LTC Commission briefing - CMOH / HPPA

Robert Lerch, Liam Scott
on Wednesday, September 23, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants attending remotely, on the 23rd day of September, 2020, 10:02 a.m. to 12:13 p.m.

BEFORE:

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

PRESENTERS:

Liam Scott, Counsel, Ontario Ministry of Health and Ministry of Long-Term Care

Robert Lerch, Manager, Immunization Policy & Programs, Ontario Ministry of Health and Long-Term Care

Melissa Helferty, Manager, Infectious Disease Policy & Programs, Ontario Ministry of Health and Long-Term Care

Dr. Daniel Warshafsky, Senior Medical Consultant at the Office of the Chief Medical Officer of Health, Ontario

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat

Dawn Palin Rokosh, Director of Operations With the Long-Term Care Commission

Derek Lett, Policy Director, Long-Term Care Commission Secretariat

Amy Leamen, Counsel, Legal Services Branch for the Ministries of Health and Long-Term Care

John Callaghan, Lead Counsel, Long-Term Care Commission Secretariat

PARTICIPANTS (cont'd):

Roopa Mann, Counsel, Crown Law Office Civil.

Ann Christian-Brown, Counsel, Crown Law Office Civil.

Judith Parker, Crown Law Office Civil.

Lynn Mahoney, Counsel to the Ministry of Health and Long-Term Care.

ALSO PRESENT:

Judith M. Caputo, Stenographer/Transcriptionist

COMMISSIONER MARROCCO: Good morning. I'm Frank Marrocco, one of the commissioners on this Commission.

There's Dr. Jack Kitts, who is here as the second commissioner, and Commissioner Angela Coke, who is on the screen, is the third commissioner.

We are the three commissioners on this inquiry, and why don't you introduce yourselves.

MR. SCOTT: Hi, it's Liam Scott here. I'm counsel with the Ontario Ministry of Health, and my practice area is public health.

COMMISSIONER MARROCCO: And who's making the presentation, Mr. Scott?

MR. SCOTT: I will be making the first part of the presentation, then my clients will be completing the presentation at the end of mine.

COMMISSIONER MARROCCO: All right. Well, let me -- there are a variety of other people here, lawyers and -- that are with the commission, John Callaghan and Lynn Mahoney, and I don't know where Ida is, and it's on -- you perhaps met Dawn. Dawn, where are you?

MS. PALIN ROKOSH: I am here, Commissioner. Dawn Palin Rokosh. Hi, good

morning.

Commissioner, we also have Alison Drummond here, and I think that largely rounds out the folks here from the Commission and Secretariat.

COMMISSIONER MARROCCO: I just didn't see Alison on my screen. But, in any event, Alison Drummond is our executive director.

Mr. Scott, and to your client, I want to thank you for coming to see us. It will be very instructive, I'm sure. And we're very much grateful for the briefing.

What we'll do is ask questions as we go to avoid circling back. So don't think we're rude if somebody interrupts in the middle of something to ask a question.

It just seems to work better from our point of view, and I hope it won't be too disturbing to whoever is speaking to be interrupted with a question.

I think that's basically it. We're ready to go. Oh, and of course I don't know if you've met Ms. Caputo, who is here from Neesons and who is transcribing.

MR. SCOTT: Thank you.

Mr. Commissioner, thank you to all the

Commissioners and to the other supporting counsel and Secretariat for having myself and my clients here today. I know you've likely received my bio, but just by brief introduction I've been counsel at the Ministry of Health since 2000.

My practice area since 2004 has been public health and I provide advice to the Chief Medical Officer of Health and to the staff within the division, within the Ministry of Health.

I'm happy to speak with you today about the Health Protection and Promotion Act, as well as the Emergency Management and Civil Protection Act.

In addition to you being able to ask me questions at any time, I will break at several points in my presentation in the event that there are questions that you'd like to ask at that point.

COMMISSIONER MARROCCO: I should have said, Mr. Scott, we'll probably take about ten minutes around 11:15 or so. Just so whoever is presenting kind of knows that, just to give everybody a chance to figure out what's left, and that sort of thing.

MR. SCOTT: Thank you, Mr. Commissioner, that's helpful to know. If I can have the first slide, please.

Thank you. So I'd like to speak to you today about the Health Protection and Promotion Act, which is the key public health statute in Ontario.

I'd like to talk to you about powers and responsibilities of local Medical Officers of Health, Associate Medical Officers of Health and public health inspectors. Those are the three key statutory actors that have powers under the Health Protection and Promotion Act at the local level.

Then I would like to summarize the appointment and powers of the provincial Chief Medical Officer of Health. And finally, I will summarize Minister of Health powers under the Health Protection and Promotion Act.

In the second part of my presentation, I will talk about the Emergency Management and Civil Protection Act, which is not Ministry of Health legislation. It is legislation of the Ministry of the Solicitor General, but I am happy to speak to you about that legislation as well.

So next slide, please. So under the Health Protection and Promotion Act, as I mentioned, the key actors are local Medical Officers of Health, Associate Medical Officers of

Health and public health inspectors, the Chief Medical Officer of Health -- the Chief Medical Officer of Health has various Associate Chief Medical Officers of Health -- and finally the Minister of Health, all of whom have powers under the Health Protection and Promotion Act.

Next slide, please.

So it's important to note with most disease outbreaks that the first response to any infectious disease outbreak tends to be local, not provincial or federal.

However, with a pandemic the scale of COVID, all have roles to play, as has been demonstrated so far in this pandemic.

At the local level, there are currently 34 public health units that are divided. They have different boundaries than Local Health Integration Networks.

They each have a Board of Health and a Medical Officer of Health. The Medical Officer of Health is a physician with particular public health expertise that is set out in a regulation under the Health Protection and Promotion Act that sets out qualifications of the Medical Officer of Health.

There are three legal types of Boards

of Health. The first type, which is the Majority of Boards of Health, are established as corporate entities under the Health Protection and Promotion Act. An example would be Middlesex London Health Unit.

The second type are those which are an independent Board of Health, but are entirely appointed by the city itself.

I should say type one, to back up, that are established under the Health Protection and Promotion Act, there are a majority of municipally appointed members within the health unit, so municipalities appoint a majority of those members.

A minority of those members are appointed through Order in Council by the Province.

The second type, which are established under city-specific acts, and the two best examples of this are Ottawa, the City of Ottawa Board of Health, and the City of Toronto Board of Health. This is a Board of Health that exists independently of the municipality, but all of the members are appointed by the municipality.

So the City of Ottawa, for example, appoints all of the members of the City of Ottawa Board of Health.

The third type is where regional municipality acts as the Board of Health. So in this circumstance, there is no independent Board of Health, but the regional municipality, such as in Durham, Peel or Halton, will have basically a department that acts as the Board of Health.

So these Boards of Health, as I say, there are three types of them, but they all are responsible under the Act for various responsibilities which I will come to in a minute. And they all employ the Medical Officer of Health.

It's important to note that these Boards of Health are independent from the Province of Ontario. They are not Crown agents, they are not otherwise agents of the Province.

Now, for orders that can be issued under the Health Protection and Promotion Act, Medical Officers of Health, and/or public health inspectors have two key powers.

One is issuing health hazard orders under Section 13 of the Health Protection and Promotion Act, which I will describe in a minute.

And the second is Communicable Disease Orders, which we see much more commonly during an infectious disease outbreak such as COVID, which is

Section 22 of the Health Protection and Promotion Act. So I will describe these two key powers next.

Next slide, please. Health hazard orders.

A health hazard is anything that may cause harm to human health that is not a disease in a person.

So for example, COVID-19 is not a health hazard. A health hazard could be anything from diseased food, from a gas leak, from other things that may cause harm to human health.

It is a very broad definition in the Act, and that's intentional because there may be various hazards to human health that may not be known.

It is important to note, though, that for example, for zoonotic illnesses or diseases in animals -- distemper, as I understand it, is not a disease that can be passed from animals to humans.

So, for example, a dog with distemper would not be a health hazard, as an example.

Where there is a potential health hazard, a Medical Officer of Health, an Associate Medical Officer of Health -- because various bigger health units will not only have a Medical Officer

of Health. For example, Toronto has a number of Associate Medical Officers of Health.

They have the same statutory powers as a Medical Officer of Health. Certain smaller health units only have Medical Officers of Health.

So a Medical Officer of Health or public health inspector may issue a Section 13 health hazard order, which can include vacating a premises, removing, cleaning or disinfecting an object.

For example, if there's an inspection prevention and control issue that happens in a dental clinic, for example, equipment could be ordered to be cleaned by a public health inspector or the Medical Officer of Health.

It could also involve destruction of a matter, so if there's diseased food that's found, that food could be ordered to be destroyed by the Medical Officer of Health or public health inspector.

It's important to note, though, for health hazard orders, unlike Communicable Disease Orders, which I'll come to in a minute, there's no ability to issue class health hazard orders to more than one person.

So a specific premises could be vacated, not a class of premises.

Or a specific item could be disinfected, not necessarily a class of persons subject to that order.

No other person other than a Medical Officer of Health, Associate Medical Officer of Health or public health inspector could issue one of these orders. The orders may be made orally in urgent circumstances, but must be followed up in writing with reasons.

And as I will go into in a minute, all of these orders, health hazard and Communicable Disease Orders, may be appealed by the person who is subject to the order to the Health Services Appeal and Review Board.

Next slide, please.

COMMISSIONER KITTS: Can I just interrupt for a second?

MR. SCOTT: Go ahead.

COMMISSIONER KITTS: A slide before, you talked about all public health boards in the municipalities are independent of Ontario.

MR. SCOTT: Yes.

COMMISSIONER KITTS: Is that

independent of the public health officer in Ontario? What do you mean "independent of Ontario"?

MR. SCOTT: I mean they are not employees of the Province, or employees of the Chief Medical Officer of Health or our agents. They are not directly directed by the Province.

There are measures by which the Province can exercise accountability over the local Medical Officers of Health and Boards of Health, but I mean to say they are not equivalent to employees of the Province. They cannot be directly directed that way.

COMMISSIONER KITTS: But they can act -- they act independently of the Public Health Office of Ontario?

MR. SCOTT: They act independently of the Ministry of Health, they act independently of the Chief Medical Officer of Health and they act independently of Public Health Ontario, yes.

They have their own powers. These powers that I'm going through are their powers to exercise, and they exercise those powers independently of the Province.

COMMISSIONER MARROCCO: And is this true of both types of situations, where you're

dealing with a health hazard or a communicable disease?

MR. SCOTT: Yes. Correct. In both cases they have discretion, independent statutory discretion to exercise that power without being told to do so by the Chief Medical Officer of Health or Ontario, correct.

COMMISSIONER KITTS: And is the appeal board you spoke to, if someone disagrees with the local public health officer; the appeal board, is that an Ontario board or a local board?

MR. SCOTT: No, no. It's an Ontario appeal board. It's an administrative board established under provincial legislation that hears the appeal at first instance.

It may then be appealed after that point to Divisional Court. So there is a further appeal specified in the Health Protection and Promotion Act to Divisional Court, from the Health Services Appeal and Review Board.

COMMISSIONER MARROCCO: Mr. Scott, if there's an appeal to the review board --

MR. SCOTT: Yes?

COMMISSIONER MARROCCO: -- does the order under appeal remain in effect?

MR. SCOTT: It does. The person appealing to the appeal and review board can request a stay of the order.

COMMISSIONER MARROCCO: Okay.

MR. SCOTT: But the order remains in effect unless a stay is issued by the Health Services Appeal and Review Board, yes.

COMMISSIONER MARROCCO: So you cannot delay the complying with the order by filing an appeal? You have to bring a motion in or something explaining why the order should not apply while you're appealing?

MR. SCOTT: Correct. That's exactly right.

COMMISSIONER MARROCCO: Okay.

MR. SCOTT: Are there further questions about that? I will come to Communicable Disease Orders, where I talk a bit more about appeals under that provision.

COMMISSIONER MARROCCO: Go ahead. That's fine.

MR. SCOTT: Okay, thank you. So the second key power in addition to health hazard orders is Communicable Disease Orders, which is more relevant to COVID-19.

You should know that Communicable Disease Orders could be made in respect of any diseases which are specified by Minister regulation under the Health Protection and Promotion Act. I list the regulation number for you there and a link to it.

COVID-19 has been designated as a communicable disease. So a local Medical Officer of Health or Associate Medical Officer of Health may make an order in writing, requiring a person who is the subject of the order to stop doing any action, specified in the order, or to do something in respect of a communicable disease.

The legal test for the Medical Officer of Health includes that an Medical Officer of Health, on reasonable and probable grounds, is of the opinion that a communicable disease or an outbreak of one exists or may exist.

If the Medical Officer of Health is of the opinion that a disease exists or may exist, that the requirements in the order are necessary to address the risk, and the communicable disease presents harm of, potential risk of harm to the persons in the public health unit, that is the three-part test that the Medical Officer of Health

-- it's specified in Section 22 sub(2) of the Act.

Where a Medical Officer of Health is of that opinion, only a Medical Officer of Health, not a public health inspector, can issue a Communicable Disease Order.

COMMISSIONER MARROCCO: If I can just stop you for a minute.

MR. SCOTT: Yes.

COMMISSIONER MARROCCO: If COVID-19 is specified in a ministerial regulation, then I assume -- am I right in assuming that the Medical Officer of Health must be -- I guess -- the Medical Officer of Health must be then of the view that a communicable disease exists?

I guess the only thing is they could say: "Not here. We don't have any cases here. So yes, it's a communicable disease but it's not in my area, so we don't have one. I can't make an order".

MR. SCOTT: I agree with you, Mr. Commissioner. I think that's correct.

For example, in Northwestern Health Unit in Kenora, my understanding is Kenora has had few to no cases of COVID-19. So the Medical Officer of Health in Northwestern Health Unit may

have more difficulty saying that they are of the view that in their health unit that a communicable disease exists or may exist.

For example, Toronto's Medical Officer of Health, Ottawa's Medical Officer of Health, Peel's Medical Officer of Health, would have no difficulty, correct, finding that a communicable disease exists or may exist in their health unit?

Because that's the test for a Medical Officer of Health, not whether it exists anywhere in Ontario, but whether it exists within their health unit because their powers are exercised within the boundaries of their health unit.

COMMISSIONER KITTS: Does the declaration that it's a pandemic change that?

MR. SCOTT: No, it does not. So the declaration of the WHO that COVID-19 is a pandemic -- I shouldn't say when I say, no, it does not. The Medical Officer of Health might rely on that as some of the evidence necessary to establish reasonable and probable grounds to issue an order. So I don't want to say that isn't relevant.

But, for example, there are a myriad of other diseases other than COVID which are never declared to be pandemic illnesses that Medical

Officers of Health issue orders on routinely.

So I would say, though, for COVID, yes, that would be a contributing factor, and when issuing these orders, they do so in writing. And normally it has, at the beginning, the evidence that's relied upon by the Medical Officer of Health, which could include, for example, the WHO's declaration that COVID is a pandemic, okay?

So the orders, as I say, must contain reasons. It's the same with the health hazard order. In urgent circumstances the Medical Officer of Health might orally say: I'm asking you to self isolate immediately. And then follow up with an order in writing specifying that the order is being issued.

The order, we discussed this previously, the order may be appealed to the Health Services Appeal and Review Board, which is an Ontario review board established by legislation, within 15 days of the order being issued. But the order takes effect immediately.

Now, note that with Communicable Disease Orders, unlike health hazard orders, class orders may be issued to more than one person.

So, for example, and I've included an

example for you there. Wellington, Dufferin, Guelph's Medical Officer of Health issued an order recently requiring that all persons attending a commercial establishment were required to wear a face covering.

That was a class order that was issued under Section 22 of the Health Protection and Promotion Act.

But again, for example, Communicable Disease Orders can require a person to isolate themselves; it can require a person to take other steps to prevent spreading the illness to others, which could involve, for example, not attending at a workplace, or not attending in public spaces.

The list of things that may be in an order, which are specified in the Act, is not closed. So the Medical Officer of Health can look at the risk that the disease presents, and, within reason, set requirements for the person. Normally it requires the person to isolate themselves.

By the way, too, in terms of terminology, just to mention, often you'll hear the terms "quarantine" and "isolation". At the provincial and local level we refer to isolation, which is basically telling someone not to attend at

public spaces, to remain in their home, and not expose others to infection.

Federally, when orders are issued under the Quarantine Act, they call that "quarantine". So although you'll see the media using both terms interchangeably, we will normally use the term "isolation" at a provincial and local level.

Again, note that, as I mentioned, COVID was specified in January of this year as a communicable disease. But note that there is a subclass that's more serious called virulent diseases. Tuberculosis is a example of a virulent disease.

And orders for virulent diseases can include requiring a person to be treated by a physician without their consent. That is not the case for COVID.

For COVID, a person could be ordered to be examined by a physician. That's part of one of the orders that a communicable disease can capture. But they could not be ordered to be treated without their consent. The reason for that for tuberculosis is because often people with tuberculosis, if you're in the same room as a person that has tuberculosis, you will almost

assuredly get tuberculosis.

For diseases like that, which are even more dangerous than standard communicable diseases, there is this subclass where people can be treated without their consent. Of course, there is no current treatment or vaccine for COVID.

My clients can speak further obviously to the designation of COVID as a communicable disease, but it's important to know legally that there's a distinction between disease types.

Next slide, please.

You'll also hear COVID is a reportable disease, called in the Act a disease of public health significance.

Diseases that are listed as reportable, such as COVID, must be reported to Medical Officers of Health by the following persons: Institutions, including long-term care homes; childcare centres; psychiatric facilities; private hospitals; provincial correctional facilities; police detention centres; adult supported living residences; and any other place of a similar nature.

Physicians also have to report any patient that has or may have a communicable

disease.

Practitioners, including chiropractors, nurses, pharmacists, optometrists, naturopaths also have a duty to report.

Hospital administrators for in-patients also have a duty to report where a person has or may have a communicable disease.

School principals have a duty to report for school-based outbreaks of disease such as measles.

COMMISSIONER MARROCCO: Before you go on.

MR. SCOTT: Yes.

COMMISSIONER MARROCCO: So then a local Medical Officer of Health could make an order pertaining to all the long-term care homes in his or her health unit?

MR. SCOTT: Correct. So going back to the Communicable Disease Order-making provision, if it's a Communicable Disease Order, yes. The Medical Officer of Health, if the legal test was met, could issue a Communicable Disease Order to all of the long-term care homes in that Medical Officer of Health's health unit, yes.

Labs also have a duty to report.

So who are they reporting this to? All individuals have a statutory requirement to report to the local Medical Officer of Health that a patient has or may have COVID-19.

When they receive that report, if they have -- for example, let's say, a laboratory reports that a person at a long-term care home or a hospital had a disease that was acquired at that facility, and the facility does not also report to the Medical Officer of Health, the Act provides, in Section 29.1, that the local Medical Officer of Health can report COVID to that facility.

So they can say: A patient that was reported to us through a laboratory at your facility has COVID-19. We are notifying you of that fact.

There are specific --

COMMISSIONER MARROCCO: Is there any restriction on the types of orders that the local Medical Officer of Health could make? I mean, apart from ordering them to report, could you order them to do other things?

MR. SCOTT: Oh, under a Communicable Disease Order under Section 22?

COMMISSIONER MARROCCO: Yes.

MR. SCOTT: Yes, there are a number of things that can be ordered that are specified, including cleaning and disinfecting, taking various restrictions with regards to who is allowed as visitors. Those would all be things that could potentially be included in a local Medical Officer of Health class order, yes, depending on the comfort level of that individual Medical Officer of Health.

As I noted, that power is discretionary, so if they're comfortable including those elements in their order, the list of matters that may be included in Section 22, Subsection (4) is not closed.

And that is intentional, to allow the Medical Officer of Health to address a disease outbreak.

COMMISSIONER MARROCCO: Okay.

MR. SCOTT: So in terms of these reports, they come to Medical Officers of Health, and then Medical Officers of Health have to report these diseases to the Ministry and to Public Health Ontario, using a particular disease reporting system, iPHIS, or other method specified by the Ministry.

So these reports come into both Public Health Ontario and the Ministry. My clients could speak further to this, but my understanding is Public Health Ontario receives specifics such as John Smith has COVID, whereas the Ministry of Health receives summary reports that does not include that level of detail from Public Health Ontario.

I understand Public Health Ontario is also coming to speak with you. They may have more details about those reports that they provide.

Again, and we've seen this several times in this outbreak situation of COVID, Medical Officers of Health can also issue Communicable Disease Orders where there's an outbreak at a hospital or an institution.

So that includes a long-term care home, where the Medical Officer of Health is of the opinion on reasonable and probable ground -- so it's a similar test to Section 22 orders -- that a communicable disease exists or may exist at the hospital or institution.

And there have been some Section 29.2 orders that have been issued by several Medical Officers of Health and several health units that we

are aware of that have been issued both to hospitals and to long-term care homes to provide hospital staff to assist the long-term care home experiencing an outbreak.

This is a very similar authority to Section 22. Some of you may ask, why is that there?

It was because some years ago, Medical Officers of Health were concerned that a Section 22 order, because it's directed to persons, may not clearly allow them to give specific directions through one of these orders, to a hospital, long-term care home, or other institution.

And so that power was added within the last ten years to allow for those orders to be made to hospitals or long-term care homes.

Yes?

COMMISSIONER MARROCCO: Mr. Scott, if the Medical Officer of Health, the local Medical Officer of Health, thinks that a communicable disease exists at a long-term care facility, can the local Medical Officer of Health order the hospital to do something?

The hospital -- let's say in the hypothetical, that is next door or around the

corner from the health unit -- from the long-term care facility?

MR. SCOTT: They can definitely do that with respect to the long-term care home. Whether they can for the hospital depends on whether they feel that the legal test is met.

In theory, yes. And in practice, I am aware of several Medical Officers of Health who have issued Section 29.2 orders both to a hospital and to a long-term care home to direct the hospital to send staff to the long-term care home to assist with an outbreak.

So I guess that's a longwinded way of saying "yes".

I thought someone else had a question? Does anyone else have a question.

COMMISSIONER KITTS: No, mine was exactly the same. I wanted to be sure I heard that the local Medical Officer of Health can give an order to a hospital to help a long-term care home control an outbreak.

MR. SCOTT: And the answer is "yes". If the legal test is met, yes.

COMMISSIONER KITTS: Okay.

COMMISSIONER MARROCCO: Just to pursue

that for one more second, if persons were routinely going to the hospital, and some of them were COVID-19 positive, then there could be reasonable -- let's say, there could be reasonable and probable grounds to believe that the disease exists at the hospital?

MR. SCOTT: Correct.

COMMISSIONER MARROCCO: And then if there are people in the long-term care facility in the same -- who also have COVID, there could be reasonable and probable grounds to think that the disease exists in the long-term care facility?

MR. SCOTT: Correct.

COMMISSIONER MARROCCO: And so then the officer -- certainly in that case then, the local Medical Officer of Health -- when I say certainly, I'm asking, not stating -- could make an order that one, that the long-term care facility bring somebody to the hospital or that the hospital sends somebody to the long-term care facility, they could make that kind of an order?

MR. SCOTT: Yes, as long as the requirements in the order are necessary to deal with the outbreak, then the answer is, yes. Yes.

COMMISSIONER MARROCCO: Okay.

Commissioner Coke?

COMMISSIONER COKE: I just want to clarify. The order that you talked about in terms of at the local level asking a hospital to go and help with a long-term care home?

MR. SCOTT: Yes.

COMMISSIONER COKE: Is that authority also at the provincial level, or just the local level?

MR. SCOTT: There is an authority that I will come to shortly for the Chief Medical Officer of Health in certain circumstances to exercise powers of a Medical Officer of Health.

So, yes, potentially for the Chief Medical Officer of Health. No, for other provincial persons such as the Minister of Long-Term Care or the Minister of Health. Potentially for the Chief Medical Officer of Health, yes.

COMMISSIONER COKE: Okay, thanks.

MR. SCOTT: Okay. Next slide, please.

So I do want to talk now about the Chief Medical Officer of Health.

So Dr. David Williams is the current Chief Medical Officer of Health. He is appointed

by the Lieutenant Governor in Council, by Order in Council, on address of the Legislative Assembly.

If you look at that provision, you would think that Dr. David Williams is an officer of the Legislature, like the Ombudsman or Privacy Commissioner.

However, he is not because he is appointed in the same way as an officer of the Legislative Assembly, but he is a public servant and he has an appointment within the Ministry of Health and he reports to the Deputy Minister of Health.

But as I will discuss, he has some independent statutory powers which I will come to in a minute.

So the Chief Medical Officer of Health holds office for a term of five years and may be reappointed.

Normally, how Chief Medical Officers of Health have been appointed -- this is not specified in the legislation -- is an all party committee interviews candidates, selects a candidate. There is a vote in the Legislature to affirm the candidate. And then Cabinet, by Order in Council, appoints the Chief Medical Officer of Health, who

has been selected by the Assembly.

In order to be a Chief Medical Officer of Health, the person must be a physician of at least five years of standing, and has to possess the same qualifications as a Medical Officer of Health.

That's why the persons you see occupying the role of Chief Medical Officer of Health tend to be senior physicians, because they do have to have a measure of public experience in health.

They may only be removed from their position by the Lieutenant Governor in Council on address of the Legislative Assembly, so they have job protection in the role.

Dr. David Williams, who was appointed in 2016 -- his appointment expires in February of 2021. Again, the legislation says that he may be re-appointed to that role.

The responsibilities of the Chief Medical Officer of Health, they must stay informed in respect of any occupational or environmental health matters.

They must deliver an annual report on the state of public health to the Legislative

Assembly.

And they must give a copy of that report to the Minister of Health 30 days in advance. The Minister of Health has no ability to edit that report or censor it.

The Chief Medical Officer of Health simply provides a copy of her or his report to the Minister of Health, because obviously, when the report is released, the media immediately go to the Minister of Health and ask what her or his view is on the CMOH's report.

And the CMOH may make any other reports respecting public health as they consider appropriate and present that report to the public at any time.

The current Chief Medical Officer of Health has not issued such reports. The previous Chief Medical Officer of Health, Dr. Arlene King, did so several times.

She issued a H1N1 report on the H1N1 outbreak in 2009. She did that in 2011. And the report she did on wind turbines and the health effects of wind turbines in 2011. Those were reports that were issued under her authority under the legislation.

Next slide, please. The Associate Chief Medical Officer of Health. This is a person who is basically the right hand person, if I may put it that way, to the Chief Medical Officer of Health.

The position is held by the person or persons who, by virtue of their position, hold the title of Associate CMOH in the Ministry. You'll notice immediately this person is not appointed in the same way as the Chief Medical Officer of Health is.

They are a person who holds the title within the Ministry. So they are a Ministry employee, as is Dr. David Williams, but they do not have the same manner of appointment, or term of office, or dismissal protections as the Chief Medical Officer of Health does.

This associate must also be a physician, and possess the same qualifications as a Medical Officer of Health does. There are currently three Associate CMOHs who I have listed there.

You will see and hear from all of them at various times in the pandemic, when David Williams has been absent, or when David Williams

has otherwise asked them to exercise his powers.

Their responsibilities are to act as the Chief Medical Officer of Health where that person is absent, for example, if David Williams is on vacation; the CMOH is unable to perform the functions of his or her office, so the person becomes incapacitated for example, for some reason; or the office is vacant.

So at the end of the CMOH's term if there is no reappointment of that CMOH, the Associate CMOH can step in and act as the CMOH until a permanent CMOH is appointed.

Next slide, please. So what are the CMOH's powers? And this, one of you as Commissioners, Commissioner Coke, I think you asked this question or maybe it was another Commissioner who asked me.

The CMOH has various powers including, and the most significant of his powers -- there are two most significant powers. One of them is where the CMOH may act where there is a risk to health in Section 77.1 of the Act.

This provides that where the CMOH is of the opinion -- note that he just simply needs to be of the opinion, not that he has to be of the

opinion on reasonable and probable grounds -- that there is a risk to health, he or she may investigate the situation and take such action as is necessary to prevent, eliminate or decrease the risk.

So in so doing, the Chief Medical Officer of Health may exercise any of the powers of a Board of Health or a Medical Officer of Health, including appointing another Medical Officer of Health, for example.

Or, directing staff of the Board of Health within a public health unit. Say, for example, Toronto Public Health staff could be directed by the Chief Medical Officer of Health to do anything that is within their power to do.

Now, this power is a very strong power. It allows the Chief Medical Officer of Health to exercise powers of either a Board of Health or a Medical Officer of Health.

And it is seen -- this is not specified in the legislation, but it is seen by Medical Officers of Health as being punitive, because you could imagine if the Chief Medical Officer of Health came in, and said, Dr. de Villa, I am exercising an order within your jurisdiction within

Toronto Public Health. It would suggest that he felt that Dr. de Villa was not able or unwilling to exercise her powers within Toronto.

COMMISSIONER MARROCCO: But is that -- Mr. Scott, I mean that may be how they feel.

MR. SCOTT: Yes?

COMMISSIONER MARROCCO: But according to this, if Dr. Williams is of the opinion that there's a risk to health, he can investigate and issue orders?

MR. SCOTT: Correct.

COMMISSIONER MARROCCO: So it would be open to him in a situation where you have a pandemic, to say that this is somewhat broader than a local health unit matter.

And so I'm issuing an order to all health units across the Province, you know, to isolate, engage, test, do whatever struck him as reasonable, pretty much.

MR. SCOTT: Yes, I agree with you. What I was mentioning was more historical practice. It's not specified in the Act.

So I should say, where the Chief Medical Officer of Health exercises Medical Officer of Health powers, in this case "he" because the

current occupant is a "he", he must meet the same statutory tests as the Medical Officer of Health does.

So he would have to be of the opinion on reasonable and probable grounds that a communicable disease exists or may exist, as I mentioned earlier when discussing Section 22 Communicable Disease Orders.

If he wanted to issue a class order under Section 22, he would have to meet the same test that a Medical Officer of Health does, and persons subject to that class order could appeal that to the Health Services Appeal and Review Board.

So what you say is correct; the Chief Medical Officer of Health has this authority. And it is stated very broadly in the Health Protection and Promotion Act.

COMMISSIONER MARROCCO: And if somebody appeals his order, or -- "his" because it is a he -- his order stands unless somebody stays it?

MR. SCOTT: Correct, that is correct.

COMMISSIONER MARROCCO: Correct me if I'm wrong. But it seems to me then that, what you're telling me is that the Chief Medical Officer

of Health is really the person in charge when there's a communicable disease in the community?

MR. SCOTT: No, I wouldn't say in charge. I would say that where there is a communicable disease outbreak at a local level, it is addressed at first instance by the Medical Officer of Health.

Where a disease, though, spreads over more than one health unit, the Chief Medical Officer of Health will always be notified of that and may work with and coordinate with the local Medical Officers of Health to deal with that situation. My clients who are speaking subsequent to me may have more information about that.

COMMISSIONER MARROCCO: But do I understand it, work with, communicate with -- but he can order?

MR. SCOTT: He can. His power allows him to order, correct, yeah.

COMMISSIONER MARROCCO: So a person can eventually say, "I don't want to talk to you anymore; this is what I want you to do"?

MR. SCOTT: Correct. He has the ability to issue this type of order, to exercise powers of a Medical Officer of Health, yes.

COMMISSIONER MARROCCO: And do I have it right that apart from appealing to the review board or -- I don't have the correct name of the board. But appealing, there's nothing anybody else can do to countermand what the Chief Medical Officer of Health has done?

MR. SCOTT: Yeah, the only other thing I would say is the person, because it is a statutory power of decision, could bring a judicial review as well, but how successful that would be given you already have a right of appeal to the HSARB and to Divisional Court; but, yes, correct.

COMMISSIONER MARROCCO: You might find they won't hear it because you have a right of appeal?

MR. SCOTT: That's what I would think as well.

The Chief Medical Officer of Health may also apply to a judge of the Superior Court of Justice for an order requiring a Board of Health to take such action as the judge considers appropriate to prevent, eliminate or decrease the risk.

So this application to court has not happened. Because normally, when the CMOH issues an order, which has happened infrequently, to

Boards of Health or to Medical Officers of Health, they immediately comply.

So there has not been a situation in my time as public health counsel, since 2004, where the Chief Medical Officer of Health has had to apply to a judge to enforce an order issued under Section 77.1. But that authority exists.

Next slide, please. Thank you.

The Chief Medical Officer of Health may also issue an order to request a Board of Health, a local Board of Health provide information, such information as the CMOH specifies about the Board of Health and the Health Unit.

Now this power does not allow the Chief Medical Officer of Health to request clinical information.

And normally, the Chief Medical Officer of Health would simply pick up the phone, call the Medical Officer of Health and say to Dr. Etches, in Ottawa, I require the following information from you. And Dr. Etches would provide it.

If it's clinical information, then the CMOH can only obtain that by order through Section 77.6, which is an order to provide personal health information or clinical information.

The CMOH may direct any health information custodian -- so that refers back to the Personal Health Information Protection Privacy Act, PHIPA, which lists health information custodians. That includes long-term care homes, regulated health professionals, pharmacists, labs, others.

The CMOH may direct any of these persons to supply the CMOH with any information specified, including clinical information, where the CMOH is of the opinion that there is an immediate and serious risk to the health of persons, and the information is necessary to investigate, eliminate or reduce the risk.

COMMISSIONER MARROCCO: This may seem like a foolish question, but I just want to ask it anyway.

I take it in the situation we have, where we're dealing with a pandemic, there's not much doubt about the disease and its danger to the community and so on? These tests are relatively easily met?

MR. SCOTT: That would be up to the Chief Medical Officer of Health to determine whether, in consultation with any legal advice he required, to determine if the test was met. So I

don't know if I can answer that question. It's his power to exercise.

COMMISSIONER MARROCCO: Okay. I think you're hedging, Mr. Scott, but I'll -- I'm okay with it.

MR. SCOTT: I'm sorry, Mr. Commissioner, I'm not Dr. David Williams, so I'm trying to be careful in how I answer that question.

COMMISSIONER MARROCCO: All right.

MR. SCOTT: The information supplied to the Chief Medical Officer of Health is subject to limits. It must be no more than is reasonably necessary and it may only be used to investigate, eliminate or reduce the risk.

So it cannot be used, for example, for disclosure to other actors or persons who are not directly investigating, eliminating or reducing the risk.

So as an extreme example, the Chief Medical Officer of Health could not compel clinical information and have it disclosed to Statistics Canada, because Statistics Canada is not dealing with the specific outbreak. Public Health Agency of Canada is.

It cannot, for example, be used either

for research purposes. This power has not been exercised yet to date in the current pandemic.

Next slide, please. Now, this is a power which we do see exercised, we did see exercised in prior disease outbreaks that had provincial scope, and we see it has been used many times, five, to date, in the current pandemic.

Which is where the Chief Medical Officer of Health is of the opinion that there is or may be an immediate risk to health, he or she may issue a directive to any healthcare provider or healthcare entity regarding precautions and procedures to protect the health of persons.

Precautions and procedures can include things like wearing a mask. Wearing a gown. Using surgical gloves; other kinds of steps.

Where the Chief Medical Officer of Health is issuing such a directive that affects worker health and safety, the Section 77.7 provides that the CMOH must consider the precautionary principle.

The precautionary principle is not defined. It can be defined by regulation under this Section; it has not been.

Generally it is better known in

environment law and it means generically, to my understanding, to act without scientific certainty.

But again, it is not well-known in the health sector. And this legislation, at the time the directives were added to the legislation, in 2007, this is the first reference to it in any health legislation.

The directive may not be used to compel regulated health professionals to provide services without their consent. So, for example, you cannot say, Nurse X, I ask you to go to long-term care home Y and provide services there. That cannot be part of the directive.

I should also say, where there is a conflict between the Occupational Health and Safety Act, and a directive, the Occupational Health and Safety Act prevails.

The Chief Medical Officer of Health has exercised this power a number of times during COVID-19, and has issued five directives to date which have been amended from time to time.

Obviously, for the long-term care sector, the most relevant for those would be in this order: Probably Directive 3, Directive 5, and Directive 1 also deals with personal protective

equipment as well. But there are five in total that have been issued.

There is also a power, which was added to the Health Protection and Promotion Act in 2011, which allows the Chief Medical Officer of Health to issue directives to local boards of health and medical officers of health under certain emergency type situations, such as a pandemic, on policies and measures to ensure consistency in public health.

The reason why this provision was added -- this is not specified in the legislation -- the reason why this power was added in 2011 was because it was recommended by a former Chief Medical Officer of Health, Dr. Arlene King, who wanted the ability to direct Medical Officers of Health on certain policies and measures to ensure consistency, such as ensuring priority groups were followed for immunization clinics.

She mentioned in her 2011 report that there are were some issues with ensuring priority groups were immunized in all health units. So that power was added for that reason; it has not been exercised to COVID to date.

That particular power directives

definitely have. So in terms of directives, a healthcare provider or healthcare entity -- I've listed all of the persons there who may be subject to a directive. And I bolded obviously that it may -- long-term care homes may have directives issued to them. They are a healthcare provider or healthcare entity.

We can also prescribe additional persons who are healthcare providers or healthcare entities, if necessary, by regulation. No regulation has been proposed under that authority.

Next slide, please. Another Chief Medical Officer of Health power is the collection of preexisting laboratory specimen and test results.

So where the Chief Medical Officer of Health is of the opinion that there's an immediate and serious risk to health, the Chief Medical Officer of Health may collect, retain and use any previously collected lab specimens.

Note that the CMOH cannot compel an individual to provide a blood sample. But the Chief Medical Officer of Health can go to a lab and say, I understand that you have lab specimens. I am compelling them from you, laboratory, to provide

them to the public health laboratory under Public Health Ontario, for example.

This power allows the Chief Medical Officer of Health to collect preexisting lab specimens. It has not been exercised during COVID to date.

Next slide. So the Minister of Health also has powers. Those are the key Chief Medical Officer of Health powers. There are some ways in which the Chief Medical Officer of Health is involved in Minister of Health powers.

But briefly, what are Minister of Health powers under the Act? The Minister of Health publishes the Ontario Public Health Standards, which are directions or instructions to Boards of Health on programs and services that they must provide under the Act.

Boards of Health must comply with the Ontario Public Health Standards. They must be provided to Boards of Health and must be available for public inspection, which the Ministry does by posting the Ontario Public Health Standards on their website.

The Ontario Public Health Standards are not regulations, so there's no Cabinet approval

required for changes. But amendments to them, any amendments to them need to be made by the -- sorry, I'm getting a note over top here.

But amendments to them need to be approved by the Minister. And in practice, the Chief Medical Officer of Health reviews and approves all changes to the Ontario Public Health Standards, or protocols which are published under those standards.

If you have more questions about the Ontario Public Health Standards, my clients could provide more detail, but these are ways in which the Ministry sets standards that Boards of Health must meet at a local level in terms of programs and services.

Next slide, please. The Minister also may make regulations. The Minister may make regulations specifying which diseases are reportable. The Minister may also specify what diseases are communicable, or virulent.

So as I mentioned before, COVID-19 was designated by Minister regulation in January 2020 as a disease of public health significance, i.e., as a reportable disease and as a communicable disease. It has not been specified as a virulent

disease.

All other regulations under the Act are made by Cabinet with limited exceptions. But that's the key, for COVID, power that the Minister has to specify diseases.

COMMISSIONER MARROCCO: So the Minister did that in January?

MR. SCOTT: Correct. In January of this year, COVID-19 was listed as a communicable disease. So as of January, local Medical Officers of Health could issue Communicable Disease Orders for COVID.

And the persons I listed on the previous slide who have a duty to report communicable diseases had a duty to report as of January of this year.

In terms of funding of Boards of Health, the Medical Officer of Health may make grants for such purposes of the Health Protection and Promotion Act on such terms and conditions as the Minister considers appropriate.

So the Act says that funding is discretionary on the part of Ontario. In practice, public health funding -- because there's another section in Section 72 that says, all expenses of

Boards of Health and Medical Officers of Health are to be paid by municipalities.

But over the years, the Province has provided a certain percentage of funding to local Boards of Health. In 2019, it was approximately 75 percent provincial funding for local Board of Health expenses. And the obligated municipalities, single and upper tier municipalities, would pay the remainder.

This is obviously in flux currently because of the review announced on public health modernization, which is led by Mr. Jim Pine. It's currently on hold due to COVID-19, so we're not clear on what the funding model will be going forward.

But as of 2019, the Province paid 75 percent of funding. For certain programs, the Ministry, for such as immunization programs, the Ministry of Health pays 100 percent of the funding for those programs.

My clients would have more details on that if you have further questions.

Yes, Commissioner Coke, did you have a question?

COMMISSIONER COKE: I'm just inquiring

whether part of that public health modernization included the reduction of funding that was to happen to public health? Was that part of that initiative?

MR. SCOTT: In the 2019 budget, there was announced reductions in provincial funding that were to be implemented, but the review by Mr. Jim Pine is looking at more than just funding. It's looking at ways to modernize the public health system.

It has been reported in the press. I am not aware of all of the work that has been conducted on public health modernization, which is being led independently by Mr. Jim Pine, but my understanding is they're looking beyond just funding.

They're also looking at other ways to modernize the public health system. They're also conducting a review on emergency health services as well.

So that's a longwinded way of saying that the reductions in provincial funding that I think you're speaking of flowed from the 2019 provincial budget, which then were suspended, to my understanding, due to the pandemic.

My clients could provide further detail about that, but the funding changes are all on hold now due to COVID-19.

COMMISSIONER COKE: Thank you.

MR. SCOTT: Next slide, please.

It's important to note that both the Minister of Health and Chief Medical Officer of Health can appoint assessors for the purposes of carrying out an assessment of a Board of Health.

If, for example, a complaint is made that a Board of Health, say Toronto's Board of Health, is not providing services and programs they are required to do under the Act and under the Ontario Public Health Standards, or if there's an issue they're not complying with some other respect with the Health Protection and Promotion Act.

Or if there's a concern about the quality of administration or management of a particular Board of Health, either the Minister or the Chief Medical Officer of Health may order an assessment of a Board of Health.

It is a Minister power under the legislation in Section 82, but it's been authorized to be exercised by the Minister, also by the Chief Medical Officer of Health. Which is why I list it

as a Minister of Health power.

Next slide, please. Temporary isolation facilities.

So the Minister may require the occupier of a premises to deliver the premises or a part of the premises to the Minister to be used as a temporary isolation facility.

The Minister can make an order where the Chief Medical Officer of Health certifies to the Minister that there exists or there is an immediate risk of an outbreak of a communicable disease anywhere in Ontario, or an immediate risk to the health of persons, and the premises are needed for use as a temporary isolation facility.

No hearing is required to be held, and if there is noncompliance by the person who's issued such an order, a judge of the Superior Court may make an order directing the Sheriff to put the Minister or the Minister's designate in control of the premises by force if necessary.

The occupier, however, of the premises or owner is entitled to compensation. And if there's no agreement with the Crown to compensate the person, the person may apply to the OMB, and their compensation is determined in accordance with

the Expropriations Act.

There also is an ability as of 2011 for publicly owned premises to be also acquired for public health purposes. So, for example, a municipal building could be used or acquired by the Minister for use as an immunization clinic, for example.

This power has not been exercised by the Minister during the pandemic to date. But it does allow for these temporary isolation facilities to be established.

Next slide, please. Seizure of medications and supplies by the Minister.

Now I will explain in a minute that this power is somewhat limited and why.

But on its face, it authorizes the Minister of Health, on certification by the Chief Medical Officer of Health, where an immediate risk to human health exists or may exist, to procure, acquire or seize medications and supplies, subject to compensation, that are essential for safeguarding human health where regular supply and procurement is unable or insufficient to address the risk.

There is, however, a limitation to this

power. If there is an immediate risk that the health of patients in another province or territory of Canada would be jeopardized, the person who's subject to the order is not required to comply with it.

So, for example, if you have a drug company, for example, that has a delivery order to British Columbia, the Minister cannot say, "You have to provide these medications and supplies to us in Ontario".

The drug company can say: "But it will jeopardize the health of patients in British Columbia or Nunavut or the Northwest Territories", for example.

There is no hearing required by the Minister before such a seizure takes place. And the Minister also has a power to request information which has been used, and I'm going to come to this in a minute, to issue a direction requiring a person to provide information about persons who may have medications and supplies.

So, for example, the Minister could issue a direction to, for example, a hospital, saying, or a long-term care home, saying: I want you to provide me with information about other

persons that you're aware of who may have these medications and supplies.

And you see there, the definition of medications and supplies is very broadly defined: Antitoxins; antivirals; serums; vaccines; immunizing agents; antibiotics; other pharmaceutical agents; medical supplies and medical equipment. So that can include personal protective equipment, for example.

As I mentioned, this power has been exercised once during the pandemic to require specified persons to provide information on medications and supplies.

It was paired with another power, which is why I'm not mentioning it on this slide. I will mention it when I speak about the next slide. But it has been exercised once, compelling persons to provide information about who has medications and supplies.

Next slide, please. There is a relatively new power that was added to the legislation in 2018, which allows the Minister of Health to make an order where she is of the opinion that there exists or may exist an immediate risk to health from a new or emerging disease.

Note the Minister of Health can issue this order to a new or emerging disease. It does not have to be designated as a communicable disease.

And the Minister may direct any healthcare provider or healthcare entity -- those are the same people that are listed in the directives power, including long-term care homes -- to provide the Minister with information that is specified in the order.

The information, though, cannot include any personal information, or personal health information. So no identifiable information in the information that is compelled.

This power was exercised first in March of 2020, and updated in June, with regards to information regarding personal protective equipment which was issued both to long-term care homes and to retirement homes, hospitals and others, to require them to report to an Ontario Health website their stockpile of personal protective equipment.

And, as I mentioned there, it included retirement homes and long-term care homes.

So that power was exercised. The reason why it was used, with Section 77.5 sub (6),

is that healthcare providers or healthcare entities do not directly refer to retirement homes.

So the power was paired with Section 77.5, because that can be issued to any persons.

Just so you know, the Ministry of Seniors Affairs made an amendment to the Retirement Homes Act regulation to require retirement homes to follow directives of the Chief Medical Officer of Health. So there is quote, "no gap" in terms of retirement homes complying with directives.

But that's a longwinded legal explanation about why those two powers were combined to issue to all healthcare providers and healthcare entities, saying, what personal protective equipment do you have?

And please report it to an Ontario website so it can be tracked.

Thank you. Next slide, please. So the Minister also --

COMMISSIONER MARROCCO: Excuse me, Mr. Scott.

That power rests with the Minister, but not with the Chief Medical Officer of Health?

MR. SCOTT: That is correct. It exists

with the Minister, not with the Chief Medical Officer of Health; that is correct.

COMMISSIONER MARROCCO: Okay.

MR. SCOTT: The Minister of Health also must approve all appointments of Medical Officers of Health and Associate Medical Officers of Health.

So when the Board hires them, the Board of Health hires them, they have to write to the Minister saying, "Please approve this candidate as the Medical Officer of Health for this health unit".

And also significantly, any dismissal of a Medical Officer of Health or Associate Medical Officer of Health also must be approved by the Minister.

It requires a two-thirds vote of the Board of Health to dismiss a Medical Officer of Health. And the Medical Officer of Health can also attend the meeting and make representations; they're entitled to that by legislation.

Then the Board of Health has to come and seek approval from the Minister of Health for any dismissal of a Medical Officer of Health. So that provides them with some measure of job protection from their employer, the Board of

Health.

The Minister can also approve postgraduate public health requirements for Medical Officers of Health or Associates, if they take that qualification outside -- a university outside of Canada.

Next slide, please. Okay, I know that you had mentioned to me before, Commissioner Marrocco, there might need to be a break at 11:15.

I don't know if you want me to talk about the Emergency Management and Civil Protection Act at this time, or allow you to take the break?

COMMISSIONER MARROCCO: Why don't we take the ten minutes before you start the topic.

MR. SCOTT: Thank you.

COMMISSIONER MARROCCO: Okay. So we will be back at 11:25.

-- RECESS TAKEN AT 11:15 --

-- UPON RESUMING AT 11:25 --

COMMISSIONER MARROCCO: Carry on then, Mr. Scott. When you're ready, we're ready.

MR. SCOTT: Thank you, Mr. Commissioner.

I'd like to ask are there any further questions about the Health Protection and Promotion Act before I go on -- and this section is shorter --

to the Emergency Management and Civil Protection Act; are there any further questions before I go on?

COMMISSIONER MARROCCO: I just had one question.

You were describing the appointment of the Chief Medical Officer of Health, and the nature of which, obviously the Legislature goes to some considerable length to get some unanimity, or some multi-party support for the commissioner.

So they recommend a person, but the Minister of Health has to approve that person before -- I must have misunderstood?

MR. SCOTT: No, the Minister of Health approves all local Medical Officer of Health appointments. In terms of the Chief Medical Officer of Health, as you say, they are appointed by an all-party committee of the Legislature.

There is a vote in the Legislature, and then, by Order in Council, Cabinet appoints that person who the Legislature has named as the Chief Medical Officer of Health. So that is a decision by Cabinet.

COMMISSIONER MARROCCO: But if there is an appointment of a local, a recommendation or --

but there's a vacancy as far as the local Medical Officer of Health is concerned, that appointment is made by the Minister of Health?

MR. SCOTT: It's approved by the Minister of Health. So if there's a vacancy with a local Medical Officer of Health, the Board of Health locally will interview candidates, select a person, approve them by Board resolution.

And then they will come to the Minister of Health and say, we have appointed person X through our interview process to be the Medical Officer of Health. We are writing to you, Minister, to approve that appointment.

COMMISSIONER MARROCCO: All right.

MR. SCOTT: Okay, so the Emergency Management and Civil Protection Act. I do want to say at the outset, before I describe this legislation, that public health powers that I described to you earlier continue to exist during a declared emergency.

So they exist prior to, during, and after a declared emergency in Ontario. There was, of course --

COMMISSIONER MARROCCO: Excuse me, Mr. Scott. Let me make sure I have this correct.

Notwithstanding whatever order was made on March 17th, the powers and jurisdiction of the Chief Medical Officer of Health and the local Medical Officers of Health is in effect a carve out from that? It continues as it always was?

MR. SCOTT: They continue as they are. There is a conflict provision that says in the event of a conflict, an emergency order will prevail.

So if there was a direct conflict between a Medical Officer of Health order, say, and what was specified in an emergency order, the courts would have to interpret it, obviously. But it is likely that the emergency order would prevail in that circumstance.

But often, I am asked the question, when I present to medical residents or law students, they say, well, an emergency is declared so the Chief Medical Officer of Health or Medical Officers of Health no longer have their powers? That is not correct.

They continue to have their powers. And indeed, they've exercised those powers in some cases during the actual emergency that has been declared on March 17th.

So again, emergencies are declared in Ontario under the Emergency Management and Civil Protection Act.

There is no power for declaration of a public health emergency, for example, which exists in British Columbia. That does not happen in Ontario.

In Ontario, emergencies are declared under the Emergency Management and Civil Protection Act by the Premier or by Cabinet. There is a high legal test that applies to declare an emergency which I won't go into; you can see it on the slide there.

It obviously was deemed to be met in March of this year due to COVID, and an emergency was declared. Once an emergency is declared, there are extensive order-making powers of Cabinet, so these are Cabinet authorities, to regulate or prohibit travel or movement; closing any place whether public or private; constructing works; distributing goods and services; fixing prices in the case of price gouging; authorizing but not requiring any class of persons to provide services that they are reasonably qualified to provide.

I italicize that to note in the slides,

to note that emergency orders cannot compel, much as a Chief Medical Officer of Health directive cannot compel, a regulated health professional such as a doctor or nurse to provide services without their consent.

It can require the collection, use and disclosure of information, including potentially personal information.

Or -- and it has a very broad what lawyers call "basket clause", that basically says any other order taking such actions or implementing such other measures as Cabinet considers necessary in order to respond to or alleviate the effects of the emergency.

And we've seen many orders, many, many orders issued during COVID-19, which I talk about in the next slide. Next slide, please.

So there have been many emergency orders issued. I provide a link there to all of the current ongoing COVID orders that still have legal effect. As I come to shortly, there was some orders that expired when the emergency was terminated and the various orders were moved under new legislation in July, which I will come to in a minute.

But these emergency orders that are issued are regulations under the Emergency Management and Civil Protection Act. So that's how they're actually made; they're regulations.

Emergency orders, when an emergency is declared, let's go back to the emergency declaration.

When you have a declaration of emergency on March 17th, you may have seen in the media, there were many media announcements saying the Premier has extended the emergency.

That's because it lasts for only 14 days, and can only be renewed once for 14 days. And after that, further extensions require the Legislative Assembly to agree to extend the emergency for an additional 28 days.

Which is why you saw, starting in April, the Premier was bringing, and the government was going to the Legislature asking for approval to extend the emergency declaration.

In terms of emergency orders that can be issued, they also last only for 14 days and can be extended by Cabinet, who issues them for a period or additional periods of up to 14 days.

And when the emergency has ended,

emergency orders that are necessary to deal with the effects of the emergency can be extended under the Emergency Management and Civil Protection Act for further periods than 14 days.

So even the emergency orders only have an initial life of 14 days and must be extended. The emergency did expire on -- I mentioned termination before. It did not terminate. It expired on July 24th, and there is new legislation that replaced it.

The Reopening Ontario (A Flexible Response to COVID-19) Act 2020, which, again, is Ministry of Solicitor General legislation, much as the Emergency Management and Civil Protection Act is Ministry of Solicitor General legislation.

Next slide, please. The Reopening Ontario Act, for short, continues most orders that are made under the Emergency Management and Civil Protection Act. There were certain orders that were deemed to have expired, and those were not continued under the new legislation.

Under the new legislation, orders continue for 30 days. So it isn't a 14-day period anymore for orders. And they may be extended by Cabinet for an additional 30 days. So instead of

14 days and renewal, you have 30 days and renewal.

Some orders may be amended by Cabinet, which are specified in this legislation, including restricting gatherings, workplace measures and closing places.

But other orders listed in the Act dealing with other subject matters can only be extended; they can't be amended.

There is -- the power to amend or extend orders under this legislation expires after one year.

And the Legislative Assembly is the only person who can extend it beyond the year. So really this act allows for action within a year without being extended.

And reports are required once every 30 days to a standing committee of the Legislative Assembly. So the government has to go once every 30 days to indicate what steps they've taken under this legislation in the last 30-day period, and the Premier is responsible for tabling a report in the Legislative Assembly after 120 days.

So it's important to note that these emergency orders are exercised by Cabinet. They are not exercised by the Chief Medical Officer of

Health or Minister of Health.

The Minister of Health, as part of Cabinet, does have obviously a say, as all Cabinet members do on Cabinet orders.

And that's the end of my legal presentation. Are there any further questions for me before I turn it over to Robert Lerch, one of my clients?

COMMISSIONER MARROCCO: No, I think we're -- I don't see anybody wanting to ask a question.

So you can turn it over to Mr. Lerch when you're ready to do so.

MR. SCOTT: Thank you, Commissioner Marrocco. Thank you all, Commissioners, and I turn it over to you, Robert.

MR. LERCH: Thanks, Liam, and thank you, Commissioners, for the invitation.

I think you have received the bios for myself and my two colleagues, who are actually in the room with me here. Dr. Warshafsky, and Melissa Helferty, we are all with the Office of the Chief Medical Officer of Health, Public Health within the Ministry of Health.

And what I will do is pick up on some

of the specific pieces around long-term care and mostly around the directives. So thank you again for the invitation. If you do have questions, I may turn it to one of my colleagues if they're better able to respond to those questions.

Our role, I would basically start off in saying, was more around one specific piece that I will be referring to, is around Directive 3.

As Liam mentioned earlier, one of the powers of the CMOH is around releasing directives, which has been done five times within the course of the COVID pandemic.

I will focus mostly on one of those, but there are, as Liam mentioned, long-term care homes are mentioned or have sort of implicated in a few of the directives.

Two of the specific directives are number three, where this is directed to long-term care homes. And then Directive 5 is sort of referencing long-term care homes and hospitals. And, as Liam mentioned, Directive 1 also has some implications around PPE, as well as sort of providers.

So with Directive 3, as Liam mentioned, the directives are to provide specific direction to

either sectors or specific groups. And in the case of Directive 3, that is out to long-term care homes specifically.

There are sort of language or provisions in there around application also to retirement homes, Retirement Homes Act.

The directive is directed at long-term care homes in terms of the items in there. There have been nine, and I'll go into sort of the chronology in some of the additional slides, or later slides. But there have been nine versions of Directive 3 released since the first one in March.

The other directive, which I won't go into detail on, and I understand there will be a specific presentation around PPE.

And Directive 5 focuses a lot around PPE as well as point of care risk assessments specific to hospitals and long-term care homes. So I will leave that one for future presentations.

One of the other things I also wanted to mention, it's not under the directives, but another sort of vehicle or communication channel used to send either recommendations or guidance out to various sectors or organizations, which has been used a number of times for long-term care homes and

other organizations, are memos.

The Chief Medical Officer of Health has released a few memos since March specific to long-term care homes. Other memos have been released also to long-term care homes and other sectors, but from various levels.

So some of those were released from Deputy Minister level, both in the Ministry of Health as well as some of the other ministries. But those are providing recommendations or asking for particular courses of action, not direction per the directives in the CMOH powers that Liam mentioned.

Next slide, please. So specifically around Directive 3, in terms of sort of development review and approval processes, this is sort of a general sort of an overview of how that evolved.

There could be some variation depending on the specific versions or the updates that were being looked at.

Additional review processes could have been added in there. Various other ministries or partners could have been consulted, based on subject matter or sector-specific expertise.

In terms of development, the Ministry

Emergency Operation Centre sort of led the review of that and sort of the revisions of the directives.

And then following, there would be review of specific content by Chief Medical --

COMMISSIONER MARROCCO: Can I just stop you for a second?

MR. LERCH: Of course.

COMMISSIONER MARROCCO: The Ministry Emergency Operations Centre, that's the Ministry of Health?

MR. LERCH: Yes, sorry, Ministry of Health Emergency Operations Centre, yes.

COMMISSIONER MARROCCO: All right.

MR. LERCH: Any further question on that one, sorry?

COMMISSIONER MARROCCO: I'm just trying to understand. The directive is coming from the Chief Medical Officer of Health?

MR. LERCH: Yes, that is correct.

COMMISSIONER MARROCCO: But it is being drafted by the Emergency Operations Centre within the Ministry of Health?

MR. LERCH: Yes, the directives and drafting of those and the reviews, and sort of

leading those processes occurred to the Emergency Operations Centre.

COMMISSIONER MARROCCO: All right. Go ahead.

COMMISSIONER KITTS: Just a follow up on that.

Does the emergency -- does the Ministry Emergency Operations Centre include more than Ministry of Health?

MR. LERCH: So the Ministry of Health Operations Centre (verbatim) is focused around the Ministry of Health. And you'll see in the reviews in the later pieces is the engagement of those partner sort of ministries, to be able to develop sort of the content to provide that sector-specific expertise, as well as link in other sort of necessary information from those areas and those ministries.

COMMISSIONER KITTS: So the Ministry of Long-Term Care is not represented at that MEOC?

MR. LERCH: Yeah, the MEOC is specific to the Ministry of Health, yes.

You had a presentation on sort of the overall sort of IMS and Command Table structure. If you do require additional information on the

sort of Ministry Emergency Operations Centre, how it fits within that, we can sort of follow up and provide that to you, if that would be of use. Yes? Is that --

COMMISSIONER KITTS: Yes, I think that would be very helpful.

So just the revisions to the draft affecting long-term care homes is done by the Ministry of Health, MEOC?

MR. LERCH: The main sort of lead in drafting those revisions and holding the pen, I'll say, sat with sort of the MEOC, yes.

The review processes is where we sort of engaged. So as you'll see there, Public Health Ontario sort of providing the technical expertise from that angle.

Then Ministry of Long-Term Care, Ministry of Seniors and Accessibility, as well as the Ministry of Labour, Training and Skills Development, providing sort of review and input into sort of those drafts and provisions, providing that sort of other expertise and information as required, depending on the items that were further being looked at.

And then we sort of, after we have

those reviews, and there is sort of input from the various sort of areas in the ministries, there could also be, as I mentioned, other reviews that are done, depending on the specific item.

There could be specific consultations done with other areas, or expertise, ethics tables or those sorts of things as required depending on what the items would be.

COMMISSIONER MARROCCO: So did the Ministry Emergency Operations Centre decide on what it was going to revise?

MR. LERCH: So the revisions would come from various sort of tables. Some of that could be coming from the Ministry of Long-Term Care, MSAA. It could come from command table or other sort of information sources.

So part of that revision process would be for the MEOC to look at what was being sort of, let's say, released in memos that had been provided as recommendations from various tables. Looking at other sort of pieces.

One example: The Ministry of Long-Term Care had done some things under the EMCPA around working locations.

So part of that would be an information

gathering process, reaching out, gathering from various tables and various structures as well as other documents. So the MEOC sort of played that sort of central role in pulling that information together from various sort of sources.

COMMISSIONER MARROCCO: Who is in the Ministry Emergency Operations Centre?

MR. LERCH: Go ahead, sorry.

COMMISSIONER MARROCCO: No, who does, what does that look like? Who is in there?

MR. LERCH: So the overall sort of -- it is the director of the house services and emergency management branch is sort of the lead within the direct centre there.

What I can do or what I'll follow up with is sort of a more comprehensive structure in how that actually fits within the overall sort of governance model within the Ministry.

Thank you. Commissioner Coke, did you want to ask a question?

COMMISSIONER COKE: That's fine, if they're going to provide some more details. I'm just trying to understand the governance as well. Thank you.

MR. LERCH: We'll definitely follow up

on that. Thank you, Commissioners.

At the later part of the process and once there was the draft that would be ready to send forward, then that would go through a legal review within the Ministry of Health legal services, Mr. Scott's area, or other legal counsel and any other sort of engagement needed from the legal side of things.

Following that, there would be submission for final reviews and approvals, reviews being both Chief Medical Officer of Health and then the Minister's Office.

And final sort of approval to release, as these are directives under the Chief Medical Officer of Health, would be then Dr. Williams in this case as the CMOH final approval before those would be released under his powers.

COMMISSIONER MARROCCO: So, the Minister of Health is conducting a final review and approval of a directive that's being issued by the Chief Medical Officer of Health?

MR. LERCH: The final approval would be from Dr. Williams to release that as a CMOH. The sort of sending for review and approval is not sort of that final approval to the Minister of Health

and the office there.

It's review of the content more so to see what was in there, as well as sort of that final look before it would be approved then by Dr. Williams for official release.

COMMISSIONER MARROCCO: So if the Minister wasn't content on her review, it would go back to the MEOC?

MR. LERCH: Potentially. I'm not aware of some of those pieces that would happen in MEOC and the Minister's office or the Minister.

I'm sort of -- was at a different level and I don't think -- I think my colleagues are similar to me. I'm just looking in the room here in terms of roles.

So we're more the development part of it, versus that sort of upper level sort of final review and approval.

COMMISSIONER MARROCCO: Okay.

MR. LERCH: We can sort of provide information also for you in terms of that final process with the governance.

Okay, thank you. So next slide, please. Then just in terms of the chronology of sort of Directive 3 specifically. We released the

first version on March 22nd, and went through up to nine versions, taking us to September 10th.

I'll walk a bit through some of the sort of main pieces, or changes over this sort of timeline or chronology here for Directive 3, as I'm going to say its evidence and information evolved on the pandemic, as well as information in other sort of areas, including the sectors in terms of responding to the pandemic, and how that then involved in terms of some of the content areas.

So next slide, please. So if we go back to the first sort of document there and sort of releasing a directive. At that time, what we were seeing in terms of context was we were starting to see outbreaks in long-term care homes and seeing some high mortality.

So looking then to what we would have in place as sort of foundational pieces, as this is a respiratory virus, and we were in respiratory virus season. So a number of things were already in place within facilities.

But then looking to develop specific directives out to be able to provide that to the sector around how to control sort of COVID-19 as a respiratory virus.

So listed there are some of the foundational documents that have been place for a while and used by facilities and public health units around controlling other respiratory viruses.

So outbreaks in long-term care facilities, we've had sort of respiratory guidance out for quite a number of years on that.

Other protocols, as Liam mentioned under the Ontario Public Health Standards, there are protocols and guidance that are provided in general for various communicable diseases.

And those sort of stand in terms of some of the general practices around infection prevention and control and those things when it comes to specific diseases. Like contact droplet precautions and those sorts of things.

Environmental cleaning, another big piece in terms of pulling from that sort of existing evidence base where evolving evidence was occurring on COVID. So looking to what was actually sort of there and available to sort of prepare the directive for that initial release.

COMMISSIONER MARROCCO: So the initial release is March 22nd?

MR. LERCH: Yes.

COMMISSIONER MARROCCO: When did the -- when did the MEOC start working on the release?

MR. LERCH: Start working on the draft, sorry, is that what you said?

COMMISSIONER MARROCCO: Well, the first version or the first iteration is March 22nd?

MR. LERCH: Yup.

COMMISSIONER MARROCCO: I'm just saying, when did they start working on it?

MR. LERCH: I will sort of -- I'm looking to my colleagues in the room here for that. I wasn't involved in the first one.

COMMISSIONER MARROCCO: They can just speak up. It's best if you not all speak at the same time, but as long as people speak. If somebody knows, it would be helpful.

MR. LERCH: You bet. Yeah, nobody seems to have the specific date on when that was initiated. I will add that to the list of things we will get back to you on in terms of when that work was specifically initiated for that piece.

COMMISSIONER MARROCCO: Okay.

MR. LERCH: Thank you. So then just in terms of the bit of the chronology there and I won't go through all the specific items through

each one. I know we are getting close on time.

But in terms of some of the items that evolved over sort of the course of the various versions, we were looking at screening and sort of strengthening the screening that was done for residents as well as those coming into the homes.

The visitors was another piece that had evolved over time in terms of that essential visitors and limiting those at the initial piece or the initial part of the pandemic, around the essential visitors. And then sort of how that evolved.

The masking policies was another piece in terms of that universal masking for both essential visitors and staff coming into the facilities.

So it was picking up and sort of including information that was evolving in other areas and directives as well.

The PPE and those sorts of things were also sort of part of this.

Admissions and hospital transfers and readmissions were also, I'm going to say, another evolving piece that had sort of changed from sort of temporary halting hospital admissions to then

allowing hospital admissions to occur.

And sort of what these, the direction was around that, around testing and self-isolation with people coming into homes to make sure that there was sort of containment, if necessary, if somebody had come in.

So making sure there's not potential there for sort of a spread of the virus, if that was a factor there.

So a number of them sort of have evolved. Another piece around that was, as I mentioned earlier, was the limitation of work locations for the staff.

That was a piece that had evolved but had come in through the Emergency Act in terms of long-term care homes and then retirement homes. So then reflecting sort of that evolving situation was another part of that piece there.

COMMISSIONER MARROCCO: Commissioner Kitts?

COMMISSIONER KITTS: Was that situation then reversed? Is that where they said you could work in more than one home?

MR. LERCH: Initially that was the sort of the, there was, I'm going to say the

recommendation that people would limit the work locations of the facilities.

And then there was the regulation put under the Emergency Management and Civil Protection Acts, the Ministry of Long-Term Care had put in a piece that said employers were not to have people working in more than one location. Then retirement homes did a similar thing in the regulation under the EMCPA also.

So that was sort of the evolution of that part. There was more of a consider doing this, and then that involved into more regulatory elements which were then put into the directive or reflected in the directive, I should say.

COMMISSIONER KITTS: Am I interpreting right that the initial directive said you could work only in one home? This reflecting the new limitation in working only on one location, does that mean you can now work in more than one, if you limit them? Or what does that mean?

MR. LERCH: Are you referring, sorry, just so I get this correct, thanks Commissioner.

In terms of the regulation that's in place?

COMMISSIONER KITTS: Yeah, the version

4, April 15, 2020, says: Updated to reflect the new limitation on working in only one location.

What does that mean?

MR. LERCH: Yes, so that is specific then, that piece there was specific to the regulation under the EMCPA for long-term care homes.

So employers then had to abide by the regulation, whereby their employees or staff were to limit the locations that they were working in. So they weren't to work in more than one location. That was coming under the regulation.

Then in the next piece, in the version on May 21st, where it says "work locations", that one was specific then to the retirement homes regulation.

So it was that sort of evolving to the long-term care homes and in the next version that was also then under the regulation, a specific one around the retirement homes, basically saying the same thing around employers limiting those work locations and staff.

COMMISSIONER KITTS: So April 15th was the order to work at only one site?

MR. LERCH: Yes, long-term care homes

specifically, yeah, yeah.

COMMISSIONER MARROCCO: Was the -- sorry, go ahead, Commissioner Coke.

COMMISSIONER COKE: I just wanted to clarify on that point. You're saying previous to that April 15th, there was some sort of direction they were telling people to consider that?

MR. LERCH: Yeah.

COMMISSIONER COKE: But this is when it was formulated into a more strict regulation.

MR. LERCH: Yes, that's when the regulation was put in under the EMCPA, yes, correct, thank you.

COMMISSIONER MARROCCO: Did the federal government have any role in this process? I mean, it's a national disease, but is this all done -- is there -- does the federal government participate in any way in what you're outlining?

MR. LERCH: In terms of the general pieces here and what's in the directive, or specifically around the work location piece?

COMMISSIONER MARROCCO: Sorry, generally.

MR. LERCH: Generally, not so much in terms of directing pieces here. Part of the

consideration would be looking at what the federal government would be releasing in terms of guidance and those things.

But the specific pieces here would be more within the purview of the province versus anything outside of that that would be federal jurisdiction.

COMMISSIONER MARROCCO: Okay.

MR. LERCH: Okay. So then I will move into the next slide then, please.

So this basically we're continuing with the chronology here in terms of some of the evolution there around, and the later pieces were sort of around admissions; readmissions is mentioned in terms of the specifics. As well as the visitor policies, and those were evolving over time also.

At the beginning, there was the memo which asked or recommended that facilities only include essential visitors. And then over the course of Directive 3, language was added around what those are specifically and there was a bit of expansion there around pieces, around service or, let's say, family providing essential care services.

To then sort of now, coming up to what is the Ministry of Long-Term Care and the MSA visitor policies, which are sort of aligned now or combined with the directive overall in terms of visitors.

COMMISSIONER MARROCCO: What's the process to go from version to version? How does that typically happen? How did that happen?

MR. LERCH: Yeah. So in terms of going from version to version, it was sort of back to that, sort of what I mentioned around the development stage.

So information coming in, in terms of other items, evolving evidence around COVID itself. Looking at what was occurring in the outbreaks within the long-term care homes, were there specific elements or things that needed to be strengthened in order to sort of shore up or ensure that we are doing things to control appropriately?

So it was sort of that mix of information-gathering that would sort of then lead to a new reversion or updates in that case. So, yeah --

COMMISSIONER MARROCCO: Did the information come in in writing?

MR. LERCH: Not necessarily. Some of it may, in terms of some of the recommendations, let's say, from the memos that were being sent out where it would look at recommending specific actions. Then those would be further looked at, consulted on in terms of does that then fit within the directive itself?

Or is that more of a guidance piece that would be more or less applicable across sector, but maybe specific settings would be more applicable or types of homes. Because we are dealing with a different, we are a large variety of homes in terms of structure and functions.

Looking at what would be directive versus more guidance pieces, which we have sort of also, and I'll mention a bit of those later.

COMMISSIONER MARROCCO: Okay.

MR. LERCH: Any further questions?

COMMISSIONER MARROCCO: We're fine. I think if you don't hear any, we're not asking any.

MR. LERCH: We are almost at time, so I do apologize.

COMMISSIONER MARROCCO: Finish your presentation.

MR. LERCH: Okay, perfect. Thank you

for that.

So next slide then. As mentioned, in order to support sort of the directive and implementation for the homes, and the sector, specific guidance documents are then also developed or were developed to carry the directives forward in terms of specifics around long-term care homes.

So we have the long-term care guidance; it's more of a general guidance document. There was a few versions of that. Then there's a specific outbreaks guidance document for long-term care homes.

So those documents then go into more detail around what homes could consider, specifics around some of the items mentioned within the directives. An example could be around staff and resident cohorting.

So then the guidance documents provide some more detail on what that could look like within a particular home.

As mentioned, sort of, there are a variety of structures in sort of homes in terms of size. So the cohorting in one home might look different than others.

So the guidance documents are really

meant to provide reference and considerations for homes and then how to apply some of these things based on their specific sort of situation there.

COMMISSIONER KITTS: Just to clarify. So on April 15, 2020, this guidance document, version four, is different than the directive?

MR. LERCH: It provides different information than the directive in terms of the level of some of the detail and how far it goes. It's more guidance.

It's not sort of you have to do this. But here's things that you should consider if you're looking at COVID-19 within your facilities and how to prepare and respond.

COMMISSIONER KITTS: So the regulation that limits staff to one site is not a guidance in the guidance document? That's a regulation and that's still in effect today; is that right?

MR. LERCH: Yes, those things are still sort of separate and sort of direction or regulation, yeah, not guidance which could be considered, yes.

COMMISSIONER KITTS: Thank you.

MR. LERCH: And then lastly there, one of the other sort of tools and one of the things

that had been a major piece in moving the directive and the guidance forward was around screening, and how to support that.

So screening documents was also sort of developed for homes to use to be able to accomplish some of those tasks. So supporting them in implementing the directives and sort of those requirements.

So next slide, and I believe that is the last slide. Just in terms of collaboration and additional supports for long-term care homes. In that information gathering piece, stakeholder meetings; there is a number of those that were occurring. So those were a good, I'm going to say, place to sort of consult and hear what the sector had to say around some of these pieces in the directives, which could then be considered in terms of potential revisions, so back to that sort of what was the triggering piece.

Communication was one of those things and sort of information stemming from various tables, stakeholders included.

As well as sort of more operational groups that were across ministries for information sharing and those things, to be able to look to see

what information or things we might consider or need to consider in sort of next revisions, or in terms of guidance or other supports.

One of those supports from that was around sort of training and development with a focus on IPAC. I know you have, I think it might be coming up next week, a presentation from Public Health Ontario.

So they can provide sort of a higher level detail or more detail, I should say, around sort of the IPAC work that they did.

There was a number of pieces that were sort of developed and put in place to support the homes and inspectors as well as the sector in general, around IPAC, which was sort of one of the main pieces identified in the early part of the pandemic we're addressing.

COMMISSIONER MARROCCO: So when was this -- so now, so there's a working group. Ministry of Health, Ministry of Long-Term Care, MSAA?

MR. LERCH: Ministry of Seniors and Accessibility, so retirement homes.

COMMISSIONER MARROCCO: So that working group, what is it producing? What does its work

produce?

MR. LERCH: That was more of a information-sharing vehicle at operation level to be able to gather potential pieces to then trigger or include updates around guidance or those other supports.

One of those was around, you'll see below there, the webinar is from PHO. So in sharing information at that group, IPAC and the need for inspectors to have more information, IPAC was identified.

And out of that came the action of putting in place some training for inspectors within long-term care homes in MSAA, so retirement homes.

COMMISSIONER MARROCCO: What is the timing on that, from the information sharing to the online training?

MR. LERCH: With that, I think it was about three weeks, I'm going to say, between sort of talking about that and getting up the training. Or revising the existing training that was in place for staff at facilities.

So, you know, part of what happened was evolving some of the content where it might be

focused for staff. Some changes in that could then make that applicable for more inspectors to allow that forum also for conversation.

COMMISSIONER MARROCCO: When approximately is that happening?

MR. LERCH: So that was around, let me just see if I can grab the date here.

The meetings on that would have started in April.

COMMISSIONER MARROCCO: Okay.

MR. LERCH: So that was sort of all I was covering in the presentation. I do have those few follow up items to bring back to yourselves, Commissioners, on those few pieces.

COMMISSIONER MARROCCO: Thank you for agreeing to follow up. That's very helpful.

MR. LERCH: Perfect.

COMMISSIONER MARROCCO: Well, are there any further -- any questions?

Well, I think that sort of exhausts us for now. The presentation is very informative. We may be back for more information as we get further into our work, but thank you for this, and thank you for the time and trouble, yourself and Mr. Scott. It's very much appreciated by us.

MR. LERCH: Thank you, Commissioners.

COMMISSIONER MARROCCO: Very good.

MR. SCOTT: Thank you.

COMMISSIONER MARROCCO: Okay, bye-bye everybody.

-- Meeting concluded at 12:08 p.m.

REPORTER'S CERTIFICATE

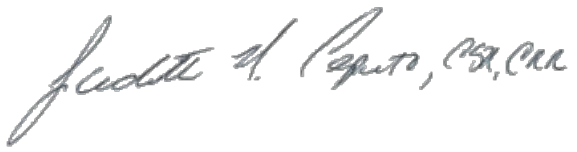
I, JUDITH M. CAPUTO, RPR, CSR, CRR, Certified Shorthand Reporter, certify;

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 24th day of September, 2020.



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