

Long Term Care Covid-19 Commission Mtg.

Ministry Briefing on CAF
on Friday, November 13, 2020



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

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending
remotely, on the 13th day of November, 2020,
9:00 a.m. to 10:05 a.m.

1 BEFORE:

2

3 The Honourable Frank N. Marrocco, Lead

4 Commissioner;

5 Angela Coke, Commissioner;

6 Dr. Jack Kitts, Commissioner.

7

8 PRESENTERS:

9 Catherine Brown, Interim Executive Lead, Health
10 System Performance and Support, Ontario Health;

11 Brian Pollard, Assistant Deputy Minister, Long-Term
12 Care Capital Development;

13

14 PARTICIPANTS:

15

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

18 Dawn Palin Rokosh, Director, Operations, Long-Term
19 Care Commission Secretariat;

20 Ida Bianchi, Counsel, Long-Term Care Commission
21 Secretariat;

22 Jessica Franklin, Policy Lead, Policy Unit,
23 Long-Term Care Commission Secretariat;

24 Derek Lett, Policy Director, Long-Term Care
25 Commission Secretariat;

1 Lynn Mahoney, Counsel to the Ministry of Health and
2 Long-Term Care;

3 Sanjay Bahal, Team Lead, Operations, Long-Term
4 Care;

5 John Callaghan, Counsel, Long-Term Care Commission
6 Secretariat;

7 Kate McGrann, Counsel, Long-Term Care Commission
8 Secretariat;

9 Ashley Dent, Acting General Counsel, Ontario
10 Health;

11 Jeffery Simser, Legal Director, Agencies;

12 Louise Verity, Strategic Advisor-Office of the CEO,
13 Ontario Health;

14 Sunil S. Mathai, Counsel, Crown Law Office Civil;

15 Roopa Mann, Counsel, Crown Law Office, Civil;

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

18 Judith Parker, Counsel, Legal Services Branch for
19 the Ministries of Health and Long-Term Care.
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1 -- Upon commencing at 9:00 a.m.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Okay. Well, we're here.

4 Mr. Pollard and Ms. Brown, I don't know
5 if you've met Commissioner Kitts and Commissioner
6 Coke. If not, consider yourself introduced.

7 BRIAN POLLARD: Good morning. I think
8 Dr. Kitts and myself have a little history but all
9 good history.

10 COMMISSIONER JACK KITTS: Yeah. Hi,
11 Brian.

12 BRIAN POLLARD: Hi, good morning.

13 COMMISSIONER JACK KITTS: Hi,
14 Catherine.

15 CATHERINE BROWN: Good morning. Good
16 morning, Angela. Good morning.

17 COMMISSIONER ANGELA COKE: Good
18 morning. Hi, Brian.

19 BRIAN POLLARD: Hello. Good morning.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 So I'll dispense with the formalities. The
22 Ministry's been here more than once.

23 We do have a transcript, and we post
24 the transcript on the website. With your
25 permission, we'll ask questions as we go along, if

1 there are any. And we're ready when you are.

2 CATHERINE BROWN: Okay. Well, good
3 morning, everyone. It's Catherine Brown. I will
4 start, and my colleague, Brian, will jump in as we
5 go.

6 So you had posed a number of questions.
7 I'll just give a bit of a chronology of how things
8 evolved for Ontario as it related to the
9 involvement of the Canadian Armed Forces.

10 On April 23rd, I was notified that the
11 Province of Ontario was accepting support from the
12 Canadian Armed Forces or the "CAF" as I will call
13 them and asked to provide a list of homes from
14 which we would select five homes for support.

15 The incident commander of the incident
16 management structure for long-term care, Mike
17 Keenan who is also an ADM at the Ministry of
18 Health, brought this to my attention. And the ask
19 had been initiated through the Ministry of Health
20 through MEOC.

21 And I understand that was as a result
22 of an exchange between the Solicitor General and
23 Minister Blair on the 22nd of April at the request
24 and the offering of support, but I wasn't a party
25 to those. I just understand that's what initiated

1 it.

2 At OH, I was asked to move quickly,
3 within hours, to identify homes that would benefit
4 from the assistance of the CAF. I reached out to
5 each region, and I asked them to submit homes that
6 were in greatest need on that day in area.

7 And it's important to note that had we
8 done it a week earlier/a week later, it might have
9 been a different group of homes. These were the
10 homes in that moment that were in the greatest
11 need. A list of 11 homes was compiled, and that
12 list is in the slide deck that we provided.

13 Those 11 homes were identified, and
14 then I discussed with each region where the
15 greatest need was. It was a very difficult
16 selection given all the homes on the list were in
17 significant need. And typically, that was related
18 to the endurance of the outbreak as well as the
19 availability and responsiveness of staff in the
20 home.

21 There were no restrictions on what
22 homes could be put forward. However, we were
23 advised that larger homes could benefit from the
24 effort of the CAF just given the number of
25 residents and staff that were needed to support

1 care.

2 As such, some of the smaller homes were
3 not selected. It should be noted that while the
4 CAF was one important team of support, all regions
5 were working with hospitals and the ministry and
6 other partners to provide supports to homes in
7 need.

8 And you'll recall, from previous
9 briefings and certainly from the Ontario Health
10 briefing, that included everything from hospital
11 staffing, Ontario Health, and LHIN staff, home care
12 staff. So many other supports were being provided
13 to homes. These were five that were deemed in
14 greatest need.

15 We selected the following homes for
16 support: Hawthorne, Eatonville, Holland
17 Christian/Grace manor is all in Central Region; and
18 Altamont and Orchard Villa in the East Region.

19 The long and the short lists were
20 provided to the Ministry of Long-Term Care and to
21 the IMS for further consideration. No changes were
22 made to the large selection of the five homes.

23 Once the list was confirmed, Ontario
24 Health reached out to all five homes to make them
25 aware and confirm their support to receive the

1 Canadian Armed Forces' supports.

2 An OH lead was identified. That was
3 me, and I began working with the CAF as a liaison
4 to begin work with the homes in Ontario.

5 I was advised that Lieutenant-Colonel
6 Sean French would be my contact, and we began
7 communication immediately on the 23rd.

8 Lieutenant-Colonel French was my ongoing contact
9 throughout the deployments.

10 I provided the names and locations of
11 the five homes that we had identified to
12 Lieutenant-Colonel French on the 23rd, and work
13 began at the CAF to reach out to the homes or the
14 hospitals that were involved with the homes.

15 As I said, we reached out to every home
16 to arrange for the initial contact to let them know
17 who would be reaching out to them from the armed
18 forces and provide information about the rep and
19 when they would be in touch and so forth.

20 Lieutenant-Colonel James Stocker was
21 the frontline contact for homes. I dealt with him
22 occasionally, but typically, my liaison was with
23 Lieutenant-Colonel French.

24 Once the contacts were identified and
25 initiated, the CAF then began their recognizance

1 work to meet with each home and identify the needs
2 in the home. They went to meet with the home.
3 They sent a separate recognizance team to assess
4 the area for accommodation and supports where they
5 would get meals, where they would be able to do
6 laundry, things like that, and to plan for the
7 deployment.

8 The Canadian Armed Forces moved very
9 swiftly to enable the teams to be on site at the
10 home, all five homes, by April 28th. So from the
11 moment we created the list to the date of
12 deployment was five days.

13 And one of the first recognizance
14 visits, it was anticipated that all five homes
15 could be surveyed in one day. And they found that
16 the first two visits were overwhelming with staff
17 just wanting to talk and to share what was going on
18 in the home, so they were unable to complete all
19 five assessments on the first assessment day.

20 And so that went through the Friday and
21 the Saturday, and so we lost a bit of time there.
22 But overall, a very swift deployment on behalf of
23 the Canadian Armed Forces.

24 The first five were initially set for
25 two to four weeks. I think we all anticipated it

1 would be four weeks, but there was the potential
2 for them to move out sooner if they felt the need.

3 As things progressed, the Canadian
4 Armed Forces notified me that they were seeing
5 substantial progress with Holland Christian manor
6 and would be ready to move on within a week or so
7 of that first conversation about the conclusion of
8 their work there. So we began preparations to
9 identify a rationale for their departure.

10 The CAF provided a set of factors that
11 they evaluated identified. And you'll see, in the
12 slide deck, an example of -- a sample of what they
13 did. A similar tool had been used in their work in
14 Quebec to determine readiness to depart.

15 And OH and the Ministry of Long-Term
16 Care reviewed their advice, confirmed with local
17 partners in the home on the advice based on that
18 red/yellow/green assessment and then determined if
19 the timing was appropriate to depart.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 Can I just stop you there for a second?

22 CATHERINE BROWN: Yes, you may.

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 The Canadian Armed Forces went into Quebec first --

25 CATHERINE BROWN: Yes.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 -- earlier than they went into Ontario?

3 CATHERINE BROWN: Yes, they did.

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 Do you know when they went in?

6 CATHERINE BROWN: I do not, no.

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 In the period up to April 23rd, do you know what
9 prompted --

10 Did Ontario request assistance? Do you
11 know whether Ontario asked for help or whether the
12 Solicitor General of Canada volunteered help? Do
13 you know?

14 CATHERINE BROWN: I don't. I know
15 there were letters exchanged, and they were to --
16 none of them were to me or to the Ontario Health
17 personnel. So I think it would be for Ministry of
18 Long-Term Care or Ministry of Health to answer that
19 question.

20 I know that we had heard for a couple
21 of days that there were discussions going on behind
22 the scenes that potentially the Canadian Armed
23 Forces would be deployed in Ontario.

24 And we had seen their work in Quebec,
25 I'd say, for about a week at that point. We had

1 seen on the news that they had been in Quebec, but
2 I couldn't say for sure, Commissioner Marrocco.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Well, what --

5 BRIAN POLLARD: It's --

6 CATHERINE BROWN: Sorry, we have a
7 response.

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 Sorry, Mr. Poland.

10 BRIAN POLLARD: Oh, I was just going --
11 to add to your question, so we would have formally
12 requested to the Federal Government for assistance
13 on April 23rd. But I'm not entirely sure if there
14 were conversations that happened elsewhere within
15 that home before that formal letter went over.

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 And picking these places, how did you do that? How
18 were they chosen? Like, what criteria were
19 applied?

20 CATHERINE BROWN: So they were homes
21 that had been struggling with outbreak and had had
22 significant staffing issues. And I can't say that
23 we identified it specifically at the time but
24 certainly in hindsight that were also struggling
25 with leadership and getting back on their feet.

1 And so we looked at, particularly,
2 staffing. A lot of the homes were fearful. And
3 because of the way in which the outbreak was being
4 managed, staff were scared to come back to work.

5 I should also note that the week prior
6 to the CAF offer, we had seen the first death of a
7 healthcare worker in Ontario, and it was a personal
8 support worker that worked at Altamont, one of the
9 five homes that was eventually selected.

10 So there was a lot of fear happening at
11 the time, a lot of concern by workers about the
12 risk of going to work. And these five homes,
13 amongst the 11, were deemed to be in critical need
14 of that extra staffing and support.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Can you say whether those homes asked --

17 Did they ask Ontario Health for help?

18 CATHERINE BROWN: They didn't ask for
19 the CAF. They asked for help. And they were in
20 varying degrees of acceptance, I would say, of what
21 was going on and their capacity to respond. So
22 the --

23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 That --

25 CATHERINE BROWN: Sorry, go ahead.

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 No, no. I'm sorry. You weren't finished.

3 CATHERINE BROWN: No, I think that it
4 was early in the -- it wasn't super early, but it
5 was --

6 Homes were just starting to see that
7 they were not coming back from this as quickly as
8 others. And I think, as with anything, they wanted
9 to be recovering, and they weren't.

10 So they weren't -- I wouldn't say they
11 were "resistant." They just felt that they could
12 do it on their own. And so even the hospital
13 supports that we sent into Orchard Villa, there was
14 a little bit of -- not "resistance," but a "we're
15 okay. We don't need this" and us saying "no, we
16 think you do. We think we need to give you this
17 extra help."

18 And I would say, for some of the homes,
19 that was their reaction with the army as well.
20 They were concerned that they didn't need that kind
21 of help but were glad of it once it got there for
22 sure.

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 It seems that this situation was so unacceptable or
25 critical, to use a more neutral word.

1 I'm having some difficulty
2 understanding why it's a consultation at that stage
3 with them. You've got a very serious problem in
4 these homes. The whole country has a problem, but
5 they have a particularly serious problem.

6 And I'm having some difficulty
7 understanding why it's really a consultation at
8 this point and why the local Medical Officer of
9 Health doesn't simply make an order.

10 CATHERINE BROWN: So at that point, we
11 were just starting to understand that kind of flow,
12 as you describe it, and the discussions and that
13 some were not taking help when it was offered.

14 And we didn't understand, I would say,
15 initially. Maybe that help should have been -- we
16 should have been pushier with the help. We now see
17 that differently, and we move very quickly, and
18 Public Health does issue orders.

19 Orchard Villa was the first Public
20 Health order that -- where we used that tool to get
21 the hospital in. So I think -- I'm not sure what
22 consultation you're referring to, but when we --

23 You know, by the time the CAF went in
24 to talk to them about coming in, they were coming
25 in. There was no -- it wasn't going to be based on

1 that discussion. They weren't going back. It was
2 "what can we do to help?"

3 Si when they did the recognizance
4 visits, it was already understood. Those were the
5 five homes they were going to. There was no
6 ability to say "no," and then CAF was there to talk
7 about what they needed.

8 So when they did the recognizance
9 visits on those two days, they talked to the home
10 about what was going on and how they could help
11 them. And they built their teams to support what
12 they thought was needed in the home based on their
13 discussions with the home and, typically, with the
14 hospital that was working with the home. Does
15 that --

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 All right. Commissioner Kitts?

18 COMMISSIONER JACK KITTS: And just
19 looking at this sequence, so the military was
20 called in to help the worst homes. Was that before
21 hospitals were called in to help the others?

22 And the second part of the question is
23 in the pandemic plan or the emergency preparedness
24 plan, was hospital support and/or military support
25 envisioned in that plan?

1 In other words, did we hit a point
2 where we had to trigger the plan to bring in the
3 military or the hospitals?

4 CATHERINE BROWN: So to your first
5 question, hospitals were already working with homes
6 in varying degrees, and so that work was already
7 well underway in differing degrees across the
8 province.

9 But certainly where homes were
10 struggling, there were lots of hospitals that were
11 working very closely with homes. So that support
12 was already in place.

13 And, in fact, Orchard Villa, one of the
14 homes that received the CAF as well as, I think,
15 Hawthorne and Eatonville, all had substantial
16 hospital involvement and still benefitted from the
17 additional supports of the Canadian Armed Forces.

18 To your second question about
19 preparedness planning, you know, we probably -- if
20 we had many teams from the CAF, we probably could
21 have deployed many more teams, especially in the
22 peak of sort of April -- early April to early May
23 where we were seeing homes hardest hit.

24 Five teams were made available. That
25 was what was contracted with the province. We did

1 ask for additional teams. They were unable to
2 provide it because they weren't providing supports
3 to Quebec. And they were -- by that point, were
4 starting towards the end of -- our time, they were
5 start to go provide supports to Alberta as well, I
6 believe.

7 So we were only able to have the five
8 teams. We did redeploy one team and part of
9 another team when they came out of the first five.
10 They were redeployed to two other homes. So we
11 were able to benefit -- or seven homes in Ontario
12 were able to benefit from the extraordinary
13 supports of the Canadian Armed Forces.

14 COMMISSIONER JACK KITTS: So it was in
15 escalation of severity when the hospitals couldn't
16 manage, then, for certain homes to call in the
17 military?

18 CATHERINE BROWN: Yeah, I understand
19 the question. It's a good question. It wasn't --
20 I wouldn't say they had the option to call in the
21 military. Because it happened so quickly, the
22 first five, we were just told that "you have this
23 option, and it's happening. Can you pick the
24 homes? And we need to know today."

25 And so I don't recall -- to be honest,

1 I don't recall contacting the hospital saying
2 "would this be helpful?" I might have done that.
3 I'd have to check my notes.

4 But we certainly conferred with the
5 regions who were in touch with the hospitals, and
6 we knew those homes were in extraordinary trouble,
7 and so we accepted the armed forces.

8 I do recall having the discussion with
9 a couple of CEOs, certainly for you Downsview and
10 Woodbridge, both head of hospitals involved, and
11 their hospitals were eager and active to -- and
12 happy to get the supports of Canadian Armed Forces,
13 yeah.

14 COMMISSIONER JACK KITTS: Thank you.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Ms. Brown, how was it that Ontario Health knew that
17 those homes were in difficulty?

18 CATHERINE BROWN: So Ontario Health's
19 role in long-term care through the pandemic was --
20 we got involved early on as homes were reaching out
21 for help with personal protective equipment and
22 with staffing.

23 And you may recall the Pinecrest was
24 the first significant outbreak in a long-term care
25 home in Bobcaygeon, Ontario. And that was at the

1 end of March, I think around the 22nd of March, and
2 they reached out to Ontario Health.

3 We have a relationship with long-term
4 care homes for a long-term care placement, and so
5 they know us, and so they called us to say "can you
6 help us with PPE, and can you help us with
7 staffing?"

8 Because we also have the home care
9 operation, so we have a liaison with all of the
10 service providers that provide home care services
11 which typically are the same health human resources
12 personnel, personal support workers, nurses,
13 et cetera.

14 So they reached out in Pinecrest to us
15 for help. And in parallel, around the same time in
16 Central Ontario, they reached out from Camilla to
17 the LHIN or Ontario Health to ask for help, and
18 then it kind of just went from there. And so we
19 got very closely involved with connecting hospitals
20 and other supports to long-term care homes on the
21 ground.

22 We have capacity on the frontline and
23 are connected to the rest healthcare system, so
24 that's how we came to be part of it in the way that
25 we were.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 When you say "capacity on the frontline," what do
3 you mean?

4 CATHERINE BROWN: We work very closely
5 with -- so we had been doing health system capacity
6 planning for COVID. We had been working with
7 hospitals to reduce their capacity so that they
8 could take in COVID patients and to down the
9 scheduled surgeries and to do all of those things.

10 So we had built a very close
11 relationship with all of the health partners in the
12 regions. Each region of Ontario Health -- there
13 are five regions -- had established a COVID
14 response table early on in the pandemic. I'm going
15 to say late February/early March.

16 And those tables became the central
17 focus for COVID response preparedness across
18 Ontario for the regions. So we had easy access to
19 the other partners. Long-term care was typically
20 involved in some way at those tables. Although, as
21 things progressed, homes were less and less able to
22 participate in a normal kind of way, and we became
23 their partner in responding.

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 One sort of final -- I don't mean to monopolize

1 this. But there were, I think, 34 health units in
2 Ontario.

3 CATHERINE BROWN: That's correct.

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 I'm curious -- was there a reason why Ontario
6 Health dealt with it on a region-by-region basis
7 rather than dealing with each of the 34 health
8 units that were all -- than each of the health
9 units?

10 CATHERINE BROWN: That's a good
11 question. The way in which Ontario Health was
12 configured, there were 14 Local Health Integration
13 Networks. They each have their own geography. And
14 those geographies were kind of pulled together into
15 five Ontario Health regions. They don't align with
16 the Public Health boundaries. They are more --
17 they are health boundaries.

18 So we did work with all 34 Public
19 Health units, and we established local
20 relationships for all of the homes and all of the
21 hospitals, wherever they resided so that,
22 currently, when we have an outbreak or a response
23 to an outbreak, it typically involves Ontario
24 Health, Ministry of Long-Term Care, the local
25 Public Health unit, and the hospital partner.

1 And we pulled together very quickly to
2 respond to homes. It was less smooth at the outset
3 because we didn't have a long-standing relationship
4 with Public Health in that way because we've never
5 worked with them in this kind of environment, this
6 kind of long-standing crisis environment, so...

7 But we worked with them from the outset
8 as best we could, yeah.

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

11 CATHERINE BROWN: Thank you.

12 COMMISSIONER ANGELA COKE: Catherine?

13 CATHERINE BROWN: Yeah.

14 COMMISSIONER ANGELA COKE: Just
15 generally speaking, in hindsight, are there any
16 sort of lessons learned from this deployment
17 process from OH's point of view? Anything you
18 would have done differently?

19 CATHERINE BROWN: That's a good
20 question. I don't know. You know, we learned a
21 lot about -- and I think part of it was through the
22 CAF.

23 We learned a lot about that readiness
24 and what was really going on in the home. And I
25 think to some of Commissioner Marrocco's questions,

1 we probably let it ride a little bit longer.

2 We heard from homes initially "no,
3 we've got this. We're doing the best we can, and
4 we're trying really hard." And we would give
5 supports, and we would offer and wait for them to
6 take it up.

7 And very quickly, we learned we needed
8 to be a little more aggressive and say "it's not
9 your choice. We are giving you this help. We are
10 not letting you fail and that being an impact for
11 residents. So we're helping you whether you need
12 the help -- whether you believe you need the help
13 or not."

14 And we still see that. We still see
15 homes saying "we're okay" and us saying "you're
16 not." And maybe you are. And if the help is
17 unnecessary and we throw some resources at you and
18 it further helps to accelerate the response of the
19 home and the stabilization, that's all for the
20 better. We'd rather that than say "you take your
21 time and try to figure it out."

22 So I think between early into Wave 1 --
23 I'd say sometime around the CAF response time, we
24 started to realize we have to be a little more
25 aggressive in offering supports.

1 And I know you've heard this before,
2 but it was all happening so fast. Like, you
3 couldn't fathom how quickly things were changing
4 for homes and across the healthcare system.

5 I think for hospitals, as well, it was
6 often their first time working in this way with
7 long-term care homes. Long-term care homes had
8 never had IPAC support of this kind or needed IPAC
9 support. It was for everybody.

10 It was a disease that was just beyond
11 anyone's comprehension. And so rallying that
12 response, it seemed to take a long time, but it was
13 relatively quick.

14 And certainly, in terms of the
15 government response, it was extraordinarily quick.
16 That -- it took weeks, not months and months. But
17 at the time, it just felt like forever sometimes to
18 get things turned around even though it took a
19 couple of days.

20 So I know, for example, people said
21 "what took so long to get the army in there?" And
22 it was -- like, it was five days from the time we
23 first talked to them to the time they had boots on
24 the ground in those homes. It was five days which
25 is extraordinary quick including recognizance

1 visits. They had to find hotels. They had to
2 identify personnel. They had to screen them and
3 train them. So it was a very quick turnaround, all
4 things considered, but five very long days for
5 those homes.

6 COMMISSIONER JACK KITTS: Catherine,
7 can I ask a question about decision-making at the
8 regional or even the local level?

9 So does the Ministry of Long-Term Care,
10 the Ministry of Health for the hospitals, Ontario
11 Health, and then the Public Health -- what was the
12 relationship between Public Health's reporting to
13 those different areas? And was Ontario Health sort
14 of the leader that brought them all together? Just
15 give us an idea of how that worked.

16 CATHERINE BROWN: Thank you. So we
17 were more of a coordinator, I'd say, in pulling
18 people together. And Public Health, as you know,
19 reports municipally, and so they were certainly
20 cooperative in most areas of the province.

21 Some places, they were a little more
22 reluctant to participate at the local tables, but
23 we worked with them as best we could in all of the
24 communities.

25 I would say they had -- with long-term

1 care, they were typically involved as it related to
2 testing and outbreak management. That is their
3 role.

4 And in some areas, they were more
5 adamant about keeping in their lane and telling us
6 kind of after the fact. It was harder to get
7 information. I think that's a learning that is
8 vastly different in Wave 2. Much more
9 communication and information going back and forth
10 in a more collaborative way.

11 And so our role, at that time, was to
12 pull the parties together. And we started
13 creating -- I think I spoke to this last time, and
14 you've heard about the red/yellow/green sort of
15 list.

16 We started creating those, and that had
17 input from Public Health from as well as the
18 Ministry of Long-Term Care and Ontario Health which
19 included input from the hospitals and other
20 partners to track the status and response, more
21 importantly, for each of the homes.

22 COMMISSIONER JACK KITTS: Excellent.
23 Thank you.

24 CATHERINE BROWN: Thank you, Dr. Kitts.
25 Shall I resume? I think I'm

1 almost done.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Sure. Go ahead.

4 CATHERINE BROWN: Yeah.

5 COMMISSIONER FRANK MARROCCO (CHAIR): I
6 don't think there are any further questions at this
7 point.

8 CATHERINE BROWN: Okay. So just on the
9 determination of homes -- departing of homes. The
10 factors that the armed forces considered and then
11 we reviewed and made a determination were four
12 factors, as you can see the chart.

13 The first one was an assessment that
14 the CAF support was not -- required any further.

15 The second one was the number of
16 COVID-19 cases, that they were able to self-manage
17 existing cases, that new cases of COVID were
18 decreasing, and the number of recovered cases.

19 The third area and fourth area were
20 typically the areas that, I'll say, languished the
21 longest and were the ones that we often waited for
22 to go green for at least a week before we came out.

23 And that was IPAC, that appropriate PPE
24 was available. You'll recall, at that time, PPE
25 was still quite challenging but also that there was

1 a management plan established for the home, that
2 they knew how to use PPE, that there was
3 appropriate donning and doffing procedures in
4 effect as well as cleaning procedures had been
5 established, waste management had been established,
6 many issues that were later identified by the CAF
7 in their report. And then, last but not least,
8 staffing.

9 And so one of the critical things that
10 the armed forces offered was that stabilization so
11 that sufficient staff could return, allowed the
12 employers and the homes to start working with their
13 staff that were off to get them to return to work,
14 that there were medical staff available for day and
15 night shifts.

16 As you may have heard, medical staff
17 coverage was not where one would have hoped it
18 would have been at that time, and so they worked on
19 ensuring that was in place. And then, as I said,
20 sick staff coming back.

21 And so in most cases, the armed forces
22 stayed for the duration of their time. In some
23 cases, they stayed a little bit longer, and the
24 departures were maintained to allowed times for the
25 homes to really adjust.

1 Once the homes -- the CAF indicated
2 they wanted to come out, we would pick a date.
3 Give the home about a week to adjust to that. We
4 often had to extend it for a day or two because
5 they wanted an opportunity to have a farewell
6 celebration with the CAF and thank them for the
7 contribution.

8 As I mentioned, the CAF then came
9 out -- the first two homes they came out of, they
10 were then redeployed. So from the Holland
11 Christian manor, they went into Downsview, and they
12 went into Downsview which was a very troubled home
13 on June the 2nd.

14 They didn't stay there a long time.
15 The hospital had been there for quite a while at
16 that point. And we were also moving into June, so
17 outbreaks were settling down.

18 But Barb Collins -- the CEO of the
19 hospital, Humber Regional Hospital that was working
20 with Downsview -- felt that there would be a
21 benefit there, and so they went in for a couple of
22 weeks there.

23 And then last but not least, when they
24 came out of Orchard Villa, which they were in for
25 quite a while, they moved to a home called

1 Woodbridge Vista, and they were there just under a
2 month.

3 And the Canada armed forces had planned
4 to be out by early June, but they extended their
5 time to be out by -- later in June but extended to
6 July the 3rd very graciously, and we were very
7 grateful for that.

8 So that, in short, is all of the
9 information I have to share this morning. I don't
10 know, Brian, if you had any other comments you
11 wanted to make.

12 BRIAN POLLARD: No. Thanks, Catherine,
13 no further comments. I'm happy to answer any
14 questions.

15 COMMISSIONER FRANK MARROCCO (CHAIR): I
16 did have a question. One of the criteria was the
17 personal protective equipment.

18 Was there a requirement that each home
19 have a supply of personal protective equipment on
20 site sort of pre-pandemic? Was there any
21 requirement like that?

22 CATHERINE BROWN: Brian would be better
23 to speak to that one, I believe.

24 BRIAN POLLARD: Yeah. So we would have
25 always required homes to have the supplies that you

1 would need to deal with outbreaks especially
2 relating to the flu because that's such a prevalent
3 disease that obviously impacts long-term care.

4 But in terms of requiring the homes to
5 have X weeks of supply of PPE, that would not have
6 been an existing requirement.

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Do you think that, given what's happened, that
9 would be a useful requirement to impose?

10 BRIAN POLLARD: I do.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Okay. Thank you. Was there any problem in terms
13 of a duplication of authority or confusion about
14 boundaries?

15 There seemed to me -- the uninitiated,
16 really, I guess, of the --

17 There's a number of organizations
18 trying to help here, each with its own
19 jurisdiction, if you like.

20 CATHERINE BROWN: That's a great
21 question. The one area that there was some -- so
22 the military was very clear. They came with their
23 own command. Their staff reported to them. They
24 worked in parallel with the home. That's why those
25 recognizance visits and those leadership

1 partnerships were critical. They needed to know
2 who their counterpart was, and they needed a
3 medical and an administrative counterpart.

4 So they set that up initially, but they
5 were very clear. Their staff reported to them.
6 The PPE rules were theirs. They were going to
7 maintain that oversight of their own teams, and
8 they were not overseeing staff in the home. So the
9 staff of the home remained the employees under the
10 oversight of the home or the hospital that was
11 managing the home.

12 The one area that they sighted as
13 problematic in some homes early on was that homes
14 were not providing the medical coverage that was
15 necessary particularly on night shifts. They were
16 deferring to the Canadian Armed Forces.

17 They flagged that for us early on that
18 that was not acceptable to them, that they are
19 working for and with the home. They cannot be the
20 only medical oversight in the home. That's not the
21 contract.

22 So we made that clear to the one or two
23 homes where that was an issue, and then we raised
24 it with all five homes to say "you need to be
25 mindful of the fact you're still responsible for

1 coverage. And they will support you, and they will
2 add additional boots on the ground, but you're
3 responsible for medical coverage on all shifts."
4 And they can augment it, but they still had to have
5 their own medical people on to make decisions.

6 COMMISSIONER FRANK MARROCCO (CHAIR): I
7 guess I was more directing my question to the
8 initial period when everybody's trying to respond
9 to this.

10 It just seems to me there are so many
11 different parts of the public -- well, you could
12 call a "Public Health system," each with its own
13 boundary, if you like, or each with its own
14 jurisdiction.

15 I was wondering -- I don't want to ask
16 you an awkward question, but it just seems like
17 maybe there's --

18 CATHERINE BROWN: But you're going to.

19 COMMISSIONER FRANK MARROCCO (CHAIR): I
20 am, yes. I was just trying to extricate myself
21 from...

22 It seems like there's too many. Do you
23 have a sense of whether the predicament the
24 long-term care homes found themselves in was a
25 function to some extent of the various

1 participants, there being too many participants?

2 CATHERINE BROWN: I would say it
3 slightly differently. I think that there were
4 certainly a lot of different parties involved. And
5 prior to COVID, the health system has always
6 operated a bit in different ways and different
7 silos and partners.

8 You know, it's an age-old problem.
9 I've worked in healthcare my whole career, and
10 issue of silos has been ever thus. And some
11 communities do it better than others and work more
12 collaboratively.

13 Long-term care homes, I think, have
14 typically been a -- this is my opinion. They're
15 sort of the end of the line, right? You typically
16 do not return from a long-term care home.

17 So when you're discharged from home or
18 hospital into a long-term care home, you are then
19 the -- you've moved into that home. You are living
20 the final months and years of your life in that
21 home.

22 Hospitals respond when residents move
23 in and out for care in a hospital, but there isn't
24 a system of care in the way that we needed it in
25 this moment. And Public Health, as well, have

1 their own responsibilities, and we weren't set up
2 to operate in a smooth way for this kind of
3 pandemic response.

4 So do I think there were too many? Not
5 necessarily.

6 Do I think that there was a lack of
7 clarity about who should be doing what and how
8 quickly they could step up to do that? Yes, there
9 was a lack of clarity.

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 And how do you impose that? I mean, I'm not -- you
12 may not be able to answer this question, but are
13 you able to say how one could impose that kind of
14 clarity at least in respect of long-term care
15 homes?

16 CATHERINE BROWN: That's a tough
17 question. You know, we've learned a lot about how
18 we could do better and how we are doing better. I
19 think putting in place clear rules that allow
20 flexibility but also make clear who is supposed to
21 be doing what and what their responsibility is in
22 that regard.

23 That said, you know, a home is
24 responsible, for example, for staffing. In normal
25 times, a long-term care home wouldn't go to the

1 hospital and say "can you give us some staff for a
2 weekend shift?"

3 And all of those responsibilities were
4 in place and will remain in place going forward.
5 It's "how do you amount that crisis response in a
6 time like this allowing people to remain
7 responsible, putting in place whatever those rules
8 need to be, holding people accountable but also
9 allowing for that flexibility to help each other
10 respond in that moment?"

11 And I think you've made suggestions in
12 your interim recommendations about staffing and how
13 things might have been differently supported from a
14 staff perspective.

15 I think, in hindsight, having had those
16 things in place prior to this would have been
17 great, but that wasn't thus. You know, we've known
18 for years in Ontario there's a personal support
19 worker shortage, and we've been working on that but
20 never with the clarity and focus that we have now.

21 So I think that's all of those things,
22 as a crisis often presents an opportunity, that has
23 happened here. But I'm not sure what the lever is
24 to make those roles and responsibilities clear but
25 still flexible enough that we can help one another

1 in a moment like this.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 Now, it --

4 BRIAN POLLARD: May I have a bit of
5 colour here?

6 CATHERINE BROWN: Yeah.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 Sure.

9 BRIAN POLLARD: Yeah. So the most
10 persistent relationship and existing relationship
11 we would have had here would have been between the
12 long-term care home and their local Public Health
13 unit.

14 And the reason that that relationship
15 exists is because of what I mentioned before which
16 is outrage of flu. So usually long-term care homes
17 would be interacting with their Public Health units
18 regularly in terms of any incidents and prevalence
19 of flu to determine if there's a need for the home
20 to be in outbreak.

21 So if you consider that as an existing
22 relationship, many homes would have turned to their
23 Public Health unit, I think, as an initial place
24 to -- you know, for help.

25 Now, the challenge comes in in that,

1 you know, the service that many of our Public
2 Health units provide would be advisory as opposed
3 to on the ground on -- you know, in homes kind of
4 helping homes turn a situation around.

5 And you can just look at IPAC as an
6 example. Certainly one of the big learnings we've
7 taken away from this is that, really, what we were
8 provided in the early days generally, you know, was
9 IPAC advisory services and what homes needed where
10 people could come in and actually help them
11 implement those recommendations.

12 So above and beyond kind of the silos
13 is also the type of service those silos provide to
14 help with the issue.

15 And certainly, to Catherine's point,
16 you know, staffing became such a critical issue
17 very, very quickly. But it's not just staffing.
18 It was also the type of staffing you needed.

19 So, you know, they were looking for --
20 you know, homes were looking for PSWs as an
21 example. And, you know, hospitals would not
22 naturally -- and I think Dr. Kitts would know this.

23 You know, hospitals wouldn't naturally
24 have a ton of PSWs just lying around. Hospitals
25 have nurses. So, you know, even getting the mix

1 right is part of the complexity here in terms of
2 being able to support homes, and the list goes on.

3 So you have IPAC. You have staffing.
4 You have PPE, et cetera. So in talking about
5 coordinating in the system, there is certainly, I
6 think, room for clarification on who is on first on
7 whatever issue, but also a recognition of we also
8 need to kind of recognize what kind of service and
9 what are the limits to the service that they can
10 provide in dealing with the pandemic.

11 COMMISSIONER FRANK MARROCCO (CHAIR):

12 It just seems -- it just seems to me -- and I want
13 to get some help with this. Not necessarily your
14 responsibility to help me, but maybe you can.

15 It would seem to me that the long-term
16 care facility would be most closely connected with
17 the local Medical Officer of Health in the unit
18 where the home is located. And local Medical
19 Officer of Health and the Chief Medical Officer of
20 Health seem to me, under the Health Protection and
21 Promotion Act, to have a lot of power to make
22 orders to give direction.

23 And so I'm having a little difficulty
24 with the idea that there would be a lack of
25 clarity. I could imagine at the beginning there

1 would be a lack of clarity because this had never
2 happened before, but there seems to be an
3 institutional structure there for clarity to emerge
4 because they're our decision-makers. And I'm
5 trying to understand whether that's correct or not.

6 BRIAN POLLARD: From my perspective,
7 Justice Marrocco, nothing you said is incorrect.
8 But I go back to, you know, my point around, you
9 know, "yes, an order has been served. What next?"

10 And I think -- you know, if we kind of
11 think ahead to kind of, you know, a future state,
12 it's unclear how those Public Health units -- and
13 this is probably what we need to think about
14 collectively.

15 It's unclear to me how those Public
16 Health units actually help with the implementation
17 and the support. And I'm not talking just about
18 virtual support but the support on the ground to
19 help homes turn their situation around.

20 And I think that that is where -- you
21 know, that is where a lot of the concerns sit. And
22 so, you know, I'm obviously speaking to my Public
23 Health unit. I'm getting -- you know, "they're
24 going to be declaring outbreak on my home. How do
25 I get out of this?"

1 And, you know, what homes were looking
2 for was not someone who is just on the phone saying
3 "well, you need to cohort residents, and you need
4 to cohort staff. You need to do A, B, C."

5 They were actually looking for tangible
6 help and how they do that to match their physical
7 surroundings and some of the very unique issues
8 they were dealing with.

9 So I just -- you know, not to kind of
10 belabour the point. I just think that, you know,
11 that ability to kind of wrap around the service and
12 the expertise in terms of how you solve the issue
13 and not just be an advisory service, I think, is
14 going to be important here as well.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 Commissioner Coke?

17 COMMISSIONER ANGELA COKE: So I just
18 want to clarify. So you're saying obviously they
19 have the authority to do certain things but not the
20 implementation and capacity?

21 BRIAN POLLARD: Yeah. Yes, thank you.
22 That's a succinct way of saying it.

23 COMMISSIONER ANGELA COKE: Okay.

24 BRIAN POLLARD: Yeah. I mean, like,
25 let me give you an example. Like, we had -- you

1 know, I have cross in my desk, you know? We had
2 spoken to a home about IPAC, and I would kind of
3 get on the phone and be like "what does that mean?
4 Does that mean that you actually just spoke to the
5 operator? Did you actually go to the home and see
6 the structure and figure out what they could do or
7 not do?" And invariably, I think it was -- you
8 know, I think it was more of the former.

9 And that comes back, Commissioner Coke,
10 to your point about implementation and capacity.
11 You know, we didn't have enough of that skill set,
12 you know, to go around.

13 And you know, then we look at, you
14 know, the homes that the CAF went into. And
15 Catherine mentioned this earlier in passing around
16 leadership: One of the elements we were dependent
17 on is that for pretty much, I think, four of them
18 out of this five were parts of larger chains.

19 So we were anticipating and expecting
20 that they would have been able to rally corporate
21 resources to help them. But, you know, that didn't
22 occur.

23 COMMISSIONER ANGELA COKE: Okay. If I
24 could just --

25 CATHERINE BROWN: If I --

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 So --

3 COMMISSIONER ANGELA COKE: Go ahead. I
4 had a question for Catherine, but go ahead.

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 No, no, no. Go ahead, Commissioner. I've asked a
7 lot of questions.

8 COMMISSIONER ANGELA COKE: Okay. No,
9 I'm just following up on some of the comments you
10 made. And, you know, in terms of your ability to
11 provide a very coordinated response, you have
12 inherent challenges pre-COVID in the healthcare
13 system being a very decentralized model.

14 So I mean, once a crisis hits, you
15 have -- at least from what I can see, even more
16 challenging to sort of rally and move quickly. Is
17 that fair to say, relative to some other
18 jurisdictions who have different models that I
19 think they can probably trigger a response quicker?

20 CATHERINE BROWN: Yeah. I think making
21 clear -- I'm going to go back, if I can, to Brian's
22 point for a second.

23 I think that at the start -- and to
24 Justice Marrocco's "shouldn't it have normalized by
25 now," maybe it should have been should have.

1 Public Health had a very distinct role.
2 The Ministry of Long-Term Care Inspections had a
3 very distinct role with long-term care homes.

4 They each -- as things started, homes
5 didn't know who to turn to. They didn't know -- to
6 Brian's point, IPAC was something that they should
7 have been doing for regular infection prevention
8 and control, for flu, for C difficile outbreaks,
9 for things like that.

10 But this kind of IPAC was different for
11 them, and Public Health was giving advice
12 virtually, not necessarily on the ground.

13 To your earlier question, Justice
14 Marrocco, we see that still that some of the Public
15 Health units are doing a phone audit of what's
16 going on with IPAC as opposed to going into the
17 home and doing an IPAC audit.

18 So I think clarifying -- to your
19 question, Commissioner Coke, I think, you know,
20 clarifying who was expected to do what and then
21 ensuring they have the capacity to do it.

22 So I go back to Brian's point on Public
23 Health. Public Health was struggling to do
24 testing; to do contact tracing; you know, IPAC on
25 top of that. And I think it's regularized a little

1 bit, but there's still a capacity stretch as we've
2 seen with contact tracing and other things. So
3 identifying those roles and responsibilities and
4 clarity of who is responsible.

5 And I think the system, I will say, has
6 worked better together than I think might have been
7 anticipated. It's actually been quite an
8 extraordinary response in many communities and in
9 many ways.

10 And Public Health, in many of those
11 communities -- Ottawa as an example; Toronto as an
12 example; there's many others -- has been central to
13 that in driving that response.

14 The last thing I just wanted to note
15 was -- and I was going to say this earlier.
16 Ontario Health didn't really exist before COVID in
17 any functional way. We were formed early in 2019,
18 but remained 21 separate agencies until December of
19 2019.

20 And so we had just started to kind of
21 come together as an organization to look at what
22 Ontario Health would be going forward. And early
23 days in COVID, we were asked to step in and set up
24 those regional tables and help to drive that
25 capacity response on the ground.

1 And so we were another partner that
2 people were sort of, like, "who are they and where
3 did they come from? Why are they calling us?"

4 But very quickly, to my earlier
5 comment, people needed some place to go. To your
6 comments, Justice Marrocco and others, like, they
7 needed to know who was responsible and where they
8 could get answers.

9 And we filled that void in some ways
10 when Public Health and others couldn't get back to
11 them as quickly or weren't able to respond in the
12 way they needed. Public Health would never be the
13 one to give them staffing or help connect them with
14 where they would get that.

15 So I think structuring that somehow
16 going forward and looking at how we can maintain
17 some of the gains here on how the system has
18 rallied to respond and connect in will be critical.

19 And that's over to you to do,
20 Commissioners. I put that back to you to figure
21 out.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 Commissioner Coke, go ahead.

24 COMMISSIONER ANGELA COKE: Sorry, I
25 just want to clarify. In terms of how Ontario

1 Health has set itself up now and the five regions,
2 the anticipation, then, is, going forward, there's
3 more coordination or collaboration driven through
4 those five regions?

5 CATHERINE BROWN: Absolutely, yeah.

6 COMMISSIONER ANGELA COKE: Okay.

7 CATHERINE BROWN: And so we continue to
8 have ongoing tables, we're just establishing more
9 sort of IMS response structures on the ground,
10 working through those tables and through those
11 regions.

12 And the Ministry of Health, Ministry of
13 Long-Term Care, we work very closely with both of
14 them on mounting the response to COVID, system
15 capacity building, funding of hospitals, expansion
16 of beds, that kind of thing all through those
17 tables and through Ontario Health regions, yes.

18 COMMISSIONER ANGELA COKE: And the
19 long-term care folks, a tighter knit as you go
20 forward? You don't fund them. Some things you do
21 for the system but not for long-term care.

22 CATHERINE BROWN: We don't have a legal
23 relationship with long-term care. We do the
24 placement and waitlisting, and we fund in a
25 flow-through kind of relationship but not in an

1 oversight relationship. The oversight is the
2 responsibility of the Ministry of Long-Term Care.

3 But that relationship on the ground is
4 vastly different now, so we are working very
5 closely -- hospitals and OH and our long-term care
6 partners and with the Ministry of Long-Term Care,
7 we're working very closely with them.

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 Okay. Commissioner Kitts?

10 COMMISSIONER JACK KITTS: Just
11 following along that vein: So as you said,
12 Catherine, in Wave 2, it's much easier to bring
13 these four -- what would -- what I would say
14 pre-COVID would be "four silos" together to work
15 together against a common threat. And it sounds
16 like you're all working collaboratively much more
17 so than in the first wave.

18 So when you look at the ultimate
19 structure for who is responsible or who is the
20 lead, you have Public Health, you have Ontario
21 Health, you have Ministry of Health, and you have
22 Ministry of Long-Term Care responsible for all the
23 parties that need to be involved on the ground and
24 in the front.

25 It sounds like if the hospital or

1 long-term care or primary care -- if anybody has a
2 problem, Ontario Health would be the first place to
3 call; am I correct?

4 CATHERINE BROWN: That is correct.
5 That is our role. Our role is to bring together
6 the parties, and we will grow more and more into
7 that oversight and functional response role. And
8 this COVID foundation has been an early start for
9 us and how that work will evolve, yeah.

10 COMMISSIONER JACK KITTS: And you have
11 a regional CEO for Ontario Health, and you have
12 local leaders as well for Ontario Health?

13 CATHERINE BROWN: So the five regional
14 leads are also the CEOs of the LHINS. So they are
15 our CEO level. There are regional leads, and then
16 there are vice presidents of -- typically home and
17 community care that are working on the long-term
18 care response and that are leading the response
19 locally with other health partners and their teams
20 that are working on that on the ground. And we
21 also rely on the partnerships with hospitals,
22 homes, Public Health, and others to build that
23 capacity, yeah.

24 COMMISSIONER JACK KITTS: Okay. So
25 regardless of the reporting relationship, if

1 there's an issue in the local area, Ontario Health
2 is open to take the call and bring things together?

3 CATHERINE BROWN: Absolutely, yes. And
4 we've done so, yeah.

5 COMMISSIONER JACK KITTS: Thank you.

6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 I'm still trying to understand the role, then, of
8 the local Medical Officer of Health and the Chief
9 Medical Officer of Health.

10 I'm still trying to understand why,
11 given that we have 34 health units, we wouldn't
12 work through those 34 units. I believe I'm missing
13 something about -- this seems, to me, to be -- that
14 the decision is that that system isn't working and
15 we needed a new system.

16 And I just -- if somebody says that,
17 then I'll understand that. But other than that, I
18 can't really appreciate why this wouldn't have
19 devolved to the local unit to deal with the local
20 long-term care home to be responsible for
21 inspecting and --

22 Because that's where the legal
23 decision-making -- the legal power is to overcome
24 resistance. It seems almost schizophrenic to me.
25 I don't mean to be provocative, but I'm just having

1 some difficulty understanding what appears to me to
2 be a duplication. Can you help me with that at
3 all, or am I beyond help as far as that goes?

4 CATHERINE BROWN: Not beyond help. I
5 would say I have learned differently in this
6 experience about the challenges of the autonomous
7 role of the Public Health units. And I see that
8 as --

9 I understand the value of that and why
10 that decision-making remains distinct and cannot be
11 directed and why that needs to be, and that's very
12 clear to me.

13 But I have seen that there was a
14 challenge, as you described, in the capacity to be
15 able to take on that responsibility. I don't say
16 it in a critical way. I think some of those
17 smaller Public Health units were overwhelmed with
18 the amount of demand.

19 And so to Brian's comment about the
20 relationship with long-term care homes, certainly
21 they had that ability. Did they have that
22 capacity?

23 So I see what you're saying, and I
24 understand that if that is the way of the future,
25 that those entities would need to be strengthened

1 such that they could oversee a response like this.
2 Then I think there's a question to them about did
3 they have what they needed to do that or what --
4 and I can't answer that, "what happened that that
5 didn't evolve in the way that you've just
6 described?"

7 It might have been capacity all along
8 or other things. I don't know. But certainly
9 capacity was part of it. There was just too much
10 going on.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Okay. Well, I think we've --

13 CATHERINE BROWN: Can I just -- I feel
14 I just have to add this, sorry, because I'm
15 mindful.

16 I think that the Public Health units,
17 for the most part, have done extraordinary things
18 in their response to this pandemic. And there have
19 been some challenges for all of us in how we've
20 mounted the response.

21 And I'll go back to the example of
22 Ottawa. We could not have done what we did in
23 Ottawa without the Public Health unit there. They
24 have been extraordinary, and they are an example of
25 how that can function and should function, and

1 there are many others like that.

2 So I don't want to leave the impression
3 that Public Health did not respond in a full way,
4 and that includes the chief and the Associate
5 Medical Officer of Health and how they guided that
6 response. It has been nothing short of
7 extraordinary in most communities if not all
8 communities across the province in some degree.

9 BRIAN POLLARD: Agreed, Catherine.
10 Agreed. And very responsive.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 Well, I accept that, but then that would seem -- is
13 that the way to organize this, then? If you have
14 these proper-functioning local health units and all
15 doing their job well and discharging their
16 responsibilities, then wouldn't that be the way,
17 then, to bring order in this kind of a crisis?

18 It should emanate from them. They're
19 in the -- I'm not an apologist for the current
20 system, not in the slightest. I'm just posing the
21 question. They're already there. They're
22 functioning very well. They have the legal
23 authority they need. Why duplicate it?

24 That's the problem I bump up against.
25 If they're not functioning properly and it was

1 necessary to supplement what went on, then I think
2 that speaks to, among other things, a structural
3 issue.

4 And as you said, Ms. Brown, you know,
5 it's one thing that -- maybe, perhaps, they were
6 overwhelmed. I don't know. But I'm having trouble
7 understanding why, if everything's okay, we don't
8 reinforce what's there. If it's not okay, I
9 understand why you have to change it.

10 CATHERINE BROWN: So maybe I'll offer a
11 personal opinion in -- around the hospital system
12 that might help to illuminate.

13 So the ministry has oversight of the
14 hospitals. If a hospital is not undertaking its
15 responsibilities in accordance with how the
16 province wishes to see them do that, they have
17 numerous levers in their tool kit to be able to say
18 "we're going to do the following funding. We're
19 going to do the following things."

20 When they direct the hospital to do
21 something, hospitals have to respond, and they have
22 to respond in the way in which they're asked to do
23 it by the province. And they have flexibility in
24 many ways in how they do that, but they can't do it
25 in a different way than the province requires them

1 to do so.

2 And so in my mind -- and if they do,
3 they can put a supervisor in. They can take over
4 the responsibilities of the hospital until it's
5 stabilized. In my mind, the structure of Public
6 Health, in order to ensure that response is even --
7 and "consistent" is too strong. It doesn't have to
8 be cookie-cutter. It has to be reliably similar
9 across the Public Health units just as it has to be
10 reliably similar across the hospitals.

11 So the structural piece of that needs
12 to allow for that while balancing the autonomy of
13 the Public Health officers, if that makes sense.

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Right. I understand what you said.

16 CATHERINE BROWN: Okay. Now I'm
17 blushing. Yeah, sure. I'm trying to be respectful
18 of the current structure, and I see its value. I
19 do.

20 I think there just has to be -- the
21 balance in how that is operationalized needs to be
22 considered in a response like this in order to
23 enable it to be relied upon in a crisis.

24 And that -- again, that is not to say
25 Public Health has been extraordinary. They have

1 been extraordinary in their response to this
2 pandemic.

3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Well, I think we've finally stopped asking
5 questions for now.

6 Thank you very much for the
7 presentation, and thank you for the answers to the
8 questions which I think took you far beyond the --

9 CATHERINE BROWN: Well beyond any --

10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 -- the Canadian Armed Forces and five long-term
12 care facilities. Thank you for constructive
13 responses to the questions.

14 And Mr. Mathai is here, so I don't have
15 to ask you to tell him we may be back.

16 SUNIL MATHAI: Thank you, Justice
17 Marrocco.

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 All right. Thank you.

20 CATHERINE BROWN: Thank you,
21 Commissioners. Thank you, Justice Marrocco.

22 SUNIL MATHAI: Have a good day,
23 everybody.

24 CATHERINE BROWN: Thank you. Bye now.

25 COMMISSIONER JACK KITTS: Thank you

1 both.

2 COMMISSIONER ANGELA COKE: Thank you.

3 -- PROCEEDINGS CONCLUDED AT 10:05 A.M. --

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1 REPORTER'S CERTIFICATE

2
3 I, MCKAYA MCDONALD, Chartered
4 Shorthand Reporter, certify;

5
6 That the foregoing proceedings were
7 taken before me at the time and place therein set
8 forth, at which time the witness was put under oath
9 by me;

10
11 That the testimony of the witness
12 and all objections made at the time of the
13 examination were recorded stenographically by me
14 and were thereafter transcribed;

15
16 That the foregoing is a true and
17 correct transcript of my shorthand notes so taken.

18
19 Dated this 13th day of November, 2020.

20
21 

22
23 _____
24 NEESONS, A VERITEXT COMPANY

25 PER: MCKAYA MCDONALD, CSR

CHARTERED SHORTHAND REPORTER

C L A R I F I C A T I O N S :

Throughout the document "recognizance" should be
"reconnaissance."

Page 38, line 4: "may I have a bit colour here"
should be "Maybe I can add a bit of colour."

Page 38, line 16: "outrage" should be "outbreak."

Page 39 line 18: "incidents" should be "incidence."

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