

Long Term Care Covid-19 Commission Mtg.

Dr. Gary Garber
on Monday, February 1, 2021



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom, with all participants attending
remotely, on the 1st day of February, 2021,
3:30 p.m. to 4:24 p.m.

1 BEFORE:

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3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

6

7 PRESENTERS:

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9 Dr. Gary Garber;

10 Ann Christian-Brown, Counsel, Crown Law Office -

11 Civil, Ministry of the Attorney General;

12 Roopa Mann, Counsel, Crown Law Office - Civil,

13 Ministry of the Attorney General;

14 Alwin Kong, Public Health Ontario;

15

16 PARTICIPANTS:

17

18 Alain Daoust, Team Lead, Long-Term Care Commission

19 Secretariat;

20 Angeline Hawthorn, Senior Policy Analyst, Long-Term

21 Care Commission Secretariat;

22 Angela Walwyn, Senior Policy Analyst, Long-Term

23 Care Commission Secretariat;

24 John Callaghan, Counsel, Gowling WLG;

25 Lynn Mahoney, Counsel, Gowling WLG;

1 Michael Finley, Counsel, Gowling WLG;
2 Joshua Shoemaker, Counsel, Gowling WLG;

3

4 ALSO PRESENT:

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6 Carissa Stabbler, Stenographer/Transcriptionist

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1 -- Upon commencing at 3:30 p.m.

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3 JOHN CALLAGHAN: Commissioners, today
4 we have Dr. Gary Garber who had worked at Public
5 Health Ontario and recently went over to the
6 Canadian Medical Protection Association, and so
7 he's going to tell us a little bit about his
8 experience in Public Health Ontario.

9 I don't know, Commissioner, if you want
10 to say anything in advance. Or Chair, I should
11 say.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Well, just welcome, Doctor. You know what we're
14 about, so I won't waste any time with that. There
15 is a transcript which we will post on the website
16 to make sure that people can follow the
17 investigations and inquiries that we're making.

18 And we will, with your permission, just
19 interrupt and ask questions as we go along rather
20 than waiting and then circling back.

21 And if that's all okay, we're ready to
22 go when you and Mr. Callaghan are.

23 JOHN CALLAGHAN: And, yes, we're going
24 to do sort of a more traditional format where I'll
25 just ask Dr. Garber questions.

1 So, Dr. Garber, I mean, many of us know
2 your background, but could you share your
3 background for the benefit of the others?

4 DR. GARY GARBER: Sure. Went -- grew
5 up in Montreal, got my BSc at McGill, MD degree
6 University of Calgary. I did my internal medicine
7 training at University of Toronto, infectious
8 disease and research training at the University of
9 British Columbia, and I've been at University of
10 Ottawa in the Ottawa Hospital since 1986.

11 My specialty, of course, is infectious
12 disease. Soon after I got to that hospital as the
13 first ID physician at the Ottawa General at that
14 time, I was asked to get involved with infection
15 control work because there was no one with
16 expertise at the time.

17 And I was involved within the hospital
18 incorporating infection control activity for, jeez,
19 about 22 years, I think, until Jack -- until I was
20 able to recruit Virginia to take over.

21 I was division chief of infectious
22 disease at the hospital for 20 years and helped set
23 up a number of programs at the hospital, the AIDS
24 program, hepatitis C program, and a number of
25 research programs as well.

1 I then moved to -- I've retained
2 part-time clinical activity with the Ottawa
3 Hospital about eight years ago. I went to Public
4 Health Ontario initially as the medical director of
5 infection prevention control to take on more a
6 provincial lens as a change.

7 That role changed to being chief as
8 they separate out infection control as a
9 department. And then last year, there were changes
10 as well within the department where it was no
11 longer a separate department. I was then called an
12 IPAC physician.

13 And then I joined the CMPA in December
14 in the role of director of medical care analytics,
15 basically the patient safety arm of the Medical
16 Protective Association.

17 JOHN CALLAGHAN: Before we go into your
18 years at Public Health Ontario, could you just
19 provide a little background in the Regional
20 Infection Control Networks and how they got
21 absorbed into Public Health Ontario?

22 DR. GARY GARBER: I'll try and describe
23 that as best I can. Basically -- Dr. Kitts would
24 remember this actually. Coming out of SARS, there
25 were really three key elements that were put into

1 play.

2 One was the Ontario Agency for Health
3 Protection and Promotion which, you know, the
4 nickname now is Public Health Ontario, and that's
5 obviously the name that's being used, PIDAC or the
6 Provincial Infectious Diseases Advisory Committee,
7 and the third aspect was Regional Infection Control
8 Networks.

9 And the Regional Infection Control
10 Networks were a series of 14 offices across the
11 province, and their goal was to try and improve
12 communication across the province so there'd be
13 harmonization of policies both for acute care and
14 long-term care as well as the general clinical
15 community and with liaison to Public Health.

16 The reason why I know Dr. Kitts would
17 remember this was he was on the SARS Commission,
18 and at that time, we had already previously put a
19 proposal together to try and set up some kind of
20 regional infection control model for eastern
21 Ontario, particularly Ottawa, and Dr. Kitts asked
22 me for that proposal, and that proposal actually
23 was imbedded as an appendix in the original SARS
24 report.

25 So they were set up for that purpose.

1 They were operational for -- you know, I haven't
2 checked back exactly when they started, somewhere
3 around '86, '87, and they still exist today in a
4 slightly different form.

5 But in 2011, I believe it is, I was no
6 longer -- so I was -- so Ottawa for the Champlain
7 region was one of the first four of the 14 that
8 were established.

9 Myself and Dr. Roth were -- we were
10 co-led as medical co-leads for the Ottawa -- what
11 we called RICN at that time. And did that for, I'd
12 say, about four years.

13 I stopped being actively involved in
14 that around 2010 when I started being involved with
15 setting up some antimicrobial stewardship programs
16 within the hospital.

17 And somewhere in that next year, the
18 programs got transferred to Public Health -- to the
19 new agency, Public Health Ontario as part of a
20 transfer of a lot of provincial programs into the
21 agency.

22 JOHN CALLAGHAN: And did they get
23 realigned into regional hubs at one point?

24 DR. GARY GARBER: They did. That
25 happened in 2016, I believe it is. We found --

1 certainly when I became the medical director and
2 then the chief, we found that there were some
3 difficulty with having very small offices of three
4 people. If you had a three-person office and,
5 frankly, one person was on mat. leave, you would
6 have a two-person office. You then would have
7 someone on holiday.

8 It wasn't really functioning very well,
9 so the idea was to have -- for partially economy of
10 scale and also to have a critical mass, we elected
11 to combine the office into larger offices still
12 with a regional presence.

13 So the goal is to really have five
14 hubs: The north, the west, the east, central, and
15 central west, but we retained a number of what we
16 called satellite offices that still retained a
17 presence.

18 So although there's east, which is
19 based in Ottawa, there's still a satellite office
20 at their provincial lab in Kingston. And north,
21 although it's one, really had people distributed
22 between Sudbury, Thunder Bay, and we had one person
23 working out of Sault Ste. Marie.

24 And our Toronto hub which had been a
25 series of offices around Toronto got centralized to

1 head office, but we had a satellite office in
2 Orillia.

3 JOHN CALLAGHAN: I'd like to sort of
4 speak about Public Health Ontario. We heard there
5 was a bit of realignment, and you mentioned it a
6 moment ago, where the IPAC was restructured. That
7 was in 2019; is that correct?

8 DR. GARY GARBER: It actually happened
9 in 2020. I first heard of this -- that there was
10 going to be a realignment in 2020.

11 In fact, my VP at the time flew up to
12 Ottawa and told me that there's going to be a
13 realignment on Christmas Eve, and it was to come
14 into effect on January 22nd, I believe was the
15 date.

16 JOHN CALLAGHAN: And while we're on it,
17 what did that mean for your role and for the focus
18 of IPAC at Public Health Ontario?

19 DR. GARY GARBER: Essentially they were
20 amalgamating or consolidating the infection control
21 department with the communicable disease and
22 emergency response team into one department which
23 was going to be called Health Protection.

24 And there was going to be a -- the
25 second team within Public Health Ontario was going

1 to be Health Promotion which would include health
2 promotion, some of the other support functions, and
3 I believe it's occupational health.

4 In doing that, my role as chief was
5 ending -- into discussions because there was going
6 to be a leadership void. I agreed to stay on as a
7 medical director until the end of March in which --
8 and in those three months, they were going to be
9 recruiting a new medical director for the Health
10 Protection department -- or portfolio I think they
11 called it.

12 JOHN CALLAGHAN: So IPAC would no
13 longer be a separate subdivision as it were?

14 DR. GARY GARBER: Separate department,
15 that's correct.

16 JOHN CALLAGHAN: Prior to this
17 reorganization, what kind of work did your IPAC
18 group do and what kind of numbers of IPAC positions
19 did you have?

20 DR. GARY GARBER: Okay. Well,
21 initially when I first started, we had about -- we
22 had about 80 FTEs in the department to distribute.
23 In our regional infection control section,
24 originally we had over 40 people distributed across
25 the province.

1 The rest of the team was divided up
2 predominantly between Toronto and the Ottawa office
3 where I had a small research team.

4 In that team, especially in the
5 regional offices, two-thirds of that staff were
6 infection control practitioners. The criteria to
7 get that position, you had to have a minimum of
8 five years of active infection control experience
9 along with having your CIC or, you know,
10 Certificate of Infection Control.

11 And these people were, in many ways,
12 go-to advisors to smaller hospitals, sometimes
13 liaising with larger hospitals when it came to
14 things like Ebola and certainly provided a lot of
15 the education, training, and support for new
16 infection control practitioners in those venues as
17 well as in long-term care.

18 JOHN CALLAGHAN: And just to be clear,
19 did you have any sort of regulatory oversight
20 function in respect of hospitals in long-term care,
21 or was it really educational?

22 DR. GARY GARBER: Well, Public Health
23 Ontario, the way the act was created or in the
24 famous napkin that Sheela Basrur wrote on, that
25 policy and enforcement was always within the

1 Ministry, and guidance and technical support was
2 within Public Health Ontario.

3 So even the Provincial Infectious
4 Diseases Advisory Committee whose guidelines are
5 used in many ways as the gold standard for
6 infection control in the province are, in fact,
7 guidelines and not policies, although hospitals and
8 organizations may adapt them as policies.

9 JOHN CALLAGHAN: And what would the
10 Public Health Ontario IPAC division's interaction
11 with long-term care have been in that period?

12 DR. GARY GARBER: It was quite
13 variable. It was anything from organizing
14 committees of practice to bring local groups
15 together either for meetings or virtually.

16 It would be for dissemination of
17 documents. So, for example, if there was a new
18 PIDAC guideline, it would be quite a cumbersome
19 guideline. It would be our regional support teams
20 that would provide the interpretation of that
21 guideline to the folks on the ground so they could
22 appropriately implement the guidelines.

23 We had a whole series of educational
24 videos and pamphlets, et cetera to teach people in
25 different clinical practice how to put on and take

1 off personal protective equipment, you know, the
2 donning and doffing we talk about.

3 And so even though the procedures are
4 the same, they were re-targeted whether you were in
5 acute care or long-term care so people felt it was
6 actually appropriate for their particular setting.

7 And the videos are made at Public
8 Health Ontario. Many of the actors were actually
9 our staff. And, of course, they were often
10 involved with teaching.

11 The teaching could either be showing
12 the video to a series of staff and going over it.
13 Sometimes it would be -- staff would be watching it
14 during their breaks when the staff would often be
15 called to go into nursing homes to do teaching or
16 long-term care in general, including helping to
17 adapt and adopt hand hygiene protocols, for
18 example.

19 And more recently or towards the end,
20 we were engaging with some long-term care homes to
21 engage a urinary tract infection program to
22 decrease the number of cultures taken for
23 asymptomatic urinary tract infections.

24 And our pilot showed that by doing
25 that, we could decrease antibiotic utilization in

1 these nursing homes by between 30 and 35 percent.

2 COMMISSIONER JACK KITTS: Gary, can I
3 just ask a question to make it more clear in my
4 mind? So SARS was a hospital disease spread in
5 hospitals, and your proposal to the SARS panel was
6 to ensure that the hospitals that had the IPAC
7 expertise shared it with the community hospitals
8 across the region as the Regional Infection Control
9 Network, and yours was one of them.

10 So since then, is the relationship
11 between hospitals and long-term care -- was that
12 taken over by IPAC central, and what is the
13 relationship between infection prevention and
14 control and long-term care homes coming into COVID?

15 DR. GARY GARBER: That's a real complex
16 question, Jack, quite honestly because it's highly
17 variable. If you break it down into segments of
18 health care -- so, for example, in acute care, we
19 have this maldistribution of infectious disease,
20 infection control, and microbiology expertise.

21 And you will see that the Ottawa
22 Hospital may have 20-odd experts, and next door we
23 have our children's hospital that has another 4 or
24 5 or 6.

25 Until recently, hospitals in Ottawa

1 like the Montfort and Queensway Carleton did not
2 have infectious disease expertise. And if you go
3 across the province of 115 or 120 hospital
4 corporations, probably three-quarters of them do
5 not have that expertise within their walls.

6 In northwestern Ontario now, you have
7 two infectious disease experts, and no one with
8 microbiology expertise. They're incredibly
9 swamped.

10 Northeastern Ontario, it's only based
11 in -- I think there's one in Sudbury and one in
12 Sault Ste. Marie. And you go right across the
13 province and see the same thing. In southwest, you
14 have your expertise really in London, but west of
15 London you don't have that expertise.

16 So the idea really was to make sure
17 that people working in these smaller hospitals --
18 and some of them aren't all that small. They can
19 be 150-, 200-bed hospitals -- can tap into the
20 expertise to make sure that their patients are
21 similarly protected as the landscape changes.

22 So that's just acute care. Long-term
23 care, there's no template. Until really the
24 spring, there was no real connection between acute
25 care and long-term care.

1 A lot of the long-term care support for
2 outbreaks, which usually would tend to be
3 respiratory outbreaks, occasionally
4 gastrointestinal outbreaks, was really under the
5 purview of the health units who would go in and
6 investigate and basically limit visitation and
7 things like that.

8 The acute care teams really had very
9 little to do with that other than at times
10 supporting the Public Health units when they had
11 questions.

12 And the Regional Infection Control
13 Networks were kind of a bit of an interface between
14 the acute care Public Health and the long-term care
15 sector either providing guidance, education,
16 support.

17 In many cases, in some of the regions,
18 we would actually do joint educational sessions
19 with the local RICN and the health department or
20 the health unit.

21 COMMISSIONER JACK KITTS: Right.

22 DR. GARY GARBER: I don't know if that
23 answers your question.

24 COMMISSIONER JACK KITTS: Well, it's --
25 where is the responsibility or accountability for

1 ensuring -- like, in the proposal after SARS, there
2 was an agreement that the hospitals that had the
3 expertise were to share it or, like, a
4 hub-and-spoke with the hospitals that didn't, and I
5 think there were created coordinators, infectious
6 disease coordinators.

7 Wouldn't the natural progress be to go
8 from there to a long-term care home and, you know,
9 where would that leadership come from?

10 DR. GARY GARBER: Again, great question
11 that I don't have a good answer for, to be honest.
12 I don't think we had one model across the province.
13 I think it was very -- I think it was very
14 regional.

15 I think just like many other aspects of
16 health care, a lot of it was dependent on kind of
17 who you know, what kind of local relationships you
18 had as opposed to saying that -- you know, there
19 wasn't -- you know, the Regional Infection Control
20 Network had a rule, and you may recall that even
21 that in some jurisdictions, not in our area, not in
22 Toronto but in other areas, there was controversy
23 into how that was funded because the regional
24 networks were actually kind of through the Public
25 Health branch, and there was a sense at one time

1 where some of the Public Health units said, "Well,
2 why is the money going to this network? Why isn't
3 it going to Public Health?"

4 So, I mean, even the setup of the RICNs
5 at this time was not without some controversy.

6 COMMISSIONER JACK KITTS: Okay.

7 DR. GARY GARBER: Just to elaborate,
8 the RICNs were initially set up in line with the
9 LHINs, the Local Health Integration Networks, even
10 before the LHINs were established.

11 And initially when the LHINs started,
12 the RICNs were not part of the LHINs and then were
13 put part of the LHINs. So there's a lot of back
14 and -- to'ing and fro'ing and back and forth
15 politically, and that's your...

16 COMMISSIONER JACK KITTS: Just one more
17 question on that then. So you're aware of the
18 hub-and-spoke model now between hospital and
19 long-term care.

20 Is that very similar to what you did
21 many years ago after SARS except it's now hospital
22 to long-term care? And if so, is this the model
23 that's going to succeed, in your opinion?

24 DR. GARY GARBER: In my opinion, I
25 think that model will work really well in Toronto

1 where you have, you know, 7 or 8 large hospitals
2 with a lot of expertise. And what, the Toronto
3 area has 23 long-term care homes? You can divide
4 that up easily.

5 If you go into eastern Ontario where
6 you have two academic -- large academic centres in
7 Kingston and Ottawa and, in between, you may have
8 70 long-term care homes, I think the numbers don't
9 add up.

10 And you have the same kind of problem
11 if you look at Hamilton and Niagara or the same
12 problem you're going to have in central west or
13 southwestern Ontario.

14 So, again, it's an issue of how do you
15 divide it up? Do you have some hospitals in
16 downtown Toronto then supporting long-term care in
17 Orillia north? I don't know if that's been really
18 thought through in terms of how you distribute the
19 expertise to 600 long-term care homes. So I do
20 have concerns about that model.

21 Back in June when we had some
22 discussions about that, you know, there was talk at
23 the time that you'd sort of have three levels. You
24 could have sort of some provincial oversight. You
25 could then have some regional support which could

1 have been the Regional Infection Control Networks
2 providing such support, and then at the local
3 level, you could have hospitals involved.

4 So you could -- so the hospitals could
5 do their part, but you'd also have another layer
6 that could fill the gaps where the hospitals
7 couldn't do it with some overall provincial
8 policies.

9 My understanding early on with some of
10 the proposals that was on the table, I don't
11 believe that has gone forward.

12 COMMISSIONER JACK KITTS: Thank you.

13 JOHN CALLAGHAN: Yes, Ms. Coke?

14 COMMISSIONER ANGELA COKE: You had
15 mentioned before in 2020 they had done the
16 realignment of IPAC function.

17 I'm just interested from your point of
18 view if that's something that has either
19 strengthened or weakened the robustness of the IPAC
20 function.

21 DR. GARY GARBER: In my opinion, I
22 would say it has significantly reduced the
23 robustness of infection control within Public
24 Health Ontario, and part of that was how it was
25 rolled out.

1 Although it was an amalgamation of two
2 departments, the entire leadership of that
3 portfolio was all from the communicable disease
4 side of the house. So all the infection control
5 expertise was much lower down.

6 So, for example, when they did set up
7 the Incident Management System, the IMS system, and
8 the infection control activity was quite low down
9 having to report through several layers before it
10 would get up to senior leadership.

11 So there's actually some -- I wouldn't
12 say it was intentional, but it ended up becoming
13 more problematic because some of the IPAC issues
14 out front unless one tried to, shall we say, jump
15 the system somewhat.

16 And certainly what that did in its
17 implementation was it truncated the ability of the
18 regional teams to do the work that they were doing
19 in the community because there had to be a number
20 of layers of approvals before, for example, they
21 could go into a long-term care home.

22 COMMISSIONER ANGELA COKE: Okay. Thank
23 you.

24 JOHN CALLAGHAN: So just take a
25 jumping-off point there, but before we do, I just

1 want to make it clear that while you had programs
2 that would assist long-term care homes, they
3 weren't required access to your program.

4 I think the phrase you used with me was
5 selection bias, which I take it means that it was
6 up to them to avail themselves of what was
7 available; is that right?

8 DR. GARY GARBER: That's correct. So
9 the urinary tract program that I mentioned, we did
10 a pilot in two. We use a municipal home and a
11 private home. We eventually rolled it out on
12 several iterations using a very iterative way of
13 getting people -- well, it's over 100 homes.

14 But we then wanted to get the next 100
15 homes in, and then it became difficult to get homes
16 to sign on to participating in the rollout of the
17 program.

18 And we have no jurisdiction to mandate
19 it. All we had was great data to show how this
20 program would be good for their residents and,
21 frankly, save their staff time, but if they weren't
22 interested, there was really nothing we could do
23 about it.

24 JOHN CALLAGHAN: So we've heard,
25 frankly, some very horrific stories about the state

1 of IPAC in some of these homes, and I take it they
2 could self-select as to whether they wanted to get
3 better by taking your educational courses or not;
4 correct?

5 DR. GARY GARBER: That is correct.
6 And, Mr. Callaghan, as we did discuss previously,
7 one of the biggest difficulties that my former
8 staff had identified was the dramatic turnover of
9 staff within long-term care homes.

10 So if you had a really good nurse and
11 you were going to put some time into him or her
12 developing skills, infection control, and my team
13 might be acting as mentorship and they're doing
14 that and trying to implement it, if that person was
15 good, probably within a number of months they were
16 given other corporate responsibilities, or they
17 would move to a different facility.

18 And it was the same thing with training
19 the staff in long-term care homes. You could train
20 the staff in hand hygiene, and three months later,
21 the staff turnover was such that you'd be starting
22 from scratch.

23 So it was very difficult to be able to
24 maintain the level of basic IPAC expertise within
25 the homes.

1 COMMISSIONER FRANK MARROCCO (CHAIR):
2 Did it matter, Doctor, whether it was a for-profit
3 or not-for-profit long-term care home?

4 DR. GARY GARBER: Commissioner, we
5 didn't really look at long-term care homes from the
6 perspective at that time. And I can tell you
7 there -- you know, there was one -- there was one
8 private or, whatever you call it, long-term care
9 home chain that was certainly very interested in
10 infection prevention control, actually asked our
11 expertise because they were trying to develop their
12 own surveillance system.

13 And yet there are other homes that I'd
14 had some meetings with who seemed interested,
15 but -- and we couldn't get to first base. Yeah, I
16 don't know if one can paint them all with the same
17 brush.

18 COMMISSIONER FRANK MARROCCO (CHAIR):
19 And the not-for-profits, any noticeable difference
20 in their attitude towards this?

21 DR. GARY GARBER: We never did --
22 certainly I didn't and my team, we never did that
23 as an analysis. The first time we really started
24 looking at the analysis was when some of my
25 colleagues -- and you know the data now -- looked

1 at the COVID rates and identified that data.

2 And, you know, I'm one of those papers.
3 One of my staff, Kevin Brown -- talked to
4 Kevin Brown who is an epidemiologist, was very
5 involved with those analyses. Prior to that, we
6 had never formally had data to substantiate a
7 difference.

8 COMMISSIONER FRANK MARROCCO (CHAIR):
9 So from your perspective, it was just a long-term
10 care home?

11 DR. GARY GARBER: Correct.

12 COMMISSIONER FRANK MARROCCO (CHAIR):
13 Could have been in private, public, charitable? It
14 didn't matter from your perspective? You weren't
15 looking at it like that?

16 DR. GARY GARBER: We were not, no.

17 JOHN CALLAGHAN: We, on a previous
18 occasion, looked at the senior management structure
19 of Public Health Ontario, and I think between the
20 beginning of 2019 and your departure, 12 of 24
21 senior managers were gone.

22 And I was wondering, did you have
23 attrition within the IPAC group over the 2019-2020
24 period?

25 DR. GARY GARBER: 2019 we had what I

1 call sort of our usual turnover of a couple of
2 people retiring or finding better -- you know,
3 better opportunities.

4 We were limited halfway through the
5 year in terms of replacing people who were leaving
6 because the concerns about the budget.

7 2020 was very different. As much as I
8 had tried, even with the change in the department,
9 to maintain a message to the staff that even though
10 IPAC was not a separate department, that the work
11 was every bit as important, particularly with the
12 start of a pandemic, and that the focus on the
13 staff should be in terms of good work and a
14 reporting relationship.

15 Nonetheless -- I'm just trying to
16 think. Probably from March until November and it
17 has continued since, we had at least ten departures
18 of senior, very experienced individuals from the
19 organization prior to my departure. And I know
20 there's been several actually just in the last
21 month.

22 JOHN CALLAGHAN: When we talk about
23 IPAC -- and Commissioner Coke was going on this
24 point. You have the regional offices, and at the
25 time that COVID hit, say, in March, how many staff

1 did you have out of the community who were IPAC
2 specialists?

3 DR. GARY GARBER: I think -- well, the
4 community would include downtown Toronto. I think
5 we had somewhere between 25 and 30 certified
6 infection control practitioners within Public
7 Health Ontario, and on top of that, we had, you
8 know, myself as a full-time physician and my
9 part-time physician colleagues who also have
10 interest in IPAC.

11 So we had a pretty sizable team in
12 terms of being able to provide support or sometimes
13 what we call the ICRT, the Infection Control
14 Resource Team. It'd be a team we'd send into a
15 hospital or long-term care in an outbreak to do a
16 one-day investigation and provide recommendations.

17 JOHN CALLAGHAN: So we've heard IPAC
18 was a continual story in all these long-term care
19 homes that went into outbreak, and I was just
20 wondering whether you felt your group was utilized,
21 and if it was, whether it was utilized
22 appropriately, and if not, what observations you
23 have about it.

24 DR. GARY GARBER: Well, it's hard to --
25 you know, part of that is, you know, I'm trying to

1 remember back what was going on and, you know, try
2 and separate sort of, like, you know, my feelings
3 from my thoughts, if you know what I mean, because
4 it was a very -- you folks know.

5 You can imagine what it's like to be
6 working 7 days a week, you know, 14, 15 hours a
7 day, and it's all bad news. And you have a group
8 of people who really want to do a lot, and you have
9 some ideas, and we were in a situation where we
10 were losing the ability as a department to really
11 get to the senior leaders saying, "Hey, you know,
12 we can do some things."

13 So, I mean, I think that was sort of --
14 so you have to sort of frame it a bit that way.
15 And part of that difficulty is that there was --
16 because of the formation of Ontario Health, there
17 was this real concern within Public Health Ontario
18 that if the organization looked too much like
19 health care, that Public Health Ontario would be
20 subsumed with the other organizations and agencies
21 into Ontario Health.

22 And so, you know, it was told to me
23 indirectly that one of the reasons to have a lower
24 profile IPAC department is we were the only
25 department within Public Health Ontario that really

1 had a clinical face. Of course, the other is the
2 lab, but, you know, the lab is the lab.

3 And so they didn't want the IPAC
4 department to have a big visibility in this. We
5 were involved with committees and things like that
6 when we're called upon, but when we brought up
7 saying, "Hey, you know, we could send in -- if
8 there's a couple of nursing homes in an outbreak,
9 we could send a team in, investigate, and make
10 recommendations."

11 You know, we were basically told, "No,
12 we don't have the bandwidth for that. No, we can't
13 do that. No, it's up to the health -- it's the
14 health unit's responsibility to do that. They can
15 call us in when we need it."

16 So one of the frustrations for a lot of
17 my staff at the time -- it was my staff really
18 until the end of March. Then I guess you could
19 call it -- it was my -- I don't even know what the
20 term is. I felt a connection but no official
21 reporting relationship.

22 There was a real frustration of the
23 fact that these people with expertise were not able
24 to basically help out to scope.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 This was fundamentally so that it would not give
2 the impression of being a health care service
3 provider because, if it was, it would get absorbed
4 by Ontario Health?

5 DR. GARY GARBER: Well, that was a
6 concern of the former CEO. My editorializing is
7 his approach to, you know, budgetary structures,
8 things like that was keep your head down so, you
9 know, no one chops it off. And so I think that was
10 why we're sort of being put below the radar.

11 But realistically, in March, the notion
12 was our role is support Public Health, and Public
13 Health's role is long-term care, so we will support
14 Public Health when they want us to support them.

15 JOHN CALLAGHAN: So that I understand,
16 you had 25 to 30 people who were quite capable of
17 going into long-term care homes and assessing --

18 DR. GARY GARBER: Correct.

19 JOHN CALLAGHAN: -- a situation from an
20 IPAC perspective --

21 DR. GARY GARBER: Correct.

22 JOHN CALLAGHAN: -- and they weren't
23 used?

24 DR. GARY GARBER: That's correct.

25 COMMISSIONER FRANK MARROCCO (CHAIR):

1 I'm sorry, Mr. Callaghan. I missed your question.
2 And they weren't used? Is that what you said?

3 JOHN CALLAGHAN: They weren't utilized.
4 In other words, there were 25, 30 senior IPAC
5 specialists, five years of training, who were
6 available to go in and assist long-term care homes
7 either individually or on a team basis, and they
8 weren't utilized by the Province. Have I got that
9 right, Dr. Garber?

10 DR. GARY GARBER: That's correct. And
11 I'll expand. Most of the people we're talking
12 about would have been people with ten or more
13 experience.

14 To give you an idea where some of these
15 people have gone since they left Public Health
16 Ontario, one is doing work for the WHO. Several
17 others are now acting as -- basically managers of
18 IPAC for some long-term care homes including, you
19 know, for hospitals, et cetera, and others are
20 doing consulting work.

21 So, I mean, they were helping out, but,
22 I mean, a lot of this happened much later on. And
23 I know those who stayed, and a number, you know,
24 before I left expressed a lot -- they've expressed
25 a lot of burnout because of the feeling of

1 frustration with what they couldn't do.

2 I think we all have the same sense that
3 we wish we all could have done more back in March
4 and April.

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 And this was largely driven, in your view, by a
7 desire to keep a low profile so as not to get
8 absorbed by Ontario Health?

9 DR. GARY GARBER: Well, I think that's
10 part of the underlying. It was a real shift that
11 even though -- the IPAC department was always
12 considered different from the other departments
13 because we had connections, not only -- our role
14 was to work with Public Health but as well the
15 health care sector.

16 So we were unique among the other
17 departments in that respect. And the push really
18 was that the focus would be exclusively to the
19 Public Health units.

20 JOHN CALLAGHAN: I think you'd
21 mentioned to me, like, this was a unique
22 experience. I mean, this is a once-in-a-century
23 pandemic for that type of worker. What did it mean
24 to the workers not -- or the IPAC specialists not
25 to dig in, as it were?

1 DR. GARY GARBER: Well, you know, at
2 the time, I was explaining it to people that, you
3 know, COVID really was the IPAC Olympics, that, you
4 know, we had people who had been training for
5 years, who had the expertise to support their
6 hospitals. We always had little outbreaks. We
7 knew how to do outbreaks. We knew how to cohort
8 people, et cetera.

9 And with all that training you've
10 heard, this was the time to get out there and --
11 you know, I don't want to say "go for the gold."
12 That's pulling that analogy way too far, but, you
13 know, at least participate. And instead, the staff
14 were sitting on the bench.

15 JOHN CALLAGHAN: Did that remain so
16 until you left in December, as far as you were
17 concerned?

18 DR. GARY GARBER: Well, it changed
19 somewhat towards the end of April, you know, as
20 the -- I mean, again, I wasn't -- you know, I was
21 peripheral to some of the discussions and because I
22 was involved with some Ontario Health committees,
23 so I had the opportunity to bring some of these
24 issues up to some of the folks there.

25 But in the end of April, some of the

1 IPAC folks were now being asked to go into
2 long-term care and review the processes and make
3 recommendations.

4 I was no longer supervising that,
5 although I did in May join one of the team members
6 in Ottawa to do a site visit because I wanted to
7 see the process myself.

8 But -- so there was some of this going
9 on, but it was -- you could almost say it was more
10 of a peacetime inspection. Most of these homes
11 were either coming out of outbreak or were
12 considered at risk of future outbreak. It was not
13 going on at the time where things were at their
14 worst.

15 JOHN CALLAGHAN: Were you called in --
16 at that time, were they called in to work with
17 inspectors of long-term care or inspectors of
18 labour, or was this an independent review?

19 DR. GARY GARBER: Jeez, now I can't
20 remember the exact details. Basically our folks
21 would often go in with someone from the health
22 unit, and I know a lot of the focus was on
23 long-term care homes that were either considered in
24 the red or yellow; in other words, they were at
25 risk of outbreaks based on previous problems or

1 because they had been previously in an outbreak.
2 So that seemed to be the priority to go into those
3 kind of homes.

4 JOHN CALLAGHAN: In March and April, I
5 take it from what you were saying -- did you raise
6 this issue with others?

7 DR. GARY GARBER: Most certainly. In
8 March, I was actually joining the Ontario Health's
9 long-term care table. I was then replaced when
10 Dr. Jessica Hopkins joined and became the medical
11 director.

12 We didn't need four people on those
13 calls, so I was focusing more on the PPE parts with
14 different aspects of the Ministry.

15 But at that time, I'd had some email
16 and I had a conversation with Catherine Brown. I
17 certainly talked to the people within Public Health
18 Ontario, you know, Shelley Deeks and then
19 Jessica Hopkins, just to remind them that we did
20 have the capability of making a difference and
21 tried to build on the expertise we had when a few
22 of the members of the Ottawa office helped with the
23 repatriation of passengers to the Trenton Air Force
24 base.

25 And our team had the -- when they went

1 there, they were actually training in realtime the
2 Red Cross volunteers and helped with the cohorting
3 of the people who came off the plane and where they
4 went into the homes for that period of time.

5 So it was -- and that was extremely
6 well received by the Federal Government, the
7 military, and the local Public Health unit where,
8 in fact, were subsequent repatriations. We then
9 got formal letters of request to enter from the
10 Federal Government.

11 So we had that expertise where we knew
12 it made a difference. If you went where people are
13 well-intentioned but didn't have the experience and
14 you had one or two people with experience, you
15 could do the training just in time to make sure
16 people had the PPE, knew what to look for, and not
17 spread disease.

18 JOHN CALLAGHAN: You mentioned emails.
19 We've had some difficulty with the emails. So
20 there were emails to Ms. Brown, Ms. Deeks, and
21 Ms. Hopkins; is that your recollection?

22 DR. GARY GARBER: Yes.

23 JOHN CALLAGHAN: We'll follow up with
24 the government to get those.

25 Now, the last thing I just wanted to

1 cover with you is you did sit at a couple of these
2 tables, and perhaps you might tell us what that
3 experience was like. You just mentioned one there,
4 the --

5 DR. GARY GARBER: A lot of the tables I
6 was at were related to either the use of PPE, the
7 appropriate use of PPE, discussions with unions in
8 terms of some of the controversies related to that,
9 and some of the other -- in fact, I was one of the,
10 I guess, advisors to the PPE allocation committee.

11 I was also providing expertise to
12 Attorney General's office related to the courts,
13 Solicitor General related to the prisons. We
14 provided advice to Ministry of Education related to
15 some of the rollout of PPE for the schools. So, I
16 mean, there's a lot of work there.

17 My experience is that -- you know,
18 sometimes when I read the newspapers or the
19 commentaries and I see people always trying to
20 provide their other points of view, I think a lot
21 of people recognized how many people were working
22 incredibly hard to do the right thing in realtime
23 with changing information and changing advice.

24 It was certainly a unique experience.
25 I would say it could be frustrating, but in most

1 cases -- you know, in almost all cases, the sense
2 of collegiality of everybody wanting to do the
3 right thing was really impressive.

4 You know, I say this only because, you
5 know, it's really easy to point fingers at people
6 who work in government in retrospect to say, "Why
7 did you make that decision?"

8 But, you know, in many cases, what I
9 saw was the best decisions were being made with the
10 information we had at the time. And then you got
11 new information, and you had to make modifications.

12 And I'm talking about the science part.
13 The politics, you guys can hear that from other
14 people.

15 JOHN CALLAGHAN: I think those are all
16 my questions. Do the Commissioners have further
17 questions?

18 COMMISSIONER FRANK MARROCCO (CHAIR): I
19 don't know that we do, but I do have one -- maybe
20 what might end up being the last question, and that
21 is is there a change that you would -- that
22 occurred to you, a different way of approaching the
23 problem?

24 DR. GARY GARBER: I'll tell you one of
25 my most frustrating moments back in March. It's

1 when I was on a call on a Friday afternoon with one
2 of the long-term care homes that was in outbreak.

3 And it was unclear at the time. They
4 had about two cases. There was four or five other
5 patients from clients/residents who were ill, who
6 were being tested.

7 And the question I asked the home with
8 the health unit was, "Can you cohort? Can you move
9 the sick people? Can you take the ones you know
10 have COVID in one place, the sick people in another
11 and separate them from the rest?" And the answer I
12 was told was no.

13 And it was the one time -- maybe one of
14 the few times in my career that I just felt
15 helpless because I just knew what was going to
16 happen.

17 I mean, it's one of those homes that
18 ended up having, like, 90 percent infection rates,
19 and you just knew it was going to happen. It was
20 very clear that on the ground, they didn't know
21 what to do about it, and we weren't in a position
22 to help.

23 And the reason why I say that is I
24 learned from that because then -- because I learned
25 that I didn't ask the right question. Because the

1 question I should have -- when they said, "No, we
2 can't cohort," the question I should have asked
3 was, "If everyone is in their room, what are you
4 doing with your dining room, or what are you doing
5 in your rec room? Can you use that space as swing
6 space to cohort sick people?"

7 How do you think outside the box when
8 you have to control your infection? You know, in a
9 submarine where there's a hole, you close off that
10 section. How do you do that in a long-term care
11 home?

12 And, yes, two months later, a lot of
13 the long-term care homes started putting in
14 outbreak protocols and figuring this out, but at
15 the time, that was not something that had ever been
16 done.

17 And I think that was a lost opportunity
18 at that time because the expertise and cohorting
19 was not in the long-term care homes, and frankly,
20 in most cases, wasn't in the health units.

21 And we had a team, and in retrospect,
22 we -- maybe we should've pushed harder to say, "No,
23 we really need to have a look at this so we can
24 help you make these decisions," but it was all
25 happening too fast.

1 So I think, to me, that's one of the
2 real lessons learned that I had was we didn't think
3 outside the box in terms of how we could use the
4 equipment, how we could use our staff. A month
5 later, we were in a better position, but a month
6 later, for some people it was too late.

7 COMMISSIONER JACK KITTS: Gary, this
8 may be in the same line of -- because I know
9 exactly what you're saying about doing the best --
10 making the best decisions with the available
11 information, both science and experience.

12 Thinking outside the box for long-term
13 care, did you think about creating capacity outside
14 the home in other facilities like pop-up areas or
15 in hospitals which had now much lower occupancy
16 rates? What was your thought process about using
17 those methods?

18 DR. GARY GARBER: Yeah, I mean, that's
19 a great question, and, you know, part of that is,
20 you know, it just happened that I was doing a
21 week-on clinical service at the General the week of
22 March break when, you know, we declared emergency.

23 And think about it. A week before, we
24 didn't feel we had an emergency. So here we are
25 declaring an emergency. I'm covering the

1 infectious disease service. The hospital is at
2 100 percent capacity.

3 Once we went to emergency, then we
4 cleared out capacity, but from March 15th probably
5 to the first week in April, that capacity in acute
6 care didn't exist.

7 So, you know, when it was being used
8 later on, you know, where hospitals are down to
9 60 percent occupancy, it made sense, you know,
10 where people were able to, you know, now use hotels
11 that were empty. I mean, again, on March 15 to
12 March 20, none of that existed.

13 So, again, that's where the
14 retrospectoscope -- could we have thought on
15 March 2nd we should clear out the hospitals? Had
16 we done it, people would have thought we were
17 crazy. So, you know, I think it's all a matter of
18 timing.

19 JOHN CALLAGHAN: You made a comment.
20 Do the Public Health units have IPAC specialists
21 or --

22 DR. GARY GARBER: Yes, they do.

23 JOHN CALLAGHAN: So they would have had
24 some scope --

25 DR. GARY GARBER: Oh, yeah, they do,

1 but, you know, again, you can have a health unit
2 where there's one person responsible for infection
3 control for a region. You know, you have a few
4 people doing communicable disease who may not have
5 IPAC experience. They have Public Health
6 inspectors.

7 But it's not as if you have a -- you
8 know, some of the bigger health units have some
9 capacity, but in the smaller health units, you just
10 don't have that person who is going to be able to
11 run around to six, seven long-term care homes.

12 JOHN CALLAGHAN: In your years, did you
13 ever get asked to attend a pandemic planning
14 session whereby you would have drilled scenarios?

15 DR. GARY GARBER: I think we did, as I
16 can recall. I remember we did training in the IMS
17 system. We did some -- we did a tabletop exercise
18 at some time or another. I honestly don't -- at
19 this point, I don't remember the details.

20 JOHN CALLAGHAN: That's fine.

21 DR. GARY GARBER: I certainly don't
22 recall it happening much after. We probably did
23 some stuff around Ebola, but I don't remember much
24 after that.

25 JOHN CALLAGHAN: Okay. Those are my

1 questions. I don't know if the Commissioners have
2 anything further.

3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 Doesn't seem like it. So, Doctor, thank you very
5 much for sharing your thoughts with us. It's a
6 perspective we didn't have really before we got a
7 chance to speak to you, and we very much appreciate
8 it. Appreciate your thoughtfulness.

9 DR. GARY GARBER: Well, thank you. I
10 was just hoping it was helpful.

11 COMMISSIONER ANGELA COKE: Thank you.

12
13 -- Adjourned at 4:24 p.m.

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1 REPORTER'S CERTIFICATE

2
3 I, CARISSA STABBLER, Registered
4 Professional 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 were
11 recorded stenographically by me and were thereafter
12 transcribed;

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

16
17
18 Dated this 1st day of February 2021.

19 

20
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22 NEESONS, A VERITEXT COMPANY

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24
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C L A R I F I C A T I O N S :

Page 8, line 3: The line "around '86, '87" should state "around" '06, '07."

Page 14, line 14: For clarity, Dr. Garber was referring to PHO staff at line 14.

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