

Long Term Care Covid-19 Commission Mtg.

Lori Stoltz
on Wednesday, January 20, 2021



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending
remotely, on the 20th day of January, 2021,
9:00 a.m. to 10:23 a.m.

BEFORE:

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

1 PRESENTERS:

2

3 Lori Stoltz, Lawyer Morris+Stoltz+Evans LLP

4

5 PARTICIPANTS:

6

7 Alison Drummond, Assistant Deputy Minister

8 Long-Term Care Commission Secretariat

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10 Ida Bianchi, Senior Legal Counsel Long-Term Care

11 Commission Secretariat

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13 Kate McGrann, Co-Lead Commission Counsel Long-Term

14 Care Commission Secretariat

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16 Derek Lett, Policy Director Long-Term Care

17 Commission Secretariat

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19 Dawn Palin Rokosh, Director, Operations Long-Term

20 Care Commission Secretariat

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22 Jessica Franklin, Policy Lead Long-Term Care

23 Commission Secretariat

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25 Alain Daoust, Team Lead Long-Term Care Commission

1 Secretariat

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3 Rose Bianchini, Senior Policy Analyst Long-Term

4 Care Commission Secretariat

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6 Angela Walwyn, Senior Policy Analyst Long-Term Care

7 Commission Secretariat

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9 Jennifer King, Gowling WLG

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11 John Callaghan, Co-Lead Commission Counsel Gowling

12 WLG

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14 Jennifer King, Gowling WLG

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16 Lynn Mahoney, Counsel Gowling WLG

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18 Max Libman, Counsel Gowling WLG

19

20 ALSO PRESENT:

21

22 Janet Belma, Stenographer/Transcriptionist

23

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

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Well, I guess, we're -- are we all here? Where is
4 Ms. Stoltz?

5 LORI STOLTZ: I am here.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 Oh, hi. Hello.

8 LORI STOLTZ: Hello. Very nice to meet
9 you virtually.

10 LYNN MAHONEY: I think --

11 COMMISSIONER FRANK MARROCCO (CHAIR):

12 Are you -- are you waiting for anyone?

13 LYNN MAHONEY: I think we're ready to
14 go, Commissioner. I don't know that -- I haven't
15 seen Mr. Callaghan, but Jennifer King is there, so
16 I think we're ready to go when you are.

17 COMMISSIONER FRANK MARROCCO (CHAIR):

18 All right. Well, Ms. Stoltz, I'm Frank Marrocco.
19 There's Commissioner Angela Coke and Commissioner
20 Dr. Jack Kitts. We are the Commission.

21 There is a transcript. A court
22 reporter will take down the presentation, and we
23 will eventually post the transcript on our website
24 so that people have some idea of what we're doing
25 and can follow along with the information that

1 we're receiving.

2 And so I think that without any further
3 ado, Ms. Mahoney, are we ready to go?

4 LYNN MAHONEY: Yes, we're ready to go,
5 Commissioner. And just -- I actually haven't met
6 Ms. Stoltz before, but our team has spoken with
7 her, and we engaged Ms. Stoltz so that she could do
8 a presentation for the Commissioners with respect
9 to the public health Framework.

10 So we would -- she's had several
11 conversations primarily with Jennifer King of our
12 office, who I believe you've met before who's on
13 the screen. And I think, as we go along -- I
14 think, Commissioners, to the extent that you have
15 questions and clarifications that you're -- that
16 you'd like to ask Ms. Stoltz about, then I think
17 that's why she's here. She's really here to try to
18 bring together some of the things that we've heard
19 about and some of the questions that you've had
20 about how this system is put together and who the
21 various players are.

22 So please interject with your
23 questions, and so I'll just -- I think Ms. Stoltz
24 is probably just ready to go.

25 LORI STOLTZ: I am. Thank you.

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MS. MAHONEY: Okay.

LORI STOLTZ: Thank you very much. And before I start, maybe just by way of brief introduction, I'll speak a little bit about my involvement in health system from a range of perspectives.

So my -- I first engaged with the public health System Legal Framework, et cetera, as counsel to a group of patients infected with HIV through the blood system before Commissioner Krever, of the Commission Inquiry into the blood system.

After that, I served as chair of the Health Protection Appeal and Review Board, which at that time was the board that heard appeals from orders issued by medical officers of health and public health inspectors under the HPPA, the Health Protection and Promotion Act.

In sort of 2002 to 2004, I was senior policy advisor to Minister Anne McLellan when she was Minister of Health, and that -- my time there coincided with SARS, so I was working with Minister McLellan when she engaged Dr. Naylor (phonetic) to do his report and when she made the

1 decision to create the Public Health Agency of
2 Canada.

3 More recently, post-SARS, I coauthored
4 a text with two other practitioners in public
5 health law, Jane Speakman and Rod Blake on the HPPA
6 and public health practice.

7 And then more recently, pre-COVID and
8 during COVID, I have been engaged to assist some
9 local medical officers of health.

10 So big picture, I guess what I'm saying
11 is I come at this having looked at the system from
12 a range of perspectives, and my focus here this
13 morning, obviously, is the legal framework.

14 So I have been asked by Commission
15 counsel to do a review of the Campbell
16 Recommendations, and to the extent that the Walker
17 Commission looked at the HPPA to address those as
18 well and to do a sort of review and audit, if you
19 will, to look at the extent to which those have
20 been taken up and are reflected in the current
21 legal framework. So we are part way through that
22 work. I will speak to that to some extent today,
23 but as I say, that's still kind of a work in
24 progress.

25 I have reviewed some of the evidence, a

1 fraction of what you have heard, but I have tried
2 to review those I thought might be germane to what
3 I'm working on, so I have reviewed the testimony of
4 some but not all of the medical officers of health
5 that you have heard from, and the Ministry
6 presentation, et cetera.

7 So I'm going to try in my remarks not
8 to repeat what you've heard but to maybe highlight
9 what I think might be of interest. So any
10 questions before I start? All right.

11 Yes, and I guess I'll apologize, I
12 guess, to some -- for a somewhat rudimentary
13 presentation. Instead of slides, I thought this
14 might be a more effective way to present the
15 content. And, obviously, I'm not going to read
16 every word of text, but what I hope to do is to
17 leave you with a little bit of a crib sheet that
18 may be of assistance as you go forward on some
19 important points.

20 Can everyone see my document? Does
21 that show for you?

22 COMMISSIONER FRANK MARROCCO (CHAIR): I
23 can. Yeah, we all can, I think.

24 LORI STOLTZ: Okay. That's great. So
25 just very briefly, page 1, a brief road map, so

1 I'll speak very briefly to some key insights, if
2 you will, that emerge from the SARS reviews on the
3 public health Legal Framework. I am going to talk
4 in some detail about local public health
5 accountabilities. I will then speak to central
6 public health, so central public health, from my
7 point of view, is comprised of the Ministry and the
8 Chief Medical Officer of Health and then PHO, also
9 part of central public health but a little bit
10 different in its mandate and the scope of its work.

11 So moving to page 2, The Impact of SARS
12 Reviews on the Legal Framework For the public
13 health System: So I just wanted to flag here some
14 key insights that I draw from review of the SARS
15 Commission Report, and I also see these themes
16 reflected in the Walker Report.

17 So the first is an emphasis on the
18 precautionary principle, and I know you as
19 Commissioners have referenced that already in your
20 interim recommendations, so the principle simply is
21 that reasonable efforts to reduce risk need not
22 await scientific proof.

23 And that is a principle at the core, I
24 would say, of public health practice, and certainly
25 has been a point of emphasis from every -- you

1 know, the commissions, the series of commissions
2 that have looked at public health issues in Ontario
3 and Canada starting with the Krever Commission,
4 then Campbell, Walker, and Naylor all referenced
5 this as a touchstone, Justice O'Connor in the
6 Walkerton Report, and again, this Commission has
7 referenced that.

8 So simply to say that
9 Commissioner Campbell made recommendations around
10 integrating the precautionary principle into the
11 legal framework of the HPPA. That has been done,
12 really, only to a limited extent as relates to
13 Occupational Health & Safety. So that may be
14 something that you as Commissioners wish to direct
15 some attention to.

16 Other key insights from Campbell and,
17 as I say, Walker, the need to protect and
18 strengthen medical independence, the capacity for
19 leadership, and the power to act quickly and
20 decisively. And Campbell looks at that both at the
21 level of the CMOH and also at the level of local
22 medical officers of health.

23 He emphasizes in his recommendations
24 and the supporting text the idea that preparedness
25 is essential, so emergency powers are part of the

1 picture but by no means the whole, and, really,
2 what you need is to be ready for what's coming.

3 When the -- when the emergency comes,
4 clarity in the emergency powers is crucial. There
5 is -- he spends a considerable time at multiple
6 points talking, you know, basically that time spent
7 in legal wrangling in times of public health
8 emergency is time much better spent, obviously, on
9 delivering care and acting as one needs to.

10 And then finally, there is an emphasis
11 on transparency and with the notion that increased
12 transparency in scientific advice will facilitate
13 greater accountability.

14 So my focus is on the HPPO which --
15 HPPA, rather, which Campbell characterised as the
16 legal engine that makes public health go, and I do
17 think that's a fair description of the Act which
18 really creates the mechanics for the system.

19 Okay. I'm going to turn to page 3. So
20 focusing on local health -- public health
21 accountabilities, I've just summarized here at the
22 top what local public health is and what -- you
23 know, what I mean and what's generally meant when
24 one refers to public health units. So I think that
25 this structure is by now probably familiar to

1 you -- to you as Commissioners.

2 What I wanted to talk in more detail
3 about -- and I'm just going to scroll up here --
4 is -- are the accountabilities of local public
5 health to central public health. So the
6 independence of local public health has been talked
7 about with some emphasis, but I think it's also
8 important to understand that there are many
9 instruments of accountability that tie local public
10 health to the Ministry and the CMOH. And I've
11 itemized them here.

12 So each public health unit will have a
13 public health funding and accountability agreement
14 with the Ministry that covers -- governs their
15 receipt of funding from the Ministry and how those
16 funds are going to be used.

17 A second key point is that boards of
18 health, i.e., local public health units, must
19 provide mandatory programs and services. That's an
20 obligation created in Section 4 of the HPPA, and
21 the actual programs and services are laid out, for
22 the most part, in Section 5.

23 There are mandatory standards, and I
24 know reference has been made to these. These are
25 the Ontario Public Health Standards, and these

1 govern the delivery of mandatory programs and
2 services by local boards of health, and one of the
3 areas also covered in the OPHS is the -- is
4 accountability. Accountability is a chapter, and
5 it deals with both accountability within the board
6 of health and to the public, and it also deals with
7 accountability to the Minister.

8 And then the last key point here is
9 that local public health is subject to the
10 exercise, the potential exercise, of substantial
11 powers by -- held by the CMOH, the Chief Medical
12 Officer of Health and the Minister. And I have
13 simply tried to itemize them here simplifying them
14 considerably but with reference to the Act where
15 you can find them.

16 So the CMOH can actually exercise,
17 choose to exercise the powers of a board of health
18 or a medical officer of health, may seek a court
19 order to direct a board of health to act, may
20 require information from a board of health and the
21 health unit. It -- the CMOH may issue a directive
22 to any or all boards of health or medical officers
23 of health requiring policies to be adopted or
24 implemented, and the three areas that are
25 specifically identified are infectious diseases,

1 health hazards, and public health emergencies. And
2 the Minister or the CMOH may -- and this is power
3 reserved more, I would suggest, where there is
4 concern for the functioning of a health unit -- to
5 appoint an assessor to assess the board of health
6 and then to follow up with written directions. And
7 there are measures that can be taken to ensure
8 compliance with the direction. So, again, in sum,
9 many instruments to assure accountability of local
10 public health to the centre.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Can I just -- I -- if I'm getting ahead of you,
13 then please tell me, and I'll wait 'til you get
14 there, but we have a pandemic. Who's -- who's
15 responsible? Like, who's responsible for making
16 decisions? I'm having a lot trouble with this
17 concept.

18 LORI STOLTZ: Okay. So I think I will
19 come to that, but let me --

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 Okay. Well, then you get there when you're going
22 to get there.

23 LORI STOLTZ: Well, no --

24 COMMISSIONER FRANK MARROCCO (CHAIR): I
25 don't want to take you out of the presentation, but

1 I --

2 LORI STOLTZ: No. No. It's -- yeah,
3 it's okay.

4 COMMISSIONER FRANK MARROCCO (CHAIR): I
5 do want to know what you think.

6 LORI STOLTZ: Yeah. So -- but what I
7 was going to say is, I will come to elements of
8 that, but let me just say briefly, at the local
9 level, obviously, the local medical officer of
10 health has the capacity and is responsible to make
11 decisions. And in making those decisions, is
12 responsible to deliver the mandatory programs and
13 services, and a component of those is -- relates to
14 infection control and the control of infectious
15 diseases, and we will come to that.

16 But there is also a decision-making
17 role at the central level, and I would say in one
18 of the areas that I'll speak to is that it is
19 perhaps more implicit in the availability of the
20 kinds of powers, you know, some of which are listed
21 here and some of which I will come to that aren't
22 specific to directing local public health.

23 But the very existence of those powers
24 implies that there is responsibility for decision
25 making centrally. And if you -- if you look to the

1 purpose of the Act, which is stated in Section 2 of
2 the HPPA, and I'll just read it: (as read)

3 "The purpose of the Act is to
4 provide for the organization and
5 delivery of public health programs
6 and services, the prevention of the
7 spread of disease, and the promotion
8 and protection of the health of the
9 people of Ontario."

10 So local medical officers of health are
11 responsible to achieve that as guided, you know,
12 within the framework of the mandatory public health
13 programs and services at the local level. But
14 there is decision making that has to take place
15 centrally to make sure that the system as a whole
16 is delivering on this mandate. And to me, that
17 is -- you know, I would say there is responsibility
18 for decision making at the centre or within central
19 public health to achieve that.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 At the centre means who?

22 LORI STOLTZ: Well, I -- well, the
23 Ministry and the CMOH. So there are itemized
24 powers here that deal with powers that can be
25 exercised by the CMOH, but then there is decision

1 making, you know, maybe not emergency order type
2 decision making, but there is decision making of a
3 different kind that is exercised, for example, in
4 the creation of the OPHS because the OPHS are
5 important, then, because they set the framework for
6 what local public health does including -- and I
7 will come to this -- as relates to long-term care,
8 what their involvement is in the long-term care
9 system.

10 So the Act gives responsibility for
11 creating those mandatory standards to the Minister,
12 so that's where accountability for that lies, and I
13 guess just a quick point to flag there is that
14 Campbell had recommended that that be a power that
15 be transferred from the Minister to the CMOH. That
16 is not a recommendation that has been taken up.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 So is there a struggle between the Chief Medical
19 Officer of Health and the Ministry of Health? Is
20 there a -- sort of a jurisdictional struggle there?

21 LORI STOLTZ: I think that -- I mean, I
22 can't speak to the evidence that you have heard. I
23 will speak to what Campbell reported on, and
24 clearly, he identified that there was -- I don't
25 know whether I would call it a struggle, but not

1 clear -- I think what he was trying to identify is
2 that the CMOH needed a clearer field to exercise
3 independent decision making as relates to medical
4 matters relevant to public health in preparation
5 for and during public health emergencies.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 Okay.

8 LORI STOLTZ: His recommendations were
9 directed to achieving that. Some of those have
10 been taken up, and some have not. So to the extent
11 that he was directing recommendations to solve a
12 problem, I guess it's an open question for you to
13 consider whether that problem has been addressed.

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 Well, at least as it effects --

16 LORI STOLTZ: As it --

17 COMMISSIONER FRANK MARROCCO (CHAIR):

18 -- what happened in the long-term care homes, at
19 the very least, in Wave 1, but probably in Waves 1
20 and 2.

21 LORI STOLTZ: Right. Yes. I
22 appreciate that your mandate is specific to what
23 happened in long-term care homes, so...

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 Okay.

1 LORI STOLTZ: Commissioner Kitts, did
2 you --

3 COMMISSIONER JACK KITTS: Yes, can I
4 just ask for clarity? When you say the local
5 medical officer of health or the Chief Medical
6 Officer or -- have the responsibility and/or
7 accountability to act, do they also have the
8 authority to act to make their decisions, or do
9 they have to get permission from others?

10 LORI STOLTZ: Well, I think the answer
11 to that question would probably -- depends on what
12 power it is they're choosing to exercise. But if
13 you are -- if your question relates to the
14 authority to issue an order, so to issue an order
15 under Section 22, to require a stated actions or
16 Section 29.2 which is an order issued by some MOHs
17 in relation to long-term care facilities, the
18 authority to issue that order lies solely with the
19 MOH. That is an exercise of discretion that must
20 be exercised by the CMOH -- by the MOH, rather, and
21 no one else --

22 COMMISSIONER JACK KITTS: Okay.

23 LORI STOLTZ: It will be informed by
24 others, but -- yeah.

25 COMMISSIONER JACK KITTS: Okay. So

1 the -- so the local officer has authority to act
2 locally but can be overruled by the Chief Medical
3 Officer or the MOH?

4 LORI STOLTZ: The Chief Medical Officer
5 of Health does have the ability, and I will come to
6 the triggers.

7 COMMISSIONER JACK KITTS: Okay.

8 LORI STOLTZ: But the -- yeah. There
9 is -- well, there is a part in the Act that gathers
10 together what are described as Provincial public
11 health powers, and there are certain triggers that
12 enable the Chief Medical Officer of Health,
13 depending upon the power, to exercise certain
14 powers. One of those powers is the ability to
15 exercise -- to effectively step into the shoes of
16 one or more MOH -- MOHs and issue that power.

17 COMMISSIONER JACK KITTS: Okay. Thank
18 you.

19 LORI STOLTZ: You're welcome.

20 Okay. So moving to the next slide, I
21 wanted to drill down on this question of the OPHS,
22 the Ontario Public Health Standards to address the
23 mandated relationship with long-term care homes
24 because I can see in the evidence that I've read
25 that there is information underlying some of the

1 testimony you've heard from MOHs that maybe is not
2 clear from your point of view.

3 So again, the HPPA in Section 7 says
4 that: Minister can create mandatory standards for
5 all boards of health and medical -- well, for
6 boards of health. The Act refers to boards of
7 health, but you can understand that to direct the
8 conduct of boards of health and the Medical Officer
9 of Health.

10 (As read)

11 "Those standards address the
12 full range of mandatory programs and
13 services that a local health unit
14 provides."

15 So I've highlighted two of them here,
16 the infectious disease -- infectious and
17 communicable diseases prevention and control;
18 that's one area of activity. Another area is
19 emergency management, but the OPHS also speak to,
20 you know, immunization, food safety, rabies
21 control, a whole range of activities that are
22 carried out at the local public health level and
23 for which the local MOH and board of health are
24 responsible.

25 So when we focus in on infectious and

1 communicable diseases prevention and control,
2 what's important to understand -- and I consider
3 these OPHS as part of the legal framework because
4 they are mandatory. By statute, compliance with
5 them is mandatory.

6 And Section 7 also permits the
7 standards to refer to protocols, and if you look at
8 the protocols, you will see that much of that
9 language is mandatory. And that informs local
10 public health as to their sphere of activity.

11 So when you look at the underlying
12 protocols, when you look at the OPHS and the
13 underlying protocols, first of all, what you see is
14 that there is -- there are differences in the way
15 local public health acts depending on the context.

16 So in relation to personal care
17 settings, so things like tattoo parlors and nail
18 salons, those are settings not otherwise regulated
19 from a health point of view, and you see that there
20 is an express board of health mandate that reads in
21 words of one syllable:

22 "The board of health shall
23 inspect and evaluate IPAC practices
24 in personal care settings."

25 So that is a regular proactive event.

1 When it comes to long-term care, there
2 is no such express mandate for public health.

3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 And just to -- sorry to interrupt, but personal
5 care settings, is that -- is that defined?

6 LORI STOLTZ: Yeah. It -- yes.

7 COMMISSIONER FRANK MARROCCO (CHAIR): I
8 just wondered why it didn't include a long-term
9 care home because just looking at the words --

10 LORI STOLTZ: Yes, I --

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 -- you would think --

13 U/T LORI STOLTZ: Right. I understand what
14 you mean, and I will get you the actual definition
15 of that term. There is one, but it relates to
16 things such as tattoo parlors --

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Okay.

19 LORI STOLTZ: -- nail salons, that kind
20 of thing.

21 COMMISSIONER FRANK MARROCCO (CHAIR):
22 All right.

23 LORI STOLTZ: Okay? When it comes to
24 long-term care homes and other institutions, and
25 institutions is a term that is defined in the -- in

1 the HPPA, what you -- there is a mandate. I'm not
2 trying to say there is no board of health mandate.
3 There clearly is, but it is framed differently.

4 The mandate to inspect and evaluate IPAC
5 for long-term care, focusing on that, is a more
6 limited responsive kind of role. So it is
7 responsive to complaints, and you see that in
8 what's called the IPAC Complaint Protocol. And
9 there is a clear role in relation to outbreaks.

10 And you see the role for long-term care
11 spelled out in -- the role of local public health
12 is -- you know, there is some content that you will
13 find in the OPHS, but then when you look at these
14 protocols, it -- they are much more granular. And
15 the two that are relevant to outbreak in this
16 context are the Institutional Facility Outbreak
17 Management Protocol and the control of respiratory
18 infection outbreaks in long-term care, which is not
19 a protocol but a guideline, as I understand it.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 So let me stop you there, if I can, if you don't
22 mind.

23 LORI STOLTZ: No.

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 We know there's outbreaks of COVID-19 in long-term

1 care homes. So that -- am I correct, that engages
2 the authority of the local medical officer of
3 health?

4 LORI STOLTZ: Correct.

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 Now, can the Chief Medical Officer of Health tell
7 the local medical officer of health, Dr. Williams
8 and Manns, what he wants the local medical officer
9 of health to do? Or does Dr. Williams have the
10 authority to do what he wants -- to order what he
11 wants done regardless of the local medical officer
12 of health?

13 LORI STOLTZ: So first of all, the OPHS
14 provide some -- provide the framework for how local
15 public health will engage in outbreak situations in
16 the long-term care setting and institutionally.

17 In a given situation, the -- in a given
18 local situation, the medical officer of health, as
19 I understand it, will typically engage informed by
20 that framework and their understanding of their
21 responsibilities, and they will exercise and
22 make -- you know, they'll exercise their authority,
23 and they'll make their decisions as they deem
24 appropriate engaging their powers if and as they
25 feel they should meeting statutory criteria,

1 et cetera. If --

2 COMMISSIONER FRANK MARROCCO (CHAIR):
3 So when they're -- sorry. Go ahead. No don't --
4 let me -- finish your thought.

5 LORI STOLTZ: Yeah. If there were a
6 situation where the Chief MOH had reason to believe
7 that an individual situation was not being handled
8 as it should, then we'll come to the various
9 powers, but you'll see that the power is there to
10 intervene on a one-off basis, okay, if there were
11 concern in a situation like that.

12 And then I guess the other question is
13 at a -- forgetting about individual situations and
14 concern about -- yeah, forget about concern about
15 individual situations. If the MOH wanted to set
16 some -- establish some further guidance around how
17 outbreaks should be managed, there are tools to do
18 that. We will come to those tools. But there are
19 tools in the hands of the CMOH.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 So you correct me if I'm wrong. When there's an
22 outbreak in a long-term care home, the person who
23 should show up making decisions in the public
24 interest is the -- first, the local medical officer
25 of health, and if the Chief Medical Officer of

1 Health isn't satisfied with the way the local
2 medical officer of health is handling the matter,
3 the Chief Medical Officer of Health can make his
4 will felt on the local medical officer of health;
5 is -- have I got that right or no?

6 LORI STOLTZ: Yes. And -- but I guess
7 the reason for the hesitation you may hear in my
8 voice is that there is not automatic reporting up
9 from the local medical officer of health to the
10 Chief Medical Officer of Health whenever an order
11 is issued, so it's not that linear a relationship.

12 But should circumstances arise such
13 that the Chief MOH had reason to be concerned, yes,
14 there would be -- there would be an ability on the
15 part of the Chief Medical Officer of Health to
16 intervene.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Yeah, and I can understand why you wouldn't report
19 up every time you made an order, but, here, you
20 know, you have all kinds of people sick, people
21 dying. I think -- I think one would expect that
22 that would get -- whether there's an obligation to
23 report or not, that's the sort of thing that would
24 get reported. I'm not asking you that, but that's
25 just the way it seems to me.

1 So in terms of the accountability for
2 making decisions to deal with the problem, this is
3 the -- is there anybody else that has
4 decision-making authority in that -- in the
5 situation where there's an outbreak and people are
6 either seriously ill, dying, or both --

7 LORI STOLTZ: Yeah.

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 -- in the long-term care home?

10 LORI STOLTZ: So it's an important
11 question because the -- to go back to -- the role
12 of the medical officer -- the local medical officer
13 of health as currently conceived by these
14 protocols, if you read the language, you will see
15 that it is different -- like, in a personal care
16 setting, for example, the MOH, the responsibility
17 lies with the health unit to manage the outbreak.
18 They -- that is, they go in. They take over. They
19 manage.

20 In the context of an institutional or
21 facility outbreak, you will see that the language
22 in those protocols speaks to -- the primary
23 responsibility for managing that outbreak lies with
24 the institution. So, for example, if it's a
25 hospital, the hospital has primary responsibility.

1 If it's a long-term care home, the long-term care
2 has primary responsibility, and the language as
3 relates to the role of public health is sort of
4 assist, support. But, obviously, at a certain
5 point, if things aren't being done that need to be
6 done, local public health and a medical officer of
7 health has the capacity to issue orders, exercise
8 authorities to make sure that things get done.

9 But in the first instance,
10 responsibility for managing the outbreak is placed
11 with the institution.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Can I just stop you for a minute? The institution,
14 if you're dealing with a for-profit long-term care
15 home, is the institution the owner or the Minister
16 of Long-Term Care?

17 LORI STOLTZ: It's the owner. It's
18 the -- it's the entity, the facility. You know, if
19 it's a --

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 And then -- okay.

22 LORI STOLTZ: -- a hospital, if it's a
23 long-term care, it's the owner/operator.

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Okay. Got it. And what's the responsibility of

1 the Ministry of Long-Term Care in this situation
2 where you have a COVID outbreak and you have people
3 sick and people dying?

4 So I get the fact that the owner has a
5 responsibility, and I think I understand that the
6 local medical officer of health has a
7 responsibility, and that the Chief Medical Officer
8 of Health can impact -- can really force the
9 situation to go in a certain direction.

10 What is the Ministry of Long-Term
11 Care's responsibility in that situation, if they
12 have one?

13 LORI STOLTZ: Yeah, they do -- they do
14 have one, as I see it, and I will say I am not
15 intimately familiar with the ins and outs of the
16 Long-term Care Homes Act. There is a clear
17 provision in the Act that creates an obligation on
18 the part of every home to have adequate IPAC. And
19 my understanding is there is an inspection regime
20 built around that. As to how they fulfill that
21 and -- you know, I can't -- I can't speak to that
22 in detail.

23 But I guess what I can say is, my read
24 of it is is that it would seem to make sense that
25 the underlying rationale or a somewhat differently

1 tasked role to public health as relates to
2 long-term care is predicated on the assumption that
3 you have long-term care inspectors who have
4 responsibilities to inspect as kind of a first
5 line, and so that public health, in that case, is,
6 in effect -- back up is the wrong expression, but
7 it's -- they're supplementary, but long-term care
8 has a primary responsibility to do the
9 investigative work.

10 So if we could just turn to the next
11 slide because I -- or I'll just bring you to the
12 next page because I wanted to anticipate the
13 possibility that, you know, should this Commission
14 form, you know, the view that public health -- IPAC
15 and long-term care homes should be more fully
16 integrated into local public health
17 responsibilities. And in addressing this issue, I
18 think I'm trying to respond to having read the
19 testimony from some of the MOHs you heard from, so
20 Dr. Kyle, for example, Dr. Moore, Dr. Sutcliffe. I
21 think I understood all of them to say that there is
22 a good fit.

23 Okay. I'm just going to let you know,
24 I've just got a message that my Internet is
25 unstable, so I hope I don't fail here, but the --

1 you know, there is a good fit for a stronger, more
2 comprehensive mandated relationship.

3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 You did freeze. You froze on our screen. We'll
5 wait 'til you come back.

6 (BREAK)

7 LORI STOLTZ: Okay. I'm back, can you
8 hear me?

9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 We can, yes.

11 Janet, where was -- what's the last
12 thing you have?

13 Just so you know -- Ms. Stoltz, just so
14 you know where you were.

15 LORI STOLTZ: Yes.

16 LYNN MAHONEY: You're on mute, Janet.

17 COURT REPORTER: Sorry. (By reading)

18 "-- so I hope I don't fail
19 here, but, you know, there's a good
20 fit for a stronger, more
21 comprehensive mandated
22 relationship."

23 LORI STOLTZ: Okay. And -- but before
24 I -- as I was unfreezing there, I just -- it
25 occurred to me that I should emphasize -- I do want

1 to be clear that it is not as if -- it is not as if
2 the protocols that I'm speaking to don't provide
3 any role for public health in long-term care.

4 It is there, but as I say, it's
5 differently cast. It's in a more supportive kind
6 of -- more of a supportive and then episodic kind
7 of role. But you did have MOHs who said, look,
8 there is a good fit here, and, you know, we've got
9 the expertise. We've got the relationships, and
10 it's very efficient to have local public health
11 be -- have more of a -- you know, like the personal
12 care settings, have the mandate to do proactive
13 IPAC inspections, that it not be an episodic thing.

14 But if that's to be better -- you know,
15 give us the -- I think Dr. Kyle said give us the
16 mandate and give us the resources.

17 So if you wanted to do that, what would
18 your -- how might that -- how could that be
19 approached? The mandate, you know, my point here
20 is the mandate and related authority should be
21 express in the legal framework to eliminate the
22 potential for dispute.

23 You know, it's great when things work
24 well, but as Campbell points out repeatedly,
25 clarity is absolutely essential to clearing the

1 field for decisive action especially in an
2 emergency context.

3 So, you know, an ongoing public health
4 unit mandate to proactively inspect and evaluate
5 IPAC practices, public health unit authority to
6 communicate with and involve others as maybe
7 necessary because you can find stumbling blocks
8 there, and what obligation, if any, to publicly
9 report outwards the results of inspections and
10 findings of lapses, if there are any.

11 So options for recommendations: You
12 can make -- you could recommend that such a mandate
13 be expressed in the Ontario Public Health
14 Standards. That's one place that could be done.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 If you're referring to your presentation, it's not
17 on the screen.

18 LORI STOLTZ: Oh, okay. That's a
19 problem. Let me --

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 Well, I mean, we can follow along too, you know.
22 There was a world before slide decks.

23 LORI STOLTZ: True, there was. There
24 was. Okay. But here. I can -- I think it's going
25 to be easier if I share it, though I just need to

1 figure out how to do that again. Just one second.

2 MS. MAHONEY: Do you see the icon at
3 the bottom of your screen?

4 LORI STOLTZ: Yeah, I've got it. I've
5 got it.

6 LYNN MAHONEY: Okay.

7 LORI STOLTZ: All right. Do you have
8 it now?

9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Yes, we have, Options For Recommendations.

11 LORI STOLTZ: Good. Okay. So express
12 Board of Health Mandate in the OPHS, that's one
13 option, to recommend that. Another option is to
14 recommend that that mandate be included right in
15 the HPPA. So I'm just going to take you to the
16 next screen where I have excerpted part of
17 Section 5 so you can get a sense of what that looks
18 like, and, you know: (as read)

19 "Mandatory health programs and
20 services: Every board of health
21 shall superintend, provide, or
22 ensure the provision of -- "

23 -- et cetera, and you see a list; 1.1
24 is, I am fairly certain, post-Walkerton, okay? And
25 then 2, which I've highlighted, relates to control

1 of infectious diseases, and the -- everything --
2 the current wording goes to the word adults, and
3 then I've just added in brackets here and
4 underlined where you might -- could think about
5 including something. Now, this wording isn't
6 probably what you would want to use. You would
7 likely want to be broader, but it gives you the
8 idea.

9 Another point just to flag quickly is
10 Section 29.2 of the HPPA is a section that various
11 medical officers of health have used to engage and
12 require action on the part of long-term care
13 facilities including allowing hospitals to come in
14 and work with them as partners on IPAC.

15 And I just wanted to identify an issue
16 for you here that I think was touched on in, I
17 believe, Dr. Kyle's presentation, but I may be
18 wrong, that there is, arguably, a shortfall in the
19 power in Section 29.2 which is fine as long as you
20 have a willing partner to send in with
21 supplementary services to long-term care but could
22 be a problem if you had to require the
23 collaboration and support of a partner.

24 So if you look at the language here,
25 you see that the capacity to issue an order tells

1 the medical officer of health they can make an
2 order requiring a public hospital or any
3 institution to take actions for the purposes of,
4 et cetera, responding to an outbreak of
5 communicable disease at the hospital.

6 So if the long-term care facility is
7 the institution with the problem, clearly, you can
8 direct an order under 29.2 to that facility, but
9 arguably, you can't use -- you can't rely on this
10 section to compel a local hospital to engage and to
11 provide support to that facility. So that was just
12 the issue I wanted to flag there.

13 Okay. I am almost out of time. I'm
14 sorry to have been so long.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 No. No. We were asking a lot of questions. You
17 know, just go ahead.

18 LORI STOLTZ: Okay. And well, I'll
19 just move more quickly through the next slide. So
20 emergency management under the OPHS, so just to say
21 that there is content in the Ontario Public Health
22 Standards that addresses what a board of health
23 should be doing to prepare for emergencies, and you
24 see here, I've bolded, in accordance with Ministry
25 policy and guidelines.

1 So you then, to understand the
2 framework fully, turn to that guideline, and the --
3 when you look at that guideline, to my reading, and
4 you may have had medical officers of health and
5 others testify as to their understanding, but the
6 focus really appears to be the continuity of board
7 of health programs and services. Certainly, there
8 is no express reference to long-term care homes.

9 And when you contrast that with the
10 SARS Commission recommendation, for example,
11 it's -- they're not the same. I -- that this does
12 not -- I would say that the current language of the
13 OPHS do not fully give expression to what I
14 understand Commissioner Campbell to have
15 recommended here.

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Can you -- can you go back to -- just go back to
18 the previous page? There. Just -- so 29.2, if you
19 have COVID-19 patients at a hospital and COVID-19
20 residents at a long-term care home, wouldn't that
21 allow the local medical officer of health to make
22 orders respecting both institutions?

23 LORI STOLTZ: Yes.

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 So in that situation, they can order -- they can

1 order them to do things.

2 LORI STOLTZ: Oh, I wasn't suggesting
3 that 29.2 couldn't be used in relation to a
4 hospital. What I was focusing on was that if it
5 was to be relied upon to order a hospital to do
6 something, the wording of the provision suggests
7 that the underlying reason for the order should be
8 a problem at the hospital.

9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 Well, that's what I was asking. The problem at the
11 hospital is the COVID-19 patients and the presence
12 of the disease --

13 LORI STOLTZ: Oh, I see.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 -- in the hospital.

16 LORI STOLTZ: Yeah.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 And there's also the presence of the disease in the
19 long-term care home, so can they not make, then, I
20 mean, I'm not --

21 LORI STOLTZ: Yeah. I --

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Why can't you just make an order, then say, look,
24 you've both got the same problem; I'm ordering you
25 to do this?

1 LORI STOLTZ: Well, but if the problem
2 is -- if the fundamental issue is inadequate IPAC
3 practice in a long-term care home, I think,
4 arguably, that's a different situation.

5 So I guess what I would say is this is
6 one example of an ambiguity --

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 M-hm.

9 LORI STOLTZ: -- that could do with
10 some clarification because that at least raises the
11 question. I mean, interestingly, you know,
12 Section 29.2 is new. There used to just be
13 Section 22, and I would have thought, really, that
14 you didn't need 29.2, that 22 gave you all the
15 powers you needed to have.

16 But 29.2 has now been added, and so it
17 does raise a question, to me, anyway, that there is
18 a little bit of ambiguity there.

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 Yeah.

21 LORI STOLTZ: And I do want to point
22 out, where you have a willing partner, the medical
23 officer of health does have the power to issue
24 directions that will engage that partner and
25 empower them in -- to assist in giving effect to

1 his or her order.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 M-hm.

4 COMMISSIONER JACK KITTS: That's what I
5 was going to raise because I think what we've seen
6 in our interviews is that where the hospitals have
7 come in to help the long-term care homes, they --
8 there's been a voluntary management order from the
9 local public health officer. And I think in a
10 couple of occasions when that wasn't seeming to
11 work out, there became a mandatory management order
12 which I think came from either the Ministry of
13 Health or the Chief Medical Officer of Health.

14 LORI STOLTZ: Yes, that may be. Okay.
15 So moving, then, to central public health, and here
16 is where -- so -- and I'm going to deal with -- so
17 central public health, I think, is fairly
18 understood to include the Ministry, the Chief
19 Medical Officer of Health, and Public Health
20 Ontario.

21 But Public Health Ontario is
22 fundamentally different. You know, it's a source
23 of technical expertise, scientific expertise. Its
24 functions are quite different, so I have separated
25 them, and here, just some general points: So, you

1 know, broad central powers for policy, direction,
2 guidance, and oversight of local public health
3 units, so that's really what I covered in part 2.

4 Then here is where I was just going to
5 review for you the broad central powers to act in
6 response to risks to health. And so post --
7 pre-SARS, some of these powers pre-existed SARS.
8 Some have been added since, some immediately
9 post-SARS, and some more laterally.

10 They have now been collected together
11 in a new Part IV, Provincial Public Health Powers,
12 and there are a lot of them. So what I've done, I
13 won't read through every one, but I'll just -- I'll
14 highlight them for you. So just so that you know,
15 I have included them all here and attempted to
16 summarize them on key points. So in bold type is
17 the substance of what -- whether it's the CMOH or
18 the Minister is empowered to do, and then I've
19 identified the trigger.

20 And you will see that there is
21 variation in the triggers, which I must say
22 standing back and looking at it, which I'm not sure
23 I understand the rationale because they do seem to
24 vary, and I'm not sure what the reason, in some
25 cases, for the variation is, but that's how I've

1 organized it, and, really, I've just gone through
2 the Act section by section.

3 "So there is an ability to
4 investigate and act as the CMOH
5 considers appropriate to prevent,
6 eliminate, or decrease identified
7 risk. This includes exercising the
8 powers of a board of health or
9 medical officer of health but is not
10 limited to that."

11 So that's a very broadly stated power.
12 There is an ability for the CMOH to seek a court
13 order to direct a board of health to act. The CMOH
14 can require the board of health -- a board of
15 health to provide information to the CMOH.

16 The Minister may require an occupier to
17 deliver premises for public health purposes, so if
18 there's a need to -- there's been discussion about
19 whether field hospitals should have been set up to
20 facilitate cohorting by long-term care homes.
21 There is an ability to require that premises be
22 delivered up to do that.

23 "The Minister may, by order,
24 require the procurement,
25 acquisition, seizure of medication

1 and supplies."

2 PPE comes to mind. Then moving to the
3 next page:

4 "A CMOH can require a health
5 information custodian to supply
6 information. A CMOH may trigger a
7 directive to any healthcare provider
8 or entity."

9 And those terms are actually defined in
10 the section, and this is the section that has been
11 used to ground the directives that have been issued
12 by the CMOH.

13 "The Minister may issue an
14 order to any healthcare provider or
15 entity directing information to be
16 provided to the Minister.

17 The CMOH can collect previously
18 collected specimens or -- "

19 That should be or information about
20 their analysis, not of.

21 "The CMOH may issue a directive
22 to any or all medical -- boards of
23 health or medical officers of health
24 requiring the adoption or
25 implementation of policies or

1 measures including as related
2 to -- "

3 And there are specific areas there.

4 So you see there are -- there is a
5 broad range of powers, and that doesn't include,
6 you know, the powers to look into the affairs of a
7 board of health that I canvassed at the beginning.
8 But in terms of the "emergency powers," that is --
9 that is the list.

10 And so just going to page 10, some key
11 points here: These powers each have their own, as
12 I said, somewhat differently expressed triggers,
13 but none of them are limited to or specific to a
14 declared provincial emergency.

15 So these powers exist whether the
16 Premier has declared an emergency or not, and, you
17 know, there's good reason for that. He may --
18 there may be a -- you know, you may have a public
19 health issue that exceeds the capacity of a given
20 health unit or that spills over multiple boundaries
21 of individual health units, and it may not be a
22 situation of provincial emergency. It may not
23 reach that threshold, but nonetheless, there are
24 risks to help that needer -- that need broader
25 powers to address them.

1 I wanted to emphasize the advantage to
2 addressing system-wide issues at the central level
3 in the context of an emergency, and it's probably
4 an obvious point, but, you know, it does have the
5 potential to clear the field for local MOHs on
6 issues that might be ambiguous or might be
7 controversial.

8 For example, you know, I guess it's
9 possible we may have a question that emerges around
10 mandatory vaccination. It doesn't make sense for
11 34 local medical officers -- local MOHs to be, you
12 know, sort of trying to wrap their heads around an
13 issue that is system wide in its implications,
14 highly complex. That's a good example of a
15 system-wide issue that could be addressed at the
16 central level very usefully, and, you know,
17 there -- I'm sure there are lots of others.

18 Another important point is that -- I
19 think it's been addressed before you already --
20 that every order issued by an MOH can be appealed.
21 There is a right of review to the Health Services
22 Appeal and Review Board, and that is -- you know,
23 it's a -- it's a wide-open review of the issuing of
24 the order.

25 So there's no entitlement that anyone

1 has to be heard by a medical officer of health
2 before an order is issued, but when the matter
3 comes for review before HSARB, there is a full on
4 review.

5 So by way of example, there was an
6 order issued by a local medical officer of health,
7 I believe, in the Windsor area that addressed
8 migrant farm workers. I may not have the health
9 unit right, actually. I think it was a different
10 health unit. But, in any event, it was in the
11 western part of the province, and that was -- that
12 was appealed, and it was a five or six-day hearing
13 before the board with another day before Divisional
14 Court.

15 So it is an advantage that if the CMOH
16 acts at a system level, you don't have to deal with
17 the diversion of resources to deal with an
18 automatic right of appeal or review.

19 In terms of the capacity for
20 enforcement, there are provisions in the Act that
21 allow the -- you know, provide authorities for the
22 orders and directions of the Chief Medical Officer
23 of Health and Minister to be enforced, and the
24 potential for an application to the Superior Court.
25 And actually, I see I got -- it should be 102(2),

1 not 102(1); (1) is for the Medical Officer of
2 Health.

3 So I just had some quick observations
4 to share with you as related to role and
5 responsibilities of the CMOH, and these don't --
6 you know, my starting point is not the evidence
7 before you, but rather, looking at the
8 SARS Commission Recommendations and the -- you
9 know, how those have been translated into the
10 current legal framework.

11 And, you know, just by way of a general
12 point, the SARS recommendations emphasize the need
13 for a robust role and responsibilities for the CMOH
14 and clear accountability.

15 There is emphasis on independence in
16 relation to medical matters pertaining to public
17 health and primary authority as relates to the
18 public health aspects of provincial emergency.

19 So we will have -- you know, I am
20 undertaking a detailed review of the individual
21 recommendations, but just some quick observations.

22 When you look at the HPPA, we have
23 limited provisions in the Act to define the role
24 and mandate of the CMOH.

25 So by comparison, a local medical

1 officer of health understands their mandate because
2 they know they are responsible under the Act -- and
3 the board of health -- they are responsible under
4 the Act to deliver the mandatory programs and
5 public health services as expanded upon by the
6 OPHS.

7 But when you look at the defined role
8 and mandate of the CMOH in the Legislation, there
9 really is not a lot that is expressly stated. So:

10 "The CMOH must report annually
11 on the state of public health and
12 may make other reports, must keep
13 informed on matters of occupational
14 and environmental health."

15 And what I wanted to -- yeah, sorry,
16 may make other reports, right, so there's an
17 obligation to report annually and a permissive
18 ability to make other reports.

19 When you look at the role -- the
20 legislative provisions in the B.C. Public Health
21 Act, they have, I would suggest, a more robust
22 explanation of this role. So first of all, in
23 paragraphs -- in Section 64, a very clear
24 statement:

25 "The Provincial Health Officer

1 is the senior public health official
2 for British Columbia."

3 And then scrolling down to Section 66,
4 you see in (1):

5 "The Provincial Health Officer
6 must monitor the health of the
7 population of British Columbia and
8 advise in an independent manner the
9 Minister and public officials on
10 matters that include -- "

11 -- you know, health promotion, which
12 is sort of the other big area of public health
13 activity and health protection. And then you see
14 other matters canvassed there.

15 In (2), somewhat stronger language
16 around the obligation to make other reports. So:

17 "Where the Provincial Public
18 Health Officer believes it would be
19 in the public interest to make a
20 report to the public, the Provincial
21 Public Health Officer must make the
22 report to the extent and in the
23 manner that he or she believes will
24 best serve the public interest."

25 And then, in (3) and (4), there are

1 provisions that deal with annual reports.

2 So not to say that you need to look at
3 this as the -- you know, as the last word on the
4 issue, but it is an interesting example of a more
5 expressly stated mandate that, then, kind of helps
6 understand one of the first questions you asked,
7 Minister -- Commissioner Marrocco, is, you know,
8 who's responsible for making decisions in relation
9 to what?

10 That could be answered, to some extent, in the
11 Legislation more fully at the central level.

12 Second point that I wanted to make here
13 as relates to the CMOH powers, and here, again, as
14 with Section 29.2, I think I'm really just pointing
15 out an ambiguity, but potentially an important one,
16 that seems to be, at least as I read it, somewhat
17 at odds with what Commissioner Campbell conceived
18 of as the role of the CMOH in an emergency.

19 So:

20 "In a declared emergency, the
21 Premier has a power under Section
22 7.0.3 which is not specific to the
23 CMOH, but includes the power --
24 gives to the Premier the power to
25 exercise the statutory powers of any

1 Crown employee."

2 And then further in that section:

3 "There is an ability that the
4 Premier has to delegate those powers
5 to the Minister, and the Premier can
6 either directly delegate to the
7 Commissioner of emergency
8 management, or a Minister could, in
9 turn, delegate to the Commissioner."

10 There is a section later on in the Act
11 that has language to the effect of: (as read)

12 "Nothing in this Act abrogates
13 the powers or should be understood
14 to abrogate the powers of the CMOH
15 except to the extent that they
16 conflict with an order, like an
17 emergency order."

18 And I'm not sure that adequately
19 protects the CMOH powers from encroachment under
20 Section 7.0.3. So I just wanted to highlight that
21 because it is different from what
22 Commissioner Campbell conceived which is that you
23 would have a CMOH who is the primary lead authority
24 on public health matters in an emergency, on the
25 medical aspects of public health matters in an

1 emergency.

2 And then the last point that I wanted
3 to highlight is in the CMH [sic] role as currently
4 conceived by the Legislative framework as CMOH has
5 limited authority to direct PHO, and so I'm just
6 going to cover that very briefly on my last slide.
7 There's lots of text, but I don't propose to walk
8 through it all with you.

9 But just to say that both SARS -- the
10 SARS Commission and Walker recommended that the
11 CMOH have the responsibility and ability to direct
12 the agency that is now PHO.

13 The current Legislative framework does
14 not provide for that. The current Legislative
15 framework for PHO is set out in the Act that I have
16 identified here, the Ontario Agency For Health
17 Protection and Promotion Act.

18 And very briefly, what you see is that
19 it has a board of directors comprised of up to 13
20 people appointed by Cabinet. A CMOH is not a
21 director. He has the entitlement to notice of the
22 meetings and to attend and participate in the
23 meetings, but he doesn't vote. He is a member of
24 the Strategic Planning Committee, but whatever PHO
25 strategic objectives are, they are subject to the

1 Minister's approval, it is not the CMOH who is
2 directing those strategic objectives.

3 And the CMOH does have the power to
4 issue directives to PHO, but it is somewhat
5 limited, and I've included that language fully
6 here:

7 "To provide scientific and
8 technical advice and operational
9 support to any person or entity in
10 an emergency or outbreak situation
11 that has health implications."

12 So that is the conclusion of my
13 prepared remarks. I would be happy to answer any
14 other questions that you have. Oh, I can't -- I
15 can see that you're speaking,
16 Commissioner Marrocco, but I think you're muted.

17 COMMISSIONER FRANK MARROCCO (CHAIR):
18 Sorry about that. So then who has the authority to
19 direct Public Health Ontario if the -- who is in
20 charge of it? I appreciate that it has a board
21 of -- it has directors, but who's in charge?

22 LORI STOLTZ: Well, who's in charge?
23 The -- I can't really take you -- I mean, it is an
24 independent agency -- well, it's a Crown agency.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 Okay.

2 LORI STOLTZ: But a board appointed by
3 Cabinet. Their strategic objectives must be
4 approved by the Minister of Health, so I would say
5 the Minister of Health has considerable power over
6 Public Health Ontario.

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 So then the original thought in the SARS
9 Commission, in the Walker Report, that Public
10 Health Ontario would take its direction from the
11 Chief Medical Officer of Health got -- I don't want
12 to say subverted, but got redirected. That
13 authority got redirected to Ministry of Health?

14 LORI STOLTZ: It's not -- I guess the
15 way I would say it is it's certainly not fully
16 reflected here. I mean, because even in Justice
17 Campbell's report, the CMOH is part of the
18 Ministry. He recommended that the CMOH hold the
19 position of Assistant Deputy Minister.

20 So to that extent, you know, there
21 was -- there was always going to be integration of
22 PHO and connection to the Ministry as part of the
23 public health infrastructure, if you will, of the
24 Province of central public health, but what is
25 missing is clear role and responsibility to the

1 CMOH over direction of PHO.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Okay. Thank you.

4 Commissioner Coke.

5 COMMISSIONER ANGELA COKE: Yeah, just
6 for clarity for me a bit more, I'm trying to
7 understand if the concept was that the Chief
8 Medical Officer of Health would be out from under
9 the Ministry and independently heading PHO or the
10 opposite, that PHO be inside under the direction of
11 the Chief Medical Officer of Health?

12 LORI STOLTZ: Are you -- you mean in
13 terms of the SARS Commission recommendations?

14 COMMISSIONER ANGELA COKE: Yes. I'm
15 trying to understand, you know, if this was to be
16 an independent body, and the Chief Medical Officer
17 the head of that, why would they still remain under
18 the Ministry as an ADM? I'm just confused with
19 which structure was really being recommended.

20 LORI STOLTZ: Yeah. So, yeah, I'm
21 struggling a little bit here because there is -- I
22 think, as I read the recommendations, the intention
23 was that there be some level of integration. It's
24 just the how that is different.

25 So Public Health Ontario is a separate

1 corporate entity, but with accountabilities to the
2 Ministry. I believe that is consistent with what
3 the SARS Commission recommended, but the conception
4 was different in the sense that the -- that the
5 CMOH was intended, I believe, to have a stronger
6 role and authority in directing the -- in directing
7 PHO.

8 Let me just look and see if I can
9 find -- if you can just give me one second. I just
10 want to see if I can put my hands very quickly on
11 Commissioner Campbell's actual language, which may
12 help.

13 COMMISSIONER FRANK MARROCCO (CHAIR):
14 Is it in Volume IV?

15 U/T LORI STOLTZ: I've actually -- I've got
16 a -- I've got them reproduced in a different place,
17 and it was in Volume V, although he, I think,
18 probably talked about it in multiple places.

19 You know what, I am -- I think probably
20 the better thing for me to do, Commissioner Coke,
21 is to get back to you with some clear information
22 on that because it's -- it is a little bit
23 confusing, and I want to faithfully relay to you
24 what the Commissioner actually recommended, so I
25 will provide --

1 COMMISSIONER ANGELA COKE: That's fine.

2 LORI STOLTZ: -- through Commission
3 counsel.

4 COMMISSIONER ANGELA COKE: That's fine.
5 Thank you.

6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 Well, I don't think we have any further questions.
8 On behalf of us, thank you very much. This has
9 been very helpful in -- for us to get a more
10 granular sense of the framework that we're dealing
11 with and to try to understand what the
12 accountabilities are in long-term care which is, of
13 course, our remit, so thank you very much.

14 LORI STOLTZ: You are very welcome.

15 COMMISSIONER ANGELA COKE: Thank you.

16 COMMISSIONER JACK KITTS: Thank you.

17 -- Adjourned at 10:23 a.m.

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REPORTER'S CERTIFICATE

I, JANET BELMA, CSR, Certified
Shorthand Reporter, certify:

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

That all remarks made at the time
were recorded stenographically by me and were
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That the foregoing is a true and
correct transcript of my shorthand notes so taken.

Dated this 21st day of January, 2021.



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CHARTERED SHORTHAND REPORTER

1 CLARIFICATIONS:

2

3 P.6 line 24 - "she" not "we"

4 P.11 line 12 - "in" not "and"

5 P.14 line 9 - "sum" not "some"

6 P.49 line 7 - "role" not "local"

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