you thought that we would have
7 had in advance an emergency response to COVID
8 thought out years before, you would be very, very
9 wrong. This was on the fly, and one of the first
10 things we encountered was there was no regulation,
11 no coordination, and we needed to coordinate
12 dramatically with our hospitals, our service
13 providers, our shelters, all of those different
14 groups that would be required to make decisive,
15 immediate responses.

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Doctor, if I can interrupt for a
18 minute.

19 DR. JEFF TURNBULL: Yes, please.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 This problem presents itself over and
22 over again, this lack of a coordinated response. A
23 lack of leadership, I think, is one of the ways we
24 have articulated it.

25 Do you have any sense of why that was

1 true with the population that you were dealing
2 with, that there was no plan, not so much for a
3 pandemic but for some contagious disease that would
4 run through the population and be bad for
5 everybody? Do you have any sense of that?

6 DR. JEFF TURNBULL: One is that there
7 are so many cooks in the kitchen. That is the
8 first thing.

9 The second thing was that often those
10 cooks don't get along, I have to tell you. They
11 are looking after their own jurisdiction
12 exclusively and not quite thinking about the better
13 good for the whole group.

14 And then I think the other one is that
15 in this environment, we never -- homelessness is
16 just the beginning of a new understanding that this
17 is a health problem, not a housing problem. These
18 people have mental health and addictions that are
19 profound, and that is the challenge in housing
20 them.

21 And so if we can deal with their mental
22 health and addictions and stabilization and have a
23 health component, then I think we would be more
24 fortunate and have a plan if there was greater
25 health input.

1 Now, finally, I have to tell you this
2 world is a world of crisis. We just go from -- we
3 are on our heels the whole time. We went from, you
4 know, opioids to COVID in a heartbeat. We deal
5 with one disaster after the next. So this is not a
6 world of planning. It is a world of reaction.

7 Now, we are good at reacting, as I
8 think you'll see, but on the other hand, we don't
9 plan very far ahead, and it is the culture.

10 Now, I can't say if that would be
11 translated to your environment, but that is our
12 environment.

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 The thing that bothers me, it seems to
15 me the ability to improvise is the function of
16 whether there is a leadership-type person who
17 happens to be in the place where you need them at
18 that moment.

19 DR. JEFF TURNBULL: Yes.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 Some people are in positions but are
22 not leaders, and they can't react in a crisis
23 because either they don't want to take
24 responsibility or they just don't have what it
25 takes.

1 DR. JEFF TURNBULL: Yes, so this is --
2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 And that seems distressing to me
4 because it is happenstance then whether --

5 DR. JEFF TURNBULL: Absolutely. Yes,
6 totally.

7 So let me just tell you -- Jack knows
8 this force of nature that works with me. Her name
9 is Wendy Muckle, and -- so Wendy would not be the
10 person that you would normally run a coordinated
11 program because of her role necessarily. However,
12 everybody turned to Wendy to run this, and we
13 had -- just to tell you, that we needed to test
14 people -- I will talk about this in a minute -- so
15 we had to create an isolation centre, because if
16 you are testing positive, and you happen to be
17 homeless, there is no place you are going to
18 isolate.

19 So we knew we needed an isolation
20 centre. Wendy had the municipality, the hospital,
21 the homeless sector down, and within one week, we
22 had commandeered a community center. We turned it
23 into a hospital-based facility. It had oxygen
24 rooms. It had every facility going. It could
25 support 120 people with COVID. One week. The

1 floors were ripped up because they were carpet. We
2 were putting in negative pressure stuff.

3 This turned into a -- so you are right,
4 it is the strength of personality of probably one
5 person. It may not necessarily be somebody who is
6 the head of Public Health or the hospital or
7 whatever, but everybody came together and said,
8 Yeah, we've got a problem.

9 And Wendy, just by virtue of the fact
10 of her personality, which is -- unfortunately you
11 can't guarantee that it is going to be there in
12 every place, just as you have said.

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 Yes, that is a problem. It is
15 frustrating too because we have heard repeatedly of
16 examples where people created temporary facilities
17 in a matter of a few days or a couple of weeks, and
18 it got them through the problem, which in the end
19 is all you are really trying to do. You are not
20 building a pyramid here. We are erecting a tent.

21 DR. JEFF TURNBULL: Yes. So --

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 Anyway, I'm taking you off the --

24 DR. JEFF TURNBULL: No, no.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 I should be listening and not giving
2 away some of the thoughts that are rattling around.

3 DR. JEFF TURNBULL: And so I'll give
4 you some other examples of just how I think we have
5 an advantage because we are unregulated. We have a
6 disadvantage because we are unregulated. But we
7 were able to be flexible, quick, nimble, and
8 responsive because we are the only game in town,
9 and we don't have to worry about regulations, and
10 we had some very good partners who helped us out.

11 So the next thing we did was we said we
12 are in trouble if we don't support our service
13 providers, and here we had a much broader view of
14 people who are service providers. These are not
15 just my health care staff in the shelters and my
16 colleagues. It is, you know, the person who is
17 serving lunches in a shelter. It is the person
18 cleaning. And we recognized if we can't help that
19 first-line group of people and protect them, they
20 won't be able to protect the homeless.

21 And so we spent a lot of time early on
22 educating them about infection control. This was
23 new for them. Unlike, I think, in the long-term
24 care world, this kind of hygiene and personal
25 protective equipment, all of that kind of stuff,

1 that was new to this community. So we spent a lot
2 of time talking to them and trying to educate them
3 about how to be safe for themselves and then how to
4 be safe for their clients.

5 And so we early on didn't have enough
6 PPE, like the long-term care, but again, what we
7 did is we put the word out. And I have to say --
8 and Jack will know Leonor Ward, who used to work
9 with me at the hospital, she said, All right, what
10 do you need? And we said we need -- oh, we need
11 gowns and we need masks. How many? Oh, 3 or 4,000
12 at least that we would have to, you know, get
13 cleaned on a regular basis, but at least let's
14 begin with 4,000. One week later, all the sewers
15 in Ottawa, Huntsville, Bancroft, were sewing gowns
16 and masks, and they were on our door in a week. It
17 is just amazing.

18 People donated hand hygiene equipment,
19 you know, alcohol. They donated masks. They
20 donated visors. It was amazing. And the hospital
21 was a great supporter, because if these people were
22 not going to stay with us, they were going to be in
23 the hospital, and so the hospital, you know,
24 recognized very quickly that they better be part of
25 this.

1 And then this gets to the
2 recommendation 3 here, got to the exact same place
3 where you were, decongesting our shelters. You
4 know, how could you really control COVID if you
5 have got a 70-bed room? Just impossible.

6 And so what has happened is a lot of
7 people have moved into encampments on their own
8 volition. They feel that the shelters are too
9 unsafe. So that is a new problem for us, how do we
10 service those encampments, especially during the
11 winter.

12 But very quickly we went to our hotels
13 around us, the university, and they all volunteered
14 space. We commandeered the Jim Durrell Community
15 Centre. We commandeered different hotels and
16 immediately started to decant people who were in
17 shelters and get them out of those congested
18 environments.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 Doctor, if I could stop you for a
21 second. As I look at the recommendations, you
22 know, put somebody in charge, support the support
23 workers, be prepared to move people out, how long
24 did it take to realize that these were the things
25 you had to do to have even a chance at controlling

1 this thing?

2 DR. JEFF TURNBULL: I think these
3 things are self-evident, you know. If you sat down
4 in a quiet moment, you would say, somebody
5 better -- we better be able to govern this, and you
6 better look after your staff, and you had better
7 decongest and manage outbreaks, et cetera. You
8 know, this is not rocket science. This is project
9 management is what this is.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Yes.

12 DR. JEFF TURNBULL: However, the
13 implementation of it is challenging, getting your
14 partners together, getting that sense of urgency,
15 you know, just doing it and worrying about the
16 money later.

17 COMMISSIONER FRANK MARROCCO (CHAIR):

18 Yes.

19 DR. JEFF TURNBULL: Getting on with --
20 you know, if somebody is in the way, then, you
21 know, just go around. We can't afford to have
22 petty politics affecting the life of our people.

23 And so we just moved ahead, and you
24 might say this is the jurisdiction of Public
25 Health. But we found Public Health at times -- you

1 know, they would give us conflicting advice. They
2 were not supported or staffed to make major inroads
3 here. And so even though they felt perhaps that
4 they should be engaged more and do more, we, to be
5 honest, didn't feel that they were in a position to
6 lead. And they became very good colleagues in
7 supporting us as we went ahead, but we were not
8 waiting.

9 I think it makes sense that you have an
10 outbreak management plan. That is pretty easy.
11 However, what is an outbreak? How do you define an
12 "outbreak"? What is going to happen to the people
13 in your facility if you have got 200 people in a
14 facility that it now has an outbreak? Are you
15 going to restrict them, prevent them from moving
16 around? Are you going to decant that population?

17 Remember, these people have mental
18 health and addictions. They don't stay put. They
19 are moving from place to place. So it is very,
20 very difficult. So we needed that plan in a hurry,
21 and so that very rapidly evolved.

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 Well, you know, there is a similarity
24 because so many residents of long-term care homes
25 have some level of dementia.

1 DR. JEFF TURNBULL: Yes.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 And are in that sense difficult to
4 "manage", I guess, is one of the words that comes
5 to mind, but it is hard to reach a consensus with a
6 person who can't remember what they agreed to.

7 DR. JEFF TURNBULL: Yes, or reach a
8 consensus with somebody who is 35, an opioid addict
9 who is profoundly addicted to their opioids, who
10 has mental health problems, schizophrenia and, you
11 know -- and lack of trust of organizations. So
12 these people move around. They have got to earn
13 money to get to their addictions, and, you know,
14 just the big issue for them are the voices that
15 they hear every day, and when I tell them, I think
16 you should wear a mask, they look at me and sort of
17 giggle.

18 So the next one -- if we can go to the
19 next series, the next slide, and I am going to end
20 on this honestly, I promise.

21 We created isolation centres that I
22 mentioned, but, you know, the isolation centres,
23 they had to be a place where we could support
24 people. So you have to think about who you were --
25 going to be there. They had to be culturally

1 relevant. You have to think that these people are,
2 you know, using and injecting opioids very
3 constantly, so we needed to have a quick Health
4 Canada exemption that would allow us to have a safe
5 injection facility right in the site.

6 We provided them food, and all of our
7 shelters came together and helped us put this
8 isolation centre together in a very short order.
9 As I said, less than a week.

10 Establish and implement screening,
11 testing and contact tracing strategies. It kind of
12 makes sense, doesn't it? But somebody who won't
13 stay put, whose biggest issues are their addiction
14 and mental health, who care very little about
15 COVID -- and 30 percent of my population have a
16 cough and cold anyways at any one point in time.

17 And so figuring out what is a new
18 symptom, figuring out how to test somebody, then
19 telling them that they, once tested, have to go to
20 an isolation facility and await the results, and it
21 may be seven days before they get the results.

22 COMMISSIONER FRANK MARROCCO (CHAIR):

23 Can I just ask you, do you have any
24 sense of what the isolation facility cost?

25 DR. JEFF TURNBULL: Well, it was empty

1 anyway, so we got it from the municipality for
2 free.

3 Then there was the retrofitting, and
4 that was substantial. We had to do many, you know,
5 things like get rid of the carpet, et cetera.

6 But then I think the biggest cost, of
7 course, at the isolation facility would be the
8 staffing, and interestingly, the people who came
9 first and foremost to help staff this were our
10 peers, the people who have lived experience, who
11 have been working with this community, who have
12 been through our programs and recovered to a
13 greater extent. They said, This is our community;
14 we are going to work for free; we'll get this
15 going.

16 And then, I think, you have to
17 recognize that there are different populations that
18 we have, so our Indigenous community, women, people
19 who have a past history of trauma, newcomers,
20 families, children, adolescents. So we had to be
21 respectful of the different populations that we
22 were serving.

23 And then as we start to think about it,
24 we are going to think about the challenges of
25 vaccination for us -- and this is where I'll end --

1 in that you have got two doses. You have got
2 somebody who may not even give you their real name.
3 You'll give them the first dose. If we can find
4 them, if they'll agree, if they are trusting enough
5 by a provider that they know, they'll take a
6 vaccination.

7 However, now you have got to document
8 that, find them in a month, get them a second dose.
9 This is a very mobile community, and it is tough to
10 actually -- you know, as Jack knows, you know, if I
11 ask for an ultrasound, if it is two days away, the
12 chances are that is not going to happen because we
13 can't find them in two days. So how am I going to
14 find these people and make sure they get their
15 second dose? It is going to be very challenging in
16 this environment.

17 So what I wanted to do, if you can
18 just -- I'll end in just a second, but to tell you
19 how did it work out.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 Don't feel unduly rushed, Doctor. We
22 are taking all this in. I think I speak for all
23 three of us. It is a bit presumptuous on my part,
24 but just go ahead.

25 DR. JEFF TURNBULL: So the next slide,

1 if we could.

2 So what are the outcomes? What
3 happened?

4 So as I said, we moved people quickly.
5 Some moved into encampments. Some people we moved
6 into hotels, and so we have been able to decongest
7 our shelters to a greater extent.

8 We created an isolation centre, and we
9 then -- for people who are awaiting test results or
10 who had tested positive. We retrofitted one of our
11 vans that is used for outreach mental health
12 through Telus and that was going to be our testing
13 van. So we went out and tested everybody, anybody
14 who had a sniffle.

15 And remember, that symptoms in this
16 population are very atypical. The most common
17 presenting symptom of COVID, headaches. Not
18 shortness of breath, cough, fever. Headaches. So
19 we had to think of atypical symptoms, and now just
20 think of this population and who has got an
21 atypical symptom? Everybody.

22 So we tested an awful lot of people.
23 We trained all of the kitchen staff of shelters.
24 We trained all our personal support workers and
25 peers. We did a lot of outreach. We got everybody

1 into PPE. And these shelters have been wiped down.
2 They are clean. And we have hand hygiene
3 everywhere, and we have enforced that all of our
4 clients, the homeless themselves, wear masks. And
5 all that has happened in a very short order.

6 So then what we started to do is we
7 started to say, you know, where are all these
8 people with COVID? Maybe they are asymptomatic,
9 because we were -- you know, we were finding one,
10 two cases of COVID every three or four days. Our
11 isolation unit would have anywhere from 10 to 15
12 people in it who are positive, no more. Remember,
13 we've got a thousand people who are at high risk.
14 We thought we would be overrun.

15 And so then we started to actually do
16 surveillance testing and just test everybody in our
17 shelters, and we found the prevalence in our
18 shelters, with all of these precautions, et cetera,
19 to be about 2 percent if there is no cases
20 whatsoever.

21 When you actually have somebody with
22 symptoms, then when we test around, you know,
23 making sure that that person -- you know, we know
24 where they are, we know where they slept, we know
25 who they work with, so we tested all of those

1 people, then you have got about a 14 percent
2 prevalence of COVID.

3 So asymptomatic, about 2 percent is
4 what our prevalence rate was, and if you have got
5 symptoms, it gets up to around 14 percent.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 So seven times as many people?

8 DR. JEFF TURNBULL: Yeah, when you have
9 somebody who has documented symptoms.

10 We have had several outbreaks in
11 different sites.

12 Interesting -- you'll like this one --
13 in one of our women's shelters, we had an outbreak
14 of two people with COVID. And I said, Well, how
15 would these people get COVID? And it turns out
16 that they live in a shelter, but they work outside
17 of the shelter. They just can't earn enough money
18 to afford Ottawa's rental circumstances. And where
19 do they work? Long-term care. And so they brought
20 COVID from a long-term care facility into the
21 shelters where we had an outbreak.

22 And I just -- it was stupid of me. I
23 just didn't think that that would be a likely
24 possibility of people working outside of -- and
25 exposing themselves and bringing COVID in that way.

1 And so we had to say to people that,
2 you know, we don't want you to do that, but on the
3 other hand, if that is the case, then you have to
4 think that they have no income. Some of our
5 personal support workers that work so hard in the
6 shelter environment, they work in two jobs, two,
7 three sites. We had to say no to that and restrict
8 movement, and again, that affected their income,
9 et cetera.

10 So we had a lot of HR issues to deal
11 with, but by and large, right now -- and the
12 fingers crossed -- I would have to say that we have
13 had no deaths. We have a very challenging
14 population. We have a population that is at a very
15 high risk. We should be overrun, but we haven't
16 been.

17 And that could be because of good luck.
18 It could be because of the fact that these people
19 are exposed to a lot of infections and may have
20 been exposed to some coronaviruses in the past and
21 have partial T-cell immunity, or it could be
22 because of all of the plans that we took into place
23 and we initiated immediately.

24 So that is where I'll end, and I would
25 be delighted to answer any questions you might have

1 about our experience.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Well, I think we -- I don't know.

4 Commissioner Kitts?

5 COMMISSIONER JACK KITTS: Yes, I just
6 want to follow up, Jeff, on your comment about the
7 strong leadership that Wendy Muckle provided.

8 You are right, I know her. She is a
9 very strong leader. So from the administrative
10 side, that was evident.

11 I want to state also that you need the
12 medical or clinical side, and I know your head is
13 going to swell, but you provide that leadership.

14 And I think it is the combination of
15 administrative and medical leadership or clinical
16 leadership that brings this all together.

17 And you are right, there may have been
18 some luck involved, but what you have described is
19 what we have been hearing as being an appropriate
20 plan or approach for the past few months in terms
21 of dealing with this, I think.

22 My question is -- clearly the
23 relationships were critical in getting you up to
24 speed so fast, leadership and relationships. Were
25 these existing relationships, or did you have to go

1 out and create a lot of relationships that hadn't
2 existed, given that you said that it is a siloed
3 system to begin with?

4 DR. JEFF TURNBULL: So I thought of
5 that too, Jack, and I was trying to think about
6 what might be a helpful suggestion.

7 The relationships, I think it is
8 important to understand that before COVID, we had
9 brought health services delivery programs through
10 Jack's help and through the hospital, and so we
11 were embedded right in the shelters. We have
12 primary care, secondary level care, even tertiary
13 level care delivered right in the shelter, not in
14 the hospital. Our people do not go to the
15 hospital. We bring the hospital to them. We have
16 palliative care, end-of-life care as well.

17 So that relationship, as Jack has
18 mentioned, was an essential first start. We were
19 there. We had our feet on the ground. It wasn't
20 as if you had to suddenly invite the hospital or
21 care providers in to help. We were there, and we
22 had these links.

23 We worked well with the hospital. You
24 know, we -- and the hospital said, Do you need PPE?
25 You know, we need it for our own staff, the

1 hospital, but they said, If you need it, we'll help
2 you too.

3 And so it was those relationships that
4 existed before that we just built on.

5 But we basically look at the shelters
6 as an extension of the hospital where the hospital,
7 their staff, everything is done within the shelter
8 environment.

9 And so you don't need the hospital as
10 much. You still need them for an ICU, you still
11 need them for an operating room, but we don't need
12 them for an emergency department. We don't need
13 them for primary care or ambulatory care. That is
14 done by us on-site with the hospital coming to us.

15 And it is that model that may be
16 helpful in terms of long-term care and its response
17 to this and any future pandemics.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 How did the relationships get started
20 originally? The reason I ask is Toronto, for
21 example, is a series of neighbourhoods. It is
22 commonly perceived by people to be a big city, but
23 it is actually a collection of neighbourhoods, and
24 in a neighbourhood, you do know where the senior
25 link people are and where the local hospital is and

1 a lot of the doctors live in the neighbourhood
2 somewhere.

3 How did -- the relationships, how does
4 that happen?

5 DR. JEFF TURNBULL: So it happened 20
6 years ago, and the hospitals slowly, through Jack's
7 help -- you know, I mean, I have to say it, Ottawa
8 Inner City Health has now become a huge enterprise,
9 and who does all of our IT work? TOH. Who does
10 our HR work? TOH.

11 So we are supported by the hospitals,
12 and I like to think we give back as much as we
13 take, but -- over these last 20 years, we have been
14 working as an extension of the hospital, and the
15 hospital has been in every shelter, every outreach
16 program. Our nursing program is
17 hospital-supported. We have nursing clinics. We
18 have the hospital ID people doing rounds, you know.

19 It is an integrated kind of approach
20 right throughout the city, and it began 20 years
21 ago, and it has just built progressively since.

22 But when COVID occurred, it was -- you
23 know, it became then very easy to build on those
24 relationships, and just as I said, you know -- I
25 mean, the hospital came to us and said, How are you

1 guys doing? It wasn't as if we were screaming.
2 They said, How are you doing?

3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 There is a common commitment to the
5 health of the community.

6 DR. JEFF TURNBULL: Yes, and, you know,
7 there is self-service there. I have to
8 understand -- you know, those 20 or 30 people that
9 are tested in our isolation centre would be in the
10 hospital.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Right. We don't have any other
13 questions. I just want to say, speaking I am sure
14 for all of us, this has been very informative, and
15 it has been very helpful because it has pulled
16 together, in the context of homelessness, so much
17 of what we have been hearing about successful
18 strategies that could easily be employed and
19 perhaps should have been employed in the long-term
20 care environment as this problem was evolving.

21 And what is also helpful is to realize
22 that even if there was no plans, this can be done,
23 at least in your example, on an ad hoc basis and
24 done quickly and, as the results show, effectively.

25 DR. JEFF TURNBULL: Yes.

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 Thanks so much.

3 DR. JEFF TURNBULL: I sincerely hope
4 that those general principles are generalizable to
5 just about any conjugate setting, you know, or a
6 setting where there is -- you know, maybe it is an
7 Indigenous reserve in the north. It may be a
8 long-term care facility. But I think that these
9 are all principles that hopefully would help us for
10 this pandemic, as we still live it, but, you know,
11 frankly, there is going to be other ones. There
12 will be other crises that are going to affect these
13 communities.

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 All right. Well -- and even if it is
16 not completely applicable, there may be local
17 variations, but at least you have some confidence
18 that your journey is -- you are walking in the
19 right direction to start with, you know.

20 DR. JEFF TURNBULL: Yes. That's right.

21 COMMISSIONER FRANK MARROCCO (CHAIR):

22 Well, Doctor, thank you very much for
23 taking the time.

24 DR. JEFF TURNBULL: No, my pleasure.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 It's very much appreciated.

2 COMMISSIONER ANGELA COKE: That was
3 very valuable. Thank you.

4 COMMISSIONER JACK KITTS: Thanks, Jeff.

5
6 -- Adjourned at 9:40 a.m.

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REPORTER'S CERTIFICATE

I, DEANA SANTEDICOLA, RPR, CRR,
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 16th day of December, 2020.



NEESONS, A VERITEXT COMPANY

PER: DEANA SANTEDICOLA, RPR, CRR, CSR

WORD INDEX

< 1 >

1,000 6:12 7:4
1,200 7:5
10 25:11
10:00 1:16
120 13:25
14 26:1, 5
15 25:11
16th 1:15 35:16

< 2 >

2 25:19 26:3
20 7:11, 14
31:5, 13, 20 32:8
200 7:7 19:13
2020 1:16 35:16

< 3 >

3 16:11 17:2
30 6:25 21:15
32:8
35 20:8
35,000 6:10

< 4 >

4 6:13
4,000 16:11, 14
4:00 6:17

< 5 >

5:00 6:17
50 7:12

< 7 >

70 6:23 7:13, 14
70-bed 17:5

< 9 >

9:00 1:16 4:1
9:40 34:6

< A >

a.m 1:16 4:1
34:6
ability 12:15
Absolutely 4:10
8:6 13:5
academic 4:25
acceptable 4:17
acute 7:3
ad 32:23
addict 20:8

addicted 20:9
addiction 21:13
addictions 7:17
11:18, 22 19:18
20:13
Adjourned 34:6
administrative
28:9, 15
adolescents
22:20
Adriana 3:6
advance 10:7
advantage 15:5
advent 6:7
advice 19:1
affect 33:12
afford 18:21
26:18
after 11:11
12:5 18:6
age 7:12, 13
age-adjusted
7:11
ago 31:6, 21
agree 23:4
agreed 20:6
ahead 12:9
18:23 19:7
23:24
alcohol 16:19
Alison 2:15
allow 21:4
amazing 16:17,
20
ambulatory
30:13
Analyst 3:6
Angela 2:4 34:2
anybody 24:13
Anyway 14:23
22:1
anyways 21:16
applicable 33:16
applied 9:23
appreciated
34:1
approach 28:20
31:19
appropriate
28:19
areas 6:15
articulated
10:24
Assistant 2:15

asymptomatic
25:8 26:3
attending 1:15
atypical 24:16,
19, 21
await 21:20
awaiting 24:9
awful 24:22

< B >

back 6:5 31:12
bad 11:4
Bancroft 16:15
basically 4:4
30:5
basis 8:24
16:13 32:23
beds 6:14, 18,
23, 24, 25
began 31:20
beginning 11:16
best 8:23
better 11:12
16:24 18:5, 6
Bianchi 2:17
big 20:14 30:22
biggest 21:13
22:6
bit 4:23 5:13
23:23
bothers 12:14
breath 24:18
bring 29:15
bringing 26:25
brings 28:16
broader 15:13
brought 26:19
29:9
build 31:23
building 14:20
built 30:4 31:21
bunks 6:24

< C >

Callaghan 2:21
Canada 4:22, 24
6:9 21:4
capacity 6:14
CARE 1:7 2:16,
17, 19, 21, 23, 25
3:3, 4, 7 5:7, 22
8:12, 14 9:20
10:3 15:15, 24
16:6 19:24
21:14 26:19, 20

29:12, 13, 16, 21
30:13, 16 32:20
33:8
caring 5:2
carpet 14:1
22:5
case 27:3
cases 25:10, 19
cell 8:21
center 13:22
centre 13:15, 20
17:15 21:8
24:8 32:9
centres 20:21,
22
CERTIFICATE
35:1
Certified 35:4
certify 35:4
cetera 7:25
8:15 9:4 18:7
22:5 25:18 27:9
CHAIR 4:3, 11,
18 10:16, 20
12:13, 20 13:2
14:13, 22, 25
17:19 18:10, 17
19:22 20:2
21:22 23:20
26:6 28:2
30:18 32:3, 11
33:1, 14, 21, 25
challenge 6:1
7:9 8:24 11:19
challenges 5:15
22:24
challenging
18:13 23:15
27:13
chance 17:25
chances 23:12
chapel 6:15
charge 17:22
cheek 6:22
children 22:20
Choconta 3:6
chronic 7:15
chronically 7:19
circumstances
6:20 8:9 26:18
CITY 2:9, 11
7:2 30:22 31:8,
20
clean 25:2

cleaned 16:13
cleaning 15:18
clear 9:19
clearly 28:22
clients 16:4
25:4
clinical 28:12,
15
clinics 31:17
co-authored 5:6
Coke 2:4 34:2
cold 6:12, 17
21:16
colleagues
15:16 19:6
collection 30:23
combination
28:14
comes 20:4
coming 30:14
commandeered
13:22 17:14, 15
commencing
4:1
comment 28:6
COMMISSION
1:7 2:16, 17, 19,
21, 23 3:1, 3, 5, 7
Commissioner
2:3, 4, 5 4:3, 11,
18 10:16, 20
12:13, 20 13:2
14:13, 22, 25
17:19 18:10, 17
19:22 20:2
21:22 23:20
26:6 28:2, 4, 5
30:18 32:3, 11
33:1, 14, 21, 25
34:2, 4
commitment
32:4
common 6:15
24:16 32:4
commonly 30:22
communities
33:13
community 9:2
13:22 16:1
17:14 22:11, 13,
18 23:9 32:5
COMPANY
35:22
completely

<p>33:16 compliant 7:24 complications 7:18 component 11:23 conducting 4:5 confidence 33:17 conflicting 19:1 congested 8:1 17:17 conjugate 5:9 8:1 9:3 33:5 consensus 20:5, 8 constantly 21:3 contact 21:11 contagion 6:2 8:14 contagious 11:3 contain 9:17 context 5:9 32:16 control 15:22 17:4 controlling 17:25 cooks 11:7, 10 coordinate 10:11 coordinated 10:22 13:10 coordinating 10:5 coordination 10:11 coronaviruses 27:20 correct 35:12 cost 21:24 22:6 cots 6:15, 18 cough 21:16 24:18 Counsel 2:17, 19, 21, 23 country 5:1, 17 couple 14:17 course 22:7 COVID 5:2, 8 6:2, 6, 8 8:2, 3, 5, 11 9:1, 17 10:5, 7 12:4 13:25 17:4 21:15 24:17</p>	<p>25:8, 10 26:2, 14, 15, 20, 25 29:8 31:22 COVID-19 1:7 5:18 create 13:15 29:1 created 14:16 20:21 24:8 crises 33:12 crisis 12:2, 22 critical 28:23 crossed 27:12 crowding 7:5 CRR 35:3, 23 CSR 35:4, 23 culturally 20:25 culture 12:9 < D > Dated 35:16 Dawn 3:2 day 1:15 20:15 35:16 days 4:7 14:17 21:21 23:11, 13 25:10 deal 5:8 11:21 12:4 27:10 dealing 11:1 28:21 deals 5:8 8:20 dealt 5:6 Deana 3:10 35:3, 23 deaths 27:13 decant 17:16 19:16 December 1:16 35:16 decisive 10:14 decongest 18:7 24:6 decongesting 17:3 define 19:11 delighted 27:25 delivered 29:13 delivery 29:9 dementia 19:25 department 30:12 Deputy 2:15 Derek 2:25 described 28:18</p>	<p>development 8:7 dial 6:5 Diaz 3:6 different 5:3 9:24, 25 10:13 17:15 22:17, 21 26:11 difficult 19:20 20:3 direct 5:21 direction 33:19 Director 2:10, 25 3:2 disadvantage 15:6 disaster 12:5 discussion 8:3 9:12 disease 7:16 11:3 distance 8:17 distressing 13:3 Doctor 4:14 10:17 17:20 23:21 33:22 doctors 31:1 document 23:7 documented 26:9 doing 18:15 31:18 32:1, 2 donated 16:18, 19, 20 door 16:16 dose 23:3, 8, 15 doses 23:1 dramatically 9:7 10:12 Drummond 2:15 Durrell 17:14 < E > early 15:21 16:5 earn 20:12 26:17 easily 32:18 easy 19:10 31:23 educate 16:2 educating 15:22 effectively 32:24 embedded 29:11</p>	<p>emergency 6:11 10:7 30:12 emphasis 9:22 employed 32:18, 19 empty 21:25 encampments 17:7, 10 24:5 encountered 10:10 encounters 8:22, 23 end-of-life 29:16 enforced 25:3 engaged 19:4 enterprise 31:8 environment 5:10, 22 9:17, 19 11:15 12:11, 12 23:16 27:6 30:8 32:20 environments 17:18 equipment 15:25 16:18 erecting 14:20 especially 17:10 essential 29:18 Establish 21:10 everybody 11:5 13:12 14:7 24:13, 21, 25 25:16 evident 28:10 evolved 19:21 evolving 32:20 exact 17:2 example 30:21 32:23 examples 14:16 15:4 exclusively 11:12 exemption 21:4 existed 29:2 30:4 existing 28:25 experience 22:10 28:1 experts 4:25 explain 4:23 6:6 exposed 27:19, 20 exposing 26:25</p>	<p>extension 30:6 31:14 extent 22:13 24:7 < F > face 5:15 6:1 FaceTime 8:17, 20 facilities 14:16 facility 13:23, 24 19:13, 14 21:5, 20, 24 22:7 26:20 33:8 facing 8:10 fact 14:9 27:18 families 22:20 fast 28:24 feel 9:12 17:8 19:5 23:21 feet 29:19 felt 19:3 fever 24:18 figuring 21:17, 18 finally 12:1 find 23:3, 8, 13, 14 finding 25:9 finger 10:3 fingers 27:12 first-line 15:19 flexible 15:7 floor 7:8 floors 14:1 fly 10:9 focus 5:12 follow 28:6 food 6:17 21:6 force 13:8 foregoing 35:5, 11 foremost 22:9 forth 35:7 fortunate 11:24 found 18:25 25:17 Frank 2:3 4:3, 11, 18 10:16, 20 12:13, 20 13:2 14:13, 22, 25 17:19 18:10, 17 19:22 20:2 21:22 23:20 26:6 28:2</p>
---	--	---	--	--

<p>30:18 32:3, 11 33:1, 14, 21, 25 Franklin 3:4 frankly 33:11 free 9:12 22:2, 14 frustrating 14:15 full 6:13 function 12:15 future 30:17</p> <p>< G > game 15:8 general 33:4 generalizable 33:4 giggle 20:17 give 15:3 19:1 23:2, 3 31:12 given 29:2 giving 15:1 Good 6:23 9:2, 3, 4 11:13 12:7 15:10 19:6 27:17 govern 18:5 gowns 16:11, 15 great 16:21 greater 11:24 22:13 24:7 ground 29:19 group 11:13 15:19 groups 10:14 growth 8:7 guarantee 14:11 guess 20:4 guys 32:1</p> <p>< H > H1N1 6:3 hand 12:8 16:18 25:2 27:3 hands 9:6 happen 13:16 19:12 23:12 31:4 happened 9:16 17:6 24:3 25:5 31:5 happens 12:17 happenstance 13:4 hard 20:5 27:5</p>	<p>head 14:6 28:12 headaches 24:17, 18 HEALTH 2:9, 11 7:17, 23 8:14 9:21, 22 10:2 11:17, 18, 22, 23, 25 14:6 15:15 18:25 19:18 20:10 21:3, 14 24:11 29:9 31:8 32:5 hear 20:15 heard 14:15 hearing 28:19 32:17 heartbeat 12:4 heels 12:3 Held 1:14 help 15:18 22:9 29:10, 21 30:1 31:7 33:9 helped 15:10 21:7 helpful 29:6 30:16 32:15, 21 high 6:24 25:13 27:15 history 22:19 hoc 32:23 homeless 5:10 7:20 8:13 9:21 13:17, 21 15:20 25:4 homelessness 5:14, 25 6:6, 9 9:21, 24 11:15 32:16 homes 19:24 honest 19:5 honestly 20:20 Honourable 2:3 Hope 6:23 33:3 hopefully 33:9 hospital 13:20 14:6 16:9, 20, 23 29:10, 14, 15, 20, 23, 24 30:1, 6, 9, 14, 25 31:14, 15, 18, 25 32:10 hospital-based 13:23</p>	<p>hospitals 10:12 31:6, 11 hospital- supported 31:17 hotels 17:12, 15 24:6 hour 4:16 house 7:4 housing 7:1 9:21, 22 11:17, 19 HR 27:10 31:10 huge 8:8 31:8 Huntsville 16:15 hurry 19:20 hygiene 7:8 15:24 16:18 25:2</p> <p>< I > ICU 30:10 ID 31:18 Ida 2:17 imagine 8:25 immediate 10:15 immediately 9:18 17:16 27:23 immunity 27:21 impact 5:1, 18 8:8 implement 21:10 implementation 18:13 implemented 5:17 important 29:8 impossible 17:5 improvise 12:15 income 27:4, 8 Indigenous 22:18 33:7 individuals 7:10 infection 15:22 infections 27:19 influenza 6:3 informative 32:14 infrequent 8:24 initiated 27:23 injecting 21:2 injection 21:5 INNER 2:9, 11 31:8</p>	<p>input 11:25 inroads 19:2 integrated 31:19 Interesting 26:12 interestingly 22:8 interrupt 10:17 invite 29:20 involved 28:18 IPAC 9:23 isolate 13:18 isolation 13:15, 19 20:21, 22 21:8, 20, 24 22:7 24:8 25:11 32:9 issue 5:24 20:14 issues 6:3 7:16 21:13 27:10</p> <p>< J > Jack 2:5 13:7 16:8 23:10 28:5 29:5, 17 34:4 Jack's 29:10 31:6 Jeff 2:10 4:10, 15, 20 10:19 11:6 12:19 13:1, 5 14:21, 24 15:3 18:2, 12, 19 20:1, 7 21:25 23:25 26:8 28:6 29:4 31:5 32:6, 25 33:3, 20, 24 34:4 Jessica 3:4 Jim 17:14 jobs 27:6 John 2:21 journey 33:18 jowl 6:22 jurisdiction 11:11 18:24</p> <p>< K > Kate 2:19 kind 15:24, 25 21:11 31:19 kitchen 11:7 24:23</p>	<p>Kitts 2:5 28:4, 5 34:4 knew 9:5 13:19 knows 13:7 23:10</p> <p>< L > lack 8:22 10:22, 23 20:11 large 27:11 Lead 2:3 3:4 19:6 leader 28:9 leaders 12:22 leadership 10:23 28:7, 13, 15, 16, 24 leadership-type 12:16 Leonor 16:8 Lett 2:25 level 19:25 29:12, 13 life 18:22 likelihood 7:13 link 30:25 links 29:22 listening 15:1 live 26:16 31:1 33:10 lived 22:10 living 7:19 local 30:25 33:16 long 17:23 LONG-TERM 1:7 2:16, 17, 19, 21, 23, 25 3:2, 4, 7 5:7, 22 9:20 15:23 16:6 19:24 26:19, 20 30:16 32:19 33:8 looking 11:11 lot 7:5 15:21 16:1 17:6 24:22, 25 27:10, 19 29:1 31:1 luck 27:17 28:18 lunches 15:17 Lynn 2:23</p> <p>< M ></p>
--	---	---	--	---

<p>made 35:8 Mahoney 2:23 major 19:2 making 25:23 manage 18:7 20:4 management 18:9 19:10 Marrocco 2:3 4:3, 11, 18 10:16, 20 12:13, 20 13:2 14:13, 22, 25 17:19 18:10, 17 19:22 20:2 21:22 23:20 26:6 28:2 30:18 32:3, 11 33:1, 14, 21, 25 mask 20:16 masks 7:25 16:11, 16, 19 25:4 mass 9:24 massive 6:20 9:5 matter 14:17 McGrann 2:19 meals 7:7 Medical 2:10 28:12, 15 MEETING 1:7 men 7:3 mental 7:17, 23 8:14 11:18, 21 19:17 20:10 21:14 24:11 mentioned 20:22 29:18 met 6:13 mind 5:4 20:5 minimize 5:18 Minister 2:15 minute 10:18 13:14 mobile 23:9 model 30:15 moment 12:18 18:4 money 18:16 20:13 26:17 month 23:8 months 28:20 mortality 7:11</p>	<p>move 6:4 17:23 20:12 moved 17:7 18:23 24:4, 5 movement 27:8 moving 19:15, 19 Muckle 13:9 28:7 municipality 10:2 13:20 22:1</p> <p>< N > nature 13:8 necessarily 13:11 14:5 needed 10:11 13:13, 19 19:20 21:3 NEESONS 35:22 negative 14:2 neighbourhood 30:24 31:1 neighbourhoods 30:21, 23 new 11:16 15:23 16:1 17:9 21:17 newcomers 22:19 night 6:10, 12 7:5 nimble 15:7 normally 13:10 north 33:7 notes 35:12 nursing 31:16, 17</p> <p>< O > obstructive 7:15 occurred 31:22 o'clock 6:13 older 7:11 ones 33:11 on-site 30:14 operating 30:11 Operations 3:2 opioid 20:8 opioids 12:4 20:9 21:2 opposed 9:19 order 21:8 25:5 organization 4:25</p>	<p>organizations 20:11 originally 30:20 OTTAWA 2:9, 10 6:11 16:15 31:7 Ottawa's 26:18 outbreak 19:10, 11, 12, 14 26:13, 21 outbreaks 18:7 26:10 outcomes 24:2 outreach 24:11, 25 31:15 outside 26:16, 24 over-crowding 6:21 overrun 8:4 25:14 27:15 oxygen 13:23</p> <p>< P > Palin 3:2 palliative 29:16 pandemic 6:1 11:3 33:10 pandemics 30:17 parallels 5:21 part 16:24 23:23 partial 27:21 participants 1:15 2:13 particularly 7:23 partners 15:10 18:14 peers 22:10 24:25 people 5:2 6:10, 12, 16, 21 7:2, 5, 7, 15, 22 9:4, 24 11:18 12:21 13:14, 25 14:16 15:14, 19 16:18, 21 17:7, 16, 23 18:22 19:12, 13, 17 20:12, 24 21:1 22:8, 10, 18 23:14 24:4, 5, 9, 22 25:8, 12, 13 26:1, 7, 14, 15,</p>	<p>24 27:1, 18 29:14 30:22, 25 31:18 32:8 perceived 30:22 percent 7:14 21:15 25:19 26:1, 3, 5 person 12:16 13:10 14:5 15:16, 17 20:6 25:23 personal 15:24 24:24 27:5 personality 14:4, 10 petty 18:22 phones 8:21 physical 7:23 pie 10:4 place 12:17 13:17 14:12 17:2 19:19 20:23 27:22 35:6 plan 11:2, 24 12:9 19:10, 20 28:20 planning 12:6 plans 27:22 32:22 playing 9:25 pleasure 33:24 point 21:16 Policy 2:25 3:4, 6 politics 18:22 population 5:19 7:21 8:5, 19 11:1, 4 19:16 21:15 24:16, 20 27:14 populations 5:3 22:17, 21 position 19:5 positions 12:21 positive 13:16 24:10 25:12 possibility 26:24 post 4:6 PPE 16:6 25:1 29:24 precautions 25:18 prepared 17:23</p>	<p>PRESENT 3:9 4:21 5:12 PRESENTERS 2:7 presenting 24:17 presents 10:21 pressure 14:2 presumptuous 23:23 pretty 19:10 prevalence 25:17 26:2, 4 prevent 19:15 primary 29:12 30:13 principles 33:4, 9 problem 9:6 10:21 11:17 14:8, 14, 18 17:9 32:20 problems 20:10 proceedings 35:5 profound 11:19 profoundly 20:9 program 13:11 31:16 programs 22:12 29:9 progressively 31:21 project 18:8 promise 20:20 protect 15:19, 20 protective 15:25 provide 28:13 provided 5:13 21:6 28:7 provider 23:5 providers 8:12, 15 10:3, 13 15:13, 14 29:21 providing 8:16 Public 10:2 14:6 18:24, 25 pulled 32:15 pulmonary 7:16 put 16:7 17:22 19:18 21:7, 13 putting 14:2 pyramid 14:20</p>
---	---	---	---	---

< Q >

question 28:22
questions 4:8
9:12 27:25
32:13
quick 15:7 21:3
quickly 16:24
17:12 24:4
32:24
quiet 18:4
quite 11:12

< R >

rapidly 19:21
rate 7:11 26:4
rattling 15:2
reach 20:5, 7
react 12:22
reacting 12:7
reaction 12:6
ready 4:13
real 23:2
realize 17:24
32:21
really 6:21
7:13 10:4
14:19 17:4
reason 30:20
recognize 22:17
recognized
15:18 16:24
recommendation
17:2
recommendation
s 4:21 5:12, 16
9:9 17:21
recorded 35:9
recovered 22:12
regular 6:14
8:24 16:13
regulation 10:10
regulations
9:23 15:9
related 7:17
relationship
29:17
relationships
28:23, 24, 25
29:1, 7 30:3, 19
31:3, 24
relevant 9:11
21:1
remarks 35:8

Remember

19:17 20:6
24:15 25:12
remotely 1:15
rental 26:18
repeatedly 14:15
report 5:4
Reporter 35:4
REPORTER'S
35:1
required 10:14
reserve 33:7
reserves 9:4
residents 19:24
respectful 22:21
respective 6:18
respiratory 6:2
respond 9:6
response 10:5,
7, 22 30:16
responses 10:15
responsibility
12:24
responsive 15:8
restrict 8:7
19:15 27:7
results 21:20,
21 24:9 32:24
retrofitted 24:10
retrofitting 22:3
rid 22:5
ripped 14:1
risk 8:13 25:13
27:15
rocket 18:8
Rokosh 3:2
role 13:11
roles 9:25
rolling 6:15
room 6:22 7:1
17:5 30:11
rooms 13:24
rounds 31:18
Royal 4:22, 24
RPR 35:3, 23
run 11:4 13:10,
12
running 10:4
rushed 23:21

< S >

safe 16:3, 4
21:4
Santedicola

3:10 35:3, 23
sat 18:3
schizophrenia
20:10
science 18:8
screaming 32:1
screening 21:10
se 9:11
secondary 29:12
Secretariat 2:16,
18, 20, 22, 24
3:1, 3, 5, 7
sector 13:21
self-evident 18:3
self-service 32:7
Senior 3:6
30:24
sense 10:25
11:5 18:14
19:9 20:3
21:12, 24
series 9:9
20:19 30:21
service 10:12
15:12, 14 17:10
services 8:12,
15, 16 10:1 29:9
serving 15:17
22:22
set 35:6
setting 5:9
8:13 33:5, 6
settings 8:1 9:3
sewers 16:14
sewing 16:15
Sharon 5:6
shelter 6:11, 14
7:1, 14, 19
15:17 26:16, 17
27:6 29:13
30:7 31:15
shelters 7:3
8:16 10:1, 13
15:15 17:3, 8,
17 21:7 24:7,
23 25:1, 17, 18
26:13, 21 29:11
30:5
Shepherds 6:22
short 21:8 25:5
Shorthand 35:4,
12
shortness 24:18
show 32:24

sick 7:15
side 28:10, 12
siloed 29:2
similarity 19:23
sincerely 33:3
site 21:5
sites 26:11
27:7
sleeping 7:25
slept 25:24
slide 6:4 9:8
20:19 23:25
slowly 31:6
sniffle 24:14
social 8:15
10:1
Society 4:22, 24
somebody 14:5
17:22 18:4, 20
20:8 21:12, 18
23:2 25:21 26:9
sort 9:11 20:16
sorts 7:16
space 17:14
speak 9:10
23:22
speaking 32:13
speed 28:24
spent 15:21
16:1
stabilization
11:22
staff 15:15
18:6 22:9
24:23 29:25
30:7
staffed 19:2
staffing 22:8
start 22:23
29:18 33:19
started 6:5
17:16 25:6, 7,
15 30:19
starting 8:11
state 28:11
stated 7:12
stay 16:22
19:18 21:13
Stenographer/Tra
nscriptionist
3:10
stenographically
35:9
stop 17:20
stopped 8:15

strategies 21:11
32:18
Straus 5:6
strength 14:4
strong 28:7, 9
stuff 14:2 15:25
stupid 26:22
substantial 22:4
successful
32:17
suddenly 29:20
suggestion 29:6
support 8:14
13:25 15:12
17:22 20:23
24:24 27:5
supported 19:2
31:11
supporter 16:21
supporting 19:7
surveillance
25:16
swell 28:13
symptom 21:18
24:17, 21
symptoms
24:15, 19 25:22
26:5, 9
system 29:3

< T >

takes 12:25
talk 6:7 13:14
talking 5:24
16:2
T-cell 27:21
Telus 24:12
temporary 14:16
tend 4:8
tent 14:20
terms 7:22
28:20 30:16
tertiary 29:12
test 13:13
21:18 24:9
25:16, 22
tested 21:19
24:10, 13, 22
25:25 32:9
testing 13:16
21:11 24:12
25:16
Thanks 33:2
34:4

thing 6:5 11:8,
9 12:14 15:11
18:1
things 10:4, 10
17:24 18:3 22:5
thinking 8:25
9:1 11:12
thought 4:20
5:11, 23 8:2, 3
10:6, 8 25:14
29:4
thoughts 15:2
thousand 7:2
25:13
three-bunk 6:24
time 7:6, 9
8:11 12:3
15:21 16:2
21:16 33:23
35:6, 8
times 8:23
18:25 26:7
TOH 31:9, 10
tonight 6:10
Toronto 30:20
totally 13:6
tough 23:9
town 15:8
tracing 21:11
trained 24:23, 24
transcribed
35:10
transcript 4:6
35:12
translated 12:11
trauma 22:19
trouble 15:12
true 11:1 35:11
trust 8:22 20:11
trusting 23:4
trying 14:19
16:2 29:5
Turnbull 2:10
4:10, 15, 20
10:19 11:6
12:19 13:1, 5
14:21, 24 15:3
18:2, 12, 19
20:1, 7 21:25
23:25 26:8
29:4 31:5 32:6,
25 33:3, 20, 24
turned 5:2
13:12, 22 14:3

turns 26:15
< U >
ultrasound
23:11
understand
5:14 6:19 29:8
32:8
understanding
11:16
understood 4:16
unduly 23:21
unfortunately
14:10
unit 25:11
university 17:13
unregulated
15:5, 6
unsafe 17:9
urgency 18:14
< V >
vaccination
22:25 23:6
valuable 34:3
van 24:13
vans 24:11
variations 33:17
VERITEXT 35:22
Videoconferenci
ng 1:14
view 15:13
violence 7:18
virtue 14:9
visors 16:20
voices 20:14
volition 17:8
volunteered
17:13
vulnerable 5:3,
19 7:10, 22
< W >
waiting 19:8
walk 8:20, 21
walking 33:18
wanted 23:17
Ward 16:8
washroom 7:8
ways 10:23
wear 7:25
20:16 25:4
website 4:6
week 13:21, 25

16:14, 16 21:9
weeks 14:17
Wendy 13:9, 12,
20 14:9 28:7
whatsoever
25:20
winter 17:11
wiped 25:1
withdrew 8:12
women 22:18
women's 7:3
26:13
won't 9:3
15:20 21:12
word 16:7
words 20:4
work 16:8
22:14 23:19
25:25 26:16, 19
27:5, 6 31:9, 10
worked 29:23
workers 17:23
24:24 27:5
working 22:11
26:24 31:14
works 13:8
world 12:2, 6
15:24
worry 15:9
worrying 18:15
writing 5:4
wrong 10:9
< Y >
Yeah 14:8 26:8
years 7:11
10:8 31:6, 13, 20
< Z >
Zoom 1:14