Long Term Care Covid-19 Commission Mtg.

Meeting with Department of National Defence / Government of Canada
on Friday, October 16, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held Virtually via Zoom, with all participants attending remotely, on the 16th day of October, 2020, 10:00 a.m. to 12:27 p.m.

BEFORE:

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

PRESENTERS:

Brigadier-General Conrad Mialkowski, Commander
Joint Task Force Central, Department of National Defence

OBSERVERS:

Colonel Ryan Smith, Chief of Staff, 4 Division, Department of National Defence
Lieutenant Commander Robyn Barnet, Legal Advisor, Department of National Defence
Major Sonia Connock, Public Affairs Officer, Department of National Defence
Major Sasha Paul, Executive Assistant to Commander Mialkowski
Robert Abramowitz, Counsel, Department of Justice

PARTICIPANTS:

Alison Drummond, Assistant Deputy Minister, Long-Term Care Commission Secretariat
John Callaghan, Counsel, Long-Term Care Commission Secretariat
Derek Lett, Policy Director, Long-Term Care Commission Secretariat
Dawn Palin Rokosh, Director, Operations, Long-Term Care Commission Secretariat
Lynn Mahoney, Counsel, Long-Term Care Commission Secretariat
Jessica Franklin, Policy Lead of the Long-Term Care Commission

ALSO PRESENT:

Olivia Arnaud, Stenographer/Transcriptionist

-- Upon commencing at 9:59 a.m. --

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you for coming. We find ourselves in a funny sort of space as a Commission. So let me just sort of set the stage for you to start.

Typically, commissions are called into existence, as you probably know, after something has happened, and they look back at it, and they try to explain to people and the public, usually, what took place and why.

We're different because the pandemic is not over. And so we've been called into existence in the middle of something. So we've concluded amongst the three of us that we should try to make some -- we'll probably in the form of a letter, but a brief response and an immediate response to the Minister.

Typically, a commission in the traditional sense would investigate, hold hearings, write a report. This process can take a couple of years. That seemed to us to be rather secondary to try to lend our voice to some recommendations that hopefully are -- can be implemented more immediately. And whether we're the first to

articulate them or not doesn't really matter. Maybe just lending our voice to something somebody has said is helpful.

And so we would be -- apart from your experiences, any thoughts that you felt that you could properly share with us as to what could be done immediately, we would be more than willing to receive. I appreciate the nature of that in all of its ramifications, Brigadier, but I just thought I'd tell you where we're coming from.

We have a transcript; we have a reporter, and we have -- we will eventually, within a few days, put the transcript on our website.

So it's our attempt to try to make sure that people can follow what we're doing and to lend as much transparency to what we're doing, as we're able to, given the speed with which we would like to turn around some remarks, thoughts to the Minister.

So with that, the other thing I guess I'd tell you is I think we're here for a couple of -- I think it's 10 to 12, if I'm not mistaken. So we'll break any time around 11:15 or so, if you let me know in terms -- if you're speaking, where you find it convenient; if not, we'll just break

around then for ten minutes or so.

So with that, I guess, lengthy introduction, we're ready when you are.

BRIGADIER-GENERAL MIALKOWSKI: Well, thank you, sir. And if I could just perhaps kind of identify -- certainly on behalf of our Chief of the Defence Staff, General Jonathan Vance, and our Deputy Minister of the National Defence, Jody Thomas, thank you for the opportunity to come before your Commission and have an opportunity to give sort of a bit of an aperçu of what we were involved in for 67 days inside, you know, seven long-term care facilities within -- in essentially the Toronto Area, as a request of the Province of Ontario.

I would kind of state upfront that I am certainly more than capable of speaking to everything associated with the military support provided to both Ontario Health and Long-Term Care, but I am no means a medical expert. My background is sort of a very traditional sort of Army background in terms of I am the commander of what we term Joint Task Force Central.

And that body, just to provide a bit of background, is a domestic response body that is

comprised of the Canadian Armed Forces military units within the province of Ontario.

Typically in a day-to-day fashion, that is not my purview. My strict day-to-day job is to be the Commander of the 4th Canadian Division, or in essence, the Army units that are garrisoned and do activities within the province of Ontario.

But whenever we have a domestic operation within the province of Ontario, I put on a different hat and respond to a different chain of command -- and I'll explain a bit of that in the presentation -- and in so doing, take on additional responsibilities.

Primarily, they're a liaison with the Province of Ontario, and quite intuitively, it's command of those units that are apportioned to that activity by both the Chief of the Defence Staff in Ottawa as well as our Commander, Canadian Joint Operations Command, who is in fact the commander that I report to for any type of domestic operation.

And in order to kind of give a bit of perspective, my normal job as Commander, 4th Canadian Division, that's roughly 15,000 men and women and defence civilians across the entirety of

the province of Ontario.

But when it flips over to Joint Task Force Central, it is anyone within the confines of the province of Ontario, and that's roughly 40,000 folks. But just to put a bit of an expectation on 40,000 people, that's inclusive of other folks that are housed and garrisoned within Ontario to include the National Capital Region.

And I wouldn't make any sort of assumption that a number of those headquarters folks, some of them outrank me by considerable margin. I don't have, sort of, command authority over them other than sort of in terms of, like, a force protection type of idea.

Typically, what would happen is within that cadre of 40,000 people, we would generate specific capabilities and then apply that to whatever the request from the Province of Ontario. And that's what we did in this case.

And in fact, previous to that, in partnership with the Ministry of Health, we had also done Operation GLOBE, which was the assisted return of Canadians through Trenton and Cornwall, Ontario, as they returned from various cruise ships starting in February and ending sort of mid-March

to early April.

I would also like to just underscore, it terms of it's the intent obviously of General Vance and Deputy Minister Thomas that everyone in uniform as well as defence civilians give full coordination to your Commission. We certainly do so voluntary, and we welcome any opportunity.

And as I said, as I'm not a medical expert, I would certainly -- you know, within the purview of your Commission, if you feel through our exchange today that you would like to get some of our military medical expertise, they are certainly prepared and ready to come by at a future appearance, if that suits the sort of direction and the line of inquiry that you get from our exchange today.

And if it doesn't happen today, in the future, we're certainly standing by to have any type of response that we can come and appear before your Commission, and this also includes documentary evidence. Of course, we have this presentation, but we do also have a series of letter exchanges that were executed between ministers, as well as at the deputy minister level for the Province of Ontario and my office and a few of the staff

exchanges that kind of document this whole thing.

And I'm not sure if that's of particular value to the Commission, but we can certainly provide that to you.

What I would also just --

COMMISSIONER FRANK MARROCCO (CHAIR): Well, let me answer that --

BRIGADIER-GENERAL MIALKOWSKI: Yes, sir.

COMMISSIONER FRANK MARROCCO (CHAIR): -- before we go any further. All of that, the documents and experts, will be particularly helpful to us as time goes on, and we will certainly take the Canadian Forces up on the offer that you've made. And we really do appreciate it. It will be a big help to us.

And the other thing: I'm calling you "Brigadier." What's the appropriate way for me to refer to you?

BRIGADIER-GENERAL MIALKOWSKI: So, sir, that's appropriate. You can call me "Brigadier," "Brigadier-General." Colloquially, we can be addressed as "General," although if you would, I'm kind of the lowest grade of general out there, and when you address "General," it's usually sort of

the top grade of general. But sort of in informal means, we're all sort of just described as "General."

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

BRIGADIER-GENERAL MIALKOWSKI: Brigadier is from our British tradition, although it is less and less used today, but I am certainly open to that, sir.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Well, then, Brigadier, the only other thing I would say is we've tended to ask questions as we go along rather than trying to go back, so if you don't mind, if we interrupt from time to time with a question, that would facilitate us in making sure we understand what you're saying.

BRIGADIER-GENERAL MIALKOWSKI: That's absolutely perfect, sir. It also gives me a chance to catch my breath, to be quite honest. And I do apologize. I tend to offer a lot in sort of single sentences, so please bear with me in my presentation style.

One other thing that I would like to just comment on before getting into the presentation, if I could, is to give you visibility

on a couple of other activities that are proceeding on the federal level that are similar in nature but obviously not with the same terms of reference of your Commission.

And the first one is the House Standing Committee on Health, which is a House of Commons committee, Parliamentary committee. Before prorogation, it had passed a motion to produce papers, and in that motion to produce papers, it was requesting, among others, the Department of National Defence and Canadian Armed Forces to provide documents that were relevant to the employment of Canadian Armed Forces within long-term care homes in Ontario.

We conducted that even with prorogation, which meant that that motion died on committee floor. Since that time, the committee has reconvened. Last Friday, it passed that motion once again to provide -- or to have those documents furnished to the committee, and we expect in the next week or two the committee will make that request of the Department of National Defence.

That body of documents is roughly 14,000 pages, and obviously, when it goes towards the House Standing Committee on Health, when the

Secretariat and that committee reviews those documents, they will then post that on the Parliamentary website, so that it will have public access, and I expect the window for that would be probably within about two weeks, although, of course, that is moderated by the activity of that committee. That's sort of the first committee.

The second committee is one we're more familiar with in uniform, and that is the Standing Committee on National Defence, and that committee has indicated that it too is interested in the Canadian Armed Forces employment in long-term care facilities in Ontario.

And while we haven't seen any motions come from it yet, we believe that we will see appearances by a number of folks in uniform on the same sort of activities. And I just raise this so you have an understanding of some of the other sort of parallel activities.

Obviously, different focus in terms of those Parliamentary committees and your Commission. But there may be opportunities where some of that documentation may be of value to your Commission.

COMMISSIONER FRANK MARROCCO (CHAIR): So the 14,000 documents that are going to go, you

expect, all things follow along the way they normally do, be available within a couple of weeks, if I understood you correctly, we would be able, then, to simply access those online?

BRIGADIER-GENERAL MIALKOWSKI: That would be one possible venue. The other one is we could certainly provide you the same body of documentation, I believe.

The issue with that may be a question of volume, but I leave that to your decision-making and, of course, the Secretariat's capabilities to support you in reviewing such documentation.

It will encompass everything from sort of strategic-level exchanges of letters down to the email exchanges of people working inside the facilities as part of their sort of daily interactions. So it's a large body of documentation.

COMMISSIONER FRANK MARROCCO (CHAIR): We have electronic document management capability, and so, then, assuming that you have permission to provide them, we would be interested in receiving them. And we will make arrangements through the executive director and through our counsel to find a convenient way for that to happen, if that seems

reasonable to you.

BRIGADIER-GENERAL MIALKOWSKI: It certainly does, sir, and we'll -- I'll definitely make note of that, and perhaps at the back end of our interaction today, just make sure I recap some of these items that we kind of take on notice, if you will, for further action.

COMMISSIONER FRANK MARROCCO (CHAIR): That's good for both of us, for all of us, I think.

BRIGADIER-GENERAL MIALKOWSKI: Yes, sir. So I'm prepared to get into the presentation, and as you recommend, certainly, just use as a framework for discussion and an opportunity to provide a bit of a structure to the conversation.

And, of course, I'm prepared to go in any direction that interests any of you at any time.

COMMISSIONER FRANK MARROCCO (CHAIR): Well, we're ready to go, and it seems on my second screen here, I have the presentation, I think. So I don't know if I do, but we're ready, anyway.

BRIGADIER-GENERAL MIALKOWSKI: Okay, okay. The title slide says "Support to Ontario Long-Term Care" --

COMMISSIONER FRANK MARROCCO (CHAIR): I

have it. We have it.

BRIGADIER-GENERAL MIALKOWSKI: Okay. Perfect. So I'll go to the first slide after the title slide. It's just the agenda. And I realize, in some ways, part of the process here is to provide a bit of a milestone in appearing before committee.

So we structured this with that in mind to not only be the basis of our discussion but, equally, be a marker for the public to be able to see what it was that was presented to you this morning.

So in essence, that is just the flow of what we're looking at, with a focus on what I understood to be how was it that the Canadian Armed Forces got to be employed within the long-term care homes, what did you observe, and the manner in which we withdrew.

And drawing from that, perhaps we can explore some of the other aspects of what the Commission is interested in, particularly in our employment.

We'll just go to the next slide, title, "Military Support to Provincial Response for Long-Term Care Facilities."

So in this one, I would just like to point out, starting with the sort of first point, the Joint Task Force Central, that organization, responsible through me, we collaborated with the Ministry of Long-Term Care in partnership with the Ministry of Health and Ontario Health to provide that temporary support at long-term care homes facing this unprecedented challenge from COVID-19.

And the Canadian Armed Forces members, we worked collaboratively with civilian partners, helping to stabilize the situation. The key part there is that collaboration, and we were always in a supporting fashion present because of a request from the Province of Ontario.

That assistance was unique to our domestic operations history and demonstrated our own agility how to face this challenge, i.e., Canadians, and really, part of the key to success that we feel was we come as a discipline force again any problem set that we approach, whether it's here in Canada or abroad, which allows us to adapt to the nature of the challenge that was presented to us.

And in this particular case, we felt that that was one of the defining features of our

support to the Province of Ontario during our employment earlier this year.

So we worked in concert with the frontline healthcare workers, and they were key to the stabilization in the long-term care facilities. It wasn't solely Canadian Armed Forces personnel.

We were sort of an added value to the homes we were applied, because of course, across the hundreds of long-term care facilities and, at times, up to 200 in the province of Ontario that were in, you know, a crisis mode during this period of time, I would underscore that we were only in five homes, present in the total of seven, but at any one time in five homes.

And that is, you know, by comparative value, a small percentage of the total problem that Ontario faced and overcame at the time.

And, again, the value of our ability to rapidly deploy and be employed is because we have a long-standing, professional working relationship with key partners in the Province of Ontario in their Emergency Management structure.

And we're, of course, that agile and adaptable force that can kind of be tailored to be able to respond to the demands of the Province.

While all this of course happened earlier in the year, we remained committed to being in a high-readiness state to be ready to provide to provincial partners.

And typically, that type of domestic response capability, we normally line up against problems to include forest fires, floodings, Ground Search and Rescue in isolated communities, particularly with our Canadian Ranger presence in northern, isolated communities who, you know, assist with the Ground Search and Rescue presence, and then some of these unusual sets like going into long-term care facilities.

The other part about putting as -- Canadian citizens into quarantine in advance of the large, sort of, covert outbreak that we went through earlier in the year.

And then of course, just to give that other perspective, as I mentioned earlier about my duties as Joint Task Force Central, we have six regions across the country. Central is focused in Ontario. So in your particular review and study, I'm the one military commander that is responsible to the Commission to be able to talk. There is no sort of subdivision within Ontario where there

would be other regional commanders.

And as I mentioned, that role really extends to sort of the command and control forces, the apportionment of forces. Any of the technical medical aspects would be best served by other appearances by some of our military medical expertise.

And when we get further into the presentation, perhaps I will offer a couple of recommendations that could assist in narrowing the scope as to who I think would be perfect to come before the Commission and provide an appearance.

That's the first slide. Any questions that stem from this particular slide?

COMMISSIONER FRANK MARROCCO (CHAIR): Well, just one or two occur to me.

The long-standing -- there's obviously a relationship between the commander and the forces that are in Ontario and the Provincial Government, based on what I'm seeing here.

Through what ministry, is it the Solicitor General?

BRIGADIER-GENERAL MIALKOWSKI: It is under the Solicitor General for Ontario, sir. And further on in the presentation, I have a graphic

slide, which I can explain. It's sort of a simplified framework, and it marries up sort of on the levels of authority and how the request will flow, both typically, and then I'll explain it with a timeline as to how we got engaged in the long-term care facilities back earlier in the spring.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

BRIGADIER-GENERAL MIALKOWSKI: But to sort of answer more directly: So my connection is with the Deputy Solicitor General for Ontario, Mr. Mario Di Tommaso. We have regular communications whenever there's any type of request for assistance, like, expectation in the Province.

But the more nuts and bolts of it occur at the Provincial Emergency Operations Centre, which is under the Office of the Fire Marshal, which of course still is under the purview of the Solicitor General for Ontario.

And we have a liaison officer who is part of that body, and we have daily communications with our regional Joint Operations Centre, and that Provincial Emergency Operations Centre.

It expanded during COVID to also

include a special emergency -- a COVID emergency response that the Province put together, and so we not only had the Provincial Emergency Ops Centre we could deal with, but we also had other provincial officials uniquely responsible to COVID, and we established point-to-point communications throughout our employment in the long-term care facilities with those officials.

At present, we're no longer active on a daily basis with them because, of course, we're not directly supporting the Province, but those communications and lines of communications can be re-established instantaneously if required.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. The other question I had was really a bit more general on that. But when did Canadian Forces, when did it occur to everybody that there might a problem with this COVID in Ontario or in Canada, but since you're responsible for Ontario, in Ontario? What would be -- in your mind, when did the light go on?

BRIGADIER-GENERAL MIALKOWSKI: Yeah, so I can certainly provide and have a timeline a little further on in the presentation where I started getting not only communications with

Mr. Di Tommaso but also the Deputy Minister for Long-Term Care, Mr. Richard Steele. That was a number of days prior to, but we had been following along for a number of weeks with the Provincial Emergency Ops Centre.

Part of it was due in no small part because we had conducted that return of Canadians from six different cruise ships, and they started in early February in Trenton, Ontario, and then we expanded from Trenton to also include Cornwall, Ontario, and that really set the framework for that sort of intimate communications, and at times, daily communications.

So typically, at my level, we sort of formalized it about once every week or so, but there was certainly daily activity at the staff level with my Regional Joint Operations Team and the Provincial Emergency Ops Centre, as well as then reaching across to Ontario Health.

The reason for that: While the whole operation to bring those Canadians back to Canada starting in early February, while that was a federal activity because it was under the auspices of the Public Health Agency of Canada, and they were in the lead, and in fact, the Canadian Armed

Forces was supporting the Public Health Agency of Canada, because the activity took place in Ontario, naturally, we required a very strong connection to the Province of Ontario because we relied on local health officials, both in the Hastings and Prince Edward County and public health unit, but also in the Stormont-Dundas-Glengarry County in Eastern Ontario health unit to support both of those locations.

And also, we had the assistance of Ontario Health providing a temporary medical facility at Canadian Forces Base Trenton to be able to provide sort of frontline healthcare for any of the residents that we held in quarantine for that 14-day period because the Public Health Agency of Canada doesn't have the sort of healthcare workers; it's the Province that holds that residential expertise.1

And so from February on, we were very closely aligned and continued to watch the problem alongside the Province.

So as we started to see the slow sort of incline of cases collectively with the Province, we started to understand that there could be a request for assistance. That started, I'm going to

say, at the final week of March. We certainly were watching it together, and of course, a month later would be the time that we went in. Our first employment started on the 24th of April.

So for the period of about a month, we were watching sort of in various ways how the transmission and infection rate was starting to increase and, you know, whether or not that would be the initiation for a request for assistance from the Province of Ontario.

Did that answer the question, sir?

COMMISSIONER FRANK MARROCCO (CHAIR): It did, thank you. Yes. And I don't have any further questions.

Commissioner Coke, Commissioner Kitts?

No, I think we're good to go, Brigadier.

BRIGADIER-GENERAL MIALKOWSKI: Okay. I'll just go on to the next slide, which is a visual representation of that sort of framework for Canadian Armed Forces support. I know I said simplified, but there seems to be an awful lot of graphic on there.

And, you know, as you expect, the military, we not only like our acronyms, but we

certainly like our, sort of, boxes and wiring diagrams.

I'll give, perhaps, a quick orientation to the slide and then get into the explanation of it.

So if we start from left to right, all those boxes in green represent the Department of National Defence and the Canadian Armed Forces.

In the centre, where it should be because it's about supporting the Province, all the boxes in blue are about the Province. And then on the right is the federal Public Safety, so the Department of Public Safety in Ottawa.

And the reason for that is by act of parliament, any employment of the Canadian Armed Forces flow -- when it comes from a provincial body, and this is true across the country, flows through the Minister of Public Safety and Emergency Preparedness.

And that is the mechanism by which Provinces request federal support writ large, and then at the federal level, between those ministers and deputy ministers, they then apportion what federal department will service the request of the Province of Ontario.

Where we start in this chart is in the blue column with the Provincial Emergency Operations Centre. There's a box there under The Deputy Solicitor General. And the reason for everything to start there is the Provincial Emergency Operations Centre is, in fact, the focal point for any type of federal assistance to the Province of Ontario.

Inside that Provincial Emergency Operations Centre are linkages to a regional Public Safety director. And so if you look in that Provincial Emergency Operations Centre box, and if you flow all the way across to the red box, you will see that Public Safety regional office.

And so it is through Public Safety that any of these requests flow, although, that's sort of the nuts and bolts of it from how the sort of officials, both provincial and federal, put it together because there's always a flow from minister to minister, which is a natural course, and that's through an exchange of letters.

So that PEOC there, in a normal case, would deal with any type of Canadian Armed Forces activity in the province of Ontario; however, because this was a specialized request outside the

norm, it wasn't about floods and fires, which we're very well attuned to. It wasn't about isolated community evacuations, which we do, you know, during threats, natural disaster, forest fires in the north. It wasn't about a more routine ground search and rescue that we conduct.

Because it was a very specific request, we then have this other set of blue boxes in between that Provincial Emergency Ops Centre and regional office from Public Safety, that was this Incident Management System for COVID response.

That was a unique body put together under co-chairing by the Minister of Long-Term Care -- or sorry, Deputy Minister of Long-Term Care, Mr. Richard Steele, and the Deputy Minister of Health, Ms. Helen Angus. And I'm sure that those two officials have probably given you this understanding about the Incident Management System, or the IMS, for COVID response.

That became the provincial official level, sort of, clearing house for all types of activities, and it also coordinated the response through the various public health units across Ontario; in particular for us, you know, the public health units and the public health network that

covered Toronto and the long-term care facilities in Toronto, which is where we were employed.

So that body actually was the one that was providing all of the detailed information to the Provincial Emergency Operations Centre because it was beyond the capability of the PEOC or the Emergency Operations Centre. It was non-standard to them. It was beyond their, sort of, regular type of watch.

And that Incident Management System was the means by which they were able to assign priority to to watch the trend analysis and to develop the plan as to how to deal with the crisis inside those long-term care homes throughout the spring and summer.

I'll pause there in case there are any questions sort of about that, like, official level, and by "officials," I mean, you know, sort of the desk officers and staff officers both from the Province in terms of this Incident Management System put together by not only provincial officials, but they also had public health experts as part of that Incident Management System from various public health networks that were advising that expertise, and then the sort of standard setup

between the Provincial Emergency Ops Centre and Public Safety at that level.

COMMISSIONER FRANK MARROCCO (CHAIR): The Incident Management System was in place, I take it, when you were -- when the first request came through. This system was -- this was how they were dealing with the response?

BRIGADIER-GENERAL MIALKOWSKI: That is correct. When we went with the request for assistance to go into the long-term care facilities, this system as described on this slide and depicted was absolutely in place. That Incident Management System was up and running and was being co-chaired by the two deputy ministers. That is correct.

And I mean, part of the body that met with that Incident Management System, to my understanding, again, like, we physically couldn't go there because it -- even today, we wouldn't due to COVID, but we had a series of calls not only at my level, but as you can well-imagine, at the sort of desk officer, working official level.

There were experts that advised this panel; for example, at times, Dr. David Williams, the Chief Medical Officer for Ontario would be an

advisor for this panel.

But their main sort of medical advisor was Dr. -- and I'm sorry, his name escapes me, but he is the president of the Health Sciences Network -- sorry, health sciences -- yeah, Health Sciences Network here in Toronto. Sorry, the University Health Sciences. So the head of, you know, Canada's largest hospital health network here in Toronto was this sort of medical expert or chief advisor in terms of that piece for that Incident Management System.

So they really created a bespoke and very active body. Again, our interface with it was through certain officials as part of that, and we were not engaged in the daily activities or operations of that Incident Management System, but it was the brain through which our ideas were sort of sifted, and then decisions would come out of that body which helped respond and frame how our response was going to be conducted.

So in terms of any sort of formal request for assistance, with the addition of this sort of co-chair by the two deputy ministers and the Incident Management System, everything else flowed as it will for any other request for

assistance by the Province of Ontario to the Federal Government.

So, again, back in the Provincial Emergency Operations Centre, in concert -- because the arrows go left and right -- on the green side, that's just a graphic sort of expression of the authorities and the chain of command on this particular problem set that we faced when we went into the long-term care facilities.

And I'll just maybe quickly speak to the green side. So obviously, under the Minister of National Defence, we've got the Chief of the Defence Staff, and of course, the Chief of the Defence Staff is also sort of with the deputy minister of the provincial ministries and our own Deputy Minister of Defence, kind of co-equals there. But for the purposes here, we're just depicting sort of the working relationships.

Because while, for example, the Deputy Ministers of Health or Long-Term Care or the Deputy Sol. Gen. can easily pick up the phone and speak to the Chief of the Defence Staff, they would pick up the phone and talk to me first because I'm sort of the principal connection at their level.

And for unique calls, they would pick

up the phone and speak to the Deputy Minister of National Defence and our Chief of the Defence Staff.

Proceeding down that green block after Minister and Chief of the Defence Staff is the Canadian Joint Operations Command, and as I mentioned, that commander is responsible for all Canadian Forces operations around the globe, whether here in Canada, whether it's continental, like under NORAD, or whether it's an international operation. That individual has command of all of that activity.

We have a Task Force LASER. So just to provide you the -- the name LASER is actually assigned to a military contingency plan for a pandemic response.

And when the military looks at a problem, typically in advance, we will try to take the problem apart and look at the contingent pieces that will pose, like, military risk or potentially public risk.

And so a number of years ago, we unpacked the look at pandemic response in Canada; that was LASER, and then we also looked at pandemic response around the globe, and that one was called

VIRUS.

Early on in March, when the Chief of the Defence Staff declared Operation LASER 20-01, which is simply the date assigned to the operation -- and this particular operation, we're still in it today; we're still operating under Op LASER 20-01 -- he decreed because of the pandemic and it would affect the globe, we would ascribe everything to pandemic response.

Whether it was domestic to Canada under LASER or around the world under VIRUS, we would simply call it Operation LASER because the pandemic was going to travel around the globe, and we couldn't simply sever the problem in two.

And so Task Force LASER uniquely looked at the Canadian domestic response. And that --

COMMISSIONER FRANK MARROCCO (CHAIR): If I can interrupt you for a minute?

BRIGADIER-GENERAL MIALKOWSKI: Yes, sir.

COMMISSIONER FRANK MARROCCO (CHAIR): So 20-01, so that's January 20th?

BRIGADIER-GENERAL MIALKOWSKI: No, sir, it's -- the "20" just is simply the year. So 2020, the year we're in, and "01" is just the sequential

numbering of the operation from when it starts.

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, okay.

BRIGADIER-GENERAL MIALKOWSKI: Yeah, I'm sorry for not explaining that.

COMMISSIONER FRANK MARROCCO (CHAIR): No, that's fine. That's fine. I understand.

BRIGADIER-GENERAL MIALKOWSKI: So we could have -- potentially, you know, after the first wave of COVID and after the Canadian Armed Forces was no longer conducting operations inside the long-term care facilities, we could have potentially ceased that operation and then stood up the next Operation LASER, but it didn't make sense because it changed from pandemic planning to response in Ontario and Québec and still planning across the rest of the country.

And then we came out of Ontario and Québec in terms of a presence, and that planning still continues. So at that time it was determined we would simply keep it as Operation LASER, 20-01 throughout.

Under that Commander Task Force LASER, and that commander actually is in Kingston and has a headquarters there known as the 1st Canadian

Division, then I fell under that commander as the Commander Joint Task Force Central here in Toronto and was responsive to that Commander Task Force LASER throughout.

But to make it even more difficult, we stood down Task Force LASER around the same time as our initial report came out because it had been imagined that the response of the Canadian Forces would have been from coast to coast to coast and would have required a degree of, sort of, fidelity that did not materialize because we were able to manage in time the response here in Ontario and the response in Québec singly at my and my counterpart in Québec's level, and then we could report back to the Canadian Joint Operations Command.

So we removed that layer in mid-May. It stood down and was then no longer part of this activity.

And again, my connection from Commander Joint Task Force Central box, you know, goes across to Mr. Di Tommaso, the Deputy Sol. Gen., to Mr. Richard Steele, the Deputy Minister of Long-Term Care, and to Ms. Helen Angus, the Deputy Minister of Health.

So that's the kind of connectivity

there at our level when we would have those sort of interactions when required.

Typically, interactions on a formal level were through letter exchange, and we have a series of letter exchanges which document the extension of the request for assistance because, as I'll show you on the timeline slide coming up shortly, the initial request for assistance specified a period of no less than 14 and no more than 30 days.

We were in Ontario long-term care facilities for 67 days, so there were a period of renewal and extension approved by the Minister of National Defence and through the formal process by the Deputy Solicitor General and the Government Operations Centre advising the Minister. And I'll get into that sort of structure momentarily. But that -- those formal exchanges document that.

It also documents our shared understanding when it was time to withdraw from a home and put a team into another home. We were limited to only five homes. Part of that limitation was due to the capacity of the Canadian Armed Forces to support this request, as well as the request that was going on in Québec, and still

maintain our military public health system, both in Canada as well as to our deployed missions abroad.

And so that -- because there was five, and we went to five initial facilities and then withdrew over time and then went into two others, it kind of was -- we officially managed that through a formal letter exchange, again, between myself and the Deputy Solicitor General, enabled by everyone starting from that Incident Management System and the operations team and the Provincial Operations Centre and that line that goes through the Public Safety regional office.

That was an -- like an all-informed network of those provincial and federal and military officials that reviewed the status in each of those homes and agreed to a series of conditions, and I'll get to them later in the presentation, that would describe stability and looked to re-deploy our teams to other facilities.

And then just continuing on that left-hand side, I'm going to pause for a second, how I executed this activity inside of Ontario: We established an operational unit we call Territorial Battle Group 1. That group of people were Canadian Armed Forces, Army Reservists from across Ontario,

who we had activated because we believe that the capacity for military response would require additional people in uniform to be ready.

So to give you a little bit of a sense, normally, I keep a unit of approximately, sort of, 2- to 400 people on a high-readiness standby every day to be able to respond in Ontario, and they are able to respond on, sort of, a 12 to 24-hour basis, and that could be for any sort of provincial contingency.

Typically, it would be for forest fires and flooding or anything that would be beyond the capacity of the Province of Ontario. And of course, it would need to go through the approval process, which I'll use our example to describe that in a little bit greater detail.

But we do keep those folks on a high-readiness standby.

Under Operation LASER, we increased that level to having two units of that size, and then we also had a number of other units that were put on even higher degrees of standby.

At one time, we had about 24,000 people across the country who would have been able to deploy within, sort of, 24 hours to 5 days to be

able to accommodate the various requests of the Province. We thank heavens we never got there because, you know, that would have been indicative of a much greater problem than what we collectively dealt with in the spring.

But we didn't really understand COVID collectively as a country at that time, and so to be prepared, Chief of the Defence Staff, through my commander at the Canadian Joint Operations Command, created this structure to be able to respond in those six different Joint Task Force areas across the country with that force of 24,000.

And it wouldn't matter where in Canada. We had the capability to move those capabilities around the countryside if it exceeded the capacity. Say, in Ontario, if I didn't have what I needed, I could rely on other areas to provide that capability to me.

And, in fact, that's what occurred in this particular example here in Ontario and also in Québec because I typically do not have military medical resources, sort of, under my finger 24 and 7.

They're owned by other commanders, and they're responsive to those needs, not only from a

clinical level across our bases and garrisons and wings, you know, in the idea of a medical facility that treats people much like a public health facility, like a hospital, but also the deployable medical capability.

Day-to-day, I don't own that, but for this particular piece, both myself and my colleague in Québec, we were reinforced with medical teams from around Canada to be able to deal with this situation.

And that's why we nested all of that under this unit Territorial Battle Group 1, which took on military medical professionals and was the body of a number of Army Reservists from across Ontario, the framework of which was based on the Army Reservists out of Toronto, because we anticipated that we would have activity in Toronto, and it made sense that we would use people with a local knowledge as opposed to me brining a unit from another part of Ontario down to Toronto where they may not understand -- you know, just getting around in the city can be something.

So that's why we specifically created this unit. We built it early. We put it in Canadian Forces Base Borden. We kept it isolated

so that it would be excluded from any transmission or infection and protected there in a -- like, not on the base but out in a training area of the base in a cadet camp to prevent any type of infection getting to that unit.

And within that unit, we then built these Augmented Civilian Care Teams, and those were the teams that actually went into the homes and were there to reinforce both the, sort of, long-term care support and medical support in the homes.

And they were the teams that -- with medical expertise and assisted by what we call general duty support or just military members who could do jobs like portering, delivering food, to do, you know, housekeeping, all those sorts of things. That's how we, you know, created sort of a bespoke solution to go into a -- like, a non-standard task like going into long-term care.

I'll pause there with a view to sort of explaining then the authorities flow as to how we got in there.

COMMISSIONER FRANK MARROCCO (CHAIR): I think we're good as far as questions are concerned, so when you're ready to continue, we're ready.

BRIGADIER-GENERAL MIALKOWSKI: Certainly, certainly. So in any type of request for assistance, as you'd expect, there's a bunch of parallel activities. And for Ontario, there's parallel activities that will happen here in Toronto obviously with provincial officials, and there are parallel activities that happen in Ottawa with federal officials.

In each and every case, the Canadian Armed Forces, if it's going to be something that relies on Armed Forces, we'll be involved, but not every request for assistance from the Province of Ontario requires the Canadian Armed Forces to participate. There can be other federal departments that help out in a non-standard or non, sort of, Memorandum of Understanding way to achieve something.

I mention Memorandum of Understanding because there are standing Memorandum of Understandings between the Canadian Armed Forces and specific law enforcement capabilities where we have, like, standing agreements that do not need to go through this particular activity, because as you can expect with the graphic chart, there are many steps to proceed through here, all of them that

need to be done because they're part of the sort of acts and legislation that govern Canadian Armed Forces employment in Canada.

And also need to satisfy -- when we come in support of a province or Ontario and Canada, we need to make sure we're satisfying not only the provincial legislation that governs our -- you know, that particular activity that we're going to assist, but also the federal statutes that govern federal activities in that domain.

So that is in no small part why there is this system, and that is enshrined in practice inside the Federal Government with use of the framework of Public Safety on the right-hand side which has a regional office, and in our case is here in Toronto, the Government Operations Centre in Ottawa, and of course the Office of the Minister of Public Safety.

And that request, as it happened for this particular one, the genesis of it was created inside the PEOC, but it was fed by the Incident Management System. And our awareness both of the Joint Task Force Central and the Public Safety regional office, we collectively created the request for assistance to make sure it would not

only map towards military capabilities but also fit within all of the sort of framework of those legal statutes.

It's all compiled under the purview of the Deputy Solicitor General, who then provides that to the Solicitor General for Ontario. And so she then caused a letter to flow across at her level to Minister Blair, the Minister of Public Safety and Emergency Preparedness, who then, you know, with the team, and for COVID, there was a special deputy minister-level team created in Ottawa not reflected on this side that looked at how federal capability would be apportioned across the spectrum of requests.

And from there, the request flowed over to Minister Sajjan, the Minister of National Defence, who accepted the request for assistance, sent that response back to the Minister of Public Safety and Emergency Preparedness, where it flowed back to the Solicitor General for Ontario, and then from her down to the Deputy Sol. Gen.

And that kind of completed the flow of the request, and from the request, that gave us the authority to then go and be employed within the long-term care facilities.

As you'd expect, there were like a series of sort of -- not limitations, but there were parameters in that letter exchange. There's parameters of time expressed. There's parameters of what type of activity, and I will -- I'll get into that detail further on in the presentation.

But that provides sort of not only the flow of requests for assistance and the communication flow between the various bodies, but hopefully, as the title said, gives a simplified sort of view of how CAF support is managed traditionally and how it was managed in the case of our employment in long-term care facilities and your particular focus on our employment and how we got in there.

And I'll pause now for the questions.

COMMISSIONER FRANK MARROCCO (CHAIR): Oh, yes, Commissioner Kitts?

COMMISSIONER JACK KITTS: This is a really great illustration of how leadership, accountability, information flow, authority was created and obviously worked very well. It's a governance chart, if you will.

Will you be giving us something similar on management structure in the homes and how

leadership and accountability and alignment and authority was established there as well?

BRIGADIER-GENERAL MIALKOWSKI: I do not have a visual representation, and honestly, that one might be a good one for a future appearance by a military medical expert.

In particular, when we talk not only about, sort of, standard of practice and quality of care, which I am -- I can speak on in very generic terms, but, I mean, I don't answer to a college; I don't answer to an association.

And there's sort of that dual responsibility for our medical folks in uniform because there's the responsibility, of course, given their profession -- nurses and doctors belong to a college -- and our medical technicians also have a sort of professional responsibility. It's not as formal as a college, and some of them belong to associations, but they still hold that same professional responsibility as, you know, a medical practitioner in Canada.

And then, there is, of course, the military responsibility, and we hold people accountable for their actions, for their reporting, and we also hold them sort of accountable for a

bias of action to do something when they see something that shouldn't be done, they need to correct it and make sure that the means of correcting it are available and understood and then implemented.

COMMISSIONER JACK KITTS: Exactly. So I think I speak for the other Commissioners when I say, we would be interested in understanding how the crisis was managed once the military arrived in the homes.

BRIGADIER-GENERAL MIALKOWSKI: Understood, sir. So I've got a bit of detail on that, which I'll explain as I get to, and that might satisfy your initial sort of inquiry, but it probably speaks to the desirability to have someone who can answer in detail that degree of information in terms of how specifically inside the homes.

And we have an individual who can absolutely address that. She would be one of my, sort of, recommended folks to come to the appearance.

So on that chart in the bottom-left corner, that Augmented Civilian Care Teams, that team was commanded by a senior nursing officer, a major, and she was responsible to that commanding

officer of Territorial Battle Group 1 for all of the medical activities, and in fact, all activities inside the long-term care facilities because we put everyone under, like, a medical practitioner.

And a senior nursing officer in military terms was the most obvious choice because the nursing officers understand -- well, we didn't fully understand, sort of, resident care in a long-term care setting because that's not our forte, but they certainly, nursing officers, understand how to, you know, treat patients on a ward and the system of maintaining sort of a 24/7 presence within a medical setting.

And they also have those authorities and obligations entrusted to them to be able to administer to patients. Now, not all residents are patients, of course, but there was a certain degree of concurrency there in terms of putting that up.

So there was, you know, a sort of mid-level military leader in the form of a major, a commissioned officer, and underneath her in those teams, she had a team senior nursing officer, like a junior officer, and there were two nurses inside of each team so that they could manage a 24/7 or at least an expanded footprint. And they were the

ones who then had responsibility for each of the home.

So a junior nursing officer and a senior nursing officer assigned to each home and then given medical technicians who could do, you know, all of that sort of ward and resident medical support.

And then we also had other folks, just regular military members with no specific medical training, but certainly, you know, part of formed units and capable of taking direction and doing activities, and they provided all that support activity that goes on inside a ward or resident setting to make sure that patients or residents are sustained with the necessities of life.

COMMISSIONER JACK KITTS: Thank you very much. That's very helpful. Thank you.

BRIGADIER-GENERAL MIALKOWSKI: So I'm certainly taking note that that -- that particular individual, and her name is Major Karoline -- of course, Conrad, I'll get you her name.

COMMISSIONER FRANK MARROCCO (CHAIR): I'm glad I'm not the only person to whom that happens to.

BRIGADIER-GENERAL MIALKOWSKI:

Absolutely. She commanded that team, and she, I think, would be useful. And the other -- perhaps they could co-share or co-appear before you -- would be a doctor in Ottawa who was responsible at the level of our Directorate of Health Services Operations, and that's a senior officer physician, and that particular physician is responsible for all operational health issues and the sort of deployment of any medical support, be it in Canada or otherwise, and their area of expertise is exactly in doing operational medicine.

Typically, again, it's for us in uniform in places around the world, under sort of different circumstances than downtown Toronto, but at the same time, that physician has the same scope of duties in terms of making sure that all the levels of medical support, you know, that need to respect colleges and associations and interface with hospitals, because we have military members deployed around the countryside that do resident activities and are also specialists inside of hospitals to keep their skills high.

Like, that individual knows all that framework and more, and I would suggest that those two individuals come before you.

And I do now recall, it's Major Karoline Martin, M-A-R-T-I-N. And the Colonel in Ottawa -- he's moved on, but would absolutely be available to you -- is a fellow by the name of Colonel McGregor.

And those two individuals were instrumental. And the other thing -- so Major Martin, she's great because she can explain what the teams did in terms of daily activity, how they responded to incidents within those facilities because she was part of the command structure over top of those five facilities day-to-day and their daily activities and their daily reporting back to her.

And she was instrumental in harnessing the understanding and the information that we then turned into our formal report, which I provided up the military chain of command on the 14th of May, and then which I was authorized to share with the Province and did so on the 24th of May.

And that was sort of the -- you know, also both the Premier of Ontario and the Prime Minister released that publicly on the 25th of May, the Monday, that report and spoke to it.

So she is great, and the other

individual, Colonel Scott McGregor -- wait, no, I'm confusing -- I'll get his name -- is also great because the two of them can give that understanding of what went on in Ontario.

But the colonel also was managing the same thing going on in Québec and has a much better understanding of that from a medical perspective, and how it was delivered -- again, I can describe in the same manner I spoke to you here how from an overall military perspective things took place in Québec, and we actually patterned ourselves and developed off of each other as to how to respond.

So it was a very common approach in both provinces, partly, not to confuse ourselves because we were, again, doing something completely unconventional in terms of putting military people into a long-term care facility. Like, I never imagined, you know, in my career going to the recruiting centre that I'd ever do anything like that and certainly had no exposure to that until this point.

But more importantly, they also were able to make sure that they respected those military medical expectations, not only from colleges and associations, but uniquely to that

particular province because our military folks may belong, you know, to the college of physicians in one province but do military practice in Canada elsewhere or abroad. Like, these folks were the experts in understanding what were those -- what was the standard expected in the province.

And so I think the both of them reporting and appearing to you in the future would be ideal.

COMMISSIONER JACK KITTS: I agree. Thank you very much for that excellent explanation. Much appreciated.

BRIGADIER-GENERAL MIALKOWSKI: Okay. I would move on to the next slide, but if there's any other questions stemming from, sort of, this degree of -- this framework of not only how we entered the homes in support of the Province of Ontario, but also, you know, continued to have the face-to-face, daily, weekly, and formal interactions were all patterned after this sort of overall structure.

And, again, less that particular piece about the Incident Management System for COVID in the centre and the two deputy ministers, it's the same for everything else we do in terms of floods, fires, or any other response inside of Ontario.

The one piece that is different than this is, because we have an understanding with the Ontario Provincial Police for Ground Search and Rescue inside of northern and isolated communities where we have Canadian Ranger patrols, and those are part-time military members who are members of the community living in those isolated communities, but they will transition to Canadian Ranger service to do Ground Search and Rescue typically because the police and search resources do not exist in those isolated communities.

And so that one doesn't follow this because they happen when needed, but everything else in terms of formal military support follows this pattern.

And I also need to correct the individual's name who should appear before you, that colonel who is the former Director of Health Services Operations. It's Colonel Scott Malcolm, not McGregor. I -- there's a Scott McGregor who's in uniform as well, and often I get them confused. I apologize for that.

But Colonel Scott Malcolm is, in my mind, an ideal individual to appear alongside Major Karoline Martin to be able to explain the

medical pieces that consisted of our response in the spring and early summer here in Ontario.

COMMISSIONER FRANK MARROCCO (CHAIR): We'll follow up. Thank you.

BRIGADIER-GENERAL MIALKOWSKI: Okay, certainly.

If I now get into the timeline, and you know, we can cover this as quickly or as deliberately as required. In many cases, I've already spoken to it in the slide. And I'm not sure if you have the paper slide before you or just the representation on the screen, but everything in terms of timeline kind of connects back to this graphical, simplified framework for CAF support and can assist in explaining the timelines that I'm going to go through.

But I would then go on to the next slide, titled "Initiating CAF Support." And in this particular one, the way that the formal piece, our interchange occurred, as explained earlier, we had worked together since early February in dealing with COVID but in a different light in Ontario, and that was the return of Canadian citizens or Canadian-entitled persons to Canada during their sort of -- some were on cruise ships. We also had

a group from Wuhan Province came back to Canada as well.

So we were monitoring in concert with the Province of Ontario, but the actual request for assistance, so a document that was submitted in letter form by Solicitor General Jones to the Minister of Public Safety, Bill Blair, on the 22nd of April. So that's the first formal date where we had the request for assistance.

And as you can expect and given your extensive background, you know that to build that letter there was all types of interface at the levels I described from that Emergency Management System, Provincial Emergency Ops Centre, my regional Gen Ops Centre, and of course, the regional office of the Public Safety.

All of that work occurred in the days preceding that, and in fact, it was the two days prior, we actually sat down to start constructing what that would look like in tandem with the Province.

And on that same day, Minister Blair sent to the Minister of National Defence, Minister Sajjan, who approved on the same day, the 22nd, and it was with an initial electronic

approval, and then the formalization of the letters followed up by the 24th of April back to the Solicitor General that the CAF would support the request.

And while, of course, these formal letter exchanges are the legal authority, it never prevented any of our coordination or initiation work with the Province of Ontario. Work started as soon as we had the request for assistance in.

The next area gives you an indication of what was inside the request for assistance, and it was a two-page document, and we'll furnish that to you.

They asked for an initial period of 14 days and no more than 30 days. They were looking for trained medical and associated support staff to provide humanitarian relief and medical support in the long-term care homes, and there were four sort of principal areas: Liaison, reconnaissance, to identify the employment, protocols of CAF personnel.

Again, all of us were sensitive to that military medical or Augmented Civilian Care Teams were not attenuated to the needs of long-term care residents. Certainly from a medical perspective,

they can deal with medical emergencies and also you know, chronic medical conditions, but elder care is not something that is practised a whole lot in the Canadian Armed Forces.

Of course, tasked with the patient management and medical care, which is intuitive to why we were called in, general duties support, and again, that is sort of our lexicon for those who are non-medical staff but performing duties within the homes.

And as I outlined, people who would porter food, people who would help with cleaners when the cleaners weren't available to make sure that linens were changed, clothing were changed, bathing, assisting with bathing, assisting of porting and moving people, all things that have to go on inside a ward setting or a resident setting and then beyond.

In some cases, for example, the housekeeping and maintenance staff were unavailable in homes, and so we had troops in uniform doing things like typical maintenance duties; not only cleaning, but things like small repair to rooms and electrical and that sort of stuff like changing light bulbs that hadn't been changed because they

burnt out during COVID, and all that kind of stuff. I mean, you know, minor, but the overall effect of that improves the lives inside the care homes.

On the 23rd, that's where the Ministry of Health and also the Ministry of Long-Term Care in partnership with Ontario Health and each of the individual homes confirms five -- the five sites that would be supported.

So the Canadian Armed Forces, we did not select the homes we went into; rather, we were requested that, you know, both those ministries in partnership with Ontario Health through that emergency management -- the Emergency Management system that was established for COVID, that they knew which homes were in the greatest peril, and those homes typically centered on Toronto.

We had identified to the Province that we would deploy anywhere in the province, but if we had an opportunity, we would prefer to concentrate in a single area where we could make better use of our own effect. And in terms of our own deployment to an area and the real-life support to our teams, we would prefer not to be dispersed across the province if at all possible.

In the end, after the triage by the

Ministry of Long-Term Care, by the Ministry of Health, and Ontario Health, those five homes all centered on the Greater Toronto Area because those were the ones that they assessed at the time on that 23 of April to be the ones in the greatest need.

As you know, over time, that re-est- -- adjusted elsewhere in the province, but at that point, we had been committed, and that's why we went into homes in Toronto, because it was assessed -- or our understanding is that it was assessed as the homes with the greatest need or had the greatest potential for vulnerability given the location and what the home itself in terms of infrastructure and staffing and positioning was going to experience.

After we got that, Mike Heenan, the Assistant Deputy Minister of Hospitals in Capital Division in the Ministry of Health discussed with my operations director, Lieutenant-Colonel Sean French, they communicated those five locations, and of course, during the initial discussion between Deputy Minister Helen Angus and the Chief of the Defence Staff on their own call, the CDS had told Minister -- or sorry, Deputy Minister Angus that we

would deploy to the hardest-hit homes; send us where you need us the most.

And General Vance obviously set the tone, and he said the same thing in Québec. And so that's how the homes were selected on sort of the merits of where the need was greatest required.

COMMISSIONER JACK KITTS: Excuse me, Brigadier.

BRIGADIER-GENERAL MIALKOWSKI: Yes.

COMMISSIONER JACK KITTS: Just a point of clarification: So I think I heard you say earlier that you would go to the homes that are hardest-hit, but they needed to be all in the same similar geographic area; is that correct?

BRIGADIER-GENERAL MIALKOWSKI: Yeah, so -- sorry, sir. We had requested of Ontario, if at all possible, we would like to concentrate in a single area, but we never put that as a formal limit, or we said it's a desirable but not an essential.

But the essential to us was actually going to where the greatest need was.

COMMISSIONER JACK KITTS: Okay, thank you.

BRIGADIER-GENERAL MIALKOWSKI: And the

assessment at that time, as conveyed to us by those officials in Ministry of Health, Ministry of Long-Term Care, Ontario Health, and that Incident Management System for COVID, they said, we got it. In the end, those five facilities were, in fact, five long-term care facilities inside of the GTA.

COMMISSIONER JACK KITTS: Okay. Thank you very much.

BRIGADIER-GENERAL MIALKOWSKI: Okay. I'll move on unless there are further questions with this particular piece. And I also have a graphical timeline that will kind of encapsulate all of these points.

So the next slide is entitled "Deployment," and it notes sort of between the 24th and 26th of April, which was a weekend, elements of our response conducted site reconnaissance. So we went and we visited Holland Christian, Altamont, Orchard Villa, Eatonville, and Hawthorne to determine -- well, first, it was to make contact with the individual home.

It was to determine that the capability we were bringing was one that they actually needed because up until that point, we hadn't had point-to-point communications with any of the site

management nor the medical authority present in each of those facilities, and so we went and did face-to-face, and in that vein, we then constructed the teams that we would assemble.

And I mentioned this a little bit earlier, but as we had done in Québec, we developed these small teams that would look to the specific needs of each home, so not every team was a carbon copy or a cookie cutter of the same team.

We had a general model, and then we would tailor it to be able to deliver a particular impact in each of the homes, though, in general, most of them looked quite similar to one another.

COMMISSIONER FRANK MARROCCO (CHAIR): Did the different reconnaissance groups report back in writing, or was it oral?

BRIGADIER-GENERAL MIALKOWSKI: That, initially, it was oral, yes, sir, and it was done from each of those sort of senior nursing officers for each team, but they were accompanied by Major Martin, the overall commander of the Augmented Civilian Care Teams, and then my commander of that Territorial Battle Group 1, so it had the formal commanders as well as the individual team.

They didn't go to all homes

simultaneously; they went one-by-one to make sure that the senior nursing officer and that local commander had a good sense and could adjust the teams as required to be able to deliver that care inside of each facility.

And so they had heard everything orally, and their initial report back to me, yes, sir, it was oral in terms of what they were providing.

And what I got, as you'd expect, did not get into the nuts and bolts of how it was that they were going to, sort of, address each problem; rather, we talked in specifics about sort of what their initial observations were in terms of the need, and all five, as you'd expect, came back as there was strong, urgent need to get folks into those homes.

But equally, because we were not attenuated to deliver, sort of, elder care, we did two things that weekend. With the teams themselves, Deputy Minister Steele of Long-Term Care had identified to us that there was an electronic, sort of, preparation module that you could deliver online to folks going into long-term care facilities to get an understanding as to, you

know, what is it that goes on in a long-term care home.

And then each of the homes had their own onboarding requirements to make sure that the team that was being received understood the rules and the practices and the residents and patients in the homes before we actually went live with, sort of, 24 and 7 care.

So there was a bit of time, and that time was worked out by each particular home during that reconnaissance to say, hey, we'll be ready to onboard you on this date, and we'll be ready to have you go live and integrated into our shift schedule on this date. But it happened very quickly.

Most of those -- most of our deployments, as you'll see in the timeline, by the 28th of April, we were doing shift work inside the homes. And the day before is when we did the sort of onboarding at each of those places at the same time as getting our troops out of Borden and down into, like, real-life support nodes on the economy.

The hospitality industry, it was shut down at this time. We got some hotels to open where we could accommodate our folks because we

don't have a bunch of military quarters, or nor would we establish, like, a field environment living setting in downtown Toronto when things like hotels could be contracted, opened up, and provide the necessities of life to those folks who were living in proximity to the homes to be able to deliver their support in that sort of shift schedule.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

BRIGADIER-GENERAL MIALKOWSKI: The only other piece that I mentioned in terms of the distance learning package is that bullet, 24th and 26th.

So we also needed to make sure that our folks were fully trained on PPE and the, obviously, risks to the COVID. I mean, intuitively, you know, as a military force, we get things in terms of biological warfare training, but we gave them, through that military medical chain, the best understanding of how COVID was, you know, spread, transmitted, how infections manifest themselves, again, based on the knowledge in April.

And we also ensured that not the -- the military medical folks would understand infection

prevention and control procedures, but making sure that the soldiers that went in to support also got an understanding of medical infection prevention and control, because it's a little different than our training for biological warfare. Military forces are attuned to biological warfare, but not in this type of setting, not in a residential setting looking after elders.

COMMISSIONER FRANK MARROCCO (CHAIR): All right.

BRIGADIER-GENERAL MIALKOWSKI: And I think that I've given you a sense of this sort of Territorial Battle Group 1, that senior officer responsive to me who commanded these five teams who also commanded the medical staff inside those five teams.

And that body, that Territorial Battle Group, that unit, over time had about 750 people within it, and there was 678, I think, of that 750 who were directly connected over time from April to July in one way, shape, or form in terms of being in the homes or supporting the homes throughout that entire 67-day period.

COMMISSIONER FRANK MARROCCO (CHAIR): Brigadier, if you're moving on to a separate topic,

is this a good time to take the ten-minute break, or is there something that you want to finish there?

BRIGADIER-GENERAL MIALKOWSKI: I think it -- no, I think it is for me. I think we have a natural break here with the deployment, so I think ten minutes would probably do us all well.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay, fine. Ten minutes. Just you want to turn off the camera and the mic, but don't disconnect because we want to make sure you come back.

BRIGADIER-GENERAL MIALKOWSKI: Yes, sir. I'm famous for disconnecting in inappropriate ways, so thank you for your counsel, sir.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

-- Recess at 11:22 a.m. --

-- Upon resuming at 11:33 a.m. --

COMMISSIONER FRANK MARROCCO (CHAIR): We, I guess, are reassembled.

So, Brigadier, we're ready when you are.

BRIGADIER-GENERAL MIALKOWSKI: Yes, sir. Perhaps one thing I should check with you, sir, and the other Commissioners is, I believe that

I've got about half an hour in terms of the remainder of the presentation and could abbreviate.

Because I'm mindful of your time and the fact that you also might have, like, another appearance or other business to attend to at the conclusion of this, is that sort of -- if we keep this and aim towards 12, 12 o'clock, or do you have a little bit of flexibility? I just want to make sure --

COMMISSIONER FRANK MARROCCO (CHAIR): We have a little bit of flexibility, so if you think you've got a half an hour left, then why don't you just give us the half hour. We'll be okay on our end.

BRIGADIER-GENERAL MIALKOWSKI: Understood, sir. Thank you.

So then moving to the next presentation slide entitled "Employment Timeline," which is now viewing on the screen, much of this I've already covered, but what this one seeks to do in a graphical depiction is provide locations, times, activities, and all of that sort of rolled up on one slide.

And so in order to orient you to the graphic, in the upper-left corner are those seven

homes across the GTA that we were employed in and conducted support alongside the resident staff that was there and some of the additional staff that was brought in to help stabilize the situation in addition to our presence.

In the upper-right, that is just a graphical depiction to describe the team itself, and I'll get into a little more of that. And then the bottom portion shows over time with each of those locations, you know, where we were and what we were doing throughout that 67-day period from the 22nd of April till the 3rd of July.

And so going to the upper-left very quickly, as I mentioned, those initial five, and then follow on two locations were all determined out of that Incident Management Structure through the Ministry of Long-Term Care, through the Ministry of Health, and Ontario Health, and the overall structure that was dealing with the crisis, they're the ones that selected those GTA locations.

In the upper-right, this is just a graphical depiction, a very generic one, as to what a team looked like that went to each of the long-term care facilities.

So as I mentioned, the top red box,

that is the nurse in command. So that's a senior nursing officer. They add a second-in-command, and then they broke into two shifts, a shift 1 and a shift 2.

Almost every home initially, at least the first five, they were operating on 12-on, 12-off shifts, which, for those that have done shift work in this environment, becomes very difficult over time, particularly for those in a supervisory capacity or in charge because not only do they have to do their medical duties for 12 hours, they also had a reporting regime that we required of them to update, like, every day at the end of their shift, and then they also had to organize their shift handovers.

But of the medical folks there -- you see the two nursing officers in deep red -- in the pink depicts those medical technicians, and medical technicians are like paramedics, but they're sort of military-attuned paramedics.

So they do, like, combat casualty care, they do battlefield evacuation, they do care in forward areas in austere sort of treatment centres, and they can also be employed in a ward in clinical settings. And they are around the world in various

ways, shapes, and forms.

In this particular case, because our Surgeon General, the Surgeon General of the Canadian Armed Forces, directed that any activity that was conducted at the home needed to have medical oversight, we relied on the medical technicians to also be the ones that monitored the hour-to-hour activities of those general duty personnel who were doing the non-medical but the support tasks inside the homes.

And part of that goes back to the question that was raised by Commissioner Kitts in terms of the sort of standard of practice and requirements of, you know, medical competency in Canada. The Surgeon General reinforced that.

Because I mentioned to you before that, you know, I could tap in to thousands of people, the obvious question is, why, then, Commander Joint Task Force Central, did you not have more than five homes at any one time?

Our primary limiting factor was the availability of medical staff across the country and around the world to re-apportion them on to this activity.

And it was in no small part because

what we didn't want to do is introduce teams without sufficient medical oversight and medical expertise -- sorry?

COMMISSIONER FRANK MARROCCO (CHAIR): Could you just repeat that last sentence? It broke up for me, sorry.

BRIGADIER-GENERAL MIALKOWSKI: Oh, I'm sorry, sir.

So as I mentioned, I had the ability with numbers of people to be able to generate greater numbers of teams, but my greatest limiting factor was the fact that I didn't have that sufficient military medical expertise to do the correct oversight and clinical work inside of these locations. And that's why I was only able to respond at any one time in five facilities.

And it was a limiting factor. I think you'd appreciate that the military medical capability that we possess in the Canadian Armed Forces is really geared to supporting us to do our sort of medical clinical work when we're at a base or garrison or a home setting.

We go -- we don't typically go first to a downtown clinic; we typically go to a military clinic, treated by our own, and then for any

outside specialists or, you know, greater sort of clinical work, we go and rely on the public health system.

And really, our orientation is to do things outside of the country to make sure we have our own military standard of care to deployed operations. And that is a limiting factor in this particular case because we simply couldn't generate the numbers.

And the reason I say that is, so those two nurses plus the medical technicians were about 12 people in each of these five teams. And the total number I had, sort of, at any one time was about 125 medical folks.

Of course, I had a much larger ability to have other general duties and people who outside the homes made sure that their day-to-day, real-life support, you know, feeding, care, sleep, laundry, all that stuff was looked after, plus the command and control to make sure we were reporting, accurately understanding going on in the home, all that other support activity.

But the real work was conducted by these teams, and again, each of them had about 12 medical practitioners -- the two nurses and about

ten technicians -- and they split themselves into teams of six for a 12 and a 12 shift.

And then eventually, we got to a point where it would stabilize in the home, and they would go to an 8- or a 10-hour shift, negotiated with the facility's own competent medical authority and their own management, depending on what the home was capable of carrying out in terms of capacity.

Some homes were in dire situations because their staff had been absolutely decimated for a variety of reasons. Some of them were suffering COVID, others needed to extricate to care for others in their own families who were suffering COVID, and any number of other instances.

And so each -- like I said, each home is different, and the specifics of those, I think, are best provided by, you know, Major Martin in a future discussion.

The general duty shifts that were added, so we would typically add to that 12-person team about 30 to 40 additional military members depending on the site and what was required to sustain the team inside to help with residents in a non-medical fashion inside, and then all the

exterior pieces required such as transport; in some cases, they had cleaning; they had their own infection prevention and contamination control outside of the building which they managed; a whole number of other duties.

And so that's where the variability between teams existed, was in the non-military, general duties. The medical teams all had the same amount of medical personnel in each of them that were apportioned to each of those homes when they went in --

COMMISSIONER FRANK MARROCCO (CHAIR): I'm just not clear, Brigadier. The 30 people that were added, where would they come from?

BRIGADIER-GENERAL MIALKOWSKI: So they came from that organization we built, sir, that Territorial Battle Group. So they were --

COMMISSIONER FRANK MARROCCO (CHAIR): They were Canadian military people?

BRIGADIER-GENERAL MIALKOWSKI: Yes, they were. Yes. They were Army Reservists from across the province of Ontario who came out for this specific task.

COMMISSIONER FRANK MARROCCO (CHAIR): Thank you.

BRIGADIER-GENERAL MIALKOWSKI: And then moving down to the bottom area, it is simply -- gives you a graphic. So you see in time where we were in each of those locations in the upper left, starting on the far left with Bullet No. 1, which corresponds to the little text beside each with the date and then the activities that we conducted throughout this time.

So as you see, initially during the first sort of couple of days on the far left, that's where we were conducting our request for assistance, or RFA, activities, letter exchanges.

And as the box shows in the graphic, that's where we were training our teams in terms of making sure they formed as a team, because the medical expertise came out from across the province and around Canada.

They then joined up with a formed team of those non-military, general-duty folks. They trained together. They did the additional medical training. They then did the onboarding training that each home required so that they were oriented to not only the specifics of the home but the general sort of concepts of elder care.

And then we commenced on the 28th in

those five homes. As you see there, Holland Christian, which is actually Grace Manor.

Holland Christian is a large complex in sort of Western Toronto, Etobicoke -- it is -- it's massive -- but we were in Grace Manor, which is the most acute part of that long-term care facility; Orchard Villa out in the East; Eatonville, as well in Etobicoke; Altamont, which is also out in the East; and Hawthorne, which is more central, close to sort of Finch and the 400.

And so that's -- that timeline indicates when we deployed. Bullet No. 5 is our first extension, because as I mentioned, we were authorized for 14 and up to 30, so the 14 was a given. The Province of Ontario asked to extend beyond the 14 to the 30 days, so we continued to do that.

You'll see by Bullet No. 6, the 24th of May, that's when we provided the observation report to the Province.

Moving along to the 26th of May, that's when we extended. Also, at the same time, we came out of Holland Christian on a letter exchange of the 24th. And then we reoriented a team to then pick up the Downsview Long-Term Care facility near

the Downsview Airport and continued to do extensions and transitions to include, finally, Woodbridge Vista, which is just out in the western end of Toronto, northwestern end, and then, you know, terminated our activities on the 3rd of July over that 67-day period from initial first shift on the 28th of April until the 3rd of July.

And as we -- the reason we didn't continue to have five homes covered was the situation was stabilizing across Ontario into June and July where we were no longer needed. By the time we hit early July on the 3rd of July, Ontario no longer required CAF support to help stabilize those homes. And so we terminated the request for assistance on the 3rd of July.

COMMISSIONER FRANK MARROCCO (CHAIR): Would the nurses or the medical technicians have a sense of the model that you needed in terms of what it took to run the homes that they were in?

BRIGADIER-GENERAL MIALKOWSKI: They certainly did, sir, through, I would say, their experiential contact throughout their employment in those homes.

Because each home, as you well understand, they're different sizes --

COMMISSIONER FRANK MARROCCO (CHAIR): Yes.

BRIGADIER-GENERAL MIALKOWSKI: -- they also have different layouts, different patient rooms in a number of different facilities that would kind of demand, you know, the degree of staffing that would be required and, like, understand as well the management structure, some of which changed through, you know, ordinances by the Province where management was transitioned in some of these homes.

And the actual medical oversight in some cases was ordered by the local public health unit to be with an associated hospital.

So it really depended on each set, and I don't believe from our experience in these seven that that would be different from the whole number of long-term care facilities that suffered outbreak, saw a degree of that sort of transition and changes in oversight depending on where it was during the crisis.

COMMISSIONER FRANK MARROCCO (CHAIR): Did the relationship with the local hospital, was that -- did that succeed? Were those successful relationships, or...?

BRIGADIER-GENERAL MIALKOWSKI: So I'm not sure of the long-term view on that, sir, but for the period of time that we were engaged in the homes and saw that relationship, again, in a crisis situation, we saw it as a very positive move and saw positive changes in the homes that were affected by that actual change of both management as well as the imposition of the public health unit and an associated hospital getting into the business of resident care.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay. Thank you.

BRIGADIER-GENERAL MIALKOWSKI: And, like, I would hesitate, again, as a non-medical practitioner and with no background in long-term care of what type of promise that would show in other conditions and during a second or subsequent wave.

But I think your question actually is a good solid point, sir, and at the time in those homes, it was a positive move towards success in achieving stability because it brought a focus as well as resources from that hospital to include physicians that normally don't attend to these residential homes on a frequent basis, or that was

our understanding.

But both physicians and, you know, other medical expertise by specialist nurses was then brought to bear, communicated with the management as well as the senior staff present as well as our own teams supporting, and we saw noticeable change in sort of the effect of resident care at that period of time.

COMMISSIONER FRANK MARROCCO (CHAIR): Okay.

BRIGADIER-GENERAL MIALKOWSKI: This, Commissioners, is all I have for this particular slide. Unless you have any further questions, we would move on to some points on the Observation Report.

COMMISSIONER FRANK MARROCCO (CHAIR): I think we can move on.

BRIGADIER-GENERAL MIALKOWSKI: So the next slide just speaks to the Observation Report. Now, I didn't include the details of either report that I wrote on the 14th of May. We certainly have the ability to provide that in detail.

I mean, it was publicly released by the Premier and the Prime Minister, and you may have already had an opportunity to read it. I can

certainly provide any emphasis on that Observation Report, but the reality is everything that was contained in that report was meant to be a window and a milestone on the two issues of standard of practice and quality of care that we observed in those facilities at that time in early May from our deployment on, sort of, the 28th of April to early May.

And so to frame that, whenever we conduct operations of any sort -- like, military organizations are fixated on understanding the situation of their subordinate levels. No matter where you are on the structure, you always have a duty to continually update your superiors with the situation.

And that's true on operations overseas, in -- you know, in difficult places around the world, and we certainly bring that characteristic to attention when we came and did the deployment here in Ontario.

So we demand, as part of our military culture, an obligation to report on activities that are going on, particularly when they pertain to what our mission set is about.

Equally, we sort of have a bias for

action. No one will sort of stand idly by. So it's not just sort of observe, report, continue to observe. Our culture necessitates observe and report, and while doing the both of them, simultaneous, do something about the issue you see as best you can, and that is how I would describe our bias for actions.

So I've just attuned towards the second bullet there. So while we were providing that medical care and support to the long-term care facilities in those early days, we did observe a number of medical, professional, and technical issues by our nurses and medical technicians.

And so we reported that both up the military chain. So each of those teams at their shift level, they report in to their senior nursing officer. That senior nursing officer was reporting it to the Augmented Care Team Officer, that Major Karoline Martin, who I believe will be a great person to appear before you.

She, in turn, was reporting that up the military medical chain because it has its own obligations, as identified by Commissioner Kitts earlier, and equally up the command chain, which I'm responsible for.

And as we started to get, in the early days, this piece, we always ensured that each of the team at the shift level with their own shift they were supporting were identifying those issues and seeking local initiatives to correct it.

Then, at the team level in the home, with the team management and the competent medical authority at whatever level was present inside that facility, they reported it.

Then Major Martin and the commander of Territorial Battle Group No. 1, Lieutenant-Colonel J.J. Stalker (ph), they then engaged the management and oversight of each of those facilities and brought forward these concerns.

All the while, we were formulating the written report because from our perspective, while it's useful to have a written report in order to inform superiors -- and certainly at my level, those are the types of interactions we typically have beyond the verbal reporting because it lays down sort of a greater degree of milestone and a reference point to create larger action -- there's always that bias for action at the lowest possible level to correct what you can. And we did that throughout with each of the homes.

And what I'm trying to get there is, we did not in a vacuum simply observe issues, create a report, and fire it off to our superiors without trying to fix what we were seeing down at the lowest possible level.

And the manner on how that occurred can be described in some detail by Major Martin, and it certainly was a characteristic of all of the reporting that I received in my capacity as the overall Commander for Ontario.

It was very clear that every sort of piece that was being brought forward was trying to be resolved at its own level. Sometimes it simply couldn't because of a paucity of staff or of resources like PPE. It simply wasn't there at the time because our initial deployment in terms of that -- the graphical sort of representation of the first wave, we actually deployed at the end of April when Ontario and the long-term care facilities ultimately suffered sort of the greatest impacts of the disease.

We didn't know it at the time. We just went when we went. But over time, as the Province reviewed, sort of, the make-up of the first wave and its impact on long-term care homes, we kind of

arrived at the right time, which, to me, sort of shows that how we got there worked because we didn't come too early and weren't applied in incorrect locations, and we didn't come too late to actually not be of any value to be able to stabilize those homes.

And hopefully that type of observation could be borne out by -- separately by the Province through your inquiries.

And you know, finally, the pieces that -- like, our -- we believe that the overall means of reporting helped increase that sort of patient safety and constructive understanding of the situation inside the homes across the military chain of command because our intent had always been to provide the formal reporting to the Province because we were there at the request of the Province.

And it would be, you know, completely inconsistent with providing support and not providing reporting as part of that support to the Province. And that, of course, occurred on the 24th of May.

So the next slide is just a timeline associated with each of those reports to give you

the sense of, you know, what we were observing.

So during that initial period, as the first bullet points out, of 28th of April to the 3rd of July, our teams did observe a number of military medical professional -- or, sorry, of -- my mistake -- of medical professional and technical issues and communicated that to the long-term care facility staff and management in each locations.

They were reserved continuously from the outset at the team level, and in an effort to immediately resolve issues, we focused on ones that impacted right off the spot on resident care and well-being.

And that was the focus of the teams. It was to remove all degree of, sort of, immediacy and emotion from the reporting, but simply to catalogue, you know, what was going on while they were effecting change inside the home itself.

And overall, as I mentioned, it was about standard of practice and quality of medical care. And the timeline that follows simply indicates our formal communications interior to the military and exterior to the Province.

So on the 7th of May, that's when I received the first consolidated report from my

Territorial Battle Group Commanding Officer. And we reviewed that together on the 8th, and I directed that he provide me a formal, site-by-site observational report. Because as you can imagine, from shifts that were doing 12-on, 12-off, we were getting lots of good reporting, identifying issues, explaining the corrective measures that they were doing in place, but we didn't have a very clear, presentable picture that could be provided at, you know, a strategic level with the Province of Ontario, nor one that was quite clear in its summation of issues that could be provided up my military chain of command.

So we did -- we worked on that with them, and by the 11th of May, they provided me that report. And by the 14th of May, after the typical sorts of review, I provided that letter, which then became public later to my commander, the Commander of Canadian Joint Operations Command.

Now, throughout that time, please don't think that, you know, the formal reporting was done in isolation, because clearly we were communicating with our partners at various levels to state, hey, we've -- we're noticing these issues, and we're going to encapsulate it in a report, and we're

working hard at the local level to fix them. So just be patient with us and stand by, and we'll get that report to you.

And that was certainly shared with my counterparts. They knew something was coming, and what I waited on was authority to be able to provide them that report because it was not clear to me at the time that I had that authority, given the fact that it had been a request for assistance approved at a much higher level than myself.

But needless to say, at the local level, and at the sort of -- the level of each of the supervisors of those homes, whether they were management or they were the competent medical authority responsible for those homes, that was being shared on a daily basis of what was happening.

It really came as no surprise, I'll add, because we shouldn't have a short memory that this was the middle of a crisis, and the reason we were in those homes was because it was crisis conditions inside the homes.

And that was another motivation for us wanting to make sure that we captured what was happening at the time, not so much to have a

retrospective view of it view, but just to make sure we laid down a milestone as to, here were the conditions that we observed when we first came in, with an intent to make sure we documented the conditions of observation once we completed the task with the Province.

And if there was -- if it was going to be an extended, multi-month period of time, we would obviously have periodic reporting because, again, as I go back, it's part of our culture to make sure we conduct these reports whenever we conduct operations; all the more so because we were operating in a very unfamiliar environment as we did this.

And the sort of remainder of the timeline on the 24th of May, I shared our report with Deputy Minister Steele, and then once we shared those reports, our Chief of Defence Staff directed both to Ontario and Québec that we do regular reporting up through a -- not only the Province, but also through the military chain of command.

And we did weekly Observation Reports after that time: 14, 21st, 28th of June, and the 5th of July, which we were actually -- under the

Long-Term Care Act, the Director of Long-Term Care Inspections, and presently, that's Ms. Stacey Colameco. She has the jurisdictional authority to receive that type of reporting, and so we obliged by the statute and provided her with those weekly observation reports on those dates, reinforcing not only what the CDS directed but making sure all the while that we were consistent with Ontario's act because we were operating on Ontario's behalf throughout that period of time.

And when we came to the back end of our request for assistance, I sent a final Observation Report addressing the same areas of concern, which painted a different sort of picture because we were no longer in crisis.

We had stabilized alongside our other public health partners in those homes. And overall, Ontario had stabilized in all of its long-term care facilities. In fact, by this point, many were being declared COVID-free.

I sent a final report. That final report then went around the federal ring, and by a number of days later, on the 4th of August after the weekend, I was authorized to send that to Mr. Richard Steele, the Deputy Minister of

Long-Term Care.

And that sort of gives the timeline of both our initial and our final report during this period. And I'll pause to take your questions.

COMMISSIONER FRANK MARROCCO (CHAIR): No, I think we're following along. It's quite complete.

BRIGADIER-GENERAL MIALKOWSKI: Thank you. Thank you, sir.

I'll just give a little bit of sort of explanation to how it was that we would move from one home to another or ultimately withdraw, and that's on the slide titled "Extension, Transition, Withdrawal."

So in any military operation, we always look for the conditions that will allow us to either move on to other activities within the operation or ultimately cease the operation.

And knowing that our initial authority had been for 14, then 30 days, and then consistently extended by requests from the Province by Minister Jones to the Federal Minister, Public Safety Minister Blair, to the Minister of National Defence, Minister Sajjan, down through the CDS, these continuing extensions, we, you know, needed

to develop a means by which we would identify in conjunction with officials and the Province of Ontario and with the folks who were doing all the practice inside the homes, not only provincial but military, what were those conditions that needed to exist to allow us to withdraw from a home.

And those are numbered on the slide, you know, 1 through 4. What I would say is the first two speak to the stabilization inside the home itself during the crisis, and the second two talk about the ability to regenerate capacity within the long-term care facility.

And, again, the nuts and bolts of that are best described by our medical team, but it was a collaborative approach. So not only at my level did I agree with the Deputy Solicitor General, Mr. Di Tommaso, but it all occurred at the facility level and then through the Incident Management Structure. We shared the same view on these four things.

So for us to leave, we had to agree at the facility level between both management and the medical authority, the competent medical authority responsible for that particular home, and our team, as well as at the official level inside the

Incident Management Structure, alongside Federal Public Safety and my own regional Joint Operations Team, and then again, at that deputy minister level, we all had to agree that these four conditions would be met.

And we did that in all seven cases, and we formalized that with a letter of exchange between myself and the Deputy Solicitor General, Mario Di Tommaso. So the first --

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

BRIGADIER-GENERAL MIALKOWSKI: Yes, sir.

COMMISSIONER FRANK MARROCCO (CHAIR): The first of the four, Ministry of Health and Long-Term Care assess that CAF support is no longer required.

Did I understand you to say that that's correct, but you also had to agree?

BRIGADIER-GENERAL MIALKOWSKI: Yes, sir.

COMMISSIONER FRANK MARROCCO (CHAIR): You wouldn't know what -- yeah, all right. So --

BRIGADIER-GENERAL MIALKOWSKI: Yes, sir. So what I would say is perhaps that first

bullet is kind of the chapeau that allows 2, 3, and 4 to exist. So if 2, 3, and 4, if you will, those conditions are met, then the chapeau condition is actually met.

So you're right in your analysis, sir, that it's -- then, ultimately, because we're there on a request of the Province, we cannot unilaterally as a military say, we're complete, and we're packing up shop, and we're going somewhere else. We need to make sure the Province says, your support is no longer required.

That's really what that one speaks to, sir.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Okay.

BRIGADIER-GENERAL MIALKOWSKI: The second one, it's about the capacity inside the facility to actually manage their current COVID-19 cases. Not all of them -- like, we didn't have declarations of COVID-free in all cases while we were there. Many cases, we had left because the home was able to manage it.

All the homes were different. They have different wards, different rooms, different sort of practices, and so they had to agree along

with our assessment, that they had sufficient capability and capacity sometimes because of staffing or infection prevention and control or other resources or they then had the public health unit and linked hospital now involved. All those conditions would contribute to whether or not No. 2 was satisfied at the home level.

And then the last two really speak to nuts and bolts. That infection prevention and control was established and was being followed, and they had all the resources to do it. They had the education, they had the PPE, they had the cleanliness, they had the separation of those who were infected and those who were not. You know, there was no commingling, there was all that whole raft of medical expertise and activity.

And then, you know, really important here, because we were valuable in terms of bringing numbers, is they now had the staff that was sufficiently trained and had been onboarded and were able to execute duties in lieu of us being there.

All four of those, we had to agree. And you know, we reviewed this consistently. Daily at the PEOC, we had daily assessment on each home

at that Provincial Emergency Operations Centre, and it was fed by the Ministry of Health Operations Centre, separate of the Provincial Emergency Ops Centre.

And then, of course, Public Safety also helped us with general updates, being the sort of federal body that, you know, handles requests for assistance, notwithstanding what we brought to the table.

And then every week, we held that meeting at the director level, so at the sort of mid-management level, to specifically discuss progress at each of those facilities based on the daily updates. And we reported that daily, and we shared that daily update amongst the provincial bodies as well as the Public Safety body associated at that Provincial Emergency Ops Centre.

So we had a shared understanding, a shared picture of what each of these conditions looked like in each of those homes. And when we finally transitioned to a point where we believed it to be successful, that's where the higher levels than the director, it would percolate up through the Ontario system to Deputy Minister Steele and Deputy Minister Angus who then would ultimately

cause the Deputy Solicitor General and I to have a formal conversation and a formal exchange of letters to facilitate our withdrawal or transition out of a home to another home, depending on where we were throughout the crisis.

And I think that probably adequately describes the information conveyed on this point, pending your questions.

COMMISSIONER FRANK MARROCCO (CHAIR): We're good.

BRIGADIER-GENERAL MIALKOWSKI: The next slide is simply a timeline that gives, like, a sort of historical overview of the various extensions and withdrawals from each of the homes. It is simply a more deliberate repeat from that graphical slide that had the timeline on the bottom to give just a summary of each of those actions.

I'm not introducing anything other than the specificity of dates here, but there's nothing in addition to what we've covered in the previous employment timeline.

But I'll give you a moment perhaps to review, and if it causes any sort of questions or further discussion.

COMMISSIONER FRANK MARROCCO (CHAIR):

No questions from us.

BRIGADIER-GENERAL MIALKOWSKI: Thank you, sir. And so what I'll go to, then, is our final slide and really make sure as well, at the back end of this, that I cover the points that we've sort of raised in terms of follow-on activity for the Canadian Armed Forces and Department of National Defence and certainly take any of your, you know, larger questions that were provoked not only by our discussion but, you know, by your appearances of others already to date.

So, I mean, the first point, we are quite honestly very proud to have been called to help Ontario and Ontarians in their time of need, and the same is true of our colleagues in Québec.

Because, quite frankly, from a military perspective and being relevant to Canadians in our community, if we can't be called upon in the middle of a crisis, then our value is both questionable, and quite honestly, you have to wonder what it is that we are actually all about.

And we believe that though small in terms of our contribution, we were like a surgical instrument that was put into a crisis at the right place at the right time to be able to effect change

in some of the worst locations.

There certainly were other hard-hit locations, but it is our belief given our interactions with the Province of Ontario, I believe, shared view with those public officials that we were applied by them at the right time based on their knowledge of the situation, and then the results that we were able to achieve together with those frontline healthcare workers who remain inside those facilities and the public health structure that supported it and eventually was tuned towards formal linkages with hospitals as well as public health units to overcome this initial crisis.

You know, throughout, we were always in a supporting role, and throughout, we were always looking to stabilize, make sure the Province was able to get back to a position where they did no longer require our support, and then transition out to make sure we got out of the way of the Province to be able to allow their much larger system to then bring further stability to the homes.

And we believe that, you know, shoulder to shoulder in the homes, that that actually worked, and we overcame the crisis together.

You know, I think I've made the point throughout that military deployment to long-term care facilities is a very non-standard military task, but again, this is what we're here for.

At the end of the day, when there is no other force, we become the force of last resort, and we may not have the full range of capabilities, but we will adapt to be able to do what we can do in times of a crisis.

And obviously, that's our mandate, from my domestic operations point of view.

And finally, it's mostly to reassure each of you on this Commission that, you know, we continue to be ready for other emergencies that will materialize under COVID. It could be the potential to go back into long-term care facilities. And at least in that vein, we would have some previous expertise and understanding, and you know, based on that body of knowledge that now exists with several hundred folks in Ontario and several hundred folks in Québec who have done this, and it can be for any other public emergency that is required by the Province of Ontario.

But that having been said, what I would emphasize is that our Minister of National Defence,

the Chief of Defence Staff, our deputy minister, and my commander in Ottawa in terms of the domestic operations response, we continue to do COVID-19 contingency planning under that Operation LASER that I mentioned before. So it's not kind of just we were used once and we were done.

We continue to consider the re-employment of the Canadian Armed Forces in sort of the traditional domestic ops role, but we also do contingency planning and scenario play in terms of what else we could be called upon to do, because, you know, what we've done already to date in terms of offering formal Public Health Agency of Canada controlled quarantine zones, to employment in the long-term care facilities is just, you know, I guess, the first part of a new spectrum of a range of employability which we have not yet explored.

And we'll see what comes, you know, of this pandemic. I mean, heaven forbid that it is in a time of crisis, but ultimately, that's the rationale and the raison d'être of our existence in terms of protecting Canadians.

I'll stop there in terms of that. Sir, ma'am, and sir, certainly in terms of our offer of

documentation, I owe you through your Secretariat, confirmation as to whether or not we'll direct shot the 14,000 or so pages of documentation that was requested from a motion to produce papers by the Standing House Committee on Health. We certainly owe you that.

I will follow up with our team in Ottawa in terms of the provision of two additional witnesses. And I would recommend Major Karoline Martin, who was the senior nursing officer in charge of our Augmented Civilian Care Team because she could speak to specifically the homes.

And then from a much wider perspective, Colonel -- I'll make sure I get his name right this time -- Colonel Scott Malcolm --

COMMISSIONER FRANK MARROCCO (CHAIR): Malcolm.

BRIGADIER-GENERAL MIALKOWSKI: -- who was formerly our Director of Health Services Operations, and he is in the lynchpin or was the lynchpin as a practising physician for the -- not only the apportionments of military medical care, but as sort of the right arm of the Surgeon General of the Canadian Forces, and the Commander of our Health Services Group was the sort of agent behind

the scenes in all of this.

Equally, Colonel Malcolm has, like, a connection to the Ontario College of Physicians through his -- the duties, like an ex officio capacity as that, a Director of Health Services Operations and can explain all that duty to report, medical professional piece in a far-greater capacity than I've offered today --

COMMISSIONER FRANK MARROCCO (CHAIR): Well, Let me just --

BRIGADIER-GENERAL MIALKOWSKI: -- and I believe --

COMMISSIONER FRANK MARROCCO (CHAIR): Let me just stop you there for a second.

BRIGADIER-GENERAL MIALKOWSKI: Yes, sir.

COMMISSIONER FRANK MARROCCO (CHAIR): I just ask the other Commissioners, would we like to hear from those two witnesses, the nurse in charge and Colonel Malcolm?

COMMISSIONER ANGELA COKE: I think that would be very valuable.

COMMISSIONER FRANK MARROCCO (CHAIR): Commissioner Kitts?

COMMISSIONER JACK KITTS: Yeah, I

agree. I think we could have lots of learnings from what they did in terms of leadership and operations in those homes.

COMMISSIONER FRANK MARROCCO (CHAIR): So, you know, Brigadier, we accept the offer -- we accept the suggestion that we hear from them, and if you can make arrangements for them to contact us, we'll arrange a mutually convenient time for that to happen.

BRIGADIER-GENERAL MIALKOWSKI: Yes, sir, Commissioners, absolutely. And if I could recommend perhaps they come like as a dual presentation to you because I think one reinforces the other.

COMMISSIONER FRANK MARROCCO (CHAIR): Yes, that's fine.

COMMISSIONER JACK KITTS: Yeah.

BRIGADIER-GENERAL MIALKOWSKI: And the other piece with their appearance before you is I will inform them that the ability to perhaps graphically represent some of those interactions in terms of what occurred in the actual facility would be helpful for your line of inquiry, particularly in terms of what occurred inside the facilities.

COMMISSIONER FRANK MARROCCO (CHAIR):

Can I --

BRIGADIER-GENERAL MIALKOWSKI: Yes, sir?

COMMISSIONER FRANK MARROCCO (CHAIR): No, you go ahead, go ahead.

BRIGADIER-GENERAL MIALKOWSKI: I was just going to say, those are the follow-up notes that I took throughout our conversation in order to make sure we come back to each of you in terms of providing you some further information on the topic.

COMMISSIONER FRANK MARROCCO (CHAIR): I did have one question.

BRIGADIER-GENERAL MIALKOWSKI: Yes, sir.

COMMISSIONER FRANK MARROCCO (CHAIR): One of the criteria for your withdrawal was the staffing, really, the staffing.

Did you have a sense from your perspective in the information you were receiving why the staffing problem that you saw when you first went there seemed to resolve itself or diminish over the time you were there?

BRIGADIER-GENERAL MIALKOWSKI: You'd probably get better, sir, from Major Martin. But

what I would offer was we believe in terms of a retrospective look at this that, you know, during the crisis, we did come at the right time, and that's borne out by the rates of infection; unfortunately, the casualty rate and the death rate that we were seeing in the homes. And the overall incidence of transmission, infection, not only in the long-term care homes but in the wider community, kind of all synchronized at that point in time.

And part of the staffing difficulty in these homes were that staff themselves were getting the illness. They were infecting themselves, their families. They were part of the transmission. A few, unfortunately, also succumbed to the disease.

So there were pressures on those folks, but over time, as everything started to stabilize in the community, and in some cases, they overcame the illness themselves and then were fit to return to their normal duties.

In other cases, they were looking after family members or other members of the community who had fallen victim in their own homes.

And over time, they, themselves, were able to return.

There was also a very coordinated effort by the Province of Ontario to recruit, to backfill folks, and so initially, we saw what we understood to be called "agency staff" or those that are temporary hires in -- you know, in various sort of domains, mostly personal support workers, who would then be infused to work in long-term care facilities.

I mean, these personal support workers could be employed in any range of public health, but they were, you know, projected towards the long-term care facilities.

And I think that action by Ontario, coupled with the regenerative effect of people being able to come back from either suffering the disease or having others that they were caring for recover from the disease was kind of a mosaic effect of building strength back inside the facilities and allowing staffing to return close to normal levels.

But it wasn't just one thing. It was the combined effect of that.

And my own sense of this was that a large part was played by very deliberate efforts by the Province to reinforce staff in those homes at

the time.

COMMISSIONER FRANK MARROCCO (CHAIR): All right. Well, thank you. I don't think we have any further questions, and so let me say, if you've completed your remarks --

BRIGADIER-GENERAL MIALKOWSKI: Yes, sir.

COMMISSIONER FRANK MARROCCO (CHAIR): -- let me say on behalf of the Commissioners that we very much appreciate your assistance, and we appreciate the description of the chain of command because, quite frankly, we were having some difficulty with that, and we appreciate the fact that you started off with letting us understand where the support fit in the overall chain of command.

I think on behalf of all of us -- I'll speak for myself, but I think I speak for the other two -- it was a source of some comfort to me as a citizen when I found out that you were going into these places that were having so much difficulty, and it seems that that confidence was aptly borne out by what happened.

So please accept the thanks of at least, I think, three citizens of Ontario, citizens

of Canada for that.

We will look forward to the follow-up that you promised us, and I won't forget your offer to at least consider a request for other assistance, should it occur to us. So we'll feel free to bother you in the future, and you can feel free to tell us that that's not possible, but we will probably show up again.

In any event, thank you very much, Brigadier. It's been extremely helpful.

COMMISSIONER ANGELA COKE: Yes, thank you. Very thorough.

COMMISSIONER JACK KITTS: Yeah, thank you.

COMMISSIONER FRANK MARROCCO (CHAIR): Bye-bye.

BRIGADIER-GENERAL MIALKOWSKI: Bye-bye, sir, bye-bye ma'am, sir.

COMMISSIONER ANGELA COKE: Take care.

-- Adjourned at 12:27 p.m.

FOOTNOTE

1 Page 24: It should be clarified that it was not under the authority of the Canadian Armed Forces (CAF) that civilians were held in quarantine.

CAF provided a quaratine facility at the request of another federal government department, but "we" were not holding them quarantine.

REPORTER'S CERTIFICATE

I, OLIVIA ARNAUD, CSR, Certified Shorthand Reporter, certify:

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

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

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

Dated this 16th day of October, 2020.

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