

Long Term Care Covid-19 Commission Mtg.

Former Senior Advisor to the SARS
Commission/Expert for ONA
on Wednesday, December 16, 2020



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MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

--- Held via Zoom Videoconferencing, with all
participants attending remotely, on the 16th day of
December, 2020, 2:00 p.m. to 3:00 p.m.

1 BEFORE:

2

3 The Honourable Frank N. Marrocco, Lead Commissioner

4 Angela Coke, Commissioner

5 Dr. Jack Kitts, Commissioner

6

7 PRESENTERS:

8

9 ONTARIO NURSES' ASSOCIATION:

10 Mario Possamai, Former Senior Advisor to the SARS

11 Commission/Expert for Ontario Nurses' Association

12 Sharan Basran, Senior Executive, Legal Counsel,

13 Ontario Nurses' Association

14

15 PARTICIPANTS:

16

17 Alison Drummond, Assistant Deputy Minister,

18 Long-Term Care Commission Secretariat

19 Ida Bianchi, Counsel, Long-Term Care Commission

20 Secretariat

21 Kate McGrann, Counsel, Long-Term Care Commission

22 Secretariat

23 John Callaghan, Counsel, Long-Term Care Commission

24 Secretariat

25 Lynn Mahoney, Counsel, Long-Term Care Commission

1 Secretariat
2 Derek Lett, Policy Director, Long-Term Care
3 Commission Secretariat
4 Dawn Palin Rokosh, Director, Operations, Long-Term
5 Care Commission Secretariat
6 Jessica Franklin, Policy Lead, Long-Term Care
7 Commission Secretariat
8 Adriana Diaz Choconta, Senior Policy Analyst,
9 Long-Term Care Commission Secretariat

10

11 ALSO PRESENT:

12 Deana Santedicola, Stenographer/Transcriptionist

13

14 **The following is a list of documents undertaken
15 to be produced or other items to be followed up**

16

17 INDEX OF UNDERTAKINGS

18 The documents to be produced are noted by U/T and
19 appear on the following pages: 51:22

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1 -- Upon commencing at 2:00 p.m.

2
3 COMMISSIONER FRANK MARROCCO (CHAIR):
4 So we have everybody here from our end,
5 so there is no reason not to get started.

6 As I indicated earlier, we do have a
7 transcriptionist here and we do post a transcript a
8 couple of days after, just in the interests of
9 maintaining as much transparency as we can in terms
10 of what we are doing and what people are telling
11 us.

12 We have sense of where you are coming
13 from, in a way, at least on whose behalf, and we
14 are ready. We will ask questions as we go along,
15 if that is all right, and we are ready when you
16 are.

17 MARIO POSSAMAI: Great. Well, thank
18 you very much.

19 I have a slide presentation and I will
20 share the screen and we'll do that. We haven't had
21 the opportunity to share it with you, and we will
22 after this presentation.

23 COMMISSIONER FRANK MARROCCO (CHAIR):
24 Thank you.

25 MARIO POSSAMAI: So thank you very much

1 for the opportunity to appear before you. Your
2 work is vital and important, and I don't envy the
3 tight timeline that you are facing and also the
4 fact that you are doing this in the middle of a
5 pandemic, not after the fact, as what occurred with
6 the SARS Commission.

7 So let me introduce myself. I was a
8 Senior Advisor to Justice Archie Campbell and the
9 SARS Commission, and it was it was an honour and
10 the highlight of my career to assist Justice
11 Campbell.

12 My areas of responsibility were
13 pandemic preparedness, and in that regard, I
14 liaised with officials in the U.S. in that regard.

15 My major responsibility was in the area
16 of occupational health and safety, and in that
17 regard I assisted Justice Campbell in
18 investigating, for example, why things went much
19 better in Vancouver than they did in Toronto. I
20 investigated the issues with respect to airborne
21 transmission, occupational health and safety, the
22 dispute, or the debate, rather, during SARS of
23 whether health care workers should be wearing
24 surgical masks or N-95s, which has some strong
25 echos in COVID-19.

1 And earlier this year, I was retained
2 by the Canadian Federation of Nurses Unions to
3 write a report looking into Canada's performance in
4 COVID-19 during the first wave, and it was
5 published in October. And I believe that you have
6 received a copy of it. It was called A Time of
7 Fear. If you haven't, we can certainly make sure
8 that you get a copy.

9 COMMISSIONER FRANK MARROCCO (CHAIR):

10 I think we do have a copy of it, but if
11 that turns out to be wrong, then we'll take you up
12 on that, for sure.

13 MARIO POSSAMAI: All right.

14 And I just want to note that the
15 findings and recommendations were endorsed by a
16 number of international experts, including
17 Dr. Donald Milton and Dr. Lidia Morawska, who were
18 the co-authors of the letter to the WHO in June of
19 this year asking them to acknowledge the airborne
20 transmission route, also Dr. Raymond Tellier in
21 Montreal and Dr. Yuguo Li in Hong Kong whose
22 research led to the first evidence that SARS could
23 be transmitted through the air.

24 I have been -- as you know, I have been
25 retained as an expert by ONA to author a report on

1 whether the lessons of SARS were applied in the
2 long-term care sector during COVID-19, especially
3 with regards to pandemic preparedness and
4 leadership, the failure to follow the precautionary
5 approach against a new pathogen and the failure to
6 learn from the clinical judgment of Registered
7 Nurses, many of whom had experience during SARS.

8 I want to begin with a quote from
9 Justice Campbell in the final report, and I have
10 re-read this many times during COVID-19 but I
11 re-read it recently, and he talks about the public
12 health system being broken and needing to be fixed
13 and he identified a problem with regards to the
14 public health system being unprepared, fragmented,
15 poorly led and uncoordinated. And much of what he
16 said then to me has echoed in COVID-19.

17 And when I began writing A Time of
18 Fear, his insights were really strong in my mind.
19 And so you know, it is my view that Canada has
20 witnessed in COVID-19 a systemic preventable
21 failure to learn from the SARS outbreak, and it has
22 been a failure to adequately prepare and to respond
23 in a manner commensurate with the threat that we
24 faced.

25 I want to begin by trying to situate

1 our record here in Canada of how well we have done,
2 and I think for many of us, you know, we look at
3 what has happened in America, and in comparison we
4 have done extremely well.

5 But I don't think that is the best
6 example. That is really a low bar. And I think,
7 you know, what has happened in America is
8 incredibly tragic, but I think a better way or a
9 better comparison would be with China, Hong Kong
10 and Taiwan who I call our SARS peers. And during
11 SARS, you know, most of the outbreaks occurred in
12 those four countries, and Canada was the only
13 nation outside of Asia to be affected by SARS.

14 And you know, when we look back on
15 SARS, it certainly didn't have the magnitude of the
16 damage that COVID-19 has, but it was a dress
17 rehearsal. It was a chance for us to learn and
18 prepare.

19 And 17 years after SARS, the evidence
20 suggests that, you know, China, Hong Kong and
21 Taiwan learned from SARS. Canada and Ontario did
22 not.

23 You know, the number of health care
24 workers who have been infected is really
25 staggering. You know, in early July, when we can

1 say was the end of the first wave, we had more than
2 6,000 health care workers infected with COVID-19 in
3 Ontario. By early December, that had grown to more
4 than 10,000.

5 And the numbers are troubling. They
6 are troubling because they are so huge and they
7 represent infections among health care workers or
8 frontline people, the people that we put in the
9 line of danger to protect us.

10 But also it shows that between July and
11 December we did not learn and we did not implement
12 enough policies to protect them.

13 You know, under the best scenario, if
14 we had learned from the first phase, if we had
15 learned from SARS, then I believe the total number
16 in early December would be much closer to what it
17 was at the end of the first wave.

18 Right now, there are more than 3,700
19 staff in long-term care with infections, and it is
20 useful to compare our numbers with China. And it
21 is important also to consider the fact that China
22 was the first country to really experience COVID-19
23 and that in late January China did something quite
24 extraordinary. They moved to airborne precautions
25 for all of their health care workers, and that was

1 done because there had been a very worrying spike
2 in health care worker infections in China up to
3 that point, and afterwards, you know, health care
4 infections dropped, dropped significantly.

5 Hong Kong also went to airborne
6 precautions, and the number of health care workers
7 is quite minimal compared to what we have here in
8 Canada.

9 When you look at the overall numbers as
10 well, it is quite shocking. You know, we have here
11 in Ontario more cases of COVID-19 than China, Hong
12 Kong and Taiwan combined.

13 And then when you look at the numbers
14 in long-term care, very significant in the fact
15 that in long-term care there is such a huge number.

16 One of the important things that China,
17 Hong Kong and Taiwan did is that when they were
18 learning from SARS and they were preparing their
19 pandemic plans, they prepared for the unknown, for
20 the unseen, for something like SARS.

21 Canada and Ontario, unfortunately,
22 prepared for the next pandemic as if it would be a
23 flu pandemic, and we treated COVID-19 as if it was
24 influenza and we forgot a really important lesson
25 from Justice Campbell. You know, he said, and I am

1 just going to quote here:

2 "As SARS demonstrated, the next
3 big outbreak might be caused by
4 something completely different,
5 totally new and entirely unexpected.
6 One major lesson from SARS is that
7 we must prepare not only for
8 potential looming threats H5N1,"
9 which was the avian flue that was on
10 the radar at the time, "but also for
11 the unexpected."

12 So in Ontario and in Canada, we
13 prepared for the flu. In March, Dr. Zoutman from
14 Scarborough General, or Scarborough Health now as
15 it is called, talked about the fact that they were
16 using influenza as a marker, as a proxy, for
17 example, in the argument about whether N-95
18 respirators or surgical masks were sufficient
19 protection for health care workers.

20 More recently, Dr. Njoo, the Deputy
21 Chief Public Health Officer, said something very
22 similar. He said Canada and Ontario too based its
23 pandemic planning on the influenza pandemic and how
24 respiratory infectious disease typically behaves.

25 The Auditor General in her special

1 report of a few weeks ago made a similar finding,
2 and she noted that Ontario relied on the influenza
3 pandemic plan, which she noted had not been updated
4 since 2013.

5 And she also noted that since it was
6 developed to deal with influenza, some aspects of
7 it were really not relevant to COVID-19. Now, you
8 know, this included things like lab testing
9 capacity, contact tracing, things of that nature.
10 But I think probably the most troubling part of it
11 is that we prepared for something that we knew
12 something about, that we knew a lot about,
13 influenza, as opposed to preparing for something
14 that was unknown and different and we really didn't
15 know its characteristics or transmission dynamics.

16 Hong Kong, which has a great record in
17 terms of protecting its long-term care residents,
18 and I know that you quoted Dr. Lum in your second
19 interim recommendations, Hong Kong planned for the
20 unknown, for another SARS, not on influenza. And,
21 you know, you can see that this really has made a
22 difference because they were ready for something
23 unseen and quite different.

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 Well, I mean, you know, I guess one of

1 the things that occurs to me is why do you think
2 they did that?

3 MARIO POSSAMAI: Well, I think that is
4 a difficult question. I have been thinking about
5 it a long time. I have been thinking about it for
6 years, actually, as I watched, you know, the
7 pandemic planning focussed on influenza.

8 But I think also it goes back in part
9 to the fact that there is a strong element in our
10 public health and medical community that seems to
11 be adverse to taking a precautionary approach, and
12 you know, I think that unless you think in a
13 precautionary way, it is hard to think outside of
14 your comfort zone, if you will.

15 You know, when you look at one of the
16 first documents that Public Health Ontario
17 published on the transmission dynamics of COVID-19,
18 this was in early March, and it really downplayed
19 the possibility of airborne transmission, and as
20 evidence of that, one of the footnotes to that
21 conclusion was a textbook from 2016 which was
22 before COVID-19 was discovered. And we can send
23 you that document, if you would like.

24 And you know, another bit of evidence
25 that was used in that document to demonstrate that

1 airborne transmission was not a concern was a
2 reference to a document published by the European
3 CDC.

4 Now, the reference, the part that is
5 being referenced has two parts. The first part
6 said there is no evidence of airborne transmission.
7 The second part says that nevertheless we are going
8 to recommend airborne precautions. The second part
9 was not stated in the Public Health Ontario
10 document.

11 The Public Health Ontario document
12 talks about the experience in China, and it was
13 published shortly after the WHO's mission to China,
14 and the Public Health document says, you know, the
15 WHO China mission found that there was no evidence
16 of airborne transmission, which is true. What it
17 failed to say is that China, in fact, had gone to
18 airborne precautions even though the evidence was
19 unclear.

20 So I think there is a problem in our
21 public health and medical community because there
22 is a strong reluctance among some members to really
23 take a precautionary approach.

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 It is interesting that you say that

1 because, of course, Justice Campbell, as you would
2 well know, articulated a precautionary approach,
3 recommended the precautionary principle. His
4 report was accepted, praised by everybody, but no
5 meaningful takeup of the precautionary principle.

6 I don't want to keep asking these
7 questions, but I mean, did you form a conclusion
8 about why this reluctance? I will eventually stop
9 asking "why" questions, but did you get a sense of
10 why there was this reluctance over the
11 precautionary principle?

12 MARIO POSSAMAI: Well, you know, again,
13 this is something that I have thought about a lot.
14 I haven't landed on the right answer, but I think
15 there are a lot of aspects to it.

16 One is the fact that the
17 decision-makers in public health are in a very
18 narrow range of disciplines, so epidemiology and
19 infectious disease control expertise, and these are
20 important areas of expertise, very valuable and
21 crucial to public health and public health
22 prevention.

23 But what is missing there is a lot of
24 the other ranges of expertise. You know, we don't
25 have occupational hygienists who are the engineers,

1 who are the specialists in occupational safety. We
2 don't have the bio-aerosol people who are the
3 scientists and physicists who are doing this
4 cutting edge science research into aerosols and how
5 they behave.

6 And you know, when you listen to the
7 language of public health and many of our leading
8 experts, they use terms like "large droplet" and
9 "contact transmission". These, when you talk to
10 the cutting edge researchers in bio-aerosol, these
11 are really outdated terms. They are based on
12 research from Harvard from the 1930s, and science
13 has really evolved from that.

14 So there is really a clash of new
15 science, cutting edge science, with the
16 foundational elements of it.

17 And the other point I would like to
18 make is that throughout COVID-19, as occurred
19 during SARS, public health and infectious disease
20 experts were looking for certainty. They wanted
21 evidence, complete certain evidence of airborne
22 transmission.

23 Justice Campbell and worker safety
24 experts and bio-aerosol people, they were not
25 saying that the evidence and the studies are

1 conclusive proof of airborne, but what they were
2 saying is that there is sufficient evidence,
3 sufficient foundation to take a precautionary
4 approach.

5 We saw this most glaringly after the
6 letter to the WHO by Donald Milton and the others
7 in June where what they said was we believe there
8 is sufficient evidence to take a precautionary
9 approach, to follow the precautionary principle
10 with airborne transmission.

11 There was a letter sent to the same
12 publication about a week later by a large group of
13 infectious diseases experts countering that
14 proposal, and they focussed again on certainty.
15 They really disregarded the precautionary approach.
16 And I note that about half the signatories to that
17 letter were Canadians.

18 I hope that begins to answer the
19 question.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 Yes, I appreciate that and I appreciate
22 that I am asking you to conclude something that is
23 really a deduction from what you have investigated
24 and I appreciate the answer.

25 MARIO POSSAMAI: Thank you.

1 I go into this in more detail in A Time
2 of Fear, and if there are any documents, original
3 documents cited there that you would like, please
4 ask.

5 COMMISSIONER FRANK MARROCCO (CHAIR):
6 All right.

7 MARIO POSSAMAI: I want to go back to
8 Dr. Lum in Hong Kong and the Hong Kong experience.
9 Basically, they moved with great urgency to protect
10 their long-term care residents, again, based on the
11 SARS experience.

12 And when you compare with the way that
13 the Ontario Government has acted in terms of
14 responding to the long-term care needs, there was a
15 lack of urgency. You know, Dr. Lum talks about the
16 importance of preventing transmission from
17 hospitals to long-term care facilities.

18 If you look at this table, this didn't
19 happen in Ontario until April 15th, so there was a
20 real delay there. You know, on March 22nd the
21 directive said that, Directive #3 said, you know,
22 "wherever possible" homes should restrict health
23 care workers to one facility. You know, this
24 wasn't implemented until late April.

25 So there was a real lack of urgency to

1 take action, where Hong Kong, from all the
2 evidence, acted in a very urgent manner.

3 Moving on to preparedness, Justice
4 Campbell was quite eloquent, as he was throughout
5 the report, but he really emphasized the importance
6 of being ready, of being prepared, and being
7 prepared not just with equipment, N-95s and what
8 have you, but also resources of people. He was
9 very aware that we had to be ready to have surge
10 capacity for human resources that would be in great
11 demand during a pandemic.

12 In response to the SARS Commission
13 recommendations, Ontario established a stockpile of
14 55 million N-95s, and then three years ago the
15 Auditor General revealed that 80 percent of that
16 stockpile had expired and was being destroyed. And
17 what is really striking is that most of those
18 supplies had not been put into the health care
19 system before they expired so that they could be
20 used.

21 And the last part that I think is
22 stunning to this day is that evidently the budget
23 to store those supplies were only for storage and
24 not the management of them.

25 Now, I understand that the Auditor

1 General is examining this issue and --

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 That seems to be like an odd
4 distinction. Managing it would involve presumably
5 using it before it is useless.

6 MARIO POSSAMAI: Absolutely.

7 COMMISSIONER FRANK MARROCCO (CHAIR):

8 Well, I won't -- anyway, go ahead.

9 MARIO POSSAMAI: Okay. So you know,
10 setting aside the issue of what happened and how it
11 happened and how things could have gone so badly,
12 which I expect that you are investigating, as is
13 the Auditor General, I want to focus on a different
14 aspect of it and that is that no one warned us that
15 this was happening.

16 You know, when 55 million respirators
17 were taken out of the system, it severely hampered
18 our ability to protect health care workers at an
19 airborne level, and this was a question that
20 troubled Justice Campbell. You know, he wondered,
21 how can we be sure that these kinds of major health
22 risks are brought to the public, to the attention
23 of the public and of government if governments
24 neglect to take the proper actions.

25 And so in his view, what he felt was

1 that the Chief Medical Officer of Health should
2 play that role. After all, the Chief Medical
3 Officer of Health would be in charge of pandemic
4 planning and response. They would be closest to
5 what was happening.

6 But also, it fit the DNA of public
7 health leaders, you know, going back to Dr. John
8 Snow in London with the cholera outbreak and
9 fast-forwarding to the '50s and '60s and '70s with
10 the successful campaign by Public Health to warn
11 about smoking and obesity and these types of
12 things.

13 And so on Justice Campbell's
14 recommendation, the Health Protection and Promotion
15 Act was amended to give the Chief Medical Officer
16 of Health the right to independence to warn the
17 public about public health risks.

18 And so his recommendation, and this is
19 from Volume 4, was that the Chief Medical Officer
20 of Health should have operational independence from
21 government in respect of public health decisions
22 during an outbreak.

23 But then he said that the Chief Medical
24 Officer of Health requires the independent duty and
25 authority to communicate directly with the public

1 and the Legislative Assembly whenever he or she
2 deems necessary.

3 And I believe one of the troubling
4 aspects of the lead-up to COVID-19 is that our
5 Chief Medical Officer of Health did not warn us and
6 did not warn legislatures that we weren't ready for
7 a pandemic.

8 You know, in 2018 the Chief Medical
9 Officer of Health issued a report on health
10 inequalities, a very important issue, but he did
11 not use that opportunity of the annual report to
12 address the issue of pandemic preparedness.

13 Now, under the Act he is able to issue
14 an annual report and also reports on an ad hoc
15 basis, but one year later the Chief Medical Officer
16 of Health's report dealt with, you know, another
17 important health issue for the community, but
18 again, he did not use that opportunity to address
19 the issue of pandemic preparedness.

20 And you know, as I indicated, he did
21 not issue an ad hoc report, as he could have under
22 the Act, to warn about Ontario's lack of pandemic
23 preparedness.

24 And in fact, you know, when I see
25 statements like the one quoted below, it makes me

1 wonder whether Dr. Williams was aware of how badly
2 we were unprepared for a pandemic. You know, when
3 he said "We're light years ahead of where we were
4 in 2003", I would take issue with that statement,
5 frankly.

6 COMMISSIONER FRANK MARROCCO (CHAIR):

7 When did it come to light or when did
8 the Auditor General point out, in what year, that
9 80 percent of the 55 million N-95 masks had
10 expired?

11 MARIO POSSAMAI: That was December of
12 2017.

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 So that would go directly, at least in
15 your view, and correct me if I'm wrong, that would
16 go directly to your preparedness to respond to a
17 seriously infectious disease, even if you don't
18 think in terms of a pandemic.

19 MARIO POSSAMAI: Absolutely.

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 So is it your view that he has some
22 responsibility to know whether that supply has been
23 replaced or not?

24 MARIO POSSAMAI: Absolutely. You know,
25 I know that, you know, there is some controversy

1 about using military analogies in dealing with a
2 pandemic, but you know, this is like -- you know,
3 the Chief Medical Officer of Health is akin to a
4 general leading troops into battle. A general
5 would have to know how many troops he had, he or
6 she had, how many tanks, how much artillery, and by
7 going into a pandemic without knowing what he had
8 in store, what was available, I think is troubling,
9 to say the least.

10 But as someone who, you know, is in
11 charge of pandemic preparedness and pandemic
12 response, I think it was incumbent on Dr. Williams
13 to know what was happening on the ground. Plus,
14 the Auditor General's report was a public report.
15 It was no secret the fact that --

16 COMMISSIONER FRANK MARROCCO (CHAIR):

17 But some of these people, and I don't
18 know about Dr. Williams, and maybe you can help me
19 with that, but some of these people were around for
20 SARS.

21 MARIO POSSAMAI: Yes, and Dr. Williams
22 was around for SARS as well.

23 COMMISSIONER FRANK MARROCCO (CHAIR):

24 Yes, and I think Dr. Yaffe?

25 MARIO POSSAMAI: Yes, Dr. Yaffe was

1 there, yes.

2 No, I am perplexed that none of them
3 spoke out and warned us that we weren't ready.

4 You know, the 55 million respirators -
5 and you know, Dr. Kitts would know better than I -
6 you know, the burn rate in a large hospital with
7 N-95s is quite significant, but 55 million
8 respirators would have made a huge difference for
9 us. It would have allowed us to protect our health
10 care workers close to the level that the Chinese
11 have done, and we can see that they were -- it was
12 very, very effective.

13 COMMISSIONER FRANK MARROCCO (CHAIR):

14 In the course of your investigation,
15 did you come across the fact that we - I thought I
16 saw this on the news, anyway - that we shipped
17 personal protective equipment to China in February?

18 MARIO POSSAMAI: Yes, yes, yes. Yes,
19 we did that --

20 COMMISSIONER FRANK MARROCCO (CHAIR):

21 That wasn't Dr. Williams, to be clear.
22 That was the federal government. That has not got
23 anything to do with him.

24 MARIO POSSAMAI: Exactly, yes, yes.

25 That's correct.

1 COMMISSIONER FRANK MARROCCO (CHAIR):

2 Okay, go ahead, Mr. Possamai.

3 MARIO POSSAMAI: And, you know, when
4 you look at -- so we just talked a bit about, you
5 know, the lead-up to COVID-19, but also the fact
6 that we just did not act in a very urgent manner
7 once COVID-19 presented itself.

8 And I like to compare what happened in
9 Ontario with what happened in Alberta. You know,
10 in December of last year, a year ago right now,
11 when the first word of something unusual happening
12 in Hong Kong was occurring, Alberta put in two
13 orders for N-95 respirators and other equipment
14 just to be on the safe side. There is no record of
15 our government here doing anything similar.

16 And then in January of 2020, there was
17 all kinds of media about wholesalers and retailers
18 in Ontario who carried N-95s running out of stock.
19 There was a wholesaler in Mississauga who said that
20 for awhile there were lineups of up two to three
21 hours long of people outside of his office who
22 bought N-95 respirators to ship to their family,
23 friends or colleagues in the Far East.

24 I myself, I have a cousin who is a
25 nurse in Italy, and they were having terrible

1 problems there well before COVID hit us, and I sent
2 some N-95s to her and her staff at the hospital in
3 Bologna.

4 But the fact is that this was public,
5 and there was no effort, to my knowledge, by the
6 Ontario Government to seize the supplies of N-95
7 respirators or to buy them or to take them into
8 account. There was no urgency there.

9 And the Mississauga wholesaler that I
10 mentioned before, he said that by the time
11 government came to him asking to buy additional
12 N-95s, the shelves were empty. It was too late.

13 So there was a real lack of urgency.

14 Another example of a lack of urgency is
15 with respect to elastomeric masks. You have
16 probably seen what they look like. They are masks
17 with two filters on the outside. These are
18 respirators that have re-useable filters, which is
19 great because it means that you can cut down on the
20 burn rate of N-95 respirators.

21 So at the beginning of our pandemic, in
22 February or so, some health worker experts were
23 saying let's get elastomerics. Let's use them.
24 They are as effective as N-95s. And this will
25 reduce the strain on the N-95 supply.

1 And to this date, the Government of
2 Ontario has not acted to introduce elastomerics in
3 any great quantity into the system. So there is a
4 real lack of urgency there.

5 So I just want to focus a bit on the
6 precautionary principle and the area of airborne
7 transmission.

8 You know, the precautionary principle
9 talks about, you know, acting with caution and
10 erring on the side of safety in the face of a new
11 pathogen, but it also extends to other areas as
12 well. It also means erring on the side of safety
13 with regards to a new pathogen. It is different.
14 It acts in a different way.

15 And I have a quote later on in the
16 presentation from Dr. Fauci from America and he
17 said that we need to be humble, and I think in the
18 face of a new pathogen, we need humility and I am
19 not sure that we exhibited that quality.

20 I want to fast-forward to the issue of
21 airborne transmission. In another echo of
22 COVID-19, during SARS there was a real debate about
23 whether SARS could be spread through the air, and
24 at the time of SARS health care workers were saying
25 let's err on the side of caution. There was

1 controversy about that.

2 The evidence, the first evidence of
3 airborne transmission did not come until after the
4 outbreak, and in Justice Campbell's view, it was
5 the fact that the evidence came out after the
6 outbreak certainly validated those who were
7 advocating a precautionary approach and that
8 influenced his finding on the precautionary
9 principle.

10 COVID-19 is different. Over the past
11 17 years there has been a lot of good research done
12 on airborne transmission, which is difficult to
13 pinpoint and difficult to research on. It is no
14 wonder it has been called the elusive pathway.

15 But during COVID-19, there was a body
16 of evidence built up before 2020 on airborne
17 transmission, and then since the start of the
18 pandemic, there has been growing evidence of
19 airborne transmission and it has been disregarded.

20 And what health care workers and unions
21 and experts on the health worker side were saying
22 is, you know, we may not be certain that it spreads
23 through the air, but gosh, let's err on the side of
24 caution. Let's take the evidence, the growing
25 evidence, as sufficient grounds to take a

1 precautionary approach.

2 COMMISSIONER FRANK MARROCCO (CHAIR):

3 And what would that entail? Like what
4 would be the sort of bare minimum that you would
5 see that you would do if you assume it is airborne?

6 MARIO POSSAMAI: Well, first of all,
7 you would protect health care workers at the
8 airborne level.

9 Secondly, you would also begin to look
10 at ventilation and air quality and air purification
11 and things of that nature.

12 So through much of COVID-19, the
13 emphasis has been on contact, close contact, and on
14 surface cleaning and hand-washing. Now, over time
15 we have found that the need for surface cleaning
16 and hand-washing may not be as critical as maybe it
17 was, so that the transmission through fomites is
18 not as significant as many of us feared.

19 But in focussing on those important
20 issues, and I am not saying that we should not
21 have, but in focussing on those important issues,
22 we should also have focussed on airborne. We
23 should also have focussed on ventilation, on
24 separation, on things like public masking.

25 So you know, by not taking a

1 precautionary approach, not only did we not protect
2 health care workers as we should have, but we also
3 didn't begin to do things like really focus on
4 ventilation in long-term care facilities, in
5 schools, in workplaces, because all the policies
6 were driven on the policy that COVID-19 would
7 spread through fomites, that is, surface
8 transmission or close contact.

9 COMMISSIONER FRANK MARROCCO (CHAIR):

10 I think we are fine, so go ahead.

11 MARIO POSSAMAI: Okay.

12 COMMISSIONER FRANK MARROCCO (CHAIR):

13 We'll speak up.

14 MARIO POSSAMAI: Okay.

15 COMMISSIONER FRANK MARROCCO (CHAIR):

16 Don't worry.

17 MARIO POSSAMAI: Okay, I want to turn
18 now to the decision in March of this year where we
19 downgraded our precautions from the airborne
20 precautionary level.

21 So the precautionary principle was
22 embedded into the Health Protection and Promotion
23 Act, as per the recommendation of Justice Campbell
24 in his report.

25 And in the first period of COVID-19, we

1 were following a precautionary approach. The
2 recommendation was that health care workers should
3 wear N-95s, but then in early March, on March 10th,
4 Ontario downgraded those protections to droplet and
5 contact.

6 And you know, back to your point,
7 Justice Marrocco, about why things are the way they
8 are here in Ontario, there was a very influential
9 public campaign to get Dr. Williams to downgrade
10 those protections and to drop the precautionary
11 approach.

12 A letter was leaked to the Toronto Star
13 that made sort of the front page saying that N-95s
14 and airborne precautions were not needed. You
15 know, there was another -- there was some articles
16 in The Globe and Mail saying the same thing. And
17 both those articles said, you know, that there is
18 sufficient that COVID-19 does not spread through
19 the air and we don't need to have N-95s.

20 And have you know, the evidence I think
21 is light and it is questionable, and you know, in
22 hindsight, with the benefit of hindsight, the
23 evidence just was not substantive enough to require
24 the downgrading of precautions.

25 And if I may just add, it is that, you

1 know, one of the missing pieces of the Health
2 Protection and Promotion Act was how easy it was to
3 throw out the precautionary principle, and that is
4 a huge move because it meant, you know, as I
5 indicated earlier, that not only health care
6 workers were not sufficiently protected but we
7 didn't do the things that we should have with
8 regards to ventilation and other things in schools
9 and workplaces and long-term care facilities.

10 So in my view, and I would invite you
11 to consider this, is that any decision by the Chief
12 Medical Officer of Health to downgrade protections
13 and to decide that the precautionary principle was
14 not warranted should be the subject of some kind of
15 oversight, hearings by the legislatures, for
16 example, things of that nature, so that there is a
17 sense of oversight for the importance of taking
18 such a decision.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 Do you think on the basis of your work
21 that the decision in March to downgrade was driven
22 by the fact that there was no -- by the shortages
23 of personal protective equipment, which presumably
24 somebody knew?

25 MARIO POSSAMAI: Yes, I think it was a

1 case of supply over science, and I think that
2 that's a very -- that was a very dangerous
3 precedent because, you know, it is one thing to say
4 that we have a supply problem and let's deal with
5 it. It is another thing to say that the science
6 shows us that we don't have to worry about airborne
7 transmission.

8 I think a far better approach would
9 have been to say, you know, it is early. We don't
10 know enough about this thing. Let's take a
11 precautionary approach. We also have supply
12 problems, and let's deal with them separately.
13 Let's do our best to ensure that we can protect
14 health care workers at a high level.

15 And you know, as I indicated, there was
16 no urgency to do that on the supply side. It was
17 late in coming.

18 COMMISSIONER FRANK MARROCCO (CHAIR):

19 But I have a little difficulty
20 understanding that because if you don't have -- for
21 example, let's just take the masks; for example, if
22 you don't have enough of the appropriate quality of
23 mask, you can't really deal with them separately
24 because there won't be masks for people to wear.

25 MARIO POSSAMAI: Right. Right, so I

1 think we have to separate the science from the
2 supply side.

3 So on the one hand, if that is the
4 case, if you don't have supply shortages, you
5 shouldn't say you don't need N-95s because the
6 science tells us that we don't need it. If you do
7 that, in my view, then you are bringing science
8 into disrepute.

9 I think a far better approach is to
10 take the one that the CDC did which is to say, you
11 know, let's take a precautionary approach. We wish
12 that we could take care of everyone with N-95s. We
13 have to take measures to protect health care
14 workers. That may be unconventional and
15 unexpected. But let's try to get the supply of
16 N-95s and other respirators up to speed quickly.
17 And you know, we didn't do that.

18 I hope that answers your question.

19 COMMISSIONER FRANK MARROCCO (CHAIR):

20 No, it does. It does. To the extent
21 that there is a concrete answer that you and I are
22 aware of, no, it does respond to my question. We
23 are both talking about the same thing.

24 MARIO POSSAMAI: Okay, thank you.

25 Commissioner Coke, did you have a

1 question?

2 COMMISSIONER ANGELA COKE: Actually, my
3 question was that exact question, which you have
4 answered. I understand what you are saying. Thank
5 you.

6 MARIO POSSAMAI: Okay, thank you.

7 May I proceed?

8 COMMISSIONER FRANK MARROCCO (CHAIR):

9 Yes, please.

10 MARIO POSSAMAI: I think we have
11 probably covered this, but ONA went to Court to
12 challenge the downgrading of protections, and
13 Dr. McGeer was the affiant for the government, and
14 Justice Morgan cited her, her affidavit, with
15 regards to making his finding.

16 But again, you know, in her affidavit
17 she talks about evolving evidence that respirators
18 were not needed, and you know, I question her
19 finding in that regard. I don't think that we had
20 the evidence at the time to say that with any kind
21 of certainty.

22 And you know, in his decision Justice
23 Morgan talked about this duality, if you will,
24 between science and supply, and he found in favour
25 of ONA and of health care workers in saying - and

1 this is my reading of his finding, or of his
2 judgment, rather - that, you know, we should not
3 mix science with supply shortages. We should keep
4 those apart.

5 And then there is this troubling quote
6 which is attributed to Michael Hurley, the union
7 leader, and he said that -- and let me read it to
8 you:

9 "I heard Dr. Williams say that
10 when we get the supply problem dealt
11 with, we can return to the
12 precautionary principle [...]"

13 And you know, I think that speaks to
14 this troubling duality separating science -- that
15 tries to blend, rather, and commingle science and
16 supply. I think we need to keep those separate,
17 and I think we need to really be open with the
18 public about what we know and what we don't know
19 and what we know for certain.

20 You know, the decision by Public Health
21 Ontario to downgrade the precautions, the
22 precautionary level, was really troubling for
23 nurses. Nurses play a really important role in
24 long-term care facilities. They are often in
25 charge of the facility. They play a leadership

1 role. They manage care.

2 And you know, nurses are steeped in the
3 precautionary principle. Nurses probably have the
4 most direct clinical experience with COVID-19
5 patients of any profession. And you know, they
6 were aware from day one that the precautionary
7 principle should have prevailed. You know, many of
8 them lived through SARS. They follow science very
9 closely. And their views, and we have a few slides
10 with their comments, but they really show that for
11 them, you know, they were concerned about airborne
12 transmission and they were concerned that the
13 precautions were being downplayed.

14 And you know, and put yourself in their
15 position. So, you know, they are steeped in the
16 precautionary principle. They lived through SARS.
17 They follow the science. They follow the fact that
18 month after month since January there was growing
19 evidence of airborne transmission. And yet they
20 were being told by their employers and by infection
21 control people from hospitals that you don't need
22 an N-95 respirator, that it doesn't spread through
23 the air. And now, you know, months later the fears
24 of these nurses were validated and were borne out.
25 You know, it is now recognized even by PHAC that

1 COVID has an airborne transmission component to it.

2 And you know, that really is a
3 troubling -- that raises troubling issues of trust
4 by nurses and by frontline health care workers into
5 whether they can really rely on the advice of
6 public health agencies.

7 You know, in the bottom quote on this
8 page, you know, a nurse says:

9 "I felt like a lamb being led
10 to slaughter. I have an infection
11 control background, and everything I
12 was taught was thrown out the
13 window."

14 You know, they learned nothing from
15 SARS.

16 And what is also troubling to me is the
17 fact that our Minister of Health does not appear to
18 understand the precautionary principle. You know,
19 she spoke in the house on November 30th, and you
20 know, what she said was, and I will quote. She
21 says that not -- she says that airborne
22 transmission:

23 "[...] is still very
24 controversial. Not all of the
25 experts agree on that. Most of the

1 experts right now believe that it is
2 generated through water droplets
3 [...]"

4 I think that was probably a mistake on
5 her part.

6 "The science is still being
7 developed in that area and we are
8 still awaiting some of the results."

9 So, you know, when she says that we are
10 making decisions based on clinical evidence and
11 based on science, she really misunderstands the
12 current situation or the situation that she
13 described.

14 When the evidence is uncertain, when
15 the evidence is mixed, when there is conflict of
16 this nature, that is precisely the time we need to
17 take a precautionary approach.

18 And I also want to add that, you know,
19 in early November PHAC acknowledged the possibility
20 of airborne transmission, but to date, until now
21 Ontario has not updated its PPE guidelines to
22 reflect that.

23 So put yourself in the position of
24 health care workers. You know, they have read that
25 PHAC has acknowledged that there is airborne

1 transmission, but they are still working under the
2 old PPE guidelines for contact and droplet
3 precautions.

4 I want to move on to an issue that
5 echoed in SARS and in COVID-19, and that is the
6 failure to listen to nurses. And this was an issue
7 that Justice Campbell found very compelling, and in
8 the SARS report Justice Campbell cited a decision
9 by Mr. Justice Sinclair in 2000 with regards to his
10 inquiry into the pediatric deaths at the Winnipeg
11 Hospital. And he found that the concerns of nurses
12 were not listened to, and he says:

13 "[...] the attempted silencing
14 of members of the nursing
15 profession, and the failure to
16 accept the legitimacy of the
17 concerns, meant that serious
18 problems in the paediatric cardiac
19 surgery programme were not
20 recognized or addressed in a timely
21 manner. As a result, patient care
22 was compromised."

23 During SARS, we had a very similar
24 experience at North York General. You may or may
25 not recall, but there were two waves of SARS. At

1 the end of the first wave, which probably ended
2 around April, everyone thought that SARS was over.
3 You know, we were celebrating, and there were full
4 page ads in the newspaper and things of that
5 nature.

6 But nurses at North York General were
7 warning that SARS had not gone away and was active,
8 and no one listened. You know, in the SARS report
9 Justice Campbell quotes some doctors who went into
10 a meeting with nurses, and what they said basically
11 was that, you know, they were going in there to
12 assure and calm down the nurses because they felt
13 that the nurses' concerns just had no basis.

14 In fact, the nurses were right. SARS
15 had not gone away. There was a second wave. 17
16 people died, including a nurse, at North York
17 General, Nelia Laroza, and Justice Campbell wrote:

18 "It turns out that the nurses
19 were exactly right and the
20 hospital's assurances were exactly
21 wrong."

22 And Justice Campbell drew an important
23 lesson from that, and that is listening to
24 frontline nurses is vital because they have
25 important information and warnings about what is

1 going on on the ground, and he talks about the fact
2 that nurses especially, because of their
3 experience, are like an early warning system, like
4 canaries in the cage, for example, and that their
5 information is vital to identifying early outbreaks
6 and things of that nature.

7 And he was concerned that - and this is
8 something that we found during the SARS Commission
9 and I believe that you may have found the same
10 thing during COVID-19 - that nurses were afraid to
11 speak out because of fear of reprisal.

12 And in Justice Campbell's view, the
13 fact that nurses were afraid to speak out meant
14 that we were losing an important ability to protect
15 the community, and he said:

16 "These fears have the potential
17 to impede the reporting of
18 information that is vital to the
19 protection of other health care
20 workers and the public, particularly
21 in the case of an infectious disease
22 [...]"

23 And to that end, he recommended
24 whistleblower protections in the Health Protection
25 and Promotion Act, and he felt that those were

1 needed in addition to any other protections through
2 the Public Inquiries Act, for example.

3 These recommendations were not
4 implemented.

5 So I think the fourth bullet is
6 particularly relevant to COVID-19. This
7 whistleblower protection, in his view, should apply
8 to the risk of spread of an infectious disease and
9 to failures to conform to the Act. It prohibits
10 any form of reprisal.

11 So I think this is an important aspect
12 that Justice Campbell found, and he was really
13 concerned that without whistleblower protection, we
14 were losing -- not only were the rights of health
15 care workers harmed, but also we as a community
16 were losing a really important tool to protect
17 ourselves.

18 And, you know, as I have done my
19 research and work in the report that I am preparing
20 for ONA, you know, I came across instance after
21 instance after instance of nurses who were on
22 point, who really knew what was happening, and you
23 know, whose clinical judgment was really being
24 disregarded.

25 You know, they were saying -- nurses

1 like the one quote in the first quote there were
2 telling their employers and were telling infection
3 control people from hospitals that, you know, the
4 science is mixed. We don't know whether it is
5 droplet only or airborne. But they were told no,
6 you are wrong. The science shows that you don't
7 have to worry about airborne and you don't need an
8 N-95.

9 And there are many, many cases where,
10 as you know, health care workers had the ability to
11 use their own clinical judgment in a particular
12 situation to ask for an N-95, and there were so
13 many instances where, you know, they were told by
14 the employer or perhaps the IPAC lead that, yes, of
15 course you can have an N-95, but you know that it
16 is not needed and you know that you are wasting a
17 valuable resource.

18 So I think, you know, one of the
19 findings of the SARS Commission, one of Justice
20 Campbell's findings was that it is important to
21 have, you know, all the best minds, all the best
22 experts around the table making the decision.

23 And there is a section in my report A
24 Time of Fear where I quote a very senior WHO
25 official who was speaking right after the June

1 letter, expert letter was received by the WHO, and
2 she was very critical of the letter and she tried
3 to disparage it by saying, did you notice that the
4 recommendations come from engineers and aerosol
5 experts and other scientists and physicists, you
6 know, disparaging the fact that the WHO letter
7 really reflects a broad range of opinion.

8 And, I think that is part of what is
9 missing here in Ontario. You know, we need to have
10 all the right people at the table. Now, there are
11 science people, there are science tables and they
12 do include a variety of experts, but in my
13 experience, those science tables have been more or
14 less tick-box acknowledgments of participation.
15 The worker safety experts have not been seriously
16 listened to.

17 You know, we need to have people around
18 the table with equal authority to discuss issues
19 and to make those decisions. We need to be guided
20 by the clinical experience of frontline staff,
21 including nurses. And I think we need to really
22 emphasize the importance of the precautionary
23 principle, that we can't wait for scientific
24 certainty.

25 And I think, you know, one of the

1 problems is that what has been applied to the
2 airborne transmission debate by public health
3 infectious disease people is a requirement of
4 certainty.

5 Now, certainty is really important with
6 respect to deciding whether a vaccine is safe or a
7 medical procedure or a new pharmaceutical, but
8 requiring that level of scientific certainty before
9 protecting workers is really wrong-headed and it is
10 really we should be taking a precautionary approach
11 for that, not that type of rigid certainty.

12 And I think, you know, I mentioned
13 earlier humility. This is a very striking quote
14 from the SARS Commission Report, and it said, and I
15 quote from a physician who was not identified, and
16 he said:

17 "I think what SARS did is it
18 humbled us and it also made us
19 realize that even when we think we
20 know everything, we don't.

21 We have to be attuned to the
22 clues that come from the ground up,
23 not necessarily from the top to the
24 bottom.

25 So I think humility makes the

1 better nurse and doctor. I would
2 always err on the side of caution.
3 And these comments are echoed by
4 Dr. Fauci. You know, Dr. Fauci, this was a lecture
5 he gave at Harvard in August, and if you haven't
6 listened to it, I would invite you to do so. I can
7 send you the link, if that is helpful. But he
8 said, when he was talking about airborne
9 transmission, he said:

10 "We've really gotten it wrong
11 over many years...the bottom line is
12 there is much [more to] aerosols
13 than we thought..."

14 And then he said:

15 "And you've got to be flexible
16 enough to change your
17 recommendations, your guidelines,
18 your policies, depending upon the
19 information and the data that
20 evolves."

21 And then he said at the end:

22 "You've just got to be humble
23 enough to realize that we do not
24 know it all from the get-go and even
25 as we get into it."

1 So one of the recommendations that
2 Justice Campbell made that was not followed, and I
3 think we are paying a price for that. When Justice
4 Campbell recommended the establishment of a public
5 health agency in Ontario, he said it should be
6 modelled on the CDC and also have a component
7 equivalent to NIOSH. And NIOSH is the agency, part
8 of the CDC, which is responsible for workers'
9 safety research. And it does a lot of things. For
10 example, the N-95 respirator is based on the
11 certification of NIOSH.

12 And Justice Campbell recommended that
13 Ontario have our own NIOSH. We saw the price that
14 we paid for not having one. Earlier this year
15 there was a company in Cambridge that developed its
16 own N-95 equivalent, and it had to go to the U.S.
17 to NIOSH to get it certified. And in going there,
18 as one of the company officials said, they were at
19 the back of the line because NIOSH, in certifying
20 new respirators, was giving prominence to American
21 companies, as you would expect.

22 So we didn't have that ability here.

23 You know, when we go back to the 55
24 million respirators that were destroyed, it would
25 have been helpful to have the kind of technical

1 laboratories that NIOSH has to understand whether
2 they could be re-used, how they could be re-used,
3 things of this nature.

4 But also what is really important is
5 that NIOSH brings together not just epidemiologists
6 and infectious disease people. It brings together
7 occupational hygienists, the engineers, the
8 physicists, the aerosol experts, all together
9 working collaboratively. And I think Justice
10 Campbell saw that as really, you know, a much
11 better framework to make decisions on worker safety
12 and the safety of the public.

13 And because we didn't have our own
14 NIOSH capability, our own experts, our own labs of
15 this nature, you know, we really have lacked the
16 ability to develop our own guidance and best
17 practices on the PPE supply chain, including
18 storage, replenishment, distribution and
19 management.

20 You know, we are always citing the CDC
21 or the European CDC. We should have our own
22 experts here developing that knowledge and making
23 our own developments on our own and in a timely
24 fashion.

25 So that wraps up my presentation.

1 Thank you. Thank you for the opportunity. And I
2 am open to your questions.

3 COMMISSIONER FRANK MARROCCO (CHAIR):

4 Well, I think we asked them as we went
5 along. I don't see that there are any further
6 questions.

7 On behalf of the Commission, I want to
8 thank you for the presentation. We had referenced
9 many times Justice Campbell's report, but this is a
10 very helpful comparison. It gives us a sense of
11 whether the recommendations and observations which
12 he made and which were accepted at the time are
13 still practiced, or if something happened to them,
14 what happened to them.

15 And so it is very helpful in that
16 respect, and so thank you both very much.

17 And we will take you up probably on the
18 offer that if there are original documents to which
19 you refer and which we don't have, we may very well
20 ask you for them and thank you for offering them.

21 MARIO POSSAMAI: Great.

22 U/T SHARAN BASRAN: Yes, and we would be
23 happy to follow up, yes.

24 COMMISSIONER FRANK MARROCCO (CHAIR):

25 Thank you. Bye-bye.

1 MARIO POSSAMAI: Thank you.

2 SHARAN BASRAN: Thank you, bye-bye.

3 COMMISSIONER ANGELA COKE: Bye-bye.

4

5

6 -- Adjourned at 3:10 p.m.

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REPORTER'S CERTIFICATE

I, DEANA SANTEDICOLA, RPR, CRR,
CSR, Certified Shorthand Reporter, certify:

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

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

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

Dated this 16th day of December, 2020.



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