

Long-Term Care Covid-19 Commission Mtg.

Meeting with Dr. Robert Kyle
on Friday, October 2, 2020

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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending
remotely, on the 2nd day of October, 2020,
9:00 a.m. to 10:00 a.m.

1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead

4 Commissioner;

5 Angela Coke, Commissioner;

6 Dr. Jack Kitts, Commissioner.

7

8 PRESENTERS:

9

10 Dr. Robert Kyle, BSc, MD, MHSc, CCFP, FRCPC, FACPM

11 Commissioner & Medical Officer of Health Durham

12 Region Health Department.

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 John Callaghan, Counsel, Long-Term Care Commission

21 Secretariat;

22 Derek Lett, Policy Director, Long-Term Care

23 Commission Secretariat;

24 Lynn Mahoney, Counsel to the Ministry of Health and

25 Long-Term Care;

1 Dr. Pepi McTavish, Assistant Medical Officer of
2 Health at the Durham Region Health Department;
3 Cindy Boyd, Solicitor Regional Municipality of
4 Durham;
5 Arend Wakefield, Senior Solicitor Regional
6 Municipality of Durham.

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8 ALSO PRESENT:

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10 McKaya McDonald, Stenographer/Transcriptionist.

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1 -- Upon commencing at 9:06 a.m.

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3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Well, we're now assembled. I think I've done the
5 introductions as far as you're concerned.

6 Are you alone, or are you with somebody
7 else?

8 DR. ROBERT KYLE: So, Commissioners,
9 thank you for inviting us here.

10 So with me is my Assistant MOH Dr. Pepi
11 McTavish. Good morning, Pepi.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Good morning.

14 DR. ROBERT KYLE: And I think in the
15 background, to save me from myself, are two legal
16 counsel from the region.

17 Cindy Boyd, who really does yeoman's
18 work with respect to helping us with respect to
19 Public Health legal matters.

20 And her colleague Arend Wakeford who
21 has done the same on this with respect to privacy
22 matters.

23 So that's who's at our end, and for
24 those Commissioners who are kind of unfamiliar with
25 the structure of Public Health, I'm in a Public

1 Health unit that is embedded in a regional
2 municipality.

3 So, Commissioner, I was briefed ahead
4 of time as to some of the questions that the
5 Commission may be interested in, so I've wrapped
6 some bullet points under each of the headings.

7 And I'd be prepared to go through them,
8 but my suggestion would be interrupt me at any
9 time. I was just trying to collect my thoughts in
10 an organized fashion.

11 And if I think I can capture some of
12 the bullet points I've made in writing so that you
13 can get into your questions, then I will indicate
14 that, and you can let me know whether you want me
15 to walk through it or just send it to you in
16 writing.

17 COMMISSIONER FRANK MARROCCO (CHAIR): I
18 think that --

19 DR. ROBERT KYLE: Yeah.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 If I can -- since you invited me to interrupt, I
22 will.

23 DR. ROBERT KYLE: Sure.

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 Yeah. You know, Mr. Callaghan, who you may have

1 been speaking to, is our counsel. He reports to
2 us. He takes his instructions from us.

3 So if there's something further in
4 writing that you think should be forwarded to us,
5 don't hesitate to send it to him, and he'll make
6 sure that it gets to the three of us.

7 DR. ROBERT KYLE: Yeah, okay.

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 And he's our counsel, and he doesn't have any other
10 client.

11 Secondly, just so we're clear on
12 what -- you know, Doctor, we find ourselves as a
13 Commission in a bit of an odd situation. You were
14 involved with SARS.

15 DR. ROBERT KYLE: Yes.

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 And so you -- and Justice Campbell -- but, you
18 know, typically a commission -- it looks back at
19 something that happened and tries to explain what
20 happened and analyzes it. The thing is over --

21 DR. ROBERT KYLE: Yeah.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 -- and you're looking back at it. Of course, that
24 is not our reality at all. And so we have
25 tentatively concluded that we should try to make

1 some recommendations, some interim recommendations,
2 as soon as we're in a position to do that --

3 DR. ROBERT KYLE: Yeah.

4 COMMISSIONER FRANK MARROCCO (CHAIR):
5 -- and then continue the exercise of looking back
6 at Wave 1 and try to figure out --

7 That's the general thought we've had,
8 and that's how we're kind of pursuing things, just
9 so you understand where we're --

10 DR. ROBERT KYLE: Yeah.

11 COMMISSIONER FRANK MARROCCO (CHAIR):
12 -- coming from. So with that, we're in your
13 hands.

14 DR. ROBERT KYLE: Okay.

15 COMMISSIONER FRANK MARROCCO (CHAIR):
16 We will interrupt but just for the reason you
17 mentioned, that that way we don't have to go back.
18 We'll just ask questions at the time, and we look
19 forward to your answers.

20 DR. ROBERT KYLE: Okay. And,
21 Commissioner, can I ask, have you interviewed any
22 other MOHs up to now? Because if not, there's a
23 bit of context that I think probably is useful.
24 But if you've heard it before, I'll just skip
25 ahead.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 You know, I think the best way to go about this is
3 if you think we need to hear something, then you
4 tell us.

5 DR. ROBERT KYLE: Okay.

6 COMMISSIONER FRANK MARROCCO (CHAIR):
7 And we'll tell you if we've kind of heard it
8 before.

9 DR. ROBERT KYLE: Okay.

10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 And you won't need to spend too much time on it.

12 DR. ROBERT KYLE: Okay. So in terms of
13 opening remarks, the only other thing I wanted
14 to -- only other -- the two other things I wanted
15 to mention is, first, I was on the frontlines not
16 only with respect to SARS but with respect to the
17 pandemic and influenza.

18 And I was explaining to John that, with
19 respect to long-term care homes and retirement
20 homes, at least I had skin in the game.

21 So I was the caregiver of two parents
22 with dementia. And combined, my parents ended
23 their years in long-term care homes. So for five
24 years, I had a front row seat with respect to the
25 care and treatment and the deterioration that I saw

1 during my parents residing in long-term care homes.
2 So I would be the first to not criticize anybody in
3 the system. They do the very best that they can.

4 And secondly, I can honestly say that
5 if COVID-19 hit the home that my mother was in, I
6 can't imagine that she would have survived. She
7 was demented. She didn't know who I was. She
8 wouldn't have understood masking. They would have
9 to have restrained her to keep her in her room.

10 So it's a real issue for me. And I
11 must say, as I was thinking through this and I was
12 going through our experience in the first wave, in
13 some ways, it hit home at a personal level. So if
14 I get a tad emotional, I'm going to apologize ahead
15 of time.

16 So I mentioned that we're one of the
17 PHs embedded in a regional government. And in
18 terms of what has our role been to date with
19 respect to COVID-19, our main focus is on case
20 contact and outbreak management.

21 We have done some surveillance and
22 facilitated testing. We do data entry on cases and
23 contacts, and we report out, and I'm very proud of
24 our data tracker -- the link to it, I can send you
25 offline.

1 But if you wanted to find out what was
2 happening in our long-term care homes and
3 retirement homes in real time, go to our data
4 tracker, click on "Institutional Outbreaks." It's
5 all there. And any information you want with
6 respect to dates, times, and numbers of cases, it's
7 all there.

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 And that would be very helpful, actually, Doctor.
10 If you could do that, that would be great.

11 DR. ROBERT KYLE: Yeah. So if
12 somebody's taking notes, "durham.ca/covidcases,"
13 and it's pure gold.

14 Our role is with respect to Public
15 Health messaging and communications. And, finally,
16 we respond to inquiries, complaints, and we engage
17 in progressive enforcement.

18 Since at least you, Chair, are a lawyer
19 or a justice, sorry, in terms of the legal tools
20 that we have used, we're heavily reliant on the
21 HPPA and the regs thereunder.

22 And in particular, for long-term care
23 homes, we have relied on Sections 13, 22, 29.2, and
24 we have given thought to -- and not used in the
25 long-term care home/retirement home sector --

1 Section 102, but we have used it. We also rely on
2 the Ontario Public Health Standards, the protocols
3 and the guidelines, which have legal authority.

4 I have issued instructions under regs
5 263/20 and 364/20 under, first, the Emergency
6 Management and Civil Protection Act and now the
7 Reopening Ontario Act.

8 And, of course, we are implementers at
9 the local level, so we rely on directives,
10 policies, guidelines from the Chief MOH, from the
11 Ministry of Health, from the Ministry of Long-Term
12 Care, from the Ministry For Seniors and
13 Accessibility -- Seniors Affairs and Accessibility.
14 And we're, of course, reliant on advice and lab
15 support from PHO.

16 So one of the questions that I was
17 asked, or we were asked, was what did we do with
18 respect to this sector.

19 So our role up to now and currently has
20 been with respect to outbreak management and
21 prevention. We did surveillance of our long-term
22 care homes and then took it upon ourselves to do
23 surveillance of our retirement homes and group
24 homes.

25 We have facilitated infection

1 prevention and control or, in the business, IPAC
2 assessments.

3 We have managed test results both
4 communicating out and interpreting positive and
5 negative test results.

6 We have interpreted for many of our
7 long-term care home retirement home stakeholders
8 interpreting directives, testing, and clearance
9 guidelines and so forth, and we've engaged in
10 dialogue with, for example, i.e., doctors locally
11 who may have questioned what was behind the
12 issuance of these directives and documents.

13 I've issued two Section 29.2 orders
14 under the HPPA. I believe you're familiar with
15 Orchard Villa. So this provided legal authority
16 for Lakeridge Health to take over and stabilize the
17 management of an outbreak in Orchard Villa.

18 And I issued a Section 29.2 order with
19 respect to -- I'm not sure how you classify it. I
20 think we landed in quasi-retirement home, but it
21 was a denominational René Goupil infirmary
22 associated with a judge who had a retreat in
23 Pickering, and I can tell you more about that.

24 I mentioned facilitating IPAC
25 assessments. So in a couple of places, René Goupil

1 and another place in Durham Region, to ensure the
2 implementation of IPAC assessments done by others,
3 we issued two Section 13 orders.

4 And one of those orders has led to
5 legal activity, as I understand it, and Cindy
6 probably can weigh into that if that's of interest
7 to the Commission.

8 We respond and continue to respond to
9 inquiries and complaints regarding long-term care
10 homes and retirement homes. As you probably are
11 aware, MPPs are very interested in what's going on
12 in their backyards, so we have held regular
13 briefings with local MPPs, particularly in Wave 1,
14 where they had homes in outbreak in their ridings.

15 Locally, a number of tables were set up
16 to work collaboratively together particularly with
17 respect to risk assessments which were then
18 communicated upward to Ontario Health. And.

19 Dr. McTavish represented us on the
20 Durham Cluster Table, and on that table included
21 representatives from Lakeridge Health and the
22 Central East LHIN.

23 We participated in a preparedness
24 assessment at the behest of Ontario Health with
25 respect to the long-term care homes.

1 Communications -- and you're probably
2 going to hear an earful from affected families of
3 affected homes. I was in the loop with respect to
4 a number of families whose loved ones lived in
5 Orchard Villa, so I did my best to respond to their
6 inquiries.

7 I don't want to downplay our role with
8 respect to René Goupil House, but I'm prepared to,
9 of course, talk about that. And lastly --

10 COMMISSIONER FRANK MARROCCO (CHAIR):

11 Doctor, if I could interrupt you for a minute.

12 Can you hear me okay?

13 DR. ROBERT KYLE: Oh, yeah, absolutely.

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 Yeah. The order under 29.2, did you issue that
16 order?

17 DR. ROBERT KYLE: I did.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 Are you forced to consult anyone, I mean, you're
20 given your position? Or do you have the discretion
21 to issue those orders as you see fit?

22 DR. ROBERT KYLE: Well, I have the
23 discretion to do that. I do that in concert with
24 my team and my legal counsel.

25 As you know, orders are appealable to

1 HSARB so you want to make sure that they are
2 defensible as possible and you have reasonable and
3 probably grounds.

4 In the case of Orchard Villa, you had
5 two parties who were keen to have Lakeridge Health
6 stabilize the situation. And I think for a whole
7 variety of reasons, Orchard Villa was willing for
8 them to come in. So the likelihood of the order
9 being appealable was very unlikely because you had
10 two willing partners.

11 But if your question is do I have to
12 consult with my Board of Health, that sort of
13 thing, no, I don't. And we turned around the order
14 fairly quickly over the weekend.

15 And credit should go to Cindy who did
16 most of the drafting and to make sure that it was
17 complete and, as I said, defensible as possible.

18 She would have reached out to the
19 Ministry of Health not for any permission but to
20 make sure that we're using the right legal tool and
21 to Lakeridge Health so that the provisions in the
22 order were such that it allowed Public Health to
23 carry out the duties embedded in the order that it
24 thought was required of them to effectively
25 stabilize the situation.

1 With respect to René Goupil House, so
2 this is an infirmary very poorly designed, very --
3 it was outdated, and it has 24 or 25 beds and quite
4 a number of deaths. I'm thinking four or five and
5 many persons in outbreak -- I'm sorry, with COVID.

6 And we had a reluctant director of care
7 who was not allowing us to do our job. So I put my
8 foot down. I was quite concerned about that home.
9 I issued that Section 29.2 order.

10 I would say to somebody at an
11 institution that was less receptive than Lakeridge
12 Health or Orchard Villa, I'm very proud of that.
13 Community Health has stepped in, and it's cleaning
14 up René Goupil. And the residents who were there
15 were transferred to other facilities to allow that
16 to happen, so I'm very pleased with that.

17 The last thing I was going to say,
18 Commissioner, was that Hillsdale Terraces, which is
19 a regional long-term care home, was, I believe, the
20 first home in outbreak in Ontario.

21 So we weren't following
22 (indiscernible), and there were a number of
23 challenges that we had to deal with, a bit of
24 ambiguity, with respect to the outbreak management.

25 It was early on in the days with

1 respect to Public Health measures that were
2 strengthened as a result of Hillsdale Terraces --
3 communications, that kind of thing. So it was
4 really a trial by fire.

5 So that's kind of a snapshot of what we
6 did. I was asked how did we work with the Chief
7 MOH and the Province?

8 It's a very, very complex landscape. A
9 lot of players, a lot of moving parts, and all
10 happening in real time as the first wave is getting
11 higher and higher.

12 My view is I think we worked with the
13 CMOH and province reasonably well. After fairly
14 short order, if there were questions from the
15 field, we would post them to the Emergency
16 Operation Centre, and they were fairly quick at
17 getting back to us. We had excellent support from,
18 in particular, the physician leaders at Public
19 Health Ontario.

20 Eventually the province got into the
21 rhythm of two teleconferences per week, and after
22 some storming and forming, they eventually normed
23 and became quite effective.

24 There's been good communications from
25 Ministry comms to our comms of folks, so that's

1 worked well. Partway through Wave 1, certain
2 regional MOHs populated a "Public Health Measures"
3 table, so this provides direct advice which is
4 influenced, I guess, by the regional reps' local
5 experiences with respect to Public Health advice to
6 the chief medical officer of health.

7 I think we all would like there to be a
8 quicker turnaround time, but I'm going to be
9 critical of anyone. I can't imagine what it would
10 be like working at the Ministry with multiple
11 inputs to consider, multiple outputs to produce,
12 dealing with multiple tables all in real time.

13 So I think everybody has done the best
14 job that they can, but I do know that, at the local
15 level, sometimes you wish the decision-making would
16 be a bit quicker.

17 A new player which we're getting used
18 to is Ontario Health. We belong to East Region.
19 My sense is that Ontario Health is finding its
20 legs.

21 I think that there is, perhaps, better
22 alignment across the -- I think it's five regions,
23 but to my mind, early on, there were some
24 inconsistencies. So I'd get inputs from other
25 MOHs, and then I would bring them over to our local

1 table that feeds up to the East Region table and
2 thought that we were quite far behind.

3 We've established, as I mentioned, a
4 local table. One of the good things, if I can call
5 it that with respect to COVID-19, is that it has
6 required us to get out of our silos and work with
7 other players -- so hospitals, long-term care
8 homes, the community, and so forth.

9 And who would have thought? Who would
10 have thought -- at least in the early days when the
11 economy was locked down, as was healthcare
12 system -- that COVID-19 would end hallway medicine?
13 But there you go.

14 I mentioned that we have been involved
15 in surveillance and testing. Government, after it
16 required us to do surveillance of long-term care
17 homes -- so this is the testing of residents and
18 staff in long-term care homes -- they turned
19 testing over to Ontario Health. And it has been
20 responsible for ongoing surveillance and testing of
21 staff and retirement homes and the long-term care
22 homes.

23 I think early on that the emperor had
24 no clothes. I think that OH was kind of struggling
25 to take on that mandate. It was certainly

1 invisible out our way, and I think some of our
2 retirement homes and long-term care homes struggled
3 to get assistance particularly with respect to
4 surveillance testing if you were a retirement home,
5 say, or a smaller long-term care home. It didn't
6 have the same sort of infrastructure that others
7 would have.

8 Eventually things normalized in
9 Lakeridge Health, and its assessment centres were
10 able to take on the testing responsibility. But
11 there was a month period -- or that's my memory --
12 where it was a bit confusing about who did what. I
13 do think --

14 COMMISSIONER FRANK MARROCCO (CHAIR):
15 Doctor, in this one-month period, when did it first
16 occur to you that there might be a problem in your
17 region?

18 DR. ROBERT KYLE: You mean in terms of
19 outbreaks, cases, and so forth?

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 When it occurred to you that this virus could be a
22 problem for you. Well, you know, whether it's an
23 outbreak or -- but something that you would need to
24 pay attention to.

25 DR. ROBERT KYLE: Well, I can tell you

1 that our first case was on February 29th because I
2 was in Toronto driving home and sort of -- or
3 taking the train home, actually, and trying to
4 orchestrate a news release and so forth. So it hit
5 home, I'm pretty sure, on February 29th.

6 We had been keeping a close eye on that
7 since the beginning of the new year. And then,
8 again, I don't have the dates in front of me,
9 Commissioner, but Hillsdale Terraces was one of the
10 first homes to be hit. So it was certainly real
11 for us fairly early on sometime in March.

12 I'm thinking we had travel-related
13 cases before then, and so we were experiencing the
14 first wave pretty close to the beginning of March
15 to late February. And certainly we were newsworthy
16 with respect to the involvement of Hillsdale
17 Terraces.

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 You just mentioned keeping an eye on things since
20 the beginning of -- or since early January?

21 DR. ROBERT KYLE: Yeah.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 So what's the thinking when you first --

24 DR. ROBERT KYLE: Yeah.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 -- wake up to the fact that there's this virus?

2 DR. ROBERT KYLE: So, Commissioner,
3 what I can tell you is that the whole world, at
4 least the Public Health community, was keeping a
5 close eye on that.

6 We have an outbreak management plan, or
7 I think it was a draft, but it was in pretty good
8 shape. We had a -- or have a Health Department
9 Emergency Master Plan. So we mobilized our plans.
10 We set up our IMS structure, and we were keeping a
11 close eye on the number of cases that were reported
12 to us as they came in.

13 And I'm going by memory, but I think we
14 activated our HIMG, so Health Incident Management
15 Group, in February. I stand to be corrected. So
16 we were already activated and kind of ready to go.

17 One of the questions posed to me was
18 what have we learned. I would say within two or
19 three weeks in March, we found that the HIMG and
20 the whole IMS structure didn't work.

21 And we replaced that with daily updates
22 by lead individuals, so a mix of directors and
23 managers, and we've met daily pretty well since,
24 I'm going to say, middle of March.

25 And we've had to set up tables that

1 deal with specific contingencies. So I mentioned
2 long-term care home surveillance. So we were asked
3 to do this, I'm thinking, late March/early April.
4 I could be wrong. And we were given a few weeks to
5 do surveillance of all of our long-term care homes,
6 so we set up a table to kind of manage that file.

7 We decided, after we had done our
8 long-term care homes, that it made sense for Public
9 Health to focus on our vulnerable populations. So
10 we did the same for all of our retirement homes and
11 our group homes, and so we had this table set up to
12 do it.

13 We have another table set up with
14 respect to schools, and I imagine we may set up a
15 table to deal with influenza.

16 So you need to be nimble. You need to
17 be quick. You need to allow people to get on to do
18 the work. And the more cumbersome an organization
19 that you set up, which needs multiple feeds and so
20 forth, the more time is taken to feed the beast
21 than is taken to actually deal with the
22 contingencies in front of you. So that is the huge
23 kind of lesson learned for me.

24 If I can just finish, Commissioner,
25 with how did we work with CMOH and province. Two

1 other points I wanted -- three other points I
2 wanted to make.

3 The first is we're not funded by OH,
4 and its communications to us, to my mind, has been
5 abysmal. And we have one Public Health rep who
6 sits at the East Region table, Vera Etches. She
7 faithfully sends out her notes with respect to
8 those tables.

9 Early on, the table that was set up did
10 include Public Health, but largely, it now focusses
11 on institutions, and we've been shut out.

12 So the communications, in my mind, from
13 OH, has been abysmal. It may be -- it may be very
14 robust for the key stakeholders more on
15 institutional side, but for Public Health, from my
16 judgement, it's been abysmal.

17 Secondly, in the first wave, the
18 inspectors for the Ministry of Long-Term Care and
19 the Retirement Home Regulatory Authority were
20 invisible. I have no idea who they are, what they
21 did. I understand that, to the extent they were
22 engaged, they did it by phone. They have been
23 completely invisible, and I have some thoughts
24 about that when I get to recommendations.

25 Lastly, a big deal was made out of

1 hospitals doing IPAC assessments at long-term care
2 homes, retirement homes. I'm sure -- well, I know
3 all of the assessments were done very, very well.
4 They're very robust. Excellent recommendations.

5 What happens if a home decides not to
6 follow the advice received? There's absolutely no
7 inspection or enforcement mechanism that I'm aware
8 of. And as I say, in a couple of instances, we
9 resorted to Section 13(2) orders to make sure that
10 action was taken.

11 But you've got all these nice IPAC
12 assessments out there, and I have no idea what's
13 happened to any or all of them and have they been
14 actioned? So it may have happened, but it's
15 invisible to me, and it's certainly invisible to us
16 if the inspectors from the Ministry of Long-Term
17 Care or RHRA have had a role in play. And it may
18 have happened when I'm out of the loop, but
19 certainly it's been invisible to me.

20 COMMISSIONER FRANK MARROCCO (CHAIR):
21 And, you know, I come at it from a different
22 discipline, of course.

23 DR. ROBERT KYLE: Yeah.

24 COMMISSIONER FRANK MARROCCO (CHAIR):
25 But it does seem, listening to this, that there are

1 a lot of tables.

2 DR. ROBERT KYLE: Oh.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Do you have the same impression or would that be --

5 DR. ROBERT KYLE: Well, this is
6 healthcare. Lots of tables. Lots of acronyms. A
7 whole lot of busy work. And you wonder -- and all
8 of these tables need to be fed, right?

9 And I don't know about -- I think
10 Dr. Kitts maybe can comment on this, although he's
11 a commissioner, but one of the experiences that
12 I've experienced is the death by dashboard.

13 There's so many friggin' dashboards out
14 there, and I've already referred you to our data
15 tracker which is the dashboard. But oh, my God.
16 It really feels like a business school is running
17 this stuff.

18 And, you know, is that good or bad? It
19 is what it is. I mean, decision-makers -- I would
20 commend government. I would commend key players in
21 using any evidence to drive decision-making. But
22 what I would say is if you set up a table, you have
23 to care and feed it. And if you set up a
24 dashboard, you have to care and feed it, and you
25 shouldn't make those decisions lightly.

1 We set up tables to deal with
2 contingencies. I'd like to say we whelmed them
3 down once the job was done. So there you go.
4 Healthcare, lots of tables, lots of acronyms, lots
5 of dashboards, lots of data, and yeah. You kind of
6 shake your head.

7 COMMISSIONER FRANK MARROCCO (CHAIR):
8 Were there things that -- and I'm asking. I'm not
9 trying to suggest.

10 Were there things that you wanted them
11 to tell you to do that they either didn't tell you
12 to do or waited so long to tell you to do it that
13 it -- you know, it didn't -- the problem didn't
14 matter anymore? Is it that kind of a thing?

15 DR. ROBERT KYLE: No, I don't think
16 that that's the issue. I think the issue is you
17 get a directive. You get a guideline. You know,
18 I'll just -- testing and clearance. Testing,
19 symptoms, that sort of thing.

20 And then you find out in the field that
21 there are real-time consequences for implementing
22 these guidelines. And if they're problematic, you
23 would inform, say, the Province through EOC, and
24 then you would wait, and then you would wait, and
25 then you would wait.

1 And while you're waiting, of course,
2 you're hearing complaints from the ID physicians
3 who you see nightly on CBC news and, you know, all
4 those other things. And, of course, that, then,
5 feeds into kind of cynicism, concern, and so forth.

6 So that's what I would say. It would
7 take a long time to change things to deal with
8 real-life consequences on the ground. Eventually
9 the fixes came in. They made sense. They helped
10 deal with the situation.

11 And far be it for me to be critical
12 because it takes time for multiple players to, you
13 know, get their hands on this and so forth, but it
14 does take time. You need to be patient, and you
15 need to do the best that you can on the frontlines
16 to deal with the uncertainties, the ambiguities,
17 sometimes the problems that arise with respect to
18 directives, policies, guidelines, and so forth.

19 So I don't think it's a lack of
20 directives, policies, guidelines. I think it is
21 the need for continual mid-course corrections as we
22 learn more about the virus and as we learn more
23 about the real-life consequences.

24 So that's a good segue, Commissioner,
25 into the next question I was asked was what have we

1 learned to date.

2 So hopefully I've conveyed to you that
3 the landscape we're dealing with is very complex.
4 We're implementers, right? We're not
5 decision-makers, although we are decision-makers on
6 the ground in dealing with real-life situations --
7 Orchard Villa, René Goupil, a few others that come
8 to mind.

9 And sometimes you can't wait, and
10 sometimes you use the tools that you have at your
11 disposal to deal with the contingency. I think
12 everybody has been acting in good faith. And as
13 long as you have reasonable, probable grounds,
14 et cetera, et cetera and you can defend the actions
15 that you're taking and live with the consequences
16 and make the changes if you've made mistakes, then
17 I think that's all that can be expected of us on
18 the frontlines. But it is a very complex
19 landscape -- multiple players, multiple inputs,
20 multiple expectations.

21 Yesterday quite a number of guidelines
22 were changed by the Ministry and sent out in a
23 batch. So when I'm finished here, I'm going to
24 have to go through them all, kind of digest them,
25 and think "So what do we have to do about those,"

1 and think "What do we have to do to add this to our
2 toolkit, change our script, change our processes to
3 incorporate it the lightest change?"

4 So you have to be thoughtful about
5 these things, but you have to be quick about these
6 things because there are real-life consequences.

7 I talked about -- oh, what did we
8 learn...

9 Oh, yeah. I was going to say so going
10 back to my own experience and reflecting upon the
11 long-term care home situation -- and I'm not going
12 to be the right person to tell you this -- but this
13 is not rocket science.

14 If a long-term care home has more money
15 and it has newer facilities, then it stands a
16 better chance of either stabilizing COVID-19
17 quicker or preventing it in the first place.

18 It's not rocket science. You have more
19 money and more up-to-date facilities, you can pay
20 your staff more so they're more likely to stay.
21 You can hire more staff. And generally speaking --
22 and I'd be shocked if the evidence says
23 otherwise -- I'd bet you that those homes -- and
24 I'm thinking about, in our case, regional homes.
25 I'm sure that they, at the end of the day, will

1 fare much better than those who are less well
2 funded, those that have poor designs, and those
3 that have more precarious workforces. So far be it
4 for me to add to that, but that's certainly an
5 observation I can make from the outside.

6 I was struggling with my wording, but I
7 do think we need to be realistic about COVID-19
8 behaviour in long-term care homes. I think what we
9 learned in Phase 1 is that once it takes hold, if
10 you've got a whole lot of factors against you --
11 poor design, inability to cohort, high number of
12 demented patients who haven't got a clue what's
13 going on, and there's no snowball's chance in hell
14 of cohorting them, of masking them, et cetera,
15 et cetera, which would have been the case with my
16 mother -- the best you can do is stabilize the
17 situation.

18 And you stabilize the situation, by and
19 large, by having enough staff there. And if you've
20 got sick staff who are off self-isolating and
21 afraid to come back to the home, the more likely it
22 is that, you know, a home is not going to fare
23 well. And I kind of think that's what happened at
24 Orchard Villa and a couple other places, and I
25 suspect that that is a risk that is being mitigated

1 as we go into second wave.

2 Carrying on, sorry.

3 I think that the legal tools that we
4 have worked well. I do think, again, when I look
5 at the -- I think it's the regs. I stand to be
6 corrected. It could be in the statute itself, but
7 I think in the regs under the Long-Term Care Homes
8 Act and the Retirement Homes Act. There's a
9 requirement for there to be an infection prevention
10 and control program in place. That said, I do
11 think there's some confusion about who enforces
12 that.

13 Now, for the well-operating homes,
14 you're going to -- they're going to say to you
15 "Enough already. We have inspections up the
16 gazoo."

17 But if you've got a home that either is
18 underresourced, is paying lip service to having a
19 bona fide program, and really needs it beefed up,
20 who's going to enforce that particularly if you've
21 got such homes and such observations awaiting the
22 second wave?

23 Is it the Ministry of Long-Term Care
24 inspectors? Did they have the tools they need to
25 turn things around? Is it Public Health? We've

1 made the decision to at least intervene in a couple
2 of places to ensure IPAC assessment recommendations
3 are implemented. But who does what?

4 And if it is Public Health, are the
5 tools adequate? Do they need to be strengthened?
6 One of the benefits of the tools that we have is
7 that we can get in there fairly quickly. And as
8 long as there's due process, as long as we have
9 reasonable and probable grounds to intervene, we
10 can get in there quite quickly.

11 I think Dr. Kitts is from Ottawa. One
12 of my colleagues indicated that a hospital needed
13 to intervene in a couple of homes in Ottawa, and it
14 was taking too long. She said "Can you give me
15 your template?" I sent her a template, and I
16 believe she intervened to make it happen while the
17 Ministry was doing its thing.

18 And I'm not being critical of the
19 Ministry, but when you set up these agreements, you
20 have the dot the I's; you have to cross the Ts. I
21 know all about it. You need to get the lawyers
22 involved. You need to get the risk managers
23 involved. It takes time.

24 Well, COVID-19 needs a situation
25 stabilized immediately. You can't take time. So

1 if a hospital or other entity needs to move in to
2 stabilize the situation, we need to be nimble and
3 quick, and hopefully there's clarity around who
4 does what and the clarity around the use of the
5 appropriate tool.

6 But in my mind, there's a bit of
7 confusion -- or maybe a bit of confusion about who
8 really owns the enforcement piece with respect to
9 long-term care homes and retirement homes.

10 I've learned that there needs to be
11 clear, consistent messaging in whatever message you
12 land on. Because if you're inconsistent, there's
13 somebody who will tear you apart and say "Well, you
14 said such and such to so-and-so back then," and so
15 there needs to be quality communication.

16 COMMISSIONER FRANK MARROCCO (CHAIR):
17 Can I just stop you for a second, Doctor?

18 DR. ROBERT KYLE: Absolutely.

19 COMMISSIONER FRANK MARROCCO (CHAIR):
20 So you're local, and you make an order.

21 DR. ROBERT KYLE: Yeah.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 And they appeal your order to the review board or
24 whatever it's called. Doesn't matter.

25 And so then do they go there with the

1 directives and say "Look, we were complying with
2 the directives. He couldn't make the order"?

3 How do the directives and the policies
4 and guidelines affect your ability at a local level
5 to do what you think you need to do?

6 Because the statute -- that's what
7 I'm -- how it plays itself out, that's what I'm
8 trying to understand.

9 DR. ROBERT KYLE: Yeah. Well, you're
10 going from the hypothetical, I think, to a specific
11 situation.

12 So what I'm familiar with are the
13 orders and the instructions that I've issued. So
14 with respect to my orders, they're all appealable
15 to HSARB. So I get legal advice. I rely on my
16 staff. We make it as defensible as possible.

17 And in the case of Orchard Villa and
18 Lakeridge Health, you had two kind of willing
19 recipients. So the likelihood of it being appealed
20 was minimal.

21 We have issued some Section 22 orders
22 on individuals who were less than forthcoming with
23 respect to names of contacts that we need to
24 control COVID-19, and the same applies. As long as
25 you have reasonable and probably grounds and meet

1 the requirements of the order, then you act in good
2 faith and do what you can.

3 With respect to the instructions,
4 they're rooted under, currently, the Reopening
5 Ontario Act. And we think there is a solid legal
6 foundation for that. And, of course, there are set
7 fines under the Reopening Ontario Act.

8 So unlike the HPPA -- I was going to
9 get into this with my recommendations. But unlike
10 the HPPA and Section 22 orders where, if there's
11 noncompliance with the virus that has a requirement
12 of self-isolation for 14 days --

13 Time is of the essence if you need to
14 ensure self-isolation and/or names and so forth.
15 I'm not a provincial offences officer, so I have to
16 resort to other sections of the Act -- in
17 particular, Section 102 -- for remedies and
18 penalties. It's not quick. It takes time. You
19 really have to think that one through, and we have
20 some experience with that.

21 So it's not the best tool to use to
22 deal with noncompliance, but it is certainly very
23 quick, and you can turn it around on a dime if you
24 think you need to use it again depending on legal
25 advice.

1 Where do directives, policies,
2 guidelines sit? In my judgment, if you need to
3 make the case for why you're intervening, the
4 reasonable/probably grounds piece, you may want to
5 rely on them, and we have relied on that.

6 With our Section 22 order, we make
7 reference to the worldwide pandemic. We make
8 reference to the states of emergencies being
9 declared. So I view those types of statements,
10 policy things, and so forth as grounds that you can
11 use to claim reasonable and probable grounds.

12 I've probably gone as far as I can go,
13 and I'm sure Cindy and Arend are probably cringing
14 on this one. But my point was on the ground -- and
15 I don't think there's confusion, but there may be
16 confusion.

17 With respect to noncompliance -- and
18 I'm talking about IPAC which is probably a shared
19 responsibility between ourselves and the Ministry
20 of Long-Term Care and the RHRA -- who trumps what,
21 does that need to be clarified, and does Public
22 Health have a stronger role to play in terms of
23 IPAC assessment recommendation and enforcement at
24 its current role which is, really, with respect to
25 outbreak management.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 Commissioner Coke, did you want to ask a question?
3 Commissioner Coke, did you want to ask
4 a question? I saw your hand moving. I wondered
5 if --

6 No? Okay. Fine.

7
8 COMMISSIONER KITTS: I'll ask a
9 question --

10 COMMISSIONER FRANK MARROCCO (CHAIR):
11 Okay.

12 COMMISSIONER KITTS: -- if you don't
13 mind. Dr. Kyle, you mentioned the IPAC assessments
14 done by probably the hospital infectious diseases
15 people.

16 And good assessments, well laid out,
17 you have no idea whether they've been implemented
18 or followed.

19 So my question for you is how many
20 homes are you responsible for, and do you have the
21 resources to be the overseer or oversight?

22 Because my look at -- you know, when
23 you issue an order, you now have a hospital perhaps
24 thinking they're in charge, long-term care thinking
25 they may still be in charge of the long-term care

1 home, you've got IPAC insisting on things, and
2 you've got Public Health.

3 Who is the person most accountable to
4 ensure that the leadership is there to have these
5 things done?

6 DR. ROBERT KYLE: So in terms of
7 numbers, I can't tell you. I'm going to say --
8 well, I can't tell you. Ballpark, maybe 30 to 40
9 long-term care homes/retirement homes.

10 My order -- and it's a matter of public
11 record, so you can read it -- it really had to do
12 with Lakeridge Health carrying out a number of
13 tasks. And I would characterize them not as,
14 maybe, taking over the management of the home but
15 stabilizing the outbreak. That was the intent.

16 And as important, there was a
17 requirement for Orchard Villa to comply with the
18 activities laid out in the order to be carried out
19 by Lakeridge Health. So I think it was very clear
20 Lakeridge Health was in charge of stabilizing the
21 situation in the home.

22 I got two updates from Lakeridge Health
23 to tell me -- really give me status reports as to
24 how things were going. So I think it was fairly
25 clear who was in charge of stabilizing the

1 situation and managing the outbreak. And I'm not
2 aware that there are any issues there.

3 With respect to the two places that I
4 referred to, René Goupil and a retirement home in
5 north Durham, among the IPAC recommendations were
6 some infrastructure changes and some important
7 changes just beyond screening, IPAC, behaviour,
8 that sort of thing.

9 And we felt because of the need for
10 compliance and the role we could play in fostering
11 that compliance, that it made sense to issue a
12 Section 13 order. Cindy or Aaron can speak to
13 this, but because of ongoing challenges with one of
14 those homes, we are taking legal action.

15 So that's something that we can do that
16 I don't believe Ministry of Long-Term Care or RHRA
17 inspectors can do.

18 COMMISSIONER KITTS: Just a follow up.
19 Is there anyone at the local level -- Public
20 Health, hospital, IPAC, local long-term -- who is
21 ultimately responsible, that as Wave 2 builds, that
22 the IPAC measures are in place?

23 DR. ROBERT KYLE: Who is responsible?
24 I don't know. You did ask me, by the way, do we
25 have the resources? There are never enough

1 resources. But clearly if Public Health needs to
2 get into the IPAC assessment game and actually be
3 another pair of eyes for, I'm going to say, 20, 30,
4 40 homes, we obviously need the resources to do
5 that. But I'm not here cap in hand. My advice is
6 make a decision.

7 And we have tools at our disposal that
8 allow us to get in there and to require actors to
9 take action a lot quicker than other tools that are
10 out there, so it is a resource worth considering as
11 we enter the second wave.

12 But in considering it, and if that's
13 the way you want to go, then I think you need to
14 think through "Are there any legal impediments?"
15 "Are there areas of confusion/ambiguity that need
16 to be tightened up in the short term so that those
17 barriers are mitigated for Public Health to do its
18 job?" So the --

19 COMMISSIONER KITTS: You know, in an
20 ideal world --

21 DR. ROBERT KYLE: Yeah.

22 COMMISSIONER KITTS: -- who would you
23 tap on the shoulder? They have enough resources.
24 Who should be most accountable and responsible for
25 long-term care homes and --

1 DR. ROBERT KYLE: I --

2 COMMISSIONER KITTS: --

3 (indiscernible) IPAC measures?

4 DR. ROBERT KYLE: Yeah, I don't know.
5 I need to do an environmental scan. I can tell you
6 that, with respect to hospitals, Lakeridge Health
7 did some; Ontario Shores did some; Unity Health did
8 some.

9 So there were -- and I'm not sure about
10 Markham Stouffville, but certainly three hospitals
11 got into the IPAC assessment game in Durham Region,
12 and I suspect that that's under consideration at
13 tables far above me, perhaps at Ontario Health.

14 If I can just finish off, in the
15 interest of time, Commissioner, in terms of lessons
16 learned. I talked about clear, consist messaging.

17 I think you need to be -- you need to
18 compartmentalize. Again, I go back to the IMS
19 structure, fine in theory, not good in practice.
20 And you need to be mobile and quick.

21 And you need to sunset tables that have
22 accomplished their work because these tables tend
23 to perpetuate. They need to be fed. They need to
24 be cared or watered, and that's time taken from
25 your day where you could do other things.

1 So I do think tables have their
2 purpose, but we need to recognize it's an
3 opportunity cost and that they do need to be sunset
4 when they've served their purpose.

5 I think that multi-sectoral
6 collaboration and partnerships are crucial. I do
7 think COVID-19 did bring us together. I do think
8 that OHTs are a work in progress. They're new
9 players, and they're finding their feet. And I do
10 think, however, that --

11 I don't know if we struck the right
12 balance between decision-making and telling us what
13 to do at the center versus enabling us to get the
14 job done and letting us deal with the contingencies
15 that arise on a day-to-day basis. I'm not sure
16 that we've got that balance right.

17 And as you've seen by actions taken by
18 some of my colleagues, most notably the MOH of
19 Toronto, I think they're trying to tighten up
20 Public Health measures beyond those taken
21 essentially, and I think that will continue to
22 exist.

23 Ontario's a big province, and I think
24 we should embrace our diversity, and I think we
25 should embrace allowing local actors to take

1 actions within a provincial framework to deal with
2 the contingencies that are at hand, and hopefully
3 they're driven as much my local epidemiology and
4 evidence as they are the whims, if you will, of the
5 individual who is in charge.

6 And I would say when I look at
7 long-term care homes versus retirement homes -- as
8 you know, retirement homes have a different legal
9 framework. They have far less infrastructure.

10 We've had to help them out with respect
11 to testing of residents and staff because some
12 don't have a full-time medical director. Or I
13 guess most don't have a full-time medical director.
14 They just don't have the wherewithal.

15 And I think that the residents in
16 retirement homes are as vulnerable to COVID-19 as
17 long-term care homes, and I think that how the two
18 sectors are regulated needs to be looked at by the
19 commission.

20 So finally, I was asked about
21 recommendations. And as a starting point -- and I
22 really don't want to drill down in this forum,
23 but -- how do I say this? -- I think that the
24 independence of the local MOH and the tools that he
25 or she needs to deal with the contingencies --

1 If you will, we're one of the foot
2 soldiers on the ground, and we need to be equipped
3 to do our jobs and to do it as independently as
4 possible so that we put, first and foremost, the
5 protection of the health of our communities first.
6 I'm not saying that that is not the case, but I do
7 think that needs to be preserved to be extent
8 possible.

9 All I would say is there was a look at
10 that in Volume IV of the Campbell commission, and,
11 as part of that volume, there were some sound
12 recommendations. I think some of those
13 recommendations are alive today, and it's worth a
14 read. And I expect that that is an input, and,
15 perhaps, you have reflected upon at least parts of
16 the report because that commission was established
17 under Section 78 of the HPPA as this one is.

18 Secondly -- I'm not sure I'm the right
19 person to address this, but I'd like to think that
20 Sections 13, 22, 29.2, 67, and 102 of the HPPA are
21 in good shape and give MOHs and their teams the
22 proper legal duties and tools to get the job done
23 to deal with the contingencies that arise on a
24 day-to-day basis.

25 And I'm not sure anything can be done

1 in the short term to make that happen, but I do
2 think that, to the extent there are barriers,
3 therein place confusion.

4 Who's responsible for IPAC, I'm going
5 to say, advancement, promotion, management in
6 homes? Is it Ministry of Long-Term Care
7 inspectors? Is it MOHs? Is it others?

8 Those sorts of things, I think, need to
9 be clarified and could be clarified in the short
10 term.

11 Likewise, again, I don't know if the
12 IPAC provisions are under regulation or in statute
13 in the Long-Term Care Homes Act and the Retirement
14 Homes Act. But I don't know. They don't seem to
15 be terribly effective, and I suspect you're going
16 to get a litany of complaints from some of the
17 families who have looked at the inspection records
18 at some of the homes that have been in outbreak
19 during COVID-19. So I'll let them speak to that.

20 The last thing I would say -- and this
21 would just be a last opportunity. So under the
22 HPPA, in order for an associate MOH to exercise his
23 or her full duties, you need to be designated an
24 associate MOH by the Minister.

25 So we've been waiting since January, so

1 I have to be absent from work in order for
2 Dr. McTavish to carry out my duties and
3 responsibilities.

4 Throughout the pandemic, I've reached
5 out to MPP offices to inquire as to the status of
6 the designation. My regional chair has written two
7 letters to the Minister with respect to that
8 designation, and I'm not alone. There are many
9 associate -- I don't know about MOHs -- associate
10 MOHs who are awaiting the Minister's designation so
11 that they can carry out the full scope of their
12 practices, and I think that would be a pretty quick
13 and easy recommendation to make in the short term.

14 In the middle of the pandemic, waiting
15 for this to happen -- and I'm not trying to be
16 critical of the Minister in office. She's got a
17 whole lot on her plate, and there may be reasons
18 for this to not be occurring. So I'm not trying to
19 be critical, but if this is due to just competing
20 demands, then place it at a higher priority, and I
21 would be sort of a happy man.

22 So those are my thoughts. I did
23 mention, when I started out, that there are
24 applicable protocols and guidelines that we follow
25 with respect to our work with respect to long-term

1 care and retirement homes.

2 The protocols and standards tell us,
3 Boards of Health, MOHs what we have to do, but the
4 triggers are based on complaints and that sort of
5 thing.

6 So in the longer term, if, in fact,
7 there is a bigger role for Public Health to play
8 with respect to IPAC practices in these places, for
9 example, then I do think that you need to take a
10 look at the protocols and guidelines.

11 And again, I'm not here with a cap in
12 hand, but if you give us the responsibility -- and
13 this is my plea. Give us the authority, and give
14 us the resources to get the job done.

15 And I think I'll end there.

16 COMMISSIONER FRANK MARROCCO (CHAIR): I
17 want to make sure I understand what you just said.
18 It's a question of giving you the -- do I
19 understand that, really, it's giving you the
20 responsibility? You have the powers --

21 DR. ROBERT KYLE: Yes.

22 COMMISSIONER FRANK MARROCCO (CHAIR):
23 -- to do what you need to do in the moment to
24 stabilize?

25 DR. ROBERT KYLE: That's right.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 But you need the responsibility to act? Have I got
3 that right?

4 DR. ROBERT KYLE: Yeah, that's right.
5 So let me concretize it for you. So if the
6 Ministry of Long -- and I must say, I'm speaking
7 off the top of my head, and I really have not had
8 any chance to dive deeply into the Long-Term Care
9 Homes Act or the Retirement Homes Act.

10 This is the point I'm trying to make,
11 and I think this will come up from families from,
12 say, Orchard Villa. If the only sanction that a
13 Ministry of Long-Term Care home inspector can use
14 to enforce, say, noncompliance of an IPAC breach is
15 somehow to pull a home's license, well, that's a
16 very blank tool. And if you were to do that, then
17 you would have to relocate all of the residents
18 there. It's just not going to happen.

19 I'm not aware, but I stand to be
20 corrected. Maybe they can take them -- maybe they
21 can find them and that sort of thing. I don't know
22 if they can. I can or our inspectors can, but we
23 don't systemically do inspections of long-term care
24 homes. We're not required to do that outside of
25 our normal duties which focus more on food safety.

1 And, of course, we get involved in outbreaks, of
2 course, in long-term care homes, and we follow
3 provincial guidelines with respect to the long-term
4 care homes.

5 Interestingly, usually we cross swords
6 with LHINs during flu season because if, in fact,
7 you have a home in outbreak and one of their
8 residents, say, is in hospital and needs to be
9 stabilized -- and I know Dr. Kitts may disagree
10 with me -- we may say, "You know, what? You need
11 to have that home out of outbreak before they can
12 return home." Well, then, of course, that blocks a
13 bed in the hospital. So we get involved in these
14 things all the time, and we're just following
15 provincial guidelines.

16 I digress, but my point is if it makes
17 sense for Public Health to have a more prominent
18 role with respect to, say, inspecting homes for
19 IPAC breaches and using the tools at its disposal
20 to deal with those breaches, then we would need a
21 mandate to do that, and there would need to be
22 resources attached to that.

23 So I think that was the point that I
24 was trying to make, but we can actually rely on
25 remedies and sanctions under the HPPA that,

1 perhaps, are more appropriate than those available
2 to Ministry of Long-Term Care home inspectors or
3 RHRA inspectors. I think that was the point I was
4 trying to make, Commissioner.

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 Okay. Thank you. All right. So, Doctor, if I
7 understand you correctly, you've completed, but --

8 DR. ROBERT KYLE: So --

9 COMMISSIONER FRANK MARROCCO (CHAIR):
10 -- then if not, carry on.

11 U/T DR. ROBERT KYLE: So those are the
12 points that I was able to cobble together in the
13 time that I had available yesterday to give some
14 thought to this.

15 And I would be happy to undertake, when
16 I can, to at least codify that in a set of bullets
17 to send to commission, counsel, or staff. Happy to
18 do that.

19 But what I've tried to do is give you
20 some, at least, preliminary thoughts based on the
21 questions that were posed to me in advance of this.
22 So what did we do? How did we work with the CMOH
23 and province? What have we learned? And what are
24 some recommendations?

25 So hopefully I've been faithful to what

1 I was asked to do. And, Commissioners, the best
2 that I could do given the time that I had and given
3 that when we finish the call it's back to COVID-19.

4 COMMISSIONER FRANK MARROCCO (CHAIR):

5 Well, we don't want to take you away from that for
6 too long a period of time.

7 But thank you, Doctor, for the
8 presentation. We probably will be back to you.

9 DR. ROBERT KYLE: I'm happy to help you
10 out any time bearing in mind that, for all of us,
11 our reality is not the reality. It's a shared
12 reality. But I've had a front row seat as an MOH
13 for over 30 years, so I'd have a few thoughts.

14 COMMISSIONER FRANK MARROCCO (CHAIR):

15 Well, I'm sure we'll be back to hear what they are.
16 But thank you again, and thank you to the two --

17 I mean, you needed two lawyers with you
18 to make sure you didn't get into any trouble, but
19 it appears that they did their job too. So thank
20 you, and we'll be in touch.

21 DR. ROBERT KYLE: Thank you very much,
22 Commissioner.

23 COMMISSIONER COKE: Thank you.

24 DR. ROBERT KYLE: Have a great day, and
25 take care and stay well.

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 Okay.

3 COMMISSIONER KITTS: Thank you.

4 DR. ROBERT KYLE: Bye-bye.

5 -- Adjourned at 10:15 a.m.

6

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1 REPORTER'S CERTIFICATE

2
3 I, MCKAYA MCDONALD, CSR, Certified
4 Shorthand Reporter, certify:

5
6 That the foregoing proceedings were
7 taken before me at the time and place therein set
8 forth;

9
10 That all remarks made at the time
11 were recorded stenographically by me and were
12 thereafter transcribed;

13
14 That the foregoing is a true and
15 correct transcript of my shorthand notes so taken.

16
17
18 Dated this 2nd day of October, 2020.

19
20 

21
22 _____
23 NEESONS, A VERITEXT COMPANY

24 PER: MCKAYA MCDONALD, CSR

25 CHARTERED SHORTHAND REPORTER

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