

# LTC Commission briefing - CMOH / HPPA

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



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1 MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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6 --- Held Virtually via Zoom, with all participants  
7 attending remotely, on the 23rd day of September, 2020,  
8 10:02 a.m. to 12:13 p.m.

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12 BEFORE:

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14 The Honourable Frank N. Marrocco, Lead Commissioner

15 Angela Coke, Commissioner

16 Dr. Jack Kitts, Commissioner

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19 PRESENTERS:

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21 Liam Scott, Counsel, Ontario Ministry of

22 Health and Ministry of Long-Term Care

23

24 Robert Lerch, Manager, Immunization Policy &

25 Programs, Ontario Ministry of Health and Long-Term Care

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

3  
4 Dr. Daniel Warshafsky, Senior Medical Consultant  
5 at the Office of the Chief Medical Officer of  
6 Health, Ontario

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8  
9 PARTICIPANTS:

10  
11 Alison Drummond, Assistant Deputy Minister,  
12 Long-Term Care Commission Secretariat

13  
14 Dawn Palin Rokosh, Director of Operations With  
15 the Long-Term Care Commission

16  
17 Derek Lett, Policy Director, Long-Term Care  
18 Commission Secretariat

19  
20 Amy Leamen, Counsel, Legal Services Branch for  
21 the Ministries of Health and Long-Term Care

22  
23 John Callaghan, Lead Counsel, Long-Term Care  
24 Commission Secretariat

1 PARTICIPANTS (cont'd):

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3 Roopa Mann, Counsel, Crown Law Office Civil.

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

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7 Judith Parker, Crown Law Office Civil.

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

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15 ALSO PRESENT:

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17 Judith M. Caputo, Stenographer/Transcriptionist

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

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

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

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

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

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

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

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

1 morning.

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

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

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

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

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

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

24 MR. SCOTT: Thank you.

25 Mr. Commissioner, thank you to all the

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

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

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

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

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

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

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

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

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

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

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



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

7 Next slide, please.

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

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

15 At the local level, there are currently  
16 34 public health units that are divided. They have  
17 different boundaries than Local Health Integration  
18 Networks.

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

25 There are three legal types of Boards

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

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

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

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

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

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

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

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

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

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

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

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

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

3 Next slide, please. Health hazard  
4 orders.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17                  Next slide, please.

18                  COMMISSIONER KITTS: Can I just  
19 interrupt for a second?

20                  MR. SCOTT: Go ahead.

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

24                  MR. SCOTT: Yes.

25                  COMMISSIONER KITTS: Is that

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

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

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

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

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

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

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

1 dealing with a health hazard or a communicable  
2 disease?

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

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

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

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

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

23 MR. SCOTT: Yes?

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



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

4 COMMISSIONER MARROCCO: Okay.

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

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

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

15 COMMISSIONER MARROCCO: Okay.

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

20 COMMISSIONER MARROCCO: Go ahead.  
21 That's fine.

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

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

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

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

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

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

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

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

8           MR. SCOTT: Yes.

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

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

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

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

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

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

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

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

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

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

1 Officers of Health issue orders on routinely.

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

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

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

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

25 So, for example, and I've included an

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

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

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

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

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

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

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

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

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

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

1 assuredly get tuberculosis.

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

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

11 Next slide, please.

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

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

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



1 disease.

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

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

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

11 COMMISSIONER MARROCCO: Before you go  
12 on.

13 MR. SCOTT: Yes.

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

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

25 Labs also have a duty to report.

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

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

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

17                   There are specific --

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

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

25                   COMMISSIONER MARROCCO: Yes.

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

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

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

18 COMMISSIONER MARROCCO: Okay.

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

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

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

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

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

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

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

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

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

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

17 Yes?

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

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

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

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

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

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

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

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

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

24 COMMISSIONER KITTS: Okay.

25 COMMISSIONER MARROCCO: Just to pursue

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

7 MR. SCOTT: Correct.

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

13 MR. SCOTT: Correct.

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

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

25 COMMISSIONER MARROCCO: Okay.

1 Commissioner Coke?

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

6 MR. SCOTT: Yes.

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

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

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

20 COMMISSIONER COKE: Okay, thanks.

21 MR. SCOTT: Okay. Next slide, please.

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

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



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

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

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

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

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

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

1 has been selected by the Assembly.

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

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

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

16 Dr. David Williams, who was appointed  
17 in 2016 -- his appointment expires in February of  
18 2021. Again, the legislation says that he may be  
19 re-appointed to that role.

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

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

1 Assembly.

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

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

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

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

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

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

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

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

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

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

1 has otherwise asked them to exercise his powers.

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

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

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

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

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

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

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

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

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

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

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

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

6 MR. SCOTT: Yes?

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

11 MR. SCOTT: Correct.

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

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

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

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

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

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

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

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

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

22 MR. SCOTT: Correct, that is correct.

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 Next slide, please. Thank you.

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

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

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

22 If it's clinical information, then the  
23 CMOH can only obtain that by order through Section  
24 77.6, which is an order to provide personal health  
25 information or clinical information.

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

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

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

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

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

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

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

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

9 COMMISSIONER MARROCCO: All right.

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

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

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

25 It cannot, for example, be used either

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

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

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

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

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

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

25 Generally it is better known in

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

3 But again, it is not well-known in the  
4 health sector. And this legislation, at the time  
5 the directives were added to the legislation, in  
6 2007, this is the first reference to it in any  
7 health legislation.

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

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

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

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

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

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

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

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

25           That particular power directives



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 disease.

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

6 COMMISSIONER MARROCCO: So the Minister  
7 did that in January?

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

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

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

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

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

3 But over the years, the Province has  
4 provided a certain percentage of funding to local  
5 Boards of Health. In 2019, it was approximately  
6 75 percent provincial funding for local Board of  
7 Health expenses. And the obligated municipalities,  
8 single and upper tier municipalities, would pay the  
9 remainder.

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

16 But as of 2019, the Province paid  
17 75 percent of funding. For certain programs, the  
18 Ministry, for such as immunization programs, the  
19 Ministry of Health pays 100 percent of the funding  
20 for those programs.

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

23 Yes, Commissioner Coke, did you have a  
24 question?

25 COMMISSIONER COKE: I'm just inquiring

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

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

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

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

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

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

4                   COMMISSIONER COKE: Thank you.

5                   MR. SCOTT: Next slide, please.

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

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

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

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

1 as a Minister of Health power.

2 Next slide, please. Temporary  
3 isolation facilities.

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

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

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

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



1 the Expropriations Act.

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

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

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

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

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

25 There is, however, a limitation to this

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 COMMISSIONER MARROCCO: Excuse me,  
22 Mr. Scott.

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

25 MR. SCOTT: That is correct. It exists

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

3 COMMISSIONER MARROCCO: Okay.

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

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

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

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

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

1 Health.

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

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

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

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

15 MR. SCOTT: Thank you.

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

18 -- RECESS TAKEN AT 11:15 --

19 -- UPON RESUMING AT 11:25 --

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

22 MR. SCOTT: Thank you, Mr. Commissioner.

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

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

4 COMMISSIONER MARROCCO: I just had one  
5 question.

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

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

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

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

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



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

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

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

14 COMMISSIONER MARROCCO: All right.

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

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

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

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

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

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

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

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

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

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

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

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

25                   I italicize that to note in the slides,

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

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

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

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

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

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

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

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

12                   That's because it lasts for only  
13 14 days, and can only be renewed once for 14 days.  
14 And after that, further extensions require the  
15 Legislative Assembly to agree to extend the  
16 emergency for an additional 28 days.

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

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

25                   And when the emergency has ended,

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

5 So even the emergency orders only have  
6 an initial life of 14 days and must be extended.

7 The emergency did expire on -- I mentioned  
8 termination before. It did not terminate. It  
9 expired on July 24th, and there is new legislation  
10 that replaced it.

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

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

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

1 14 days and renewal, you have 30 days and renewal.

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

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

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

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

16 And reports are required once every  
17 30 days to a standing committee of the Legislative  
18 Assembly. So the government has to go once every  
19 30 days to indicate what steps they've taken under  
20 this legislation in the last 30-day period, and the  
21 Premier is responsible for tabling a report in the  
22 Legislative Assembly after 120 days.

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

1 Health or Minister of Health.

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

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

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

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

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

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

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

25 And what I will do is pick up on some



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

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

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

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

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

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

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

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

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

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

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

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

1 other organizations, are memos.

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

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

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

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

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

25 In terms of development, the Ministry

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

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

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

8 MR. LERCH: Of course.

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

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

14 COMMISSIONER MARROCCO: All right.

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

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

20 MR. LERCH: Yes, that is correct.

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

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

1 leading those processes occurred to the Emergency  
2 Operations Centre.

3 COMMISSIONER MARROCCO: All right. Go  
4 ahead.

5 COMMISSIONER KITTS: Just a follow up  
6 on that.

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

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

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

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

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

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

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

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

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

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

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

25 And then we sort of, after we have

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

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

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

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

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

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

25 So part of that would be an information

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

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

8 MR. LERCH: Go ahead, sorry.

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

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

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

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

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

25 MR. LERCH: We'll definitely follow up



1 on that. Thank you, Commissioners.

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

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

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

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

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

1 and the office there.

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

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

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

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

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

19 COMMISSIONER MARROCCO: Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

25                  MR. LERCH: Yes.

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

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

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

7                   MR. LERCH:  Yup.

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

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

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

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

22                  COMMISSIONER MARROCCO:  Okay.

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

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

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

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

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

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

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

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

1 allowing hospital admissions to occur.

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

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

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

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

19 COMMISSIONER MARROCCO: Commissioner  
20 Kitts?

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

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

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

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

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

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

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

23 In terms of the regulation that's in  
24 place?

25 COMMISSIONER KITTS: Yeah, the version



1 4, April 15, 2020, says: Updated to reflect the  
2 new limitation on working in only one location.

3 What does that mean?

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

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

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

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

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

25 MR. LERCH: Yes, long-term care homes

1 specifically, yeah, yeah.

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

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

8 MR. LERCH: Yeah.

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

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

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

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

22 COMMISSIONER MARROCCO: Sorry,  
23 generally.

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

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

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

8 COMMISSIONER MARROCCO: Okay.

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

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

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

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

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

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

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

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

24                  COMMISSIONER MARROCCO: Did the  
25                  information come in in writing?

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

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

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

17 COMMISSIONER MARROCCO: Okay.

18 MR. LERCH: Any further questions?

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

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

23 COMMISSIONER MARROCCO: Finish your  
24 presentation.

25 MR. LERCH: Okay, perfect. Thank you

1 for that.

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

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

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

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

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

25 So the guidance documents are really

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

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

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

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

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

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

23 COMMISSIONER KITTS: Thank you.

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

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

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

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

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

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



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

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

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

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

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

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

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

1 produce?

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

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

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

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

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

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

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

4 COMMISSIONER MARROCCO: When  
5 approximately is that happening?

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

8 The meetings on that would have started  
9 in April.

10 COMMISSIONER MARROCCO: Okay.

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

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

17 MR. LERCH: Perfect.

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

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

1 MR. LERCH: Thank you, Commissioners.

2 COMMISSIONER MARROCCO: Very good.

3 MR. SCOTT: Thank you.

4 COMMISSIONER MARROCCO: Okay, bye-bye  
5 everybody.

6

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

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REPORTER'S CERTIFICATE

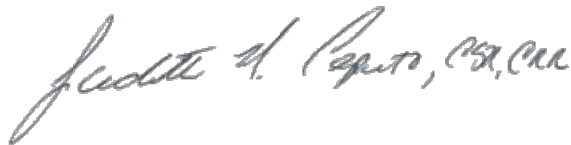
I, JUDITH M. CAPUTO, RPR, CSR, CRR,  
Certified Shorthand Reporter, certify;

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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PER: JUDITH M. CAPUTO, RPR, CSR, CRR

**WORD INDEX**

**< 1 >**

**1** 46:25 72:21  
**10:02** 1:8  
**100** 52:19  
**10th** 82:2  
**11:15** 6:19  
62:9, 18  
**11:25** 62:17, 19  
**12:08** 99:7  
**12:13** 1:8  
**120** 70:22  
**13** 10:21 12:7  
**14** 68:13, 22, 24  
69:4, 6 70:1  
**14-day** 69:23  
**15** 20:20 88:1  
94:5  
**15th** 88:23 89:6  
**17th** 65:2, 25  
68:9

**< 2 >**

**2000** 6:5  
**2004** 6:6 42:4  
**2007** 46:6  
**2009** 34:21  
**2011** 34:21, 23  
47:4, 13, 20 56:2  
**2016** 33:17  
**2018** 58:22  
**2019** 52:5, 16  
53:5, 23  
**2020** 1:7 50:22  
59:16 69:12  
88:1 94:5  
100:19  
**2021** 33:18  
**21st** 88:14  
**22** 11:1 18:1  
21:7 25:24  
26:13 27:20  
28:6, 9 39:7, 10  
**22nd** 82:1  
83:24 84:6  
**23rd** 1:7  
**24th** 69:9  
100:19  
**28** 68:16  
**29.1** 25:11  
**29.2** 27:23 29:9

**< 3 >**

**3** 46:24 72:8,  
24 73:2, 12  
74:15 81:25  
82:5 90:21  
**30** 34:3 69:23,  
25 70:1, 17, 19  
**30-day** 70:20  
**34** 8:16

**< 4 >**

**4** 26:13 88:1

**< 5 >**

**5** 46:24 72:19  
73:16

**< 6 >**

**6** 59:25

**< 7 >**

**72** 51:25  
**75** 52:6, 17  
**77.1** 36:22 42:7  
**77.5** 59:25 60:4  
**77.6** 42:24  
**77.7** 45:19

**< 8 >**

**82** 54:23

**< A >**

**a.m** 1:8  
**abide** 88:8  
**ability** 12:24  
34:4 40:24  
47:16 56:2  
**absent** 35:25  
36:4  
**Accessibility**  
77:18 96:23  
**accomplish** 95:5  
**accountability**  
14:8  
**acquire** 56:20  
**acquired** 25:8  
56:3, 5  
**Act** 6:11, 12  
7:3, 10, 15, 18,  
23 8:6, 23 9:4,  
11 10:9, 17, 22  
11:2, 13 14:13,  
14, 16, 17, 18  
15:19 17:4  
18:1 21:8, 16  
22:4 23:13

25:10 36:2, 11,  
21, 22 38:22  
39:18 43:3  
46:2, 16, 17  
47:4 49:13, 17  
51:2, 20, 22  
54:13, 16 56:1  
60:8 62:12, 25  
63:2 64:16  
66:3, 10 68:3  
69:3, 12, 14, 17,  
19 70:6, 14  
73:6 86:15  
**action** 17:12  
37:3 41:21  
70:14 74:11  
97:12  
**actions** 67:11  
92:5  
**actors** 7:9, 24  
44:16  
**acts** 9:17 10:2,  
6 87:5  
**actual** 65:24  
**add** 84:19  
**added** 28:14  
46:5 47:3, 11,  
13, 23 58:21  
74:22 90:21  
**addition** 6:13  
16:23  
**additional** 48:8  
68:16, 24 69:25  
73:10 74:21  
76:25 95:11  
**address** 17:22  
26:16 32:2  
33:14 56:23  
**addressed** 40:6  
**addressing**  
96:17  
**administration**  
54:18  
**administrative**  
15:13  
**administrators**  
24:5  
**Admissions**  
85:22, 25 86:1  
90:14  
**adult** 23:21  
**advance** 34:4  
**advice** 6:7  
43:24

**Affairs** 60:7  
**affirm** 32:23  
**after** 15:16  
64:22 68:14  
70:10, 22 77:25  
**Agency** 44:23  
**agents** 10:14,  
15 14:5 58:6, 7  
**ago** 28:8  
**agree** 18:20  
38:20 68:15  
**agreeing** 98:16  
**agreement**  
55:23  
**ahead** 13:20  
16:20 76:4  
79:8 89:3  
**aligned** 91:3  
**Alison** 2:11 5:2,  
6  
**alleviate** 67:13  
**allow** 26:15  
28:11, 15 42:14  
56:10 62:12  
98:2  
**allowed** 26:4  
**allowing** 86:1  
**allows** 37:17  
40:18 47:5  
49:3 58:22  
70:14  
**all-party** 63:18  
**amend** 70:9  
**amended** 46:21  
70:2, 8  
**amendment**  
60:7  
**amendments**  
50:1, 2, 4  
**Amy** 2:20  
**and/or** 10:18  
**Angela** 1:15 4:5  
**angle** 77:16  
**animals** 11:18,  
19  
**Ann** 3:5  
**announced**  
52:11 53:6  
**announcements**  
68:10  
**annual** 33:24  
**antibiotics** 58:6  
**Antitoxins** 58:5  
**antivirals** 58:5

**anybody** 41:4  
71:10  
**anymore** 40:22  
69:24  
**anyway** 43:16  
**apart** 25:21  
41:2  
**apologize** 92:22  
**Appeal** 13:16  
15:8, 10, 13, 15,  
18, 20, 22, 25  
16:2, 7, 10  
20:18 39:12, 13  
41:11, 15  
**appealed** 13:14  
15:16 20:17  
**appealing** 16:2,  
12 41:2, 4  
**appeals** 16:18  
39:20  
**applicable** 92:9,  
11 98:2  
**application**  
41:23 73:5  
**applies** 66:11  
**apply** 16:11  
41:19 42:6  
55:24 94:2  
**appoint** 9:13  
54:8  
**appointed** 9:8,  
12, 15, 22 31:25  
32:8, 20 33:16  
35:9 36:12  
63:17 64:10  
**appointing** 37:9  
**appointment**  
7:12 32:10  
33:17 35:15  
63:6, 25 64:2, 13  
**appointments**  
61:5 63:16  
**appoints** 9:24  
32:25 63:20  
**appreciated**  
98:25  
**appropriate**  
34:14 41:21  
51:21  
**appropriately**  
91:19  
**approval** 49:25  
61:22 68:19  
74:16 80:13, 16,

<p>20, 22, 24, 25 81:18 <b>approvals</b> 80:10 <b>approve</b> 61:5, 9 62:2 63:12 64:8, 13 <b>approved</b> 50:5 61:14 64:4 81:4 <b>approves</b> 50:7 63:15 <b>approximately</b> 52:5 98:5 <b>April</b> 68:18 88:1, 23 89:6 94:5 98:9 <b>area</b> 4:12 6:6 18:18 80:6 <b>areas</b> 76:17 78:2, 6 82:8, 10 85:19 <b>Arlene</b> 34:18 47:15 <b>asked</b> 36:1, 15, 17 65:16 90:19 <b>asking</b> 20:12 30:17 31:4 68:19 74:10 92:20 <b>Assembly</b> 32:2, 9 33:1, 14 34:1 68:15 70:12, 18, 22 <b>assessment</b> 54:9, 21 <b>assessments</b> 73:17 <b>assessors</b> 54:8 <b>assist</b> 28:3 29:11 <b>Assistant</b> 2:11 <b>Associate</b> 7:7, 25 8:3 11:23 12:2 13:7 17:9 35:1, 8, 18, 21 36:11 61:6, 13 <b>Associates</b> 62:4 <b>assume</b> 18:11 <b>assuming</b> 18:11 <b>assuredly</b> 23:1 <b>attend</b> 21:25 61:19 <b>attending</b> 1:7 21:3, 13, 14 <b>authorities</b> 66:18</p>	<p><b>authority</b> 28:5 31:7, 10 34:24 39:16 42:7 48:11 <b>authorized</b> 54:23 <b>authorizes</b> 56:16 <b>authorizing</b> 66:22 <b>available</b> 49:20 83:21 <b>avoid</b> 5:13 <b>aware</b> 28:1 29:8 53:12 58:1 81:9  &lt; B &gt; <b>back</b> 5:13 9:9 24:18 43:2 62:17 68:6 81:8 82:12 84:20 91:10 95:18 98:13, 22 <b>base</b> 83:19 <b>based</b> 74:23 94:3 <b>basically</b> 5:20 10:5 21:25 35:3 67:10 72:6 88:20 90:11 <b>basket</b> 67:10 <b>beginning</b> 20:5 90:18 <b>believe</b> 30:5 95:9 <b>best</b> 9:17 84:14 <b>bet</b> 84:17 <b>better</b> 5:16 45:25 72:5 <b>big</b> 83:17 <b>bigger</b> 11:24 <b>bio</b> 6:3 <b>bios</b> 71:19 <b>bit</b> 16:18 82:3 84:24 90:22 92:16 <b>blood</b> 48:22 <b>Board</b> 8:19 9:7, 18, 19, 20, 25 10:2, 3, 6 13:16 15:9, 10, 11, 13, 20, 22 16:2, 7 20:18, 19 37:8, 11, 18 39:14</p>	<p>41:3, 4, 20 42:10, 11, 12 52:6 54:9, 11, 19, 21 61:7, 17, 21, 25 64:6, 8 <b>Boards</b> 8:25 9:2 10:7, 13 13:22 14:9 42:1 47:6 49:16, 18, 20 50:13 51:17 52:1, 5 <b>bolded</b> 48:4 <b>boundaries</b> 8:17 19:13 <b>Branch</b> 2:20 79:13 <b>break</b> 6:14 62:9, 12 <b>brief</b> 6:4 <b>briefing</b> 5:11 <b>briefly</b> 49:12 <b>bring</b> 16:10 30:18 41:9 98:13 <b>bringing</b> 68:18 <b>British</b> 57:8, 12 66:6 <b>broad</b> 11:12 67:9 <b>broader</b> 38:14 <b>broadly</b> 39:17 58:4 <b>budget</b> 53:5, 24 <b>building</b> 56:5 <b>bye-bye</b> 99:4  &lt; C &gt; <b>Cabinet</b> 32:24 49:25 51:3 63:20, 23 66:10, 17, 18 67:12 68:23 69:25 70:2, 24 71:3, 4 <b>call</b> 22:4 42:18 67:10 <b>Callaghan</b> 2:23 4:21 <b>called</b> 22:11 23:13 <b>Canada</b> 44:22, 24 57:3 62:6 <b>candidate</b> 32:22, 24 61:9</p>	<p><b>candidates</b> 32:22 64:7 <b>capture</b> 22:20 <b>Caputo</b> 3:17 5:22 100:3, 24 <b>CARE</b> 1:1, 22, 25 2:2, 12, 15, 17, 21, 23 3:10 23:18 24:16, 23 25:7 27:17 28:2, 3, 13, 16, 21 29:2, 4, 10, 11, 20 30:9, 12, 18, 20 31:5, 17 43:5 46:11, 22 48:5 57:24 59:8, 18, 23 72:1, 14, 19, 20 73:2, 8, 17, 18, 25 74:4, 5 76:20 77:8, 17 78:14, 23 82:15 83:5 86:16 87:5 88:6, 18, 25 90:24 91:2, 16 93:7, 8, 12 95:11 96:20 97:14 <b>careful</b> 44:8 <b>Carry</b> 62:20 93:6 <b>carrying</b> 54:9 <b>carve</b> 65:4 <b>case</b> 22:17 30:15 38:25 66:22 73:1 80:16 91:22 <b>cases</b> 15:4 18:16, 24 65:24 <b>censor</b> 34:5 <b>central</b> 79:4 <b>Centre</b> 75:1, 10, 13, 22 76:2, 8, 11 77:1 78:10 79:7, 14 <b>centres</b> 23:18, 21 <b>Certain</b> 12:4 31:12 47:7, 17 52:4, 17 69:19 <b>certainly</b> 30:15, 16 <b>certainty</b> 46:2 <b>CERTIFICATE</b> 100:1</p>	<p><b>certification</b> 56:17 <b>Certified</b> 100:4 <b>certifies</b> 55:9 <b>certify</b> 100:4 <b>chance</b> 6:21 <b>change</b> 19:15 <b>changed</b> 85:24 <b>changes</b> 50:1, 7 54:2 82:4 98:1 <b>channel</b> 73:22 <b>charge</b> 40:1, 4 <b>Chief</b> 2:5 6:7 7:12 8:1, 2, 3 14:5, 18 15:6 31:11, 14, 18, 23, 25 32:16, 19, 25 33:2, 8, 20 34:6, 16, 18 35:2, 4, 10, 16 36:3 37:6, 14, 17, 23 38:23 39:15, 25 40:9 41:5, 18 42:5, 9, 14, 17 43:23 44:11, 19 45:8, 17 46:18 47:5, 14 48:12, 16, 18, 23 49:3, 8, 10 50:6 54:7, 20, 24 55:9 56:17 60:9, 24 61:1 63:7, 16, 21 65:3, 19 67:2 70:25 71:22 74:2 75:5, 19 80:11, 14, 21 <b>childcare</b> 23:18 <b>chiropractors</b> 24:2 <b>Christian-Brown</b> 3:5 <b>chronology</b> 73:10 81:24 82:5 84:24 90:12 <b>circling</b> 5:13 <b>circumstance</b> 10:3 65:15 <b>circumstances</b> 13:10 20:11 31:12 <b>city</b> 9:8, 18, 19, 23, 24</p>
--	--	---	--	---

<p><b>city-specific</b> 9:17 <b>Civil</b> 3:3, 5, 7 6:12 7:18 62:11 63:1 64:16 66:2, 9 68:3 69:3, 14, 18 87:4 <b>clarify</b> 31:3 89:5 94:4 <b>class</b> 12:24 13:2, 4 20:23 21:6 26:7 39:9, 12 66:23 <b>clause</b> 67:10 <b>cleaned</b> 12:14 <b>cleaning</b> 12:9 26:3 83:17 <b>clear</b> 52:14 <b>clearly</b> 28:11 <b>client</b> 5:8 <b>clients</b> 4:16 6:2 23:7 27:2 40:13 50:11 52:21 54:1 71:8 <b>clinic</b> 12:13 56:6 <b>clinical</b> 42:15, 22, 25 43:9 44:20 <b>clinics</b> 47:19 <b>close</b> 85:1 <b>closed</b> 21:17 26:14 <b>closing</b> 66:19 70:5 <b>CMOH</b> 34:12 35:8 36:5, 10, 11, 12, 18, 21, 23 41:24 42:12, 23 43:1, 7, 8, 10 45:20 48:21 72:10 74:12 80:16, 23 <b>CMOHs</b> 35:21 <b>CMOH's</b> 34:11 36:9, 14 <b>cohorting</b> 93:17, 23 <b>Coke</b> 1:15 4:6 31:1, 2, 7, 20 36:15 52:23, 25 54:4 79:19, 21 89:3, 4, 9</p>	<p><b>collaboration</b> 95:10 <b>colleagues</b> 71:20 72:4 81:13 84:11 <b>collect</b> 48:19 49:4 <b>collected</b> 48:20 <b>collection</b> 48:13 67:6 <b>Columbia</b> 57:8, 13 66:6 <b>combined</b> 60:14 91:4 <b>come</b> 10:10 12:23 16:17 26:20 27:1 31:11 32:14 57:19 61:21 64:9 67:21, 24 78:12, 15 86:6, 15 91:25 <b>comes</b> 83:15 <b>comfort</b> 26:8 <b>comfortable</b> 26:11 <b>coming</b> 5:9 27:10 75:18 78:14 85:6, 15 86:4 88:12 91:1, 13 96:7 <b>Command</b> 76:24 78:15 <b>commercial</b> 21:4 <b>COMMISSION</b> 1:1 2:12, 15, 18, 24 4:3, 20 5:4 <b>Commissioner</b> 1:14, 15, 16 4:1, 5, 7, 13, 18, 25 5:2, 5, 25 6:17, 24 13:18, 21, 25 14:13, 24 15:8, 21, 24 16:4, 8, 15, 20 18:6, 9, 21 19:14 24:11, 14 25:18, 25 26:18 28:18 29:17, 24, 25 30:8, 14, 25 31:1, 2, 7, 20 32:6 36:15, 16 38:4, 7, 12 39:19, 23 40:15, 20 41:1, 13</p>	<p>43:14 44:3, 6, 9 51:6 52:23, 25 54:4 60:21 61:3 62:8, 13, 16, 20, 22 63:4, 10, 24 64:14, 24 71:9, 14 75:6, 9, 14, 17, 21 76:3, 5, 19 77:5 78:9 79:6, 9, 19, 21 80:18 81:6, 19 83:23 84:1, 5, 8, 13, 22 86:19, 21 87:15, 22, 25 88:23 89:2, 3, 4, 9, 14, 22 90:8 91:6, 24 92:17, 19, 23 94:4, 15, 23 96:18, 24 97:16 98:4, 10, 15, 18 99:2, 4 <b>commissioners</b> 4:2, 8 6:1 36:15 71:15, 18 80:1 98:14 99:1 <b>committee</b> 32:21 63:18 70:17 <b>commonly</b> 10:24 <b>Communicable</b> 10:23 12:22 13:13 15:1 16:17, 24 17:1, 8, 13, 17, 22 18:4, 14, 17 19:2, 7 20:22 21:9 22:10, 20 23:3, 8, 25 24:7, 19, 20, 22 25:23 27:14, 21 28:20 39:6, 8 40:2, 5 50:20, 24 51:9, 11, 15 55:11 59:3 83:11 <b>communicate</b> 40:16 <b>communication</b> 73:22 95:20 <b>community</b> 40:2 43:20 <b>company</b> 57:7, 11 100:23 <b>compel</b> 44:20 46:8 48:21</p>	<p>67:1, 3 <b>compelled</b> 59:14 <b>compelling</b> 48:25 58:17 <b>compensate</b> 55:23 <b>compensation</b> 55:22, 25 56:21 <b>complaint</b> 54:10 <b>completing</b> 4:17 <b>comply</b> 42:2 49:18 57:4 <b>complying</b> 16:9 54:15 60:11 <b>comprehensive</b> 79:16 <b>concern</b> 54:17 <b>concerned</b> 28:9 64:2 <b>concluded</b> 99:7 <b>conditions</b> 51:20 <b>conducted</b> 53:13 <b>conducting</b> 53:19 80:19 <b>conflict</b> 46:15 65:7, 8, 10 <b>consent</b> 22:16, 22 23:5 46:10 67:5 <b>consider</b> 34:13 45:20 87:11 89:7 93:14 94:12 96:1, 2 <b>considerable</b> 63:9 <b>consideration</b> 90:1 <b>considerations</b> 94:1 <b>considered</b> 94:22 95:17 <b>considers</b> 41:21 51:21 67:12 <b>consistency</b> 47:9, 18 <b>constructing</b> 66:20 <b>consult</b> 95:15 <b>Consultant</b> 2:4 <b>consultation</b> 43:24 <b>consultations</b> 78:5</p>	<p><b>consulted</b> 74:23 92:6 <b>contact</b> 83:15 <b>contain</b> 20:9 <b>containment</b> 86:5 <b>cont'd</b> 3:1 <b>content</b> 75:5 76:15 81:2, 7 82:10 97:25 <b>context</b> 82:14 <b>continue</b> 64:19 65:6, 22 69:23 <b>continued</b> 69:21 <b>continues</b> 65:5 69:17 <b>continuing</b> 90:11 <b>contributing</b> 20:3 <b>control</b> 12:12 29:21 55:19 82:24 83:14 91:19 <b>controlling</b> 83:4 <b>conversation</b> 98:3 <b>coordinate</b> 40:11 <b>copy</b> 34:2, 7 <b>corner</b> 29:1 <b>corporate</b> 9:2 <b>Correct</b> 15:3, 7 16:13 18:21 19:7 24:18 30:7, 13 38:11 39:15, 22, 23 40:19, 23 41:3, 12 51:8 60:25 61:2 64:25 65:21 75:20 87:22 89:13 100:16 <b>correctional</b> 23:20 <b>Council</b> 9:15 32:1, 2, 24 33:13 63:20 <b>Counsel</b> 1:21 2:20, 23 3:3, 5, 9 4:11 6:1, 4 42:4 80:6 <b>countermand</b> 41:5</p>
---	---	--	---	---



**course** 5:21  
23:5 64:23  
72:11 75:8  
85:3 90:21  
**courses** 74:11  
**Court** 15:17, 19  
41:12, 19, 23  
55:17  
**courts** 65:13  
**covering** 21:5  
98:12  
**COVID** 8:13  
10:25 19:24  
20:2, 8 22:8, 17,  
18 23:6, 8, 12,  
16 25:12 27:5,  
13 30:10 47:24  
49:5 51:4, 12  
66:15 67:20  
72:12 83:20  
91:14  
**COVID-19** 1:1  
11:8 16:25  
17:7 18:9, 24  
19:17 25:4, 15  
30:3 46:20  
50:21 51:9  
52:13 54:3  
67:16 69:12  
82:24 94:13  
**Crown** 3:3, 5, 7  
10:14 55:23  
**CRR** 100:3, 24  
**CSR** 100:3, 24  
**current** 23:6  
31:24 34:16  
39:1 45:2, 7  
67:20  
**currently** 8:15  
35:21 52:10, 13  
**custodian** 43:2  
**custodians** 43:4

< D >

**danger** 43:19  
**dangerous** 23:3  
**Daniel** 2:4  
**date** 45:2, 7  
46:20 47:24  
49:6 56:9  
84:18 98:7  
**Dated** 100:19  
**David** 31:24  
32:4 33:16

35:14, 24, 25  
36:4 44:7  
**Dawn** 2:14  
4:22, 23, 25  
**day** 1:7 100:19  
**days** 20:20  
34:3 68:13, 16,  
22, 24 69:4, 6,  
23, 25 70:1, 17,  
19, 22  
**de** 37:24 38:2  
**deal** 30:23  
40:12 69:1  
**dealing** 15:1  
43:18 44:22  
70:7 92:12  
**deals** 46:25  
**decide** 78:10  
**decision** 41:9  
63:22  
**declaration**  
19:15, 17 20:8  
66:4 68:7, 8, 20  
**declare** 66:11  
**declared** 19:25  
64:20, 22 65:18,  
25 66:1, 8, 16  
68:6  
**decrease** 37:4  
41:22  
**deemed** 66:14  
69:20  
**defined** 45:23  
58:4  
**definitely** 29:3  
48:1 79:25  
**definition** 11:12  
58:3  
**delay** 16:9  
**deliver** 33:24  
55:5  
**delivery** 57:7  
**demonstrated**  
8:14  
**dental** 12:13  
**department** 10:6  
**depending** 26:7  
74:18 77:23  
78:4, 7  
**depends** 29:5  
**Deputy** 2:11  
32:11 74:8  
**Derek** 2:17  
**describe** 10:22

11:2 64:17  
**described** 64:19  
**describing** 63:6  
**designate** 55:19  
**designated** 17:7  
50:22 59:3  
**designation**  
23:8  
**destroyed** 12:18  
**destruction**  
12:16  
**detail** 27:7  
50:12 54:1  
73:14 93:14, 19  
94:9 96:10  
**details** 27:11  
52:21 79:22  
**detention** 23:21  
**determine**  
43:23, 25  
**determined**  
55:25  
**develop** 76:14  
82:22  
**developed** 93:5,  
6 95:5 96:13  
**development**  
74:15, 25 77:20  
81:16 91:12  
96:5  
**different** 8:17  
81:12 92:12  
93:24 94:6, 7  
**difficulty** 19:1, 7  
**direct** 29:10  
43:1, 7 47:16  
59:5 65:10  
79:14  
**directed** 14:6,  
12 28:10 37:14  
72:18 73:7  
**directing** 37:11  
55:18 89:25  
**direction** 57:19,  
23 72:25 74:11  
86:2 89:6 94:20  
**directions**  
28:11 49:15  
**directive** 45:11,  
18 46:8, 13, 16,  
24, 25 48:4  
67:2 72:8, 19,  
21, 24 73:2, 7,  
12, 13, 16 74:15  
75:18 80:20

81:25 82:5, 13  
83:22 87:13, 14,  
16 89:20 90:21  
91:4 92:7, 14  
93:3 94:6, 8  
95:1  
**directives** 46:5,  
20 47:6, 25  
48:1, 5 59:8  
60:9, 11 72:2,  
10, 16, 17, 25  
73:21 74:12  
75:3, 24 80:14  
82:23 85:19  
93:6, 16 95:7, 17  
**directly** 14:6, 11  
44:17 60:2  
**Director** 2:14,  
17 5:7 79:12  
**disagrees** 15:9  
**disclosed** 44:21  
**disclosure**  
44:16 67:7  
**discretion** 15:4,  
5  
**discretionary**  
26:11 51:23  
**discuss** 32:13  
**discussed** 20:16  
**discussing** 39:7  
**Disease** 2:1  
8:9, 10 10:23,  
25 11:6, 19  
12:22 13:14  
15:2 16:17, 24  
17:2, 8, 13, 17,  
20, 22 18:5, 14,  
17 19:3, 8  
20:23 21:10, 18  
22:10, 13, 20  
23:9, 10, 13  
24:1, 7, 9, 19, 20,  
22 25:8, 24  
26:16, 23 27:15,  
21 28:21 30:5,  
12 39:6, 8 40:2,  
5, 8 43:19 45:5  
50:23, 24, 25  
51:1, 10, 11  
55:12 58:25  
59:2, 4 89:16  
**diseased** 11:10  
12:17  
**diseases** 11:17  
17:3 19:24

22:12, 14 23:2,  
3, 15 26:22  
50:18, 20 51:5,  
15 83:11, 15  
**disinfected** 13:4  
**disinfecting**  
12:9 26:3  
**dismiss** 61:17  
**dismissal** 35:16  
61:12, 23  
**distemper**  
11:18, 20  
**distinction**  
23:10  
**distributing**  
66:21  
**disturbing** 5:18  
**divided** 8:16  
**division** 6:9  
**Divisional** 15:17,  
19 41:12  
**doctor** 67:4  
**document**  
82:12 93:9, 11  
94:5, 17  
**documents**  
79:3 83:2 93:5,  
13, 18, 25 95:4  
**dog** 11:20  
**doing** 17:11  
37:6 87:11  
91:19  
**door** 28:25  
**doubt** 43:19  
**draft** 77:7 80:3  
84:3  
**drafted** 75:22  
**drafting** 75:25  
77:11  
**drafts** 77:21  
**droplet** 83:15  
**drug** 57:6, 11  
**Drummond**  
2:11 5:3, 7  
**due** 52:13  
53:25 54:3  
66:15  
**Dufferin** 21:1  
**Durham** 10:5  
**duty** 24:4, 6, 8,  
25 51:14, 15

< E >

<p><b>earlier</b> 39:7 64:19 72:9 86:12 <b>early</b> 96:16 <b>easily</b> 43:21 <b>edit</b> 34:5 <b>effect</b> 15:25 16:6 20:21 65:4 67:21 94:18 <b>effects</b> 34:23 67:13 69:2 <b>elements</b> 26:12 87:13 91:17 <b>eliminate</b> 37:4 41:22 43:13 44:14 <b>eliminating</b> 44:17 <b>EMCPA</b> 78:23 87:9 88:6 89:12 <b>emergencies</b> 66:1, 8 <b>Emergency</b> 6:12 7:17 47:7 53:19 62:11 63:1 64:15, 20, 22 65:8, 12, 14, 18, 24 66:2, 5, 9, 11, 15, 16 67:1, 14, 18, 22 68:1, 2, 5, 6, 9, 11, 16, 20, 21, 25 69:1, 2, 3, 5, 7, 14, 18 70:24 75:1, 10, 13, 22 76:1, 7, 8 77:1 78:10 79:7, 13 86:15 87:4 <b>emerging</b> 58:25 59:2 <b>employ</b> 10:11 <b>employee</b> 35:14 <b>employees</b> 14:4, 11 88:9 <b>employer</b> 61:25 <b>employers</b> 87:6 88:8, 21 <b>ended</b> 68:25 <b>enforce</b> 42:6 <b>engage</b> 38:18 <b>engaged</b> 77:14 <b>engagement</b> 76:13 80:7</p>	<p><b>ensure</b> 47:9, 17 91:18 <b>ensuring</b> 47:18, 21 <b>entirely</b> 9:7 <b>entities</b> 9:3 48:10 60:1, 15 <b>entitled</b> 55:22 61:20 <b>entity</b> 45:12 48:2, 7 59:6 <b>environment</b> 46:1 <b>environmental</b> 33:22 83:17 <b>equipment</b> 12:13 47:1 58:8, 9 59:17, 21 60:16 <b>equivalent</b> 14:10 <b>essential</b> 56:21 85:8, 11, 15 90:20, 24 <b>establish</b> 19:20 <b>established</b> 9:2, 10, 16 15:14 20:19 56:11 <b>establishment</b> 21:4 <b>Etches</b> 42:19, 21 <b>ethics</b> 78:6 <b>event</b> 5:6 6:15 65:8 <b>eventually</b> 40:21 <b>everybody</b> 6:21 99:5 <b>evidence</b> 19:20 20:5 82:6 83:19 91:14 <b>evolution</b> 87:10 90:13 <b>evolved</b> 74:17 82:6 85:3, 8, 12 86:11, 14 <b>evolving</b> 83:19 85:18, 24 86:17 88:17 90:16 91:14 97:25 <b>exactly</b> 16:13 29:18 <b>examined</b> 22:19 <b>example</b> 9:4, 23 11:8, 17, 20, 21 12:1, 11, 13 18:22 19:4, 23</p>	<p>20:7, 25 21:1, 9, 13 22:12 25:6 36:4, 7 37:10, 13 44:15, 19, 25 46:10 49:2 54:10 56:4, 7 57:6, 7, 14, 22, 23 58:9 66:5 78:22 93:16 <b>examples</b> 9:17 <b>exceptions</b> 51:3 <b>Excuse</b> 60:21 64:24 <b>executive</b> 5:7 <b>exercise</b> 14:8, 22 15:5 31:13 36:1 37:7, 18 38:3 40:24 44:2 <b>exercised</b> 19:12 45:2, 4, 5 46:19 47:24 49:5 54:24 56:8 58:11, 17 59:15, 24 65:23 70:24, 25 <b>exercises</b> 38:24 <b>exercising</b> 37:25 <b>exhausts</b> 98:20 <b>exist</b> 17:18, 20 19:3, 8 27:21 39:6 56:19 58:24 64:19, 21 <b>existing</b> 83:19 97:22 <b>exists</b> 9:20 17:18, 20 18:14 19:3, 8, 10, 11 27:21 28:21 30:5, 12 39:6 42:7 55:10 56:19 58:24 60:25 66:5 <b>expansion</b> 90:23 <b>expenses</b> 51:25 52:7 <b>experience</b> 33:10 <b>experiencing</b> 28:4 <b>expertise</b> 8:22 74:24 76:16 77:15, 22 78:6 <b>expire</b> 69:7 <b>expired</b> 67:22 69:9, 20</p>	<p><b>expires</b> 33:17 70:10 <b>explain</b> 56:14 <b>explaining</b> 16:11 <b>explanation</b> 60:13 <b>expose</b> 22:2 <b>Expropriations</b> 56:1 <b>extend</b> 68:15, 20 70:10, 13 <b>extended</b> 68:11, 23 69:2, 6, 24 70:8, 15 <b>extensions</b> 68:14 <b>extensive</b> 66:17 <b>extreme</b> 44:19  &lt; F &gt; <b>face</b> 21:5 56:16 <b>facilities</b> 23:19, 20 55:3 56:10 82:21 83:3, 6 85:16 87:2 90:19 94:13 97:23 <b>facility</b> 25:9, 12, 15 28:21 29:2 30:9, 12, 18, 20 55:7, 14 <b>fact</b> 25:16 <b>factor</b> 20:3 86:9 <b>family</b> 90:24 <b>February</b> 33:17 <b>federal</b> 8:11 89:14, 17 90:1, 6 <b>Federally</b> 22:3 <b>feel</b> 29:6 38:5 <b>felt</b> 38:2 <b>figure</b> 6:21 <b>filing</b> 16:9 <b>final</b> 80:10, 13, 16, 19, 22, 25 81:4, 17, 21 <b>finally</b> 7:13 8:4 <b>find</b> 41:13 <b>finding</b> 19:7 <b>fine</b> 16:21 79:21 92:19 <b>Finish</b> 92:23 <b>fit</b> 92:6 <b>fits</b> 77:2 79:17 <b>fixing</b> 66:21</p>	<p><b>Flexible</b> 69:11 <b>flowed</b> 53:23 <b>flux</b> 52:10 <b>focus</b> 72:13 96:6 <b>focused</b> 76:11 98:1 <b>focuses</b> 73:16 <b>folks</b> 5:4 <b>follow</b> 20:13 60:9 76:5 77:2 79:15, 25 98:13, 16 <b>followed</b> 13:10 47:19 <b>following</b> 23:17 42:20 75:4 80:9 <b>food</b> 11:10 12:17, 18 <b>foolish</b> 43:15 <b>force</b> 55:20 <b>foregoing</b> 100:7, 15 <b>former</b> 47:14 <b>formulated</b> 89:10 <b>forth</b> 100:9 <b>forum</b> 98:3 <b>forward</b> 52:15 80:4 93:6 95:2 <b>found</b> 12:17 <b>foundational</b> 82:18 83:2 <b>Frank</b> 1:14 4:2 <b>functions</b> 36:6 92:13 <b>funding</b> 51:17, 22, 24 52:4, 6, 14, 17, 19 53:2, 6, 8, 16, 22 54:2 <b>future</b> 73:19  &lt; G &gt; <b>gap</b> 60:10 <b>gas</b> 11:10 <b>gather</b> 97:4 <b>gathering</b> 79:1 95:12 <b>gatherings</b> 70:4 <b>General</b> 7:20 69:13, 15 74:17 83:11, 13 89:19 93:9 96:15 <b>Generally</b> 45:25</p>
---	---	---	--	--

<p>89:23, 24 <b>generally</b> 46:1 <b>give</b> 6:20 28:11 29:19 34:2 <b>given</b> 41:11 <b>gloves</b> 45:16 <b>Good</b> 4:1, 25 95:14 99:2 <b>goods</b> 66:21 <b>gouging</b> 66:22 <b>governance</b> 79:18, 23 81:22 <b>government</b> 68:18 70:18 89:15, 17 90:2 <b>Governor</b> 32:1 33:13 <b>gown</b> 45:15 <b>grab</b> 98:7 <b>grants</b> 51:19 <b>grateful</b> 5:11 <b>ground</b> 27:19 <b>grounds</b> 17:16 19:21 30:5, 11 37:1 39:5 <b>group</b> 96:19, 25 97:9 <b>groups</b> 47:18, 22 73:1 95:24 <b>Guelph's</b> 21:2 <b>guess</b> 18:12, 15 29:13 <b>guidance</b> 73:23 83:6, 10 90:2 92:8, 15 93:5, 8, 9, 11, 18, 25 94:5, 10, 16, 17, 21 95:2 96:3 97:5</p> <p>&lt; H &gt; <b>H1N1</b> 34:20 <b>halting</b> 85:25 <b>Halton</b> 10:5 <b>hand</b> 35:3 <b>happen</b> 53:3 66:6 81:10 91:8 <b>happened</b> 41:24, 25 97:24 <b>happening</b> 98:5 <b>happens</b> 12:12 <b>happy</b> 6:10 7:20</p>	<p><b>harm</b> 11:6, 11 17:23 <b>hazard</b> 10:20 11:3, 5, 9, 21, 23 12:8, 22, 24 13:13 15:1 16:23 20:10, 23 <b>hazards</b> 11:14 <b>Health</b> 1:22, 25 2:2, 6, 21 3:10 4:11, 12 6:5, 7, 8, 9, 11 7:2, 3, 7, 8, 9, 13, 14, 15, 19, 23, 25 8:1, 2, 3, 4, 5, 6, 16, 17, 19, 20, 21, 23, 24 9:1, 2, 3, 4, 7, 10, 12, 19, 20, 25 10:2, 4, 6, 7, 11, 13, 17, 18, 20, 21 11:1, 3, 5, 6, 9, 11, 14, 21, 22, 23, 24, 25 12:1, 2, 4, 5, 6, 7, 8, 14, 15, 19, 22, 24 13:7, 8, 13, 15, 22 14:1, 5, 9, 14, 17, 18, 19 15:1, 7, 10, 18, 19 16:6, 23 17:4, 9, 15, 16, 19, 24, 25 18:2, 3, 4, 12, 13, 22, 25 19:2, 5, 6, 8, 10, 12, 13, 19 20:1, 7, 10, 12, 17, 23 21:2, 7, 17 23:14, 17 24:15, 17, 21, 24 25:3, 10, 12, 20 26:7, 9, 16, 20, 21, 22 27:2, 4, 6, 7, 9, 14, 18, 25 28:9, 19, 20, 22 29:1, 8, 19 30:16 31:12, 13, 15, 17, 19, 23, 25 32:11, 12, 16, 20, 25 33:3, 6, 9, 11, 21, 23, 25 34:3, 4, 6, 8, 10, 13, 17, 18, 22 35:2, 5, 10, 17, 20 36:3, 21 37:2, 7, 8, 10, 12, 13, 14, 17, 18, 19, 22, 24 38:1,</p>	<p>9, 15, 17, 24, 25 39:2, 11, 13, 16, 17 40:1, 7, 9, 10, 12, 25 41:6, 18, 20 42:1, 4, 5, 9, 10, 11, 13, 15, 18, 19, 24 43:1, 3, 4, 6, 11, 23 44:11, 20, 23 45:9, 10, 13, 18, 19 46:4, 7, 9, 15, 16, 18 47:4, 5, 6, 7, 10, 15, 16, 22 48:13, 17, 18, 19, 23 49:1, 2, 4, 7, 9, 10, 11, 13, 14, 16, 18, 19, 20, 22, 24 50:6, 7, 11, 13, 23 51:11, 18, 19, 24 52:1, 5, 7, 11, 19 53:1, 3, 9, 13, 18, 19 54:7, 8, 9, 11, 12, 14, 16, 19, 20, 21, 25 55:1, 9, 13 56:4, 17, 18, 19, 22 57:2, 12 58:23, 25 59:1, 12, 20 60:10, 24 61:2, 4, 6, 8, 10, 13, 14, 17, 18, 21, 22, 23 62:1, 3, 4, 24 63:7, 12, 14, 15, 17, 22 64:2, 3, 5, 6, 7, 10, 12, 18 65:3, 4, 11, 19, 20 66:5 67:2, 3 71:1, 2, 23, 24 74:2, 9 75:11, 13, 19, 23 76:9, 10, 12, 22 77:9, 14 80:5, 11, 15, 19, 21, 25 83:3, 9 96:8, 20 <b>healthcare</b> 45:11, 12 48:2, 6, 7, 9 59:6 60:1, 14, 15 <b>Health's</b> 24:24 <b>hear</b> 21:22 23:12 35:23 41:14 92:20 95:15 <b>heard</b> 29:18</p>	<p><b>hearing</b> 55:15 57:15 <b>hears</b> 15:14 <b>hedging</b> 44:4 <b>Held</b> 1:6 35:6 55:15 <b>Helferty</b> 2:1 71:22 <b>help</b> 29:20 31:5 <b>helpful</b> 6:24 77:6 84:16 98:16 <b>Hi</b> 4:10, 25 <b>high</b> 66:10 82:16 <b>higher</b> 96:9 <b>hires</b> 61:7, 8 <b>historical</b> 38:21 <b>hold</b> 35:7 52:13 54:2 <b>holding</b> 77:11 <b>holds</b> 32:17 35:12 <b>home</b> 22:1 25:7 27:17 28:3, 13 29:4, 10, 11, 20 31:5 46:12 57:24 86:23 87:17 93:20, 23 <b>homes</b> 23:18 24:16, 23 28:2, 16 43:5 48:5 59:8, 18, 19, 23 60:2, 8, 11 72:15, 19, 20 73:2, 6, 8, 18, 25 74:4, 5 77:8 82:15 85:6 86:4, 16 87:8 88:7, 15, 18, 20, 25 91:16 92:11, 13 93:4, 7, 12, 14, 22 94:2 95:5, 11 96:14, 23 97:14, 15 <b>Honourable</b> 1:14 <b>hope</b> 5:17 <b>Hospital</b> 24:5 25:8 27:16, 22 28:3, 12, 23, 24 29:5, 9, 10, 20 30:2, 6, 19 31:4 57:23 85:22, 25 86:1</p>	<p><b>hospitals</b> 23:19 28:2, 16 59:19 72:20 73:18 <b>house</b> 79:12 <b>HSARB</b> 41:12 <b>human</b> 11:6, 11, 14 56:19, 22 <b>humans</b> 11:19 <b>hypothetical</b> 28:25</p> <p>&lt; I &gt; <b>i.e</b> 50:23 <b>Ida</b> 4:22 <b>identifiable</b> 59:13 <b>identified</b> 96:16 97:11 <b>illness</b> 21:12 <b>illnesses</b> 11:17 19:25 <b>imagine</b> 37:23 <b>immediate</b> 43:11 45:10 48:17 55:11, 12 56:18 57:1 58:24 <b>immediately</b> 20:13, 21 34:9 35:9 42:2 <b>Immunization</b> 1:24 47:19 52:18 56:6 <b>immunized</b> 47:22 <b>immunizing</b> 58:6 <b>implementation</b> 93:4 <b>implemented</b> 53:7 <b>implementing</b> 67:11 95:7 <b>implicated</b> 72:15 <b>implications</b> 72:22 <b>important</b> 8:8 10:12 11:16 12:21 23:9 54:6 70:23 <b>IMS</b> 76:24 <b>incapacitated</b> 36:7 <b>include</b> 12:8 20:7 22:15 27:7 45:14</p>
--	--	---	---	---

<p>58:8 59:11 76:8 90:20 97:5 <b>included</b> 20:25 26:6, 13 53:2 59:22 95:22 <b>includes</b> 17:15 27:17 43:5 <b>including</b> 23:18 24:2 26:3, 11 36:18 37:9 43:9 59:8 67:7 70:3 82:8 85:18 <b>independent</b> 9:7 10:3, 13 13:23 14:1, 2 15:4 32:14 <b>independently</b> 9:20 14:14, 16, 17, 19, 23 53:14 <b>indicate</b> 70:19 <b>individual</b> 26:8 48:22 <b>individuals</b> 25:2 <b>infection</b> 22:2 83:13 <b>Infectious</b> 2:1 8:10 10:25 <b>information</b> 40:14 42:11, 12, 16, 20, 22, 25 43:2, 3, 4, 8, 9, 12 44:10, 21 57:18, 20, 25 58:12, 18 59:9, 11, 12, 13, 14, 17 67:7, 8 76:17, 25 77:22 78:16, 25 79:4 81:21 82:6, 7 85:18 91:13, 25 94:8 95:12, 21, 24 96:1 97:9, 10, 17 98:22 <b>information-</b> <b>gathering</b> 91:21 <b>information-</b> <b>sharing</b> 97:3 <b>informative</b> 98:21 <b>informed</b> 33:21 <b>infrequently</b> 41:25 <b>initial</b> 69:6 83:22, 23 85:9,</p>	<p>10 87:16 <b>Initially</b> 86:24 <b>initiated</b> 84:19, 21 <b>initiative</b> 53:4 <b>in-patients</b> 24:5 <b>input</b> 77:20 78:1 <b>inquiring</b> 52:25 <b>inquiry</b> 4:9 <b>inspection</b> 12:11 49:21 <b>inspector</b> 12:7, 14, 20 13:8 18:4 <b>inspectors</b> 7:8 8:1 10:19 96:14 97:10, 13 98:2 <b>instance</b> 15:15 40:6 <b>institution</b> 27:16, 22 28:13 <b>Institutions</b> 23:17 <b>instructions</b> 49:15 <b>instructive</b> 5:10 <b>insufficient</b> 56:23 <b>Integration</b> 8:17 <b>intentional</b> 11:13 26:15 <b>interchangeably</b> 22:6 <b>interpret</b> 65:13 <b>interpreting</b> 87:15 <b>interrupt</b> 13:19 <b>interrupted</b> 5:18 <b>interrupts</b> 5:14 <b>interview</b> 64:7, 11 <b>interviews</b> 32:22 <b>introduce</b> 4:9 <b>introduction</b> 6:4 <b>investigate</b> 37:3 38:9 43:13 44:13 <b>investigating</b> 44:17 <b>invitation</b> 71:18 72:3 <b>involve</b> 12:16 21:13</p>	<p><b>involved</b> 49:11 82:10 84:12 87:12 <b>IPAC</b> 96:6, 11, 15 97:9, 10 <b>iPHIS</b> 26:24 <b>isolate</b> 20:13 21:10, 20 38:18 <b>isolation</b> 21:23, 24 22:7 55:3, 7, 14 56:10 <b>issue</b> 12:7, 12, 24 13:8 18:4 19:21 20:1 24:22 27:14 38:10 39:9 40:24 42:10 45:11 47:6 51:11 54:15 57:19, 23 59:1 60:14 <b>issued</b> 10:16 16:6 20:15, 20, 24 21:2, 6 22:3 27:24 28:1 29:9 34:17, 20, 24 42:6 46:20 47:2 48:5 55:17 59:18 60:4 67:16, 19 68:2, 22 80:20 <b>issues</b> 41:24 47:21 68:23 <b>issuing</b> 10:20 20:4 38:16 45:18 <b>italicize</b> 66:25 <b>item</b> 13:3 78:4 <b>items</b> 73:8 77:23 78:8 84:25 85:2 91:14 93:15 98:13 <b>iteration</b> 84:6</p> <p>&lt; J &gt; <b>Jack</b> 1:16 4:4 <b>January</b> 22:9 50:22 51:7, 8, 10, 16 <b>jeopardize</b> 57:12 <b>jeopardized</b> 57:3 <b>Jim</b> 52:12 53:7, 14 <b>job</b> 33:15 61:24</p>	<p><b>John</b> 2:23 4:21 27:5 <b>judge</b> 41:19, 21 42:6 55:17 <b>judicial</b> 41:9 <b>Judith</b> 3:7, 17 100:3, 24 <b>July</b> 67:24 69:9 <b>June</b> 59:16 <b>jurisdiction</b> 37:25 65:2 90:7 <b>Justice</b> 41:20</p> <p>&lt; K &gt; <b>Kenora</b> 18:23 <b>key</b> 7:3, 8, 24 10:19 11:2 16:23 49:8 51:4 <b>kind</b> 6:20 30:21 <b>kinds</b> 45:16 <b>King</b> 34:18 47:15 <b>Kitts</b> 1:16 4:4 13:18, 21, 25 14:13 15:8 19:14 29:17, 24 76:5, 19 77:5 86:20, 21 87:15, 25 88:23 94:4, 15, 23 <b>known</b> 11:15 45:25 <b>knows</b> 6:20 84:16</p> <p>&lt; L &gt; <b>lab</b> 48:20, 23, 24 49:4 <b>laboratory</b> 25:6, 14 48:14, 25 49:1 <b>Labour</b> 77:19 <b>Labs</b> 24:25 43:6 <b>language</b> 73:4 90:21 <b>large</b> 92:12 <b>largely</b> 5:3 <b>lastly</b> 94:24 <b>lasts</b> 68:12 <b>Law</b> 3:3, 5, 7 46:1 65:17 <b>lawyers</b> 4:20 67:10</p>	<p><b>Lead</b> 1:14 2:23 77:10 79:13 91:21 <b>leading</b> 76:1 <b>leak</b> 11:10 <b>Leamen</b> 2:20 <b>leave</b> 73:19 <b>led</b> 52:12 53:14 75:1 <b>left</b> 6:21 <b>Legal</b> 2:20 8:25 17:14 24:21 29:6, 23 43:24 60:12 66:11 67:21 71:5 80:4, 5, 6, 8 <b>legally</b> 23:9 <b>legislation</b> 7:19, 21 15:14 20:19 32:21 33:18 34:25 37:21 46:4, 5, 7 47:12 54:23 58:22 61:20 64:18 67:24 69:9, 13, 15, 21, 22 70:3, 10, 20 <b>Legislative</b> 32:2, 9 33:14, 25 68:15 70:12, 17, 22 <b>Legislature</b> 32:5, 23 63:8, 18, 19, 21 68:19 <b>length</b> 63:9 <b>Lerch</b> 1:24 71:7, 13, 17 75:8, 12, 15, 20, 24 76:10, 21 77:10 78:12 79:8, 11, 25 80:22 81:9, 20 83:25 84:3, 7, 10, 17, 23 86:24 87:21 88:4, 25 89:8, 11, 19, 24 90:9 91:9 92:1, 18, 21, 25 94:7, 19, 24 96:22 97:2, 19 98:6, 11, 17 99:1 <b>Lett</b> 2:17 <b>level</b> 7:10 8:15 21:24 22:7 26:8 27:7 31:4,</p>
---	--	---	---	--

8, 9 40:5 50:14  
74:8 81:12, 17  
94:9 96:10 97:3  
**levels** 74:6  
**Liam** 1:21 4:10  
71:17 72:9, 14,  
21, 24 74:12  
83:8  
**Lieutenant** 32:1  
33:13  
**life** 69:6  
**limit** 87:1, 20  
88:10  
**limitation** 56:25  
86:12 87:18  
88:2  
**limited** 51:3  
56:15  
**limiting** 85:9  
88:21  
**limits** 44:12  
94:16  
**link** 17:5 67:19  
76:16  
**listed** 23:15  
35:21 48:3  
51:9, 13 59:7  
70:6 83:1  
**lists** 43:4  
**living** 23:21  
**local** 7:6, 10, 24  
8:10, 15, 17  
14:8 15:10, 11  
17:8 21:24  
22:7 24:14  
25:3, 11, 19  
26:6 28:19, 22  
29:19 30:15  
31:4, 8 38:15  
40:5, 11 42:11  
47:6 50:14  
51:10 52:4, 6  
63:15, 25 64:1,  
6 65:3  
**locally** 64:7  
**location** 87:7,  
18 88:2, 11  
89:21  
**locations** 78:24  
86:13 87:2  
88:10, 14, 22  
**London** 9:4  
**long** 30:22  
84:15  
**longer** 65:20

**LONG-TERM**  
1:1, 22, 25 2:2,  
12, 15, 17, 21, 23  
3:10 23:18  
24:16, 23 25:7  
27:17 28:2, 3,  
13, 16, 21 29:1,  
4, 10, 11, 20  
30:9, 12, 18, 20  
31:5, 17 43:5  
46:11, 22 48:5  
57:24 59:8, 18,  
23 72:1, 14, 18,  
20 73:2, 7, 18,  
25 74:4, 5  
76:20 77:8, 17  
78:14, 22 82:15  
83:5 86:16  
87:5 88:6, 18,  
25 91:2, 16  
93:7, 8, 11  
95:11 96:20  
97:14  
**longwinded**  
29:13 53:21  
60:12  
**looked** 74:20  
77:24 92:5  
**looking** 53:8, 9,  
15, 17 78:20  
81:14 82:17, 22  
83:20 84:11  
85:4 90:1  
91:15 92:14  
94:13  
**lot** 73:16  
**Lynn** 3:9 4:21  
  
< M >  
**made** 13:9  
17:2 28:15  
50:2 51:3  
54:10 60:7  
64:3 65:1 68:4  
69:18 100:11  
**Mahoney** 3:9  
4:21  
**main** 77:10  
82:4 96:16  
**major** 95:1  
**Majority** 9:1, 11,  
13  
**making** 4:14, 15  
86:7

**Management**  
6:12 7:17  
54:18 62:11  
63:1 64:16  
66:2, 9 68:3  
69:3, 14, 18  
79:13 87:4  
**Manager** 1:24  
2:1  
**Mann** 3:3  
**manner** 35:15  
**March** 59:15  
65:2, 25 66:15  
68:9 73:12  
74:3 82:1  
83:24 84:6  
**Marrocco** 1:14  
4:1, 2, 13, 18  
5:5 6:17 14:24  
15:21, 24 16:4,  
8, 15, 20 18:6, 9  
24:11, 14 25:18,  
25 26:18 28:18  
29:25 30:8, 14,  
25 38:4, 7, 12  
39:19, 23 40:15,  
20 41:1, 13  
43:14 44:3, 9  
51:6 60:21  
61:3 62:9, 13,  
16, 20 63:4, 24  
64:14, 24 71:9,  
15 75:6, 9, 14,  
17, 21 76:3  
78:9 79:6, 9  
80:18 81:6, 19  
83:23 84:1, 5, 8,  
13, 22 86:19  
89:2, 14, 22  
90:8 91:6, 24  
92:17, 19, 23  
96:18, 24 97:16  
98:4, 10, 15, 18  
99:2, 4  
**mask** 45:15  
**masking** 85:13,  
14  
**matter** 12:17  
38:15 74:24  
**matters** 26:12  
33:23 70:7  
**means** 46:1  
**meant** 94:1  
**measles** 24:10

**measure** 33:10  
61:24  
**measures** 14:7  
47:9, 17 67:12  
70:4  
**media** 22:5  
34:9 68:10  
**Medical** 2:4, 5  
6:8 7:6, 7, 13,  
24, 25 8:2, 4, 20,  
24 10:11, 18  
11:23, 24, 25  
12:2, 4, 5, 6, 15,  
19 13:6, 7 14:5,  
9, 18 15:6 17:8,  
9, 14, 15, 19, 25  
18:2, 3, 11, 12,  
24 19:4, 5, 6, 9,  
19, 25 20:6, 11  
21:2, 17 23:16  
24:15, 21, 23  
25:3, 10, 11, 20  
26:6, 8, 16, 20,  
21 27:13, 18, 24  
28:8, 19, 22  
29:8, 19 30:16  
31:11, 13, 15, 18,  
23, 25 32:16, 19,  
25 33:2, 5, 8, 21  
34:6, 16, 18  
35:2, 4, 10, 17,  
20 36:3 37:6, 8,  
9, 14, 17, 19, 21,  
23 38:24 39:2,  
11, 16, 25 40:6,  
9, 12, 25 41:5,  
18 42:1, 5, 9, 15,  
17, 19 43:23  
44:11, 20 45:8,  
17 46:18 47:5,  
7, 14, 16 48:13,  
16, 18, 23 49:3,  
8, 10 50:6  
51:10, 18 52:1  
54:7, 20, 25  
55:9 56:18  
58:7 60:9, 24  
61:1, 5, 6, 10, 13,  
17, 18, 23 62:3  
63:7, 15, 16, 22  
64:1, 6, 11 65:3,  
4, 11, 17, 19  
67:2 70:25  
71:23 74:2

75:5, 19 80:11,  
14, 21  
**medications**  
56:13, 20 57:9,  
21 58:2, 4, 13, 18  
**meet** 39:1, 10  
50:14  
**MEETING** 1:1  
61:19 99:7  
**meetings** 95:13  
98:8  
**Melissa** 2:1  
71:21  
**members** 9:12,  
13, 14, 21, 24  
71:4  
**memo** 90:18  
**memos** 74:1, 3,  
4 78:19 92:3  
**mention** 21:22  
58:16 73:21  
92:16  
**mentioned** 7:24  
22:8 39:7  
47:20 50:21  
58:10 59:22  
62:8 69:7 72:9,  
14, 15, 21, 24  
74:13 78:3  
83:8 86:12  
90:15 91:11  
93:2, 15, 21  
**mentioning**  
38:21 58:15  
**MEOC** 76:20, 21  
77:9, 12 78:18  
79:3 81:8, 10  
84:2  
**met** 4:22 5:22  
24:22 29:6, 23  
43:21, 25 66:14  
**method** 26:24  
**middle** 5:14  
**Middlesex** 9:4  
**mine** 4:17  
29:17  
**Minister** 2:11  
7:14 8:5 17:3  
31:16, 17 32:11  
34:3, 4, 8, 10  
49:7, 11, 12, 13  
50:5, 16, 17, 19,  
22 51:4, 6, 21  
54:7, 19, 22, 24  
55:1, 4, 6, 8, 10,

<p>19 56:6, 9, 13, 17 57:8, 16, 17, 22 58:22 59:1, 5, 9 60:20, 23 61:1, 4, 9, 15, 22 62:2 63:12, 14 64:3, 5, 9, 13 71:1, 2 74:8 80:19, 25 81:7, 11 <b>ministerial</b> 18:10 <b>Minister's</b> 55:19 80:12 81:11 <b>Ministries</b> 2:21 74:9, 22 76:14, 18 78:2 95:24 <b>Ministry</b> 1:21, 22, 25 2:2 3:9 4:11 6:5, 9 7:18, 20 14:17 26:22, 25 27:2, 5 32:10 35:8, 13 49:21 50:13 52:18, 19 60:6 69:13, 15 71:24 74:8, 25 75:9, 10, 12, 23 76:7, 9, 10, 12, 19, 22 77:1, 9, 17, 18, 19 78:10, 14, 22 79:7, 18 80:5 87:5 91:2 96:20, 22 <b>minority</b> 9:14 <b>minute</b> 10:10, 22 12:23 13:12 18:7 32:15 56:14 57:19 67:25 <b>minutes</b> 6:19 62:14 <b>misunderstood</b> 63:13 <b>mix</b> 91:20 <b>model</b> 52:14 79:18 <b>modernization</b> 52:12 53:1, 13 <b>modernize</b> 53:9, 18 <b>morning</b> 4:1 5:1 <b>mortality</b> 82:16 <b>motion</b> 16:10</p>	<p><b>move</b> 90:9 <b>moved</b> 67:23 <b>movement</b> 66:19 <b>moving</b> 95:1 <b>MSA</b> 91:3 <b>MSAA</b> 78:14 96:21 97:14 <b>multi-party</b> 63:10 <b>municipal</b> 56:5 <b>municipalities</b> 9:13 13:23 52:2, 7, 8 <b>municipality</b> 9:21, 22 10:2, 4 <b>municipally</b> 9:11 <b>myriad</b> 19:23  &lt; N &gt; <b>named</b> 63:21 <b>national</b> 89:16 <b>nature</b> 23:23 63:7 <b>naturopaths</b> 24:3 <b>necessarily</b> 13:4 92:1 <b>necessary</b> 17:21 19:20 30:23 37:4 43:12 44:13 48:10 55:20 67:12 69:1 76:17 86:5 <b>needed</b> 55:14 80:7 91:17 <b>needs</b> 36:24 <b>Neesons</b> 5:22 100:23 <b>Networks</b> 8:18 <b>new</b> 58:21, 25 59:2 67:24 69:9, 21, 22 87:17 88:2 91:22 <b>noncompliance</b> 55:16 <b>normally</b> 20:5 21:19 22:6 32:19 41:24 42:17 <b>Northwest</b> 57:13 <b>Northwestern</b> 18:22, 25</p>	<p><b>note</b> 8:8 10:12 11:16 12:21 20:22 22:8, 10 36:24 48:21 50:3 54:6 59:1 66:25 67:1 70:23 <b>noted</b> 26:10 <b>notes</b> 100:16 <b>notice</b> 35:9 <b>notified</b> 40:10 <b>notifying</b> 25:15 <b>Notwithstanding</b> 65:1 <b>number</b> 12:1 17:5 26:1 46:19 72:18 73:25 82:20 83:7 86:10 95:13 96:12 <b>Nunavut</b> 57:13 <b>Nurse</b> 46:11 67:4 <b>nurses</b> 24:3  &lt; O &gt; <b>object</b> 12:10 <b>obligated</b> 52:7 <b>obtain</b> 42:23 <b>occupant</b> 39:1 <b>occupational</b> 33:22 46:15, 16 <b>occupier</b> 55:5, 21 <b>occupying</b> 33:8 <b>occur</b> 86:1 <b>occurred</b> 76:1 <b>occurring</b> 83:20 91:15 95:14 <b>Office</b> 2:5 3:3, 5, 7 14:15 32:17 35:16 36:6, 8 71:22 80:12 81:1, 11 <b>Officer</b> 2:5 6:8 7:13 8:2, 3, 20, 24 10:11 11:23, 24, 25 12:4, 6, 15, 19 13:7 14:1, 5, 18 15:6, 10 17:8, 9, 14, 15, 19, 25 18:2, 3, 12, 13, 25 19:4, 5, 6, 10, 19 20:6, 11 21:2,</p>	<p>17 24:15, 21, 24 25:3, 10, 11, 20 26:6, 8, 16 27:18 28:19, 20, 22 29:19 30:15, 16 31:12, 13, 15, 18, 23, 25 32:4, 8, 16, 25 33:2, 5, 8, 21 34:6, 16, 18 35:2, 4, 10, 17, 20 36:3 37:7, 8, 9, 14, 17, 19, 23 38:24 39:2, 11, 16, 25 40:7, 10, 25 41:6, 18 42:5, 9, 15, 17, 19 43:23 44:11, 20 45:9, 17 46:18 47:5, 15 48:13, 16, 19, 23 49:4, 9, 10 50:6 51:18 54:7, 20, 25 55:9 56:18 60:9, 24 61:2, 10, 13, 14, 17, 18, 23 63:7, 15, 17, 22 64:2, 6, 12 65:3, 11, 19 67:2 70:25 71:23 74:2 75:19 80:11, 15, 21 <b>Officers</b> 7:6, 7, 25 8:4 10:18 12:2, 5 14:9 20:1 23:16 26:20, 21 27:14, 25 28:9 29:8 32:19 37:22 40:12 42:1 47:7, 16 51:10 52:1 61:5, 6 62:4 65:4, 20 <b>official</b> 81:5 <b>OMB</b> 55:24 <b>Ombudsman</b> 32:5 <b>ongoing</b> 67:20 <b>online</b> 97:18 <b>Ontario</b> 1:21, 25 2:2, 6 4:11 7:4 10:14 13:23 14:2, 15, 19 15:7, 11, 12</p>	<p>19:11 20:19 26:23 27:2, 4, 8, 9 49:2, 14, 19, 22, 24 50:7, 11 51:23 54:14 55:12 57:10 59:20 60:17 64:22 66:2, 7, 8 69:11, 17 77:15 83:9 96:8 <b>open</b> 38:13 <b>Operation</b> 75:1 97:3 <b>operational</b> 95:23 <b>Operations</b> 2:14 75:10, 13, 22 76:2, 8, 11 77:1 78:10 79:7 <b>opinion</b> 17:17, 20 18:3 27:19 36:24, 25 37:1 38:8 39:4 43:10 45:9 48:17 58:23 <b>optometrists</b> 24:3 <b>orally</b> 13:9 20:12 <b>Order</b> 9:15 12:8 13:5, 15 15:25 16:3, 5, 9, 11 17:10, 11, 12, 21 18:5, 19 19:21 20:11, 14, 16, 17, 20, 21 21:2, 6, 16 24:15, 20, 22 25:21, 24 26:7, 12 28:10, 22 29:20 30:17, 21, 23 31:3 32:1, 24 33:2 37:25 38:16 39:9, 12, 20, 21 40:17, 19, 24 41:20, 25 42:6, 10, 23, 24 46:24 54:20 55:8, 17, 18 57:4, 7 58:23 59:2, 10 63:20 65:1, 8, 11, 12, 14 67:11, 13 88:24 91:18 93:3</p>
---	---	---	---	---

<p><b>ordered</b> 12:14, 18 22:18, 21 26:2 <b>ordering</b> 25:21 <b>Order-making</b> 24:19 66:17 <b>orders</b> 10:16, 20, 24 11:4 12:22, 23, 24 13:9, 13, 14 16:18, 24 17:2 20:1, 4, 9, 23, 24 21:10 22:3, 14, 20 25:19 27:15, 20, 24 28:12, 15 29:9 38:10 39:8 51:11 67:1, 15, 16, 19, 20, 22, 23 68:1, 5, 21 69:1, 5, 17, 19, 22, 24 70:2, 6, 10, 24 71:4 <b>organizations</b> 73:24 74:1 <b>Ottawa</b> 9:18, 23, 24 42:20 <b>Ottawa's</b> 19:5 <b>outbreak</b> 8:10 10:25 17:18 26:17 27:13, 15 28:4 29:12, 21 30:24 34:21 40:5 44:23 55:11 <b>outbreaks</b> 8:9 24:9 45:5 82:15 83:5 91:15 93:11 <b>outlining</b> 89:18 <b>outset</b> 64:17 <b>outside</b> 62:5 90:6 <b>overall</b> 76:24 79:11, 17 91:4 <b>overview</b> 74:17 <b>owned</b> 56:3 <b>owner</b> 55:22</p> <p>&lt; P &gt; <b>p.m</b> 1:8 99:7 <b>paid</b> 52:2, 16 <b>paired</b> 58:14 60:3 <b>Palin</b> 2:14 4:24, 25</p>	<p><b>pandemic</b> 8:12, 14 19:15, 17, 25 20:8 35:24 38:14 43:18 45:2, 7 47:8 53:25 56:9 58:11 72:12 82:7, 9 85:10 96:17 <b>Parker</b> 3:7 <b>part</b> 4:16 7:16 22:19 46:13 51:23 53:1, 3 55:6 71:2 78:17, 25 80:2 81:16 85:10, 21 86:18 87:11 89:25 96:16 97:24 <b>participants</b> 1:6 2:9 3:1 <b>participate</b> 89:17 <b>particular</b> 8:21 26:23 47:25 54:19 74:11 93:20 <b>partner</b> 76:14 <b>partners</b> 74:23 <b>party</b> 32:21 <b>passed</b> 11:19 <b>patient</b> 23:25 25:4, 13 <b>patients</b> 57:2, 12 <b>pay</b> 52:8 <b>pays</b> 52:19 <b>Peel</b> 10:5 <b>Peel's</b> 19:6 <b>pen</b> 77:11 <b>people</b> 4:19 22:23 23:4 30:9 59:7 84:15 86:4 87:1, 6 89:7 <b>percent</b> 52:6, 17, 19 <b>percentage</b> 52:4 <b>perfect</b> 92:25 98:17 <b>perform</b> 36:5 <b>period</b> 68:24 69:23 70:20 <b>periods</b> 68:24 69:4</p>	<p><b>permanent</b> 36:12 <b>person</b> 11:7 12:25 13:6, 14 16:1 17:10 20:24 21:10, 11, 19, 20 22:15, 18, 25 24:6 25:7 33:3 35:2, 3, 6, 9, 12 36:4, 6 40:1, 20 41:8 55:16, 24 57:3, 20 63:11, 12, 21 64:8, 10 70:13 <b>personal</b> 42:24 43:3 46:25 58:8 59:12, 17, 21 60:15 67:8 <b>persons</b> 13:4 17:24 21:3 23:17 28:10 30:1 31:16 33:7 35:7 39:12 43:8, 12 44:16 45:13 48:3, 9 51:13 55:13 57:21 58:1, 12, 17 60:5 66:23 <b>pertaining</b> 24:16 <b>pharmaceutical</b> 58:7 <b>pharmacists</b> 24:3 43:6 <b>PHIPA</b> 43:4 <b>PHO</b> 97:8 <b>phone</b> 42:18 <b>physician</b> 8:21 22:16, 19 33:3 35:19 <b>Physicians</b> 23:24 33:9 <b>pick</b> 42:18 71:25 <b>picking</b> 85:17 <b>piece</b> 72:7 83:18 84:21 85:7, 9, 13, 24 86:11, 14, 18 87:6 88:5, 13 89:21 92:8 95:1, 12, 19 <b>pieces</b> 72:1 76:13 78:21 81:10 82:4, 18</p>	<p>89:20, 25 90:4, 13, 23 92:15 95:16 96:12, 16 97:4 98:14 <b>Pine</b> 52:12 53:8, 14 <b>place</b> 23:22 57:16 66:19 82:18, 21 83:2 87:24 95:15 96:13 97:13, 22 100:8 <b>places</b> 70:5 <b>play</b> 8:13 <b>played</b> 79:3 <b>point</b> 5:17 6:16 15:17 73:17 89:5 <b>points</b> 6:15 <b>police</b> 23:20 <b>policies</b> 47:8, 17 85:13 90:16 91:3 <b>Policy</b> 1:24 2:1, 17 <b>position</b> 33:13 35:6, 7 <b>positive</b> 30:3 <b>possess</b> 33:4 35:19 <b>postgraduate</b> 62:3 <b>posting</b> 49:22 <b>potential</b> 11:22 17:23 86:7 95:18 97:4 <b>potentially</b> 26:6 31:14, 18 67:7 81:9 <b>power</b> 15:5 16:23 26:10 28:14 37:15, 16 40:18 41:9 42:14 44:2 45:1, 4 46:19 47:3, 13, 23, 25 48:13 49:3 51:4 54:22 55:1 56:8, 15 57:1, 17 58:10, 14, 21 59:8, 15, 24 60:3, 23 66:4 70:9 <b>powers</b> 7:5, 9, 12, 14 8:5</p>	<p>10:19 11:2 12:3 14:20, 21, 22 19:12 31:13 32:14 36:1, 14, 18, 19, 20 37:7, 18 38:3, 25 40:25 49:8, 9, 11, 13 60:13 64:18 65:2, 20, 22, 23 66:17 72:10 74:12 80:17 <b>PPE</b> 72:22 73:15, 17 85:20 <b>practice</b> 4:12 6:6 29:7 38:21 50:5 51:23 <b>practices</b> 83:13 <b>Practitioners</b> 24:2 <b>precautionary</b> 45:20, 22 <b>precautions</b> 45:12, 14 83:16 <b>preexisting</b> 48:14 49:4 <b>Premier</b> 66:10 68:11, 18 70:21 <b>premises</b> 12:9 13:1, 2 55:5, 6, 13, 20, 21 56:3 <b>prepare</b> 83:22 94:14 <b>prescribe</b> 48:8 <b>PRESENT</b> 3:15 34:14 65:17 <b>presentation</b> 4:14, 16, 17 6:15 7:16 71:6 73:15 76:23 92:24 96:7 98:12, 21 <b>presentations</b> 73:19 <b>PRESENTERS</b> 1:19 <b>presenting</b> 6:20 <b>presents</b> 17:23 21:18 <b>press</b> 53:11 <b>pretty</b> 38:19 <b>prevail</b> 65:9, 14 <b>prevails</b> 46:17 <b>prevent</b> 21:12 37:4 41:22</p>
---	---	---	---	--

<p><b>prevention</b> 12:12 83:14</p> <p><b>previous</b> 34:17 51:14 89:5</p> <p><b>previously</b> 20:17 48:20</p> <p><b>price</b> 66:22</p> <p><b>prices</b> 66:21</p> <p><b>principals</b> 24:8</p> <p><b>principle</b> 45:21, 22</p> <p><b>prior</b> 45:5 64:21</p> <p><b>priority</b> 47:18, 21</p> <p><b>Privacy</b> 32:5 43:3</p> <p><b>private</b> 23:19 66:20</p> <p><b>probable</b> 17:16 19:21 27:19 30:4, 11 37:1 39:5</p> <p><b>procedures</b> 45:13, 14</p> <p><b>proceedings</b> 100:7</p> <p><b>process</b> 64:11 78:17 79:1 80:2 81:22 89:15 91:7</p> <p><b>processes</b> 74:16, 21 76:1 77:13</p> <p><b>procure</b> 56:19</p> <p><b>procurement</b> 56:23</p> <p><b>produce</b> 97:1</p> <p><b>producing</b> 96:25</p> <p><b>professional</b> 67:3</p> <p><b>professionals</b> 43:6 46:9</p> <p><b>Programs</b> 1:25 2:2 49:16 50:14 52:17, 18, 20 54:12</p> <p><b>prohibit</b> 66:19</p> <p><b>Promotion</b> 6:11 7:2, 10, 15, 23 8:6, 23 9:3, 11 10:17, 22 11:1 15:19 17:4 21:8 39:18</p>	<p>47:4 51:20 54:16 62:24</p> <p><b>proposed</b> 48:11</p> <p><b>protect</b> 45:13</p> <p><b>Protection</b> 6:11, 12 7:2, 10, 15, 18, 23 8:6, 23 9:3, 10 10:17, 21 11:1 15:18 17:4 21:7 33:15 39:17 43:3 47:4 51:19 54:16 61:25 62:11, 24 63:1 64:16 66:3, 9 68:3 69:3, 14, 19 87:4</p> <p><b>protections</b> 35:16</p> <p><b>protective</b> 46:25 58:8 59:17, 21 60:16</p> <p><b>protocols</b> 50:8 83:8, 10</p> <p><b>provide</b> 6:7 27:11 28:2 42:11, 21, 24 46:9, 12 48:22, 25 49:17 50:12 54:1 57:9, 20, 25 58:12, 18 59:9 66:23, 24 67:4, 19 72:25 76:15 77:3 79:22 81:20 82:23 93:18 94:1 96:9</p> <p><b>provided</b> 49:20 52:4 78:19 83:10</p> <p><b>provider</b> 45:11 48:2, 6 59:6</p> <p><b>providers</b> 48:9 60:1, 14 72:23</p> <p><b>provides</b> 25:10 34:7 36:23 45:19 61:24 94:7</p> <p><b>providing</b> 54:12 74:10 77:15, 20, 21 90:24</p> <p><b>Province</b> 9:15 10:13, 15 14:4, 6, 8, 11, 23</p>	<p>38:17 52:3, 16 57:2 90:5</p> <p><b>provincial</b> 7:12 8:11 15:14 21:24 22:7 23:20 31:8, 16 45:6 52:6 53:6, 22, 24</p> <p><b>provision</b> 16:19 24:19 32:3 47:11 65:7</p> <p><b>provisions</b> 73:5 77:21</p> <p><b>psychiatric</b> 23:19</p> <p><b>public</b> 4:12 6:7 7:3, 8 8:1, 16, 21 10:18 12:7, 14, 19 13:8, 22 14:1, 14, 19 15:10 17:24 18:4 21:14 22:1 23:13 26:22 27:1, 4, 7, 9 32:9 33:10, 25 34:13, 14 37:12, 13 38:1 42:4 44:23 47:9 49:1, 14, 19, 21, 22, 24 50:7, 11, 23 51:24 52:11 53:1, 3, 9, 13, 18 54:14 56:4 62:3 64:18 66:5, 20 71:23 77:14 83:3, 9 96:7</p> <p><b>publicly</b> 56:3</p> <p><b>published</b> 50:8</p> <p><b>publishes</b> 49:14</p> <p><b>pulling</b> 79:4 83:18</p> <p><b>punitive</b> 37:22</p> <p><b>purposes</b> 45:1 51:19 54:8 56:4</p> <p><b>pursue</b> 29:25</p> <p><b>purview</b> 90:5</p> <p><b>put</b> 35:4 55:18 87:3, 5, 13 89:12 96:13</p> <p><b>putting</b> 97:13</p> <p>&lt; Q &gt;</p>	<p><b>qualification</b> 62:5</p> <p><b>qualifications</b> 8:24 33:5 35:19</p> <p><b>qualified</b> 66:24</p> <p><b>quality</b> 54:18</p> <p><b>quarantine</b> 21:23 22:4</p> <p><b>question</b> 5:15, 19 29:15, 16 36:16 43:15 44:1, 8 52:24 63:5 65:16 71:11 75:15 79:20</p> <p><b>questions</b> 5:12 6:14, 16 16:16 50:10 52:22 62:24 63:2 71:6 72:3, 5 92:18 98:19</p> <p><b>quite</b> 83:7</p> <p><b>quote</b> 60:10</p> <p>&lt; R &gt;</p> <p><b>reaching</b> 79:1</p> <p><b>readmissions</b> 85:23 90:14</p> <p><b>ready</b> 5:21 62:21 71:13 80:3</p> <p><b>really</b> 40:1 70:14 93:25</p> <p><b>reappointed</b> 32:18</p> <p><b>re-appointed</b> 33:19</p> <p><b>reappointment</b> 36:10</p> <p><b>reason</b> 21:19 22:22 36:7 47:11, 13, 23 59:25</p> <p><b>reasonable</b> 17:16 19:21 27:19 30:3, 4, 11 37:1 38:19 39:5</p> <p><b>reasonably</b> 44:12 66:24</p> <p><b>reasons</b> 13:11 20:10</p> <p><b>receive</b> 25:5</p> <p><b>received</b> 6:3</p>	<p>71:19</p> <p><b>receives</b> 27:4, 6</p> <p><b>RECESS</b> 62:18</p> <p><b>recommend</b> 63:11</p> <p><b>recommendation</b> 63:25 87:1</p> <p><b>recommendation</b> s 73:23 74:10 78:20 92:2</p> <p><b>recommended</b> 47:14 90:19</p> <p><b>recommending</b> 92:4</p> <p><b>recorded</b> 100:12</p> <p><b>reduce</b> 43:13 44:14</p> <p><b>reducing</b> 44:17</p> <p><b>reduction</b> 53:2</p> <p><b>reductions</b> 53:6, 22</p> <p><b>refer</b> 21:24 60:2</p> <p><b>reference</b> 46:6 94:1</p> <p><b>referencing</b> 72:20</p> <p><b>referring</b> 72:8 87:21</p> <p><b>refers</b> 43:2</p> <p><b>reflect</b> 88:1</p> <p><b>reflected</b> 87:14</p> <p><b>reflecting</b> 86:17 87:17</p> <p><b>regarding</b> 45:12 59:17</p> <p><b>regards</b> 26:4 59:16</p> <p><b>regional</b> 10:1, 4</p> <p><b>regular</b> 56:22</p> <p><b>regulate</b> 66:18</p> <p><b>regulated</b> 43:5 46:9 67:3</p> <p><b>regulation</b> 8:22 17:3, 5 18:10 45:23 48:10, 11 50:22 60:8 87:3, 8, 23 88:6, 9, 12, 16, 19 89:10, 12 94:15, 17, 21</p> <p><b>regulations</b> 49:25 50:17, 18 51:2 68:2, 4</p> <p><b>regulatory</b> 87:12</p>
---	--	---	--	--



<p><b>relatively</b> 43:20 58:21 <b>release</b> 80:13, 23 81:5 83:22, 24 84:2 <b>released</b> 34:9 73:12 74:3, 5, 7 78:19 80:17 81:25 <b>releasing</b> 72:10 82:13 90:2 <b>relevant</b> 16:25 19:22 46:23 <b>relied</b> 20:6 <b>rely</b> 19:19 <b>remain</b> 15:25 22:1 <b>remainder</b> 52:9 <b>remains</b> 16:5 <b>remarks</b> 100:11 <b>remotely</b> 1:7 <b>removed</b> 33:12 <b>removing</b> 12:9 <b>renewal</b> 70:1 <b>renewed</b> 68:13 <b>Reopening</b> 69:11, 16 <b>replaced</b> 69:10 <b>report</b> 23:24 24:4, 6, 8, 25 25:2, 5, 9, 12, 21 26:21 33:24 34:3, 5, 7, 9, 11, 14, 20, 22 47:20 51:14, 15 59:20 60:17 70:21 <b>reportable</b> 23:12, 15 50:19, 24 <b>reported</b> 23:16 25:14 53:11 <b>Reporter</b> 100:4 <b>REPORTER'S</b> 100:1 <b>reporting</b> 25:1 26:23 <b>reports</b> 25:7 26:20 27:1, 6, 11 32:11 34:12, 17, 24 70:16 <b>representations</b> 61:19 <b>represented</b> 76:20</p>	<p><b>request</b> 16:3 42:10, 15 57:17 <b>require</b> 21:10, 11 42:20 55:4 58:11 59:20 60:8 67:6 68:14 76:25 <b>required</b> 21:4 43:25 50:1 54:13 55:15 57:4, 15 70:16 77:23 78:7 <b>requirement</b> 25:2 <b>requirements</b> 17:21 21:19 30:23 62:3 95:8 <b>requires</b> 21:20 61:16 <b>requiring</b> 17:10 21:3 22:15 41:20 57:20 66:23 <b>research</b> 45:1 <b>residences</b> 23:22 <b>resident</b> 93:17 <b>residents</b> 65:17 85:6 <b>resolution</b> 64:8 <b>respect</b> 17:2, 13 29:4 33:22 54:15 <b>respecting</b> 34:13 <b>respiratory</b> 82:19, 25 83:4, 6 <b>respond</b> 67:13 72:5 94:14 <b>responding</b> 82:9 <b>response</b> 8:9 69:12 <b>responsibilities</b> 7:6 10:10 33:20 36:2 <b>responsible</b> 10:9 70:21 <b>restricting</b> 70:4 <b>restriction</b> 25:19 <b>restrictions</b> 26:4 <b>rests</b> 60:23 <b>results</b> 48:15 <b>RESUMING</b> 62:19 <b>retain</b> 48:19</p>	<p><b>retirement</b> 59:19, 23 60:2, 7, 8, 11 73:6 86:16 87:7 88:15, 20 96:23 97:14 <b>reversed</b> 86:22 <b>reversion</b> 91:22 <b>Review</b> 13:16 15:20, 22 16:2, 7 20:18, 19 39:13 41:2, 10 52:11 53:7, 19 74:16, 21 75:1, 5 77:13, 20 80:5, 19, 24 81:2, 7, 18 <b>reviews</b> 50:6 75:25 76:12 78:1, 3 80:10 <b>revise</b> 78:11 <b>revising</b> 97:22 <b>revision</b> 78:17 <b>revisions</b> 75:2 77:7, 11 78:12 95:18 96:2 <b>risk</b> 17:22, 23 21:18 36:21 37:2, 5 38:9 41:22 43:11, 13 44:14, 18 45:10 48:18 55:11, 12 56:18, 24 57:1 58:24 73:17 <b>Robert</b> 1:24 71:7, 16 <b>Rokosh</b> 2:14 4:24, 25 <b>role</b> 33:8, 15, 19 72:6 79:4 89:15 <b>roles</b> 8:13 81:15 <b>room</b> 22:24 71:21 81:14 84:11 <b>Roopa</b> 3:3 <b>rounds</b> 5:3 <b>routinely</b> 20:1 30:1 <b>RPR</b> 100:3, 24 <b>rude</b> 5:13  &lt; S &gt; <b>safeguarding</b> 56:22</p>	<p><b>safety</b> 45:19 46:15, 17 <b>sample</b> 48:22 <b>sat</b> 77:12 <b>scale</b> 8:12 <b>School</b> 24:8 <b>school-based</b> 24:9 <b>scientific</b> 46:2 <b>scope</b> 45:6 <b>Scott</b> 1:21 4:10, 14, 15 5:8, 24 6:18, 23 13:20, 24 14:3, 16 15:3, 12, 21, 23 16:1, 5, 13, 16, 22 18:8, 20 19:16 24:13, 18 25:23 26:1, 19 28:18 29:3, 22 30:7, 13, 22 31:6, 10, 21 38:5, 6, 11, 20 39:22 40:3, 18, 23 41:7, 16 43:22 44:4, 6, 10 51:8 53:5 54:5 60:22, 25 61:4 62:15, 21, 22 63:14 64:4, 15, 25 65:6 71:14 98:25 99:3 <b>Scott's</b> 80:6 <b>screen</b> 4:6 5:6 <b>screening</b> 85:4, 5 95:2, 4 <b>season</b> 82:20 <b>Secretariat</b> 2:12, 18, 24 5:4 6:2 <b>Section</b> 10:21 11:1 12:7 18:1 21:7 25:11, 24 26:13 27:20, 23 28:6, 9 29:9 36:22 39:7, 10 42:7, 23 45:19, 24 51:25 54:23 59:25 60:4 62:25 <b>sector</b> 46:4, 23 82:24 92:10 93:4 95:15 96:14</p>	<p><b>sectors</b> 73:1, 24 74:6 82:8 <b>sector-specific</b> 74:24 76:15 <b>seek</b> 61:22 <b>seize</b> 56:20 <b>Seizure</b> 56:12 57:16 <b>select</b> 64:7 <b>selected</b> 33:1 <b>selects</b> 32:22 <b>self</b> 20:12 <b>self-isolation</b> 86:3 <b>send</b> 29:11 73:23 80:4 <b>sending</b> 80:24 <b>sends</b> 30:19 <b>Senior</b> 2:4 33:9 <b>Seniors</b> 60:7 77:18 96:22 <b>separate</b> 94:20 <b>September</b> 1:7 82:2 100:19 <b>serious</b> 22:11 43:11 48:18 <b>serums</b> 58:5 <b>servant</b> 32:9 <b>service</b> 90:23 <b>Services</b> 2:20 13:15 15:20 16:7 20:18 39:13 46:9, 12 49:16 50:15 53:19 54:12 66:21, 23 67:4 79:12 80:6 90:25 <b>set</b> 8:22 21:19 100:8 <b>sets</b> 8:23 50:13 <b>settings</b> 92:10 <b>sharing</b> 95:25 97:9, 17 <b>Sheriff</b> 55:18 <b>shore</b> 91:18 <b>short</b> 69:17 <b>shorter</b> 62:25 <b>Shorthand</b> 100:4, 16 <b>shortly</b> 31:11 67:21 <b>side</b> 80:8 <b>significance</b> 23:14 50:23</p>
---	--	---	--	--

<p><b>significant</b> 36:19, 20 <b>significantly</b> 61:12 <b>similar</b> 23:22 27:20 28:5 81:14 87:8 <b>simply</b> 34:7 36:24 42:18 <b>single</b> 52:8 <b>site</b> 88:24 94:16 <b>situation</b> 27:13 37:3 38:13 40:13 42:3 43:17 86:17, 21 94:3 <b>situations</b> 14:25 47:8 <b>size</b> 93:23 <b>Skills</b> 77:19 <b>slide</b> 6:25 7:22 8:7 11:3 13:17, 21 23:11 31:21 35:1 36:13 42:8 45:3 48:12 49:7 50:16 51:14 54:5 55:2 56:12 58:15, 16, 20 60:19 62:7 66:12 67:17 69:16 74:14 81:23 82:11 90:10 93:2 95:9, 10 <b>slides</b> 66:25 73:10, 11 <b>smaller</b> 12:4 <b>Smith</b> 27:5 <b>Solicitor</b> 7:20 69:13, 15 <b>somebody</b> 5:14 30:19, 20 39:19, 21 84:16 86:6 <b>somewhat</b> 38:14 56:15 <b>sorry</b> 44:6 50:2 75:12, 16 79:8 84:4 87:21 89:3, 22 <b>sort</b> 6:22 72:15, 19, 22 73:4, 9, 22 74:15, 16, 17 75:1, 2, 25</p>	<p>76:14, 15, 16, 23, 24 77:1, 2, 10, 12, 13, 15, 20, 21, 22, 25 78:1, 2, 13, 15, 18, 21 79:3, 4, 5, 11, 13, 16, 17 80:7, 13, 24 81:3, 12, 17, 20, 25 82:4, 8, 12, 18, 24 83:6, 12, 18, 21 84:10 85:3, 4, 11, 17, 21, 24 86:2, 5, 8, 10, 17, 24 87:10 88:17 89:6 90:14 91:1, 3, 10, 11, 18, 20, 21 92:15 93:3, 21, 22 94:3, 11, 20, 25 95:4, 7, 15, 18, 21, 23 96:2, 5, 9, 11, 13, 15 97:20 98:11, 20 <b>sorts</b> 78:7 83:16 85:20 <b>sources</b> 78:16 79:5 <b>spaces</b> 21:14 22:1 <b>speak</b> 6:10 7:1, 21 23:7 27:3, 10 58:16 84:14, 15 <b>speaking</b> 5:18 40:13 53:23 <b>specific</b> 13:1, 3 25:17 28:11 44:23 72:1, 7, 17, 25 73:1, 15, 18 74:3, 19 75:5 76:21 78:4, 5 82:22 83:15 84:18, 25 88:4, 5, 15, 19 90:4 91:17 92:4, 10 93:5, 11 94:3 <b>specifically</b> 73:3 74:14 81:25 84:21 89:1, 21 90:22 <b>specifics</b> 27:4 90:15 93:7, 14 <b>specified</b> 15:18 17:3, 12 18:1,</p>	<p>10 21:16 22:9 26:2, 24 32:20 37:20 38:22 43:9 47:12 50:25 58:12 59:10 65:12 70:3 <b>specifies</b> 42:12 <b>specify</b> 50:19 51:5 <b>specifying</b> 20:14 50:18 <b>specimen</b> 48:14 <b>specimens</b> 48:20, 24 49:5 <b>spoke</b> 15:9 <b>spread</b> 86:8 <b>spreading</b> 21:12 <b>spreads</b> 40:8 <b>staff</b> 6:8 28:3 29:11 37:11, 13 85:15 86:13 88:9, 22 93:16 94:16 97:23 98:1 <b>stage</b> 91:12 <b>stakeholder</b> 95:12 <b>stakeholders</b> 95:22 <b>stand</b> 83:12 <b>standard</b> 23:3 <b>Standards</b> 49:15, 19, 22, 24 50:8, 9, 11, 13 54:14 83:9 <b>standing</b> 33:4 70:17 <b>stands</b> 39:21 <b>start</b> 62:14 72:6 84:2, 3, 9 <b>started</b> 98:8 <b>starting</b> 68:17 82:15 <b>state</b> 33:25 <b>stated</b> 39:17 <b>stating</b> 30:17 <b>Statistics</b> 44:21, 22 <b>statute</b> 7:3 <b>statutory</b> 7:9 12:3 15:4 25:2 32:14 39:2 41:9 <b>stay</b> 16:3, 6</p>	<p>33:21 <b>stays</b> 39:21 <b>stemming</b> 95:21 <b>Stenographer/Tra nscriptionist</b> 3:17 <b>stenographically</b> 100:12 <b>step</b> 36:11 <b>steps</b> 21:12 45:16 70:19 <b>stockpile</b> 59:21 <b>stop</b> 17:11 18:7 75:6 <b>strengthened</b> 91:18 <b>strengthening</b> 85:5 <b>strict</b> 89:10 <b>strong</b> 37:16 <b>struck</b> 38:18 <b>structure</b> 76:24 79:16 92:13 <b>structures</b> 79:2 93:22 <b>students</b> 65:18 <b>sub</b> 59:25 <b>sub(2)</b> 18:1 <b>subclass</b> 22:11 23:4 <b>subject</b> 13:5, 15 17:11 39:12 44:11 48:3 56:20 57:4 70:7 74:24 <b>submission</b> 80:10 <b>Subsection</b> 26:13 <b>subsequent</b> 40:13 <b>successful</b> 41:10 <b>suggest</b> 38:1 <b>summarize</b> 7:11, 14 <b>summary</b> 27:6 <b>Superior</b> 41:19 55:17 <b>supplied</b> 44:10 <b>supplies</b> 56:13, 20 57:9, 21 58:2, 4, 7, 13, 19 <b>supply</b> 43:8 56:22</p>	<p><b>support</b> 63:10 93:3 95:3 96:13 <b>supported</b> 23:21 <b>supporting</b> 6:1 95:6 <b>supports</b> 95:11 96:3, 4 97:6 <b>surgical</b> 45:16 <b>suspended</b> 53:24 <b>system</b> 26:24 53:10, 18  &lt; T &gt; <b>Table</b> 76:24 78:15 <b>tables</b> 78:6, 13, 20 79:2 95:22 <b>tabling</b> 70:21 <b>takes</b> 20:21 57:16 <b>talk</b> 7:5, 17 16:18 31:22 40:21 62:10 67:16 <b>talked</b> 13:22 31:3 <b>talking</b> 97:21 <b>tasks</b> 95:6 <b>technical</b> 77:15 <b>Temporary</b> 55:2, 7, 14 56:10 85:25 <b>tend</b> 33:9 <b>tends</b> 8:10 <b>term</b> 22:6 32:17 35:15 36:9 <b>terminate</b> 69:8 <b>terminated</b> 67:23 <b>termination</b> 69:8 <b>terminology</b> 21:22 <b>terms</b> 21:21, 23 22:5 26:19 31:3 48:1 50:14 51:17, 20 60:10 63:16 68:21 73:8 74:15, 25 81:15, 21, 24 82:8, 10, 14 83:12, 18 84:20, 24 85:2, 8, 14 86:15</p>
--	---	---	--	---

87:23 89:19, 25 90:2, 12, 15 91:4, 9, 13 92:2, 6, 13 93:7, 22 94:8 95:10, 17 96:3 <b>Territories</b> 57:13 <b>territory</b> 57:2 <b>test</b> 17:14, 25 19:9 24:21 27:20 29:6, 23 38:18 39:11 43:25 48:14 66:11 <b>testing</b> 86:3 <b>tests</b> 39:2 43:20 <b>thanks</b> 31:20 71:17 87:22 <b>theory</b> 29:7 <b>thing</b> 6:22 18:15 41:7 87:8 88:21 <b>things</b> 11:11 21:15 25:22 26:2, 5 45:15 73:20 78:7, 23 80:8 82:20 83:14, 16 84:19 85:20 90:3 91:17, 19 94:2, 12, 19, 25 95:20, 25 96:1 <b>thinks</b> 28:20 <b>third</b> 4:6 10:1 <b>thought</b> 29:15 <b>three-part</b> 17:25 <b>tier</b> 52:8 <b>time</b> 6:14 34:15 42:4 46:4, 21 62:12 82:13 84:15 85:1, 8 90:17 92:21 98:24 100:8, 11 <b>timeline</b> 82:5 <b>times</b> 27:13 34:19 35:24 45:7 46:19 72:11 73:25 <b>timing</b> 97:17 <b>title</b> 35:8, 12 <b>today</b> 6:3, 10 7:2 94:18	<b>told</b> 15:6 <b>tools</b> 94:25 <b>top</b> 50:3 <b>topic</b> 62:14 <b>Toronto</b> 9:19 12:1 37:13 38:1, 3 <b>Toronto's</b> 19:4 54:11 <b>total</b> 47:1 <b>tracked</b> 60:18 <b>Training</b> 77:19 96:5 97:13, 18, 21, 22 <b>transcribed</b> 100:13 <b>transcribing</b> 5:23 <b>transcript</b> 100:16 <b>transfers</b> 85:22 <b>travel</b> 66:19 <b>treated</b> 22:15, 21 23:4 <b>treatment</b> 23:6 <b>trigger</b> 97:4 <b>triggering</b> 95:19 <b>trouble</b> 98:24 <b>true</b> 14:25 100:15 <b>trying</b> 44:7 75:17 79:23 <b>Tuberculosis</b> 22:12, 23, 24, 25 23:1 <b>turbines</b> 34:22, 23 <b>turn</b> 71:7, 12, 15 72:4 <b>two-thirds</b> 61:16 <b>type</b> 9:1, 6, 9, 16 10:1 40:24 47:8 <b>types</b> 8:25 10:8 14:25 23:10 25:19 92:11 <b>typically</b> 91:8  <b>&lt; U &gt;</b> <b>unable</b> 36:5 56:23 <b>unanimity</b> 63:9 <b>understand</b> 11:18 27:9	40:16 48:24 73:14 75:18 79:23 <b>understanding</b> 18:23 27:3 46:2 53:15, 25 <b>Unit</b> 9:5, 12 17:24 18:23, 25 19:2, 8, 12, 13 24:17, 24 29:1 37:12 38:15 40:9 42:13 61:11 <b>units</b> 8:16 11:25 12:5 27:25 38:17 47:22 83:4 <b>universal</b> 85:14 <b>university</b> 62:5 <b>unwilling</b> 38:2 <b>updated</b> 59:16 88:1 <b>updates</b> 74:19 91:22 97:5 <b>upper</b> 52:8 81:17 <b>urgent</b> 13:10 20:11  <b>&lt; V &gt;</b> <b>vacancy</b> 64:1, 5 <b>vacant</b> 36:8 <b>vacated</b> 13:2 <b>vacating</b> 12:8 <b>vacation</b> 36:5 <b>vaccine</b> 23:6 <b>vaccines</b> 58:5 <b>variation</b> 74:18 <b>variety</b> 4:19 92:12 93:22 <b>various</b> 8:3 10:9 11:14, 24 26:3 35:24 36:18 67:23 73:24 74:6, 22 78:2, 13, 20 79:2, 5 83:11 85:3 95:21 <b>vehicle</b> 73:22 97:3 <b>verbatim</b> 76:11 <b>VERITEXT</b> 100:23 <b>version</b> 82:1 84:6 87:25	88:13, 18 91:7, 10 94:6 <b>versions</b> 73:11 74:19 82:2 85:4 93:10 <b>versus</b> 81:17 90:5 92:15 <b>view</b> 5:17 18:13 19:2 34:10 <b>Villa</b> 37:24 38:2 <b>Virtually</b> 1:6 <b>virtue</b> 35:7 <b>virulent</b> 22:11, 12, 14 50:20, 25 <b>virus</b> 82:19, 20, 25 86:8 <b>viruses</b> 83:4 <b>visitor</b> 90:16 91:3 <b>visitors</b> 26:5 85:7, 9, 11, 15 90:20 91:5 <b>vote</b> 32:23 61:16 63:19  <b>&lt; W &gt;</b> <b>walk</b> 82:3 <b>wanted</b> 29:18 39:9 47:15 73:20 89:4 <b>wanting</b> 71:10 <b>Warshafsky</b> 2:4 71:21 <b>ways</b> 49:9 50:12 53:9, 17 <b>wear</b> 21:4 <b>wearing</b> 45:15 <b>webinar</b> 97:8 <b>website</b> 49:23 59:20 60:18 <b>week</b> 96:7 <b>weeks</b> 97:20 <b>Wellington</b> 21:1 <b>well-known</b> 46:3 <b>Williams</b> 31:24 32:4 33:16 35:14, 25 36:4 38:8 44:7 80:15, 23 81:5 <b>wind</b> 34:22, 23 <b>won't</b> 5:17 41:14 66:12 73:13 84:25	<b>work</b> 5:16 40:11, 16 53:12 84:21 86:12, 23 87:1, 17, 19 88:11, 14, 21, 24 89:21 96:11, 25 98:23 <b>worker</b> 45:19 <b>working</b> 78:24 84:2, 3, 9 87:7, 18 88:2, 10 96:19, 24 <b>workplace</b> 21:14 70:4 <b>works</b> 66:20 <b>write</b> 61:8 <b>writing</b> 13:11 17:10 20:4, 14 64:12 91:25 <b>wrong</b> 39:24  <b>&lt; Y &gt;</b> <b>yeah</b> 40:19 41:7 76:21 84:17 87:25 89:1, 8 91:9, 23 94:21 <b>year</b> 22:9 51:9, 16 66:15 70:11, 13, 14 <b>years</b> 28:8, 15 32:17 33:4 52:3 83:7 <b>Yup</b> 84:7  <b>&lt; Z &gt;</b> <b>Zoom</b> 1:6 <b>zoonotic</b> 11:17
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