

Long-Term Care COVID-19 Commission

Graham Webb, Jane Meadus, Alyssa Lane
on Wednesday, September 23, 2020



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1 MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

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--- Held Virtually via Zoom, with all participants

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attending remotely, on the 23rd day of September, 2020,

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1:02 p.m. to 2:52 p.m.

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10 BEFORE:

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12 The Honourable Frank N. Marrocco, Lead Commissioner

13 Angela Coke, Commissioner

14 Dr. Jack Kitts, Commissioner

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16 PRESENTERS:

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18 Graham Webb, Executive Director, Advocacy

19 Centre for the Elderly

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21 Jane Meadus, Staff Lawyer and Institutional

22 Advocate, Advocacy Centre for the Elderly

23

24 Alyssa Lane, Staff Lawyer and Institutional

25 Advocate, Advocacy Centre for the Elderly

1 PARTICIPANTS:

2

3 Alison Drummond, Assistant Deputy Minister,
4 Long-Term Care Commission Secretariat

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6 Ida Bianchi, Counsel, Long-Term Care
7 Commission Secretariat

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9 Derek Lett, Policy Director, Long-Term Care
10 Commission Secretariat

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12 Lynn Mahoney, Counsel to the Ministry of
13 Health and Long-Term Care

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18 ALSO PRESENT:

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20 Judith M. Caputo, Stenographer/Transcriptionist

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1 COMMISSIONER MARROCCO: Ms. Meadus,
2 good afternoon. I am Commissioner Frank Marrocco,
3 Commissioner Angela Coke is on your screen and
4 Commissioner Dr. Jack Kitts.

5 I take it, Mr. Webb, everybody is here
6 now from your perspective?

7 MR. WEBB: Yes. We are all here and
8 we're prepared to begin, if you wish.

9 COMMISSIONER MARROCCO: Well, thank you
10 very much for coming, because this will be very
11 informative for us and we're very much looking
12 forward to what you have to say.

13 I think the best way for you to do this
14 is to just start. We will ask questions as we go
15 along, so don't think us rude if we're interrupting
16 you with questions, because we think it's better
17 that way than to trying to go back.

18 And secondly, around quarter after
19 2:00, I'll take a ten-minute break. So any time
20 around there, if you think it's convenient to stop,
21 just say so. We're ready when you are.

22 MR. WEBB: If I may begin then, just to
23 say a few words about ourselves and our clinic.

24 I am Graham Webb, I am a lawyer here
25 and the Executive Director of the Advocacy Centre

1 for the Elderly. I'm joined by my colleagues, Jane
2 Meadus and Alyssa Lane, who are both lawyers and
3 institutional advocates.

4 The Advocacy Centre for the Elderly is
5 a specialty community legal clinic under the Legal
6 Aid Services Act. It was established to provide a
7 range of legal services to low-income seniors in
8 Ontario. Legal services include individual and
9 group client advice and representation; public
10 legal education; community development; and law
11 reform activities.

12 ACE was established in 1984, has been
13 continuously operating since then. And it was the
14 first legal clinic in Canada, with a specific
15 mandate in expertise in legal issues of older
16 adults.

17 ACE currently employs six lawyers, two
18 paralegals, and an administrative coordinator, and
19 two administrative assistants.

20 On average, we receive about 3,000
21 calls or more from older adults, families of older
22 adults, health and social service providers and
23 others every year.

24 About two-thirds of our intakes and our
25 case files are in the area of health law. Most of

1 our telephone inquiries come from the Greater
2 Toronto Area, with about 20 percent from other
3 areas of Ontario. And we also receive calls from
4 across Canada and around the world.

5 Our lawyers frequently present on all
6 issues of elder law, including long-term care
7 homes; retirement homes; consent and capacity law;
8 elder abuse; to other lawyers; to healthcare
9 professionals; to older adults and other groups.

10 And we have made many presentations at
11 the local, provincial and national and
12 international levels.

13 We have two institutional advocates who
14 provide legal services to institutionalized
15 persons, most specifically in long-term care homes
16 and hospitals.

17 Jane Meadus has been our institutional
18 advocate since 1995 and she's recognized as an
19 expert in long-term care.

20 Alyssa Lane joined in 2019, when a
21 second institutional advocate position was created.
22 Now these positions are unique across Canada. We
23 are not aware of any other lawyers in Canada who
24 are dedicated full-time to the issue of
25 institutionalized seniors. And I've often said

1 that I think personally the most important work
2 that ACE does, including elder abuse, pensions and
3 fire safety and so on, of all that work, I think
4 the most important work that we do is in the area
5 of long-term care homes, because it is the highest
6 unmet need. There is very few other resources for
7 older adults and their families to turn to when
8 they need legal advice, legal representation, and
9 general legal information in the area of Ontario
10 long-term care homes.

11 With that, I'd like to turn our remarks
12 over to the person who has been on the frontline of
13 that service for 25 years this November,
14 November 1995 she joined us, Jane Meadus.

15 MS. MEADUS: Thank you very much. I'm
16 very glad to hear that you're going to be asking
17 questions, and please do so. I think that's
18 definitely the best way to go through this.

19 So we will be putting in some written
20 submissions, because we do have a lot of
21 information to provide to the Commission, and I'm
22 sure that we will not get to all of it today. And
23 in our written submissions, we'll also refer to
24 documentation.

25 If there's any documents or anything

1 that we refer to that we don't have, or that you
2 would like to have, please let me know and we can
3 hopefully provide them or let you know where you
4 can get them.

5 COMMISSIONER MARROCCO: That's very
6 helpful, thank you. We would welcome the sort of
7 tailored remarks and any papers or documents that
8 you think would be useful for us to read. Don't
9 feel hesitant about offering them, we'd be pleased
10 to get them.

11 MS. MEADUS: Fair. And I've already
12 sent Ida a couple of documents when we had our sort
13 of informal conversation the other day. I sent a
14 couple of things that I had referenced that she
15 wasn't aware of.

16 So with that said, I just want to do a
17 little bit of history. You all probably know this,
18 but I'll talk a little bit about it.

19 So the history of long-term care in
20 Ontario goes way back. When I started practicing
21 law, there were the three different kinds of homes,
22 there were charitable homes, municipal homes and
23 rest homes, and then nursing homes.

24 At the time I started, they were
25 actually under two different ministries. So the

1 nursing homes were under the long-term -- sorry,
2 the Ministry of Health. And the other two were
3 under COMSOC at the time.

4 So that was a time, the '90s were a
5 time when they were bringing them together. They
6 certainly focused on different populations, I think
7 at the time, obviously, the charitable homes were
8 focusing on their populations that had come out of
9 different kind of linguistic, religious, ethnic
10 groups, providing services.

11 Municipal homes, of course, came out of
12 the poor homes. And nursing homes had originally
13 been sort of the retirement homes of the '60s. So
14 in the '60s, you saw a lot of newspaper reports
15 about problems in the nursing homes, like we did
16 prior in Ontario for retirement homes, prior to the
17 Retirement Home Act legislation, so there's a lot
18 of parallels there.

19 There were differences in the way they
20 were funded, the oversight, there was a lot of
21 differences certainly when I started. Certainly in
22 the late '90s and then into the 2000s there was a
23 remerging of the three types.

24 So by the time around the 2000s, if you
25 lived in a long-term care home, you shouldn't have

1 known the difference whether you were in one or the
2 other; they were more corporate. There was still
3 the three different types of legislation at the
4 time. And because of that, like the Nursing Homes
5 Act was very detailed, whereas, the others were
6 not.

7 So what really sort of governed the
8 situation was the policy manuals. And Ms. Coke, I
9 think, worked at the Ministry of Health at the
10 time, so she may be familiar with the Long-Term
11 Care Home Facilities Manual, which was a giant
12 manual about this big, which contained a lot of the
13 policies. And a lot of those policies did become
14 regulation.

15 So we hear a lot about the complaint
16 around it's highly regulated, there's hundreds of
17 sections. When you look at the history, you can
18 say, well, yeah, but a lot of those things were
19 really still there, but they were policy under the
20 old system prior to 2010.

21 So, you know, the industry will often
22 complain about how highly regulated it was,
23 starting in 2010. And in fact, most of those
24 things were there by policy and they had to do them
25 anyway beforehand.

1 We actually wrote a manual, and if
2 you'd like, we can certainly send you a copy of
3 that. We wrote a manual that went into three
4 editions, this would have been prior to 2010. We
5 have not had time, unfortunately, to write one
6 since then.

7 But which sort of took the manual, took
8 the legislation, and explained the system at the
9 time. And I think that a lot of that is still
10 relevant, given that there's a lot of that still
11 continues until today. So we can certainly provide
12 a copy of that, if you wish.

13 COMMISSIONER MARROCCO: That would be
14 helpful.

15 MS. MEADUS: Okay. It was written for
16 the lay person, so even though it discusses law --
17 you know, it's called "The Advocates Manual", and
18 it really provides for the people advocating. And
19 it talks about things like funding, and all of
20 that, which can be quite complex. As I said, a lot
21 of it hasn't changed a huge amount.

22 One of the big differences at the time,
23 was the time they had compliance advisors. So
24 their inspection process was done by compliance
25 advisors. And the compliance advisors had a dual

1 role at the time.

2 First of all, they were generally
3 assigned to specific homes. So, you know,
4 Ms. Smith would be assigned to Shady Acres, and
5 that was her home; and she had a dual role. So she
6 inspected the home, but also advised the home on
7 compliance issues. And this created a lot of
8 issues.

9 We ran into a lot of problems, because
10 if we made complaints against homes, we had
11 inspectors -- sorry, compliance advisors who might
12 have been with that home for many, many years, who
13 had a relationship with the staff, and the
14 directors and stuff, who would tell us, "oh, this
15 is a perfect home. I don't know why you would
16 complain about it, it's so wonderful".

17 So there was a lot of problems with
18 that. There was a lot of subjectivity in that
19 system. So even if a compliance advisor found
20 something that was noncompliant, they did not have
21 to actually make a finding. So they could come in
22 and find something, but they wouldn't have to note
23 it; they didn't have to report it, or anything like
24 that. It was all subjective. And so there were a
25 lot of problems inherent in that system.

1 So, you know, we came up until 2010
2 when we got the new legislation. And that
3 legislation, the Long-Term Care Homes Act I think
4 was unique from many pieces of legislation. In
5 that the Ministry actually came to the stakeholders --
6 and I'm talking about the, you know, the different
7 industry organizations, our office, Concerned
8 Friends, which is an organization for advocates for
9 people in long-term care. It pre-dated Family
10 Council and OARC, so Concerned Friends has been
11 around. Actually, they helped establish our
12 office.

13 So, you know, met with them, OARC.
14 Different people were there looking at what needed
15 to be in the Long-Term Care Homes Act. So instead
16 of what usually happens where the government drafts
17 legislation, then gives it to you and you comment,
18 we actually were all really part of the drafting of
19 the Long-Term Care Homes Act.

20 So I always laugh when people say
21 there's too many things in it, or in the
22 regulations. Because, you know, there were very
23 specific reasons for things being included in the
24 legislation, based on the experience of all of the
25 parties.

1 So I think that that is a very
2 important thing to know, that this legislation was
3 actually really in some ways a collaborative work.
4 Now, the regulations were a little bit faster, we
5 didn't have quite as much in it, because the
6 government of the day was going into an election.
7 And I think it wanted to get the Long-Term Care
8 Homes Act put into place prior to the election.

9 So they sort of quickly drafted a lot
10 of the regulations, and put them in place for
11 July 1st, 2010. And some of that was not really
12 ready at the time; and that included the inspection
13 process. So the inspection process that we have
14 now, was actually not implemented until sometime
15 quite later.

16 Rate reductions weren't available at
17 the time -- like the process wasn't in place yet
18 per the legislation, so there were certain things
19 that had to be delayed.

20 But it did replace the three pieces of
21 legislation and made it very, very clear that, you
22 know, it didn't matter who the owners were of the
23 home, all the same rules and standards applied; and
24 that, I think, was a really good thing.

25 So I'm going to talk a little bit about

1 inspections. Because we've heard, I think, a lot
2 through COVID about the inspection process, and
3 sort of what the, you know, issues around that.
4 And we've heard the government make certain
5 statements about it, and the opposition
6 complaining, so I think it's important that we be
7 able to talk a little bit about that.

8 So the inspection process that we have
9 now was based on the U.S. system that was used for
10 Medicaid and Medicare, the quality inspection
11 system there. It was created out of the University
12 of Denver, and I've been trying to find the name of
13 the person, but I cannot just find it in my notes
14 at the moment. And of course we're not at the
15 office, so I don't have access to my stuff there.

16 But it was definitely something that
17 was worked on for a very long time, it was
18 contracted, you know, and it was to really ensure
19 that the inspection process had been tested, and
20 was rigorous, and inspecting what it needed to do.

21 At the time the government promised
22 that there would be full resident quality
23 inspections -- and those are the big full
24 inspections that we see annually -- every year on
25 every home. That is what was promised to us.

1 For the first couple of years, there
2 were really only complaints and critical incident
3 inspections and a few others, because they were
4 still training and testing the system.

5 In this system, one of the differences
6 between the old system was that the inspectors were
7 required to cite non-compliances, and there were no
8 advisors in the system. And this was a criticism,
9 a criticism to which I agree, although, I don't
10 think it's the role of the inspectors to do that
11 assistance, I think it's the role of the -- or
12 should be a different part of the Ministry, and I
13 believe that was one of the Gillese Inquiry
14 recommendations, that they do that. But it can't
15 be -- the inspectors can't also be advising as they
16 were in the other system.

17 Inspectors are now assigned randomly
18 within geographic regions, but they're inspectors,
19 not investigators, which means they don't have the
20 ability to sort of weigh evidence. So they sort of
21 have to have some kind of evidence in front of
22 them. And a good example of that, where it creates
23 a problem is around, for example, abuse issues.

24 So if a resident complains that they
25 were abused, and the staff member says, "no, I

1 didn't do it". And there's no other kind of
2 evidence -- even a bruising, or marks, or broken
3 bones, you know, if they can't prove how it was
4 done, they will not make a finding around there
5 being abuse. And that's always been problematic in
6 the system, because the residents see this as, you
7 know, not being bullied; to the family, it's very
8 problematic for the family.

9 So they're not investigators, they're
10 inspectors. They have protocols based on the
11 various topics and they've hopefully been given
12 that by the Ministry.

13 In general, in a complaint or critical
14 incidents inspection, they will use whatever
15 protocol is applicable. In the resident quality
16 inspections, they interview 40 residents, have
17 other protocols to be used, and if something is
18 triggered -- so, for example, during a inspection,
19 a resident talks about abuse, then they would
20 trigger that protocol.

21 So it really became clear quite quickly
22 that there weren't enough inspectors, because these
23 inspections were taking longer, and they were also
24 getting complaints in critical incidents.

25 In and around 2013, they decided to

1 change the interpretation of the requirement under
2 Section 143 of the Act that it be an annual
3 inspection, from what would have been promised to
4 us, which was the resident quality inspection, to
5 being any inspection in a home. So if they went in
6 and inspected on food, that was an inspection.
7 That meant the home had been inspected and that met
8 the criteria.

9 However, we were able to bring pressure
10 on the government to live up to this promise,
11 because it had promised it publicly. And in 2013
12 they hired 100 new inspectors to meet the needs.

13 In 2015 the Ministry of Health and
14 Long-Term Care produced statistics through their
15 statistical analysis team that showed the
16 difference between what is found in sort of
17 critical incident and complaint inspections, and
18 what was found in resident quality inspections.

19 And they used to give us top ten lists
20 at the time I was on the long-term care quality
21 inspection advisory group, and they would bring us
22 like the top ten. So what were the top ten issues
23 that were found during a critical incident versus a
24 complaint versus RQIs; and they were very
25 different.

1 You know, they really said that we need
2 all of those things, because you can't find -- what
3 you find in a critical incident is going to be
4 different from other things. And one of the very
5 specific things was infection protocols. Because
6 people generally don't complain about infection,
7 whether or not you're complying with infection
8 protocols; because they don't know. The residents
9 don't know what they're supposed to be, families
10 don't necessarily know what they're supposed to be.
11 So they're not something that people will complain
12 about, and they're generally not things that will
13 come up in a critical incident report.

14 So that was one of the top once, and
15 very relevant to today, where we're not having
16 RQIs. As the system went on -- so we got our extra
17 100 people, they started to do the RQIs, they still
18 couldn't meet it. So then the Ministry introduced
19 sort of two levels of RQIs, one which was
20 risk-focused; and the other was intense
21 risk-focused.

22 The intense risk-focused is the one
23 that we always saw before. Whereas, the
24 risk-focused was a lesser one, had less protocols
25 and only interviewed 20 residents.

1 With the change of government in --
2 whenever it was, 2018, I guess -- there was a
3 change, and they stopped doing a lot of the RQIs.

4 My understanding is, in 2019 there was
5 less than 10 out of over 600 homes that had RQIs.
6 And this is really problematic, because complaints
7 and critical incidents are after the fact.
8 Something bad has happened, and they're inspecting
9 on that.

10 The RQIs go in and they look at
11 different things. For example, infection control,
12 you know, nursing -- there's different things that
13 they look at. And we're really missing a piece of
14 the puzzle, and prevention as well. Because they
15 can go in and they can see things -- for example,
16 they're not doing infection protocols properly, or
17 medication management is another big one, that
18 they're not doing those things properly. But it
19 may not have actually harmed anyone yet and they
20 can prevent it.

21 But if they're not looking, they're
22 coming in and doing an abuse inspection or
23 something else, they're not looking at those
24 protocols. And, therefore, we're really losing
25 something in the system.

1 The other problem with relying on the
2 critical incidents in the complaints is that
3 complaint inspections rely on people complaining.
4 There are certainly a cohort of people who complain
5 more than others. It also relies on homes actually
6 submitting critical incidents. And if you look at
7 inspection reports, you'll see that very often what
8 the findings are, are sort of examples around
9 abuse. They may not be able to determine whether
10 abuse occurred, but they can say that the home did
11 not actually report abuse when they knew -- or an
12 allegation of abuse, when they knew about it. So
13 there's a lot of those sort of, the home didn't do
14 the proper reporting.

15 While we all like to think that homes
16 are all the same, I think we know that there are
17 some homes that are able to meet standards more
18 than others, and we've certainly seen that
19 throughout the pandemic.

20 There are over 30,000 people on waiting
21 lists in long-term care in Ontario. And because of
22 that, homes have no trouble, in general, keeping
23 their beds filled; especially in big cities.
24 Hospitals put a huge amount of pressure -- and
25 Alyssa and I spent a large part of our time

1 pre-pandemic, on hospitals trying to force people
2 into homes they don't want to go into.

3 Homes that have very lengthy
4 noncompliance lists, inspection reports that are
5 very problematic, lots of problems, have no trouble
6 filling the beds, because hospitals really put a
7 lot of pressure on people.

8 And the people that tend to end up in
9 those homes are often the people who don't have
10 families. Because families will all -- you know,
11 people who do have families, the families go in and
12 say, "I'm not going to put my mom in there" and
13 that's the end of it.

14 So they tend to be the most
15 marginalized, incapable people; people who don't
16 have someone to speak up for them. So they're
17 not -- you know, so homes who have problematic, may
18 actually have less complaints because the residents
19 may be not capable, or may be fearful, and they may
20 not complain. And they may not have the family or
21 social structure to complain on their behalf.

22 And if that's the case, the homes may
23 also be less likely to make, you know, make
24 critical incident reports, because nobody is really
25 complaining and nobody is looking at it.

1 So just because a home doesn't have a
2 lot of complaints or critical incidents, doesn't
3 mean that they're very good. It maybe means that
4 there's nobody really watching.

5 MS. LANE: Yeah, and sort of speaking
6 to that point as well. Especially in rural areas,
7 we get a lot of calls from families who are fearful
8 to complain, because as soon as they make the
9 complaint, the home is going to know they made the
10 complaint. And so, you know, if they're a business
11 owner, their livelihood could be at risk. They're
12 worried about reprisal for their family member now
13 in that home.

14 And that was a big issue during COVID
15 as well, is family members fearing complaining
16 because their family member is stuck in this home,
17 and they don't have access to them, they don't know
18 what's going on in there. You know, is the family
19 member in the home then going to be provided less
20 care or poorer care, because they made a complaint
21 against the home.

22 MS. MEADUS: So one of the things, so I
23 was co-counsel with Susan Fraser for the Ontario
24 Association of Residents' Councils at the Gillese
25 Inquiry.

1 And one of the things we really saw at
2 the Gillese Inquiry, which was really clear -- and
3 I don't think this was specific to these homes, it
4 just happened to be the homes that were on the
5 stand -- was that they didn't really understand
6 their reporting obligations. There was a huge lack
7 of reporting of abuse and other issues.

8 They didn't understand a lot of things.
9 The medical director didn't understand their role,
10 they didn't understand the medication rules. So I
11 think that this again was an issue around compliance.

12 And it's interesting that -- one of the
13 sort of interesting things around the Wettlaufer
14 case was that the home, Caressant Care in Woodstock
15 which was the home where most of the murders had
16 taken place, had just had an inspection -- and it
17 wasn't the worst inspection report I've ever seen
18 by a long shot -- just before she had come out and
19 confessed.

20 Of course immediately as soon as she
21 confessed, the Ministry was in there. And the list
22 of non-compliances, when they really did a deep
23 dive, was huge. And they eventually -- so from
24 October until January, they sort of had a chance to
25 fix it, they didn't. They had to cease submission,

1 and then they went under mandatory management,
2 which I understand continues to this day, is that
3 it is being managed by a third-party.

4 So even with RQI, whether we're getting
5 to the depth of everything is really questionable.
6 But certainly we're not doing RQIs, they're not
7 looking at enough things in homes.

8 There's different levels of
9 enforcement, as you know, in long-term care:
10 Written notices; voluntary plans of correction;
11 compliance orders; work orders; direct to work
12 referrals; directors can order cease admission or
13 mandatory management orders.

14 There's a lot of -- unfortunately, the
15 system which we had hoped would really clean up the
16 system, I'm not sure that it did. We get very
17 frustrated reading reports. First of all, it's
18 often very difficult to understand what happened in
19 a compliance report.

20 Second of all, we find the overuse of
21 written notices and voluntary plans of correction.
22 So a written notice is just saying, you did
23 something bad; don't do it again.

24 Voluntary plan of correction, the home
25 is supposed to do a plan of correction. But the

1 Ministry does not review that plan; nor, do they go
2 back and check to see if they have complied.

3 Compliance order, the home is given an
4 order to comply. And the home is reinspected, but
5 there's no timeframe for that. So it could be
6 months and months later. And we also find that
7 there's less compliance these days than there used
8 to be. I don't believe that's because there's less
9 problems. Things that we used to see as a
10 compliance order, we're seeing as voluntary plan of
11 correction now.

12 And I'll give you an example. And very
13 often, the homes are given extended periods of
14 time, so they don't comply and they extend it, and
15 extend it. One I looked at recently, and I can't
16 remember the home off the top of my head. But it
17 was something like they had to fix the windows. It
18 was like two years, it went on, and on, and on, and
19 they didn't comply.

20 There is no specific fining system.
21 There can be provincial offences. To my knowledge,
22 there's never been a charge under this act. There
23 was one around the time of change in the
24 legislation and that was with respect to a whistle
25 blowing situation.

1 So we really, you know, haven't seen
2 the full -- you know, there's fines in the
3 legislation, but it's been ten years and we haven't
4 seen one, any provincial offences, despite some
5 pretty egregious situations.

6 So I don't think that -- there's not
7 much fear. I mean, homes will tell you, oh, they
8 don't like to get non-compliances and compliance
9 orders. But frankly, it doesn't change who gets
10 in, it really doesn't change a lot. Cease
11 admissions order do, and mandatory management
12 orders do, but those are used very few and far
13 between.

14 Whether there's one issue or multiple
15 under a noncompliance, it's counted as one. So,
16 for example, if they abuse one person or if they
17 abuse 20 people, it's only counted as like one
18 noncompliance. So you really have to often look at
19 inspection reports to see, you know, what happened.

20 COMMISSIONER KITTS: Can I just ask a
21 question?

22 MS. MEADUS: Sure.

23 COMMISSIONER KITTS: What role, if any,
24 does the Ministry of Labour play in this?

25 MS. MEADUS: So the Ministry of Labour

1 inspects on the labour issues. So they would
2 potentially go in and check whether or not staff
3 are under proper working conditions. But it's not
4 under the Long-Term Care Homes Act, it would be
5 under the labour legislation.

6 COMMISSIONER KITTS: So they don't have
7 any jurisdiction over staff safety, abuse?

8 MS. MEADUS: They do, but under the
9 labour legislation. So I know that, for example,
10 during COVID, they were -- they went in and were
11 inspecting on whether or not people had access to
12 PPE, for example.

13 So that would be under the Employment
14 and Labour Legislation of Safety, for that. The
15 Long-Term Care Homes Act is specifically with
16 respect to the resident.

17 COMMISSIONER KITTS: Do you think
18 Ministry of Labour should play a larger role?

19 MS. MEADUS: I think so. I think that
20 there are a lot of labour issues. I think that
21 there's a lot of poor conditions in long-term care
22 for staff. And I think that they're coming in now
23 under, you know, what is a dreadful situation.

24 And I think that's part of the problem
25 is that, you know, when the pandemic hit, many of

1 the things that we saw, whether it was, you know,
2 the Canadian Armed Forces report, whether it was
3 the labour issues, they all existed before. It was
4 just, you know, it was just expanded.

5 And I think that absolutely we think
6 that the conditions for staff in long-term care are
7 quite poor, and I think this is why we're having a
8 lot of problems keeping staff. Why they have a
9 really big problem getting staff of all type,
10 whether it be nurses, whether it be PSWs, and
11 physicians, medical directors.

12 Long-term care is sort of the poor
13 cousin of the healthcare system. It is not seen as
14 sexy as working in a hospital. And I know,
15 Dr. Kitts, you used to be at a hospital. But, you
16 know, it's not seen as a desirable place to work.
17 And I think that's one of the things we have as a
18 challenge, as a system, that we really need to
19 change the perspective and not be looking at, well,
20 since we can't cure these people, why bother? I
21 think that's really a problem.

22 COMMISSIONER KITTS: Violence in the
23 workplace brought labour into hospitals a few years
24 ago, led a lot by the RNAO and ONA.

25 Violence in the workplace sounds -- for

1 lack of a better word -- rampant in long-term care,
2 because of the high number of patients with
3 dementia and other disorders.

4 So I'm surprised that Labour hasn't
5 come in there, similar to hospitals, on staff
6 safety.

7 MR. WEBB: Dr. Kitts, may I interject?
8 I don't plan to say much this afternoon, but I
9 would like to follow up on your comment.

10 In my view, I think long-term care
11 homes are extremely intense and complicated
12 environments, because they really have, at least a
13 three-fold purpose.

14 In one sense, they are a place of
15 employment for the employees who work there. Just
16 like other people go to their place of work, this
17 is a place where people from many different
18 disciplines, caregiving, nutrition, maintenance,
19 all kind of professionals and nonprofessionals go
20 and work daily, 24-7.

21 The second thing is, it's a place of
22 business. So the licensees, whether it's a
23 municipal corporation, or a charitable institution,
24 or a for-profit corporation; or, some blend where
25 it's owned perhaps by a charitable corporation but

1 operated under a management contract to a private
2 company, it is in some sense, a place of business
3 for the licensee.

4 In fact, for years when we researched
5 the law concerning long-term care homes, we found
6 that almost all the litigation concerned the
7 business aspects of long-term care homes; it has to
8 do with licensing and financing, etcetera.

9 But most importantly -- and this is
10 unlike hospitals which are also complex --
11 long-term care homes are also the home of the
12 people who live there. Because a hospital is a
13 place where someone goes, usually, for a temporary
14 period of time -- there are exceptions of course --
15 but normally, people are visitors in hospitals.

16 But in long-term care homes, it's most
17 important to remember that these are the homes of
18 the persons who live there. And that in fact is
19 the fundamental principle of the Long-Term Care
20 Homes Act. And it really drives everything that we
21 do at the Advocacy Centre for the Elderly as we
22 regard this primarily as someone's home.

23 And, actually, we tend not to call
24 long-term care home residents "patients". They are
25 patients of a doctor, just as my mother when she

1 lived in her private apartment was a patient of her
2 physician; but a resident of her apartment.

3 Now that she lives in a personal care
4 home in Manitoba, she is a resident of the home.
5 And we think of these as residents, and that
6 perspective drives everything else that happens in
7 the long-term care home.

8 Now many years ago, long-term care
9 homes were called in Ontario, "long-term care
10 facilities". This was the legal term they were
11 called as long-term care facilities. Thankfully,
12 they're no longer called long-term care facilities,
13 they are appropriately called "long-term care
14 homes", because that is the way we look at them.

15 So I just wanted to share that
16 perspective with all of the Commissioners. Thank
17 you.

18 COMMISSIONER KITTS: Thank you.

19 We've heard from others that the acuity
20 of the residents has increased dramatically over
21 the past several years and we've heard 70 percent
22 plus have some form of dementia, and most of them
23 have one or more chronic diseases. So I think the
24 acuity going up may change the workforce and skill
25 mix, and I think staff safety is still paramount in

1 that.

2 MS. MEADUS: I think that brings us to
3 another topic, which I think is really important.
4 I agree with you, I think that the acuity level,
5 you know, I'm sure you've heard people used to
6 drive up to these places with their cars and all of
7 that. And, of course, I haven't had one client
8 ever that had a car at a long-term care home, and
9 that is not what happens.

10 I think there's been a number of things
11 that have happened over the years, certainly that
12 I've been here. And it's that the -- I think that
13 the closing, or the redistribution of patients from
14 chronic or complex care has been a big problem.

15 People who used to go to complex or
16 chronic care, now go to long-term care. Most
17 chronic care and complex care, in our opinion, has
18 become more of a rehab facility and is really not
19 truly complex anymore.

20 MS. LANE: It's a very short term,
21 yeah.

22 MS. MEADUS: Yes, chronic care is no
23 longer really a destination for people. We have a
24 lot of problems where we have clients who, we
25 believe, clearly cannot be managed in long-term

1 care. Their needs are far too high, and yet they
2 are found to be eligible by the LHIN, because
3 there's no upper level, and they're forced into
4 long-term care where it's pretty clear they can't
5 be managed.

6 Other things that have happened is, of
7 course, the closure of mental health facilities
8 without proper planning. As well as the lack of
9 access for assistive, either -- subsidized
10 retirement homes, you know, or assisted living.

11 So if you're poor, and you need some
12 help, and you can't get enough at home through home
13 care, you end up in long-term care. If you're
14 rich, you end up in a retirement home. And a lot
15 of the poorer people could be managed in long-term
16 care, so they either ended up at home unsafe, or
17 they end up in long-term care where they really
18 shouldn't be, because we don't have a subsidized
19 system, or not a lot of it out there.

20 We also have a lot of younger people
21 who might have, for example, lived in what used to
22 be the regional centres, for example. So it's not
23 uncommon for people with developmental disabilities
24 who are getting older to end up in them.

25 My youngest client right now is

1 27 years old. She resides in a long-term care home
2 in Toronto, she is totally competent. I think I
3 sent to Ida the links to some media that's been
4 about her.

5 She grew up in the Crown Ward System,
6 so she has no family, doesn't really have a support
7 system. She was in an accident and suffered a
8 partial paralysis and has gone in there. It is an
9 incredibly inappropriate place for her. And both
10 for her -- anyone younger, we have problems with.

11 I mean, we don't have problems with our
12 client, we have problems with the homes. They just
13 don't know how to manage people who are younger.
14 They don't like to be told what to do.

15 So if a client says, I want to do this,
16 this, and this, like you would in assistive living,
17 the homes don't like that. They don't understand
18 the kind of system that -- they don't understand
19 their diseases; they don't understand how to manage
20 people like that.

21 My client is trying to move. And one
22 of the reasons that she's getting refused by other
23 homes is because it's reported that she doesn't
24 want to live with a bunch of old people. Well,
25 yeah, she's 27. You know, I don't think that

1 that's an inappropriate thing to say. The problem
2 is, she doesn't have any other options at the
3 moment. So this is used against her.

4 So anybody with any kind of different
5 kinds of diseases, if you have ALS or something
6 like that, it's quite problematic trying to get
7 people cared for in long-term care. And the system
8 is very rigid at looking at things in a very
9 specific way, and assuming that everybody is old,
10 has dementia, is incapable, and that they're going
11 to come and do things their way. And this creates
12 a lot of problems in long-term care.

13 With respect to the, you know, issue we
14 talked a little bit about -- sorry, go ahead.

15 COMMISSIONER COKE: So I'm just wanting
16 to understand.

17 In terms of pre-COVID, what would be
18 sort of the top concerns that you would hear from
19 residents and families? The most consistent ones.

20 MS. MEADUS: I would say in long-term
21 care would be lack of appropriate care. So it
22 would depend on who's calling.

23 So for residents, it would be lack of
24 appropriate care; poor treatment; not respecting
25 their wishes; forcing medication; that type of

1 thing.

2 Family members, I would say it would be
3 more around potential neglect or abuse of
4 residents; lack of communication from long-term
5 care homes. So not being contacted to give consent
6 to treatment.

7 It's very common for us to get a call
8 to say, "I've just discovered that my mother is on
9 Risperidone --" for example, which is an
10 antipsychotic "-- and have no idea, and mom's
11 incapable."

12 And I ask them, "Who consented to the
13 medication?"

14 And they said, "The doctor."

15 And I said, "No, doctors don't consent
16 to medication."

17 But you know, this is a consistent
18 issue we run into where medications are given, or
19 treatments are given without consent.

20 And, again, coming in and finding
21 people dirty with feces on them, not taken out of
22 bed, not fed properly, through the whole gamut of
23 sort of neglect and abuse issues, really.

24 MS. LANE: Also lots of issues with
25 admissions. So homes denying applicants because of

1 a particular disability. So maybe they have an
2 addiction to alcohol, and the home doesn't want a
3 person who has an addiction. Maybe they have
4 behaviours, the home doesn't want individuals who
5 have behaviors. So we get a lot of complaints
6 about homes denying people for illegal reasons.

7 MS. MEADUS: And, of course, these are
8 part of our health system. And, generally, if you
9 go to hospital and you have a broken hip, they
10 don't say, "I'm sorry, I'm not going to give you
11 treatment because you're an alcoholic."

12 Long-term care homes will very often
13 say, "we're not going to take you because you're an
14 alcoholic"; or, "you're young"; or, "you use an
15 electric wheelchair". That's against the Human
16 Rights Code, that's a common one and it's a big
17 problem.

18 MR. WEBB: In response to Commissioner
19 Coke's question, would it be appropriate to touch
20 on the outcome of the Casa Verde Inquest and the
21 lack of specialized units behaviour?

22 MS. MEADUS: I can talk a little bit
23 about Casa Verde. Have you heard about the Casa
24 Verde inquest at all?

25 COMMISSIONER COKE: No.

1 MS. MEADUS: Okay. The Casa Verde
2 Inquest, which is actually known as the Elroubi
3 Inquest, was the inquest into the deaths of two
4 gentlemen at a long-term care home.

5 What happened was, a gentleman who had
6 a history of abuse, although it was not properly
7 noted in any of the documentation, was very quickly
8 admitted into a long-term care home after he
9 assaulted his wife.

10 He didn't speak English very well, he
11 was admitted on a Saturday morning. And if you
12 ever hear of homes -- I know hospitals always used
13 to complain why people won't admit on the weekends
14 -- so this is the reason why they don't admit on
15 weekends, is because they don't have the staff.

16 This gentleman was admitted on a
17 Saturday morning, basically taken by his family,
18 dropped off, not told he was going to long-term
19 care, and left. He spent the day asking to speak
20 to his family, who of course didn't want to talk to
21 him.

22 At approximately 7:00, 7:30 that night,
23 the PSW came around with the evening snack, and
24 came into his room which he shared, it was a
25 four-bedroom. One of the roommates was in hospital

1 and he shared it with two other people. He had
2 bludgeoned his two roommates to death, one with the
3 back of a toilet seat, and one with a metal bar
4 that he had ripped off of a tray, and he was across
5 the hall trying to kill a third person.

6 All the nursing staff ran and hid in
7 the nursing station. Luckily, the cleaner came to
8 the rescue and actually pulled him off of the third
9 person, or tried to.

10 The police arrived, said it was one of
11 the worst scenes they had ever seen. Had a lot of
12 trouble actually controlling this gentleman. He
13 was arrested, found not criminally responsible and
14 there was an inquest into these deaths.

15 One of the biggest things that came out
16 of that was the lack of funding and the lack of
17 specialized training in specialized units for
18 people who have behavioral issues.

19 We see in long-term care, a lot of what
20 they call "secure units". They might call them
21 "behavioral units" in some cases, but they're
22 usually what they call a "secure unit". That's
23 usually where they try to put people who have
24 either wandering, or behaviors. And, frankly,
25 those two things actually don't mix. There's

1 people who wander, don't necessarily have
2 behavioral issues, but they may be targets.

3 Those are not funded behavioral units;
4 they don't have to have any special training,
5 they're set up by the homes. We only have about
6 six, I think, behavioral units in the province.
7 For example, there's one in the Toronto area;
8 there's one at Baycrest, one at Cummer Lodge and
9 one at Sheridan.

10 I'm not sure about Ottawa. The City of
11 Ottawa used to run one, I want to say at Armstrong,
12 but I'm not sure. And it pulled out, because they
13 said they weren't funded enough. Even the
14 specialty unit was not funded enough. And so this
15 has increased problems.

16 One of the things that happened during
17 COVID, is that if there was a person on a unit that
18 had tested positive for COVID, the home generally
19 treated every person -- just assumed everybody on
20 the unit had COVID, and allowed them to intermingle
21 on these sort of behavioral units. So instead of
22 trying to have strategies to cohort, or to keep
23 them apart, they just presumed everybody already
24 had it, without any evidence, and allowed them to
25 comingle.

1 MR. WEBB: Justice Coke, in answer to
2 your question. What goes through my mind is one of
3 the most glaring deficiencies of the Long-Term Care
4 Home System Ontario is the lack of sufficient
5 behavioral specialized units.

6 One of the recommendations of the Casa
7 Verde inquest was a recommendation that there be
8 sufficient behavioral units in all parts of
9 Ontario, that they are available throughout the
10 Province without a waiting list.

11 You know, I spent 21 years as a staff
12 litigation lawyer with ACE beginning in 1995. I
13 acted in an inquest which was the longest inquest
14 in Ontario history in 1995, in which we heard
15 evidence that it's not that the long-term care home
16 system does not know how to care for residents with
17 behavioral issues; they do quite well. It's simply
18 they lack resources to provide the behavioral
19 supports they need to manage these issues.

20 And so this has been a longstanding
21 issue that, you know, I say frequently, the jails
22 are sometimes filled with people who come from
23 long-term care homes; or should be in long-term
24 care homes, because it's a health issue. But
25 there's a long waiting list for behavioral units in

1 long-term care homes, but there's no waiting list
2 for jail. And that's why we find demented
3 prisoners in jails rather than in long-term care
4 homes where they need healthcare.

5 And so this has been a longstanding
6 issue. And in COVID you particularly find problems
7 with persons with behavioral issues, because they
8 can't follow instructions to self-isolate, for
9 example. And we need more specialized care
10 throughout the system, and this has been
11 highlighted in COVID as well.

12 MS. MEADUS: And one of the things that
13 has happened during COVID is that the directives
14 say that residents are require to self-isolate when
15 admitted.

16 And what does "self-isolation" mean?
17 We have tried to get the Ministry to clarify that.
18 Because what we have found happens, is that
19 residents who have been accepted for long-term care
20 and are on waiting lists, and come to the top of
21 the list, but who are not deemed by the LHIN or the
22 home to be able to follow instructions to
23 self-isolate. So if you say, "stay in your room";
24 they wouldn't do it. They are being what they call
25 "bypassed". So the home is not refusing them, but

1 they are not being admitted because they can't
2 self-isolate.

3 Our opinion is that, first of all,
4 that's contrary to the Human Rights Code, because
5 they're not admitting people for a service based
6 upon a disability. We've asked the Ministry to
7 clarify this, because it is not being done in all
8 LHINs, only in some.

9 Our opinion is that the person has to
10 be isolated by themselves; that doesn't mean they
11 have to personally be able to do that. If we have
12 70 percent of people going into long-term care who
13 have some type of dementia; isn't that their bread
14 and butter, and aren't they turning away the exact
15 people who need to be there?

16 And we did receive a response from the
17 Ministry which was unfortunately not very
18 satisfactory. Although, I'm personally
19 interpreting it as meaning that a home has to do
20 the isolation; although, of course, it wasn't quite
21 that clear the way they wrote it.

22 But this is another issue we've had
23 during COVID is a lack of information from the
24 Ministry, a lack of clarification. So they come
25 out with directives or guidelines about things. We

1 ask questions like, what does this mean? Can you
2 tell us? Can you explain it to us? And we don't
3 get responses certainly in a timely manner and
4 sometimes we don't get responses at all.

5 And this has been an issue, actually,
6 in the last couple of years where there seems to
7 have been a change in perspective from the Ministry
8 and committees that we used to be on, where we used
9 to be able to bring some of these issues and talk
10 to them with the Ministry and with other groups
11 have been disbanded, there's not -- we have not
12 ever met with the Minister. We have never been
13 contacted by the Minister, despite having been
14 working in this area for many years and writing in
15 the area.

16 We have occasion, like today, we did
17 attend, Alyssa and I did attend something with the
18 Ministry, where they were doing some outreach on
19 something. But it has really been very clear that
20 there has been a change in perspective in that sort
21 of working with, certainly with our office and
22 other offices, which I think has been unfortunate.

23 And, you know, during COVID that has
24 been a real problem in trying to get responses to
25 things.

1 COMMISSIONER KITTS: Can I just come
2 back to your request for isolation.

3 What does "isolation" mean to you in a
4 long-term care home, recognizing that, I think, a
5 lot of rooms have four, three and two people in a
6 room?

7 MS. MEADUS: Right.

8 COMMISSIONER KITTS: Is isolation a
9 single person in a single room?

10 MS. MEADUS: So our understanding is
11 that on admission, so a new resident who's being
12 admission, that the homes are now to have rooms --
13 single rooms for those people, and they have to be
14 isolated in those rooms.

15 It's very different than what happens
16 once they're in, and cohorted. And that's, of
17 course, been a problem in -- during the pandemic,
18 that with four bedrooms, for example, that people
19 were not being cohorted, because there wasn't room
20 for them to be cohorted. And that, you know, we
21 had people continuing -- you had one person with a
22 curtain around them and, of course, that spread the
23 disease.

24 I think what that also brought up was
25 an issue around the planning and the pre-planning

1 was all to the hospitals. Even though we knew from
2 looking at Europe, from looking at Washington, that
3 we're the first places. And where it was really
4 being hit hard was long-term care homes. There was
5 really little planning on how to deal with
6 long-term care homes; how to deal with these four
7 bedrooms.

8 You know, stick a curtain around them,
9 I'm not a medical person, but -- you know, we were
10 seeing cruise ships, for example, where, you know,
11 the cruise ship that was the Diamond Princess, was
12 not allowed to dock, and how it was going through
13 there, even though they were all in their rooms.

14 It never made sense to me to allow
15 someone to stay in a room with vulnerable people,
16 not send them to hospital and just keep them there
17 and allow them to infect. If they didn't have room
18 there, they should've been sent to hospitals. But
19 hospitals don't want people from long-term care
20 homes.

21 COMMISSIONER MARROCCO: If you were put
22 on a timeline, when do you think it should have
23 been obvious that there was a problem? Or going to
24 be a problem with long-term care homes?

25 MS. MEADUS: Well, I can tell you that

1 I was interviewed by -- I want to say the Toronto
2 Star, or The Citizen, I can't remember which now --
3 right at the very beginning. And I said it from
4 the beginning.

5 COMMISSIONER MARROCCO: What do you
6 mean by "the beginning"?

7 MS. MEADUS: So I would say the
8 beginning of March. You know, around the time when
9 we were starting to go in lockdown, I was contacted
10 and I said, it is going to be a disaster in
11 long-term care. I believe that was a quote on the
12 front page of The Star at the time.

13 MS. LANE: What made it worse was there
14 was this huge push, and even change in amendments
15 to the legislation to say, get all of these
16 ALC patients out of the hospital and into long-term
17 care. And they made all these patients crisis, and
18 pushed them into these homes as quickly as possible
19 so that they would have the hospital beds.

20 And so now we're just adding more fuel
21 to this fire that's already existing, right? More
22 people now going into these homes that are getting
23 sick.

24 COMMISSIONER MARROCCO: Did anybody say
25 that?

1 MS. LANE: Well, that was the result.
2 I think very much in part there was this push to
3 get everybody out of the hospital, and also not
4 allow them to go back to the hospital. Keep them
5 in long-term care out of the hospital.

6 But the long-term care homes weren't --
7 a lot of them weren't able to handle the -- handle
8 Corona Virus, and then you have these people with
9 nowhere to put them, and nowhere to isolate them.

10 MS. MEADUS: You asked whether or not
11 people were saying this; absolutely they were.

12 COMMISSIONER MARROCCO: I'm just trying
13 to affix, you know, first of all, that I was
14 concerned about, whether people articulated that.
15 And I was just trying to get a sense of when,
16 because then I have some sense of a timeline, you
17 know.

18 MS. MEADUS: So I would say that from
19 the middle of March until May, the main part of my
20 job was media. I have not yet counted how many
21 media appearances that I made during COVID, but I
22 was probably doing four, five interviews per day,
23 as were some colleagues of mine. And these were
24 all issues that we were bringing into the media for
25 sure.

1 As I said, we didn't have contact with
2 the various government entities, the few attempts
3 that I made didn't work. So, you know, I figured
4 maybe if we did it in the front page of the Toronto
5 Star, that maybe it would get into the ears of
6 people. But I don't know that it was really
7 listened to at the time.

8 So these were definitely things that
9 were discussed, and those -- I meet regularly with
10 a variety of associations with union people in
11 different meetings, and these are things that we
12 were all discussing and trying to get into
13 meetings.

14 But, you know, we're not at the table.
15 We're not at the pandemic table, we're not at
16 long-term care tables. There's not that voice
17 there. So it has been increasingly difficult.
18 These are sort of things that we brought up at
19 committee meetings when I used to do committees.

20 So, yes, we were saying them publicly
21 and loudly and as much as we could. And hopefully
22 it was getting -- but I don't know. As I said, I
23 haven't spoken to the Ministers or the Chief
24 Medical Officer of Health.

25 MR. WEBB: Commissioner Marrocco, I

1 think it's telling that --

2 COMMISSIONER MARROCCO: Commissioner
3 Kitts had a question, so I'll come back to you in a
4 minute, okay?

5 MR. WEBB: Yes, thank you.

6 COMMISSIONER KITTS: I just want to
7 finish off with the concerns about isolation of
8 positive patients. And you go back to the Diamond
9 Princess, rightfully, that congregate settings,
10 crowded areas are going to be a problem, and you
11 saw it coming.

12 And so my question to you is, it seems
13 like you aren't comfortable with the responses from
14 the Ministry in terms of what they've done to
15 mitigate Wave 2 from this outbreak, because you
16 feel that they're still too crowded, and there
17 isn't a way to isolate these residents?

18 MS. MEADUS: Yeah. I mean, we're
19 certainly seeing obviously admissions to homes,
20 they're not allowed to admit to three and four
21 bedrooms. So if there is a new admission, the most
22 that can go into a room is two.

23 Again, this is another one of those
24 unclear areas. So in some areas homes are moving
25 everybody out of those three and four bedrooms. So

1 there's actually no admissions to the homes,
2 because they're doing it internally, so there's no
3 open beds. As soon as somebody dies, they move
4 people around so that they're only having two to a
5 room. So there's no admissions, so it's creating
6 another problem in the system.

7 My position is that I think that we
8 don't have the ability in long-term care for the
9 most part to do the proper cohorting and isolating
10 that's necessary during the pandemic. And we're
11 just going to see another wave of deaths unless
12 it's corrected.

13 And I have to look to the hospital
14 system, you know, we used to have -- and I really
15 hate to say this -- but we used to have TV
16 sanatoriums and stuff, places like that. And I
17 really think that that may be something we have to
18 do is having pandemic, you know, facilities.
19 Whether it's a wing of a hospital or something.

20 Long-term care homes aren't set up,
21 they're -- you know, especially the older ones --
22 and by the way, they were supposed to be
23 redeveloping these beds since 2009. But with
24 inaction, frankly, by the government, this has not
25 happened. And there's a whole bunch of reasons I

1 can discuss at some other time with you, because I
2 do think it's important.

3 But I just don't see the homes -- I
4 mean, some of the homes through attrition have
5 opened up a little, and I think they are leaving
6 rooms open, and they are getting some funding to
7 allow that, but I don't know that it's sufficient.

8 COMMISSIONER KITTS: So are you
9 suggesting that there might be -- because Wave 2 is
10 upon us and --

11 MS. MEADUS: Yes.

12 COMMISSIONER KITTS: -- you're not
13 confident it's going to be mitigated very much
14 better than Wave 1. Are you suggesting to put up
15 facilities to cohort positive patients in a
16 facility outside of the long-term care home; is
17 that what you're saying?

18 MS. MEADUS: I think so. That's not my
19 preference, I know people don't want to leave their
20 homes, but I just don't see any other way to
21 protect people. As soon as somebody has COVID
22 positive, if they're a resident, they need not to
23 be in those homes.

24 COMMISSIONER KITTS: Thank you.

25 MS. MEADUS: Yeah. That brings me --

1 MR. WEBB: Just a couple of comments.

2 COMMISSIONER MARROCCO: Go ahead, sorry
3 I was going to come back to you.

4 MR. WEBB: Thank you.

5 First in answer to your question,
6 Commissioner Kitts. I think it is actually, that
7 is one of the answers is to cohort COVID patients
8 outside the long-term care home.

9 Because if we come back to the
10 fundamental principles, fundamentally long-term
11 care homes are not hospitals or healthcare
12 facilities. Fundamentally, they are a person's
13 home, where older adults and other peoples live
14 congregately with other people in their home as
15 well.

16 And so, you know, as Ms. Meadus has
17 said, these homes are not equipped to handle COVID.
18 We have seen, sadly, situations where older adults
19 were in long-term care homes with presumed COVID,
20 and told they couldn't go to hospital; and the
21 opposite should be true.

22 If the person has a highly contagious
23 disease, it's not adequately equipped within the
24 long-term care home, they should be moved to
25 another healthcare facility that is equipped to

1 handle that.

2 Additionally, Commissioner Marrocco,
3 you asked a question, which to me as a litigator,
4 turns on the issue of foreseeability.

5 I think it's telling that when the
6 Canadian Armed Forces reported on their experience
7 in the long-term care homes they visited in
8 Ontario, nothing that was revealed in their report
9 was new or surprising to our staff.

10 You know, all of these problems are not
11 new problems. They are old problems that are held
12 up under a much more intense light. There's
13 greater pressure brought to bear on the system
14 through COVID than ever before. But the problems
15 that are revealed, are problems that are long known
16 to anyone who works in the system. They've been
17 there at least for the past 25 years that
18 Ms. Meadus and I have worked at the Advocacy Centre
19 for the Elderly.

20 COMMISSIONER MARROCCO: You hit on it
21 in a way. I'm asking the question, because I'm
22 trying to get a sense of how foreseeable it was.
23 I'm trying to make sure that I don't fall victim to
24 hindsight, if you know what I mean.

25 MR. WEBB: Yes.

1 COMMISSIONER MARROCCO: And then I'm
2 trying to place that in a timeline. Because once
3 you know there's a pandemic, because the day before
4 maybe you didn't know that there was going to be a
5 pandemic, until somebody calls it "pandemic".

6 But then once you know that's going to
7 be, and whether it's a declaration or whether it's
8 the Diamond Princess back in January, that's why
9 I'm asking the questions. I'm just trying to get a
10 sense of that.

11 MR. WEBB: Certainly when we saw the
12 first range of North American deaths in Washington
13 State that were in an American nursing home, I
14 think all of the alarm bells should have been
15 ringing. Because anybody who has worked in the
16 system would know, would necessarily know that if
17 this highly contagious disease got into Ontario
18 long-term care homes, that it would be disastrous.

19 MS. MEADUS: And I think that the
20 planning problems come in two different ways. One
21 is, I don't think that when they found out about
22 the pandemic, that proper planning was taking
23 place.

24 I think anybody looking, who's
25 knowledgeable about long-term care -- you know,

1 we've heard the Minister say many times, "we were
2 already in a staffing crisis." Well, that's not an
3 excuse. You had to deal with that then. If there
4 was a staffing crisis, how was she fixing it?

5 But there were a lot of issues and
6 these kind of problems in long-term care, as I
7 indicated before, and that's why I spent some time
8 on that inspection process. Is that what we had in
9 place really wasn't correcting the system.

10 And if you go back and look at the
11 myriad of reports -- and when I was doing my little
12 bit of research before this, I found a
13 RNAO document which basically is a, just a list --
14 just a list of different reports, over the last
15 20 years or something, into long-term care. There
16 is nothing about this.

17 Like all of the issues that we're
18 talking about, and all the problems we had, a lot
19 of them you couldn't fix in January or February.
20 You couldn't build new homes, and get people out of
21 four bedrooms, but we've been trying to do that
22 since 2009 without a proper plan.

23 All the plan was, was, "here's some
24 money." Homes weren't picking it up. Frankly, I
25 don't know how they'd do it anyway. In the City of

1 Toronto where there was 7,000 beds that had to be
2 redeveloped. Where do you put those 7,000 people
3 when you were redeveloping? And the Ministry kept
4 saying, "oh, it's not our problem."

5 And I think there is a lot of, "it's
6 not our problem". We've seen it in some of the
7 litigation in the defence documents of the Ministry
8 where they've said, this isn't a system, we don't
9 have responsibility.

10 And I know that is some litigation
11 speak. But I think really, you know, we've seen
12 year after year, there's been more and more things
13 placed in between the government and long-term
14 care, even though they fund and they inspect it.

15 I believe I had sent to Ida, a document
16 from 1999, which was the -- an inquest into 25
17 deaths from the flu in a place called --

18 MR. WEBB: Central Park Lodge.

19 MS. MEADUS: Yes, thank you. Central
20 Park Lodge. And I mean, you know, you read that
21 and just swap it out and put it, you know, today
22 and it was, you know, very similar kind of issues
23 and problems.

24 So this is not something that crept up
25 today, that was over 20 years ago.

1 MR. WEBB: Commissioner Kitts, you've
2 touched on the issue of isolation and the lack
3 of -- how do you put it? Resources, or the
4 presence of crowding in long-term care homes. Just
5 to tie this into the fact that these are long-term
6 issues.

7 There has been a rebuild program in
8 place for many years, and Ms. Meadus can speak to
9 this, where I can't. But, essentially, it's long
10 been the policy of the Government of Ontario to
11 rebuild long-term care homes by 2025. And the
12 current architectural standard would not have
13 multiple beds in a single room. They rather would
14 have one person in one room, perhaps with a shared
15 bathroom is the basic accommodation.

16 And for one reason or another,
17 Ms. Meadus could ably speak to, it now looks
18 impossible to meet that goal. And this is due to a
19 lack of central planning and organization of the
20 rebuild program. I'll stop there and if Ms. Meadus
21 could speak to it.

22 MS. MEADUS: I think we sort of covered
23 I think most of it. We can certainly provide
24 information about that.

25 I think this is probably a good time

1 for our break. You said you wanted to take a
2 break.

3 COMMISSIONER MARROCCO: Yes, if it's
4 convenient.

5 MS. MEADUS: Yes, I'm going on to
6 another couple of topics.

7 COMMISSIONER MARROCCO: Before we do
8 that, though, you mentioned the RNAO document.

9 MS. MEADUS: Yes.

10 COMMISSIONER MARROCCO: If you have it,
11 it would be interesting to read it.

12 MS. MEADUS: Yes. I will send that
13 along, for sure.

14 COMMISSIONER MARROCCO: All right. So
15 we'll take ten minutes and back at 2:20.

16 -- RECESS TAKEN AT 2:10 --

17 -- UPON RESUMING AT 2:23 --

18 MS. MEADUS: Okay. So I have a couple
19 of topics that I wanted to cover that could be --
20 you know, we could talk for days as you can imagine
21 on all these subjects. We certainly have a lot of
22 expertise, and we certainly can answer any
23 questions you want to ask us after, if you want to
24 meet again, we'd be pleased to do that.

25 There are two issues I would like to

1 speak to. One had to do with some of the
2 directives. And specifically with reference to the
3 Advance Care Planning documents, which was
4 contained in Directive No. 3.

5 So starting on March 30th, the
6 directive stated that -- so this would have been
7 the second version of the directive. And one of
8 the complaints, just sort of a general complaint
9 you may hear throughout, is that there were a lot
10 of directives, guidelines, all these different
11 documents.

12 There really wasn't a central
13 repository for these things and people really had
14 trouble finding them. Probably the best was the
15 Ontario Hospital Association, but they watched
16 documents -- which I didn't understand since they
17 were public -- but at least you knew what you were
18 looking for. That was a problem, and then also the
19 way things were interpreted.

20 You'd get the Chief Medical Officer
21 saying something, maybe the Ministry saying
22 something different, the home saying something
23 different, and the local public health office
24 saying yet another thing. So there was a lot of
25 confusion.

1 So I think that communication piece
2 overall, you know, from the government's
3 perspective, was quite problematic. And then of
4 course with long-term care, there were other issues
5 around communication with residents and families, a
6 lot of problems, which I know you've covered from
7 other places.

8 So the directive said that homes were
9 to review all Advance Directives. And that was on,
10 like, I believe that was on page 5. So page 5 says
11 that homes were to review all Advance Directives of
12 all residents in long-term care homes.

13 We then had a guidance document dated
14 April 15th. And that guidance document contained
15 two recommendations with respect to that they call
16 "Advanced -- with a 'D' -- Directives". It is
17 actually "Advance Directives". The first one was
18 to:

19 "Review and summarize Advance
20 Directives for all residents as part
21 of community planning with local
22 acute care facility and EMS."

23 And that was on page 5. And:

24 "Communicate with local acute
25 care hospitals regarding outbreak

1 including number of residents in the
2 facility, and number who may
3 potentially be transferred to
4 hospital if ill, based on Advance
5 Care Directives."

6 And that was on page 13 of that
7 document.

8 The problem is that Ontario law does
9 not recognize Advance Directives. When admitted to
10 long-term care, most homes will provide some type
11 of a document to the resident, or family, or
12 substitute decisionmaker. It's often called
13 a "Level of Care Form". If you want to see one, I
14 can certainly send a document.

15 But I'm actually going to refer you
16 guys to two studies that were done through our
17 office, with some other people with the Law
18 Commission, for a much bigger discussion on it;
19 because we're just going to touch the surface here.

20 But these documents, generally, if
21 you've never seen them, they usually have five
22 different choices from, "I want everything done to
23 me; take me to a hospital." To, "I don't want
24 anything. I don't want to go to a hospital, I just
25 want comfort measures."

1 So first of all, only capable
2 individuals can sign any kind of -- or make any
3 kind of future wishes; and that's what these
4 documents really are. They are not consents at all
5 under Our Healthcare Consent Act.

6 They are not consents, but only the
7 person themselves can make wishes. A substitute
8 decisionmaker has no authority to make wishes on
9 behalf of an incapable person. So, you know, homes
10 were being asked to do something that legally isn't
11 proper. And a substitute decisionmaker can only
12 consent to treatments that are being offered.

13 These documents -- and frankly, there's
14 not five choices in life, so they're quite
15 problematic from the get-go. They're often signed
16 by substitutes, who don't have authority to sign
17 them, because they're really a statement of wishes
18 about future care. And they're made mandatory. So
19 people are really forced to sign these documents.

20 They're not well understood, they're
21 usually done out of context. Often it's done by
22 whoever is doing the paperwork on admission. So
23 you might get the bookkeeper asking you to sign
24 these documents.

25 Even if the document was valid, so even

1 if a -- and I certainly have a couple of clients
2 who are capable, who have signed them and made them
3 very clear. And I tell them, they don't have to
4 choose the five choices. They can make any choices
5 they want. They can add, subtract, do something
6 else, it doesn't matter.

7 Even where a capable person signs the
8 document, of course if they continue to be capable,
9 you don't look at the document, you talk to the
10 person as to what they want at that time.

11 If a person is incapable, those
12 documents do not speak to the health provider, they
13 are not consents. They speak to the substitute,
14 and it's up to the substitute to interpret them.

15 One of the problems with what was
16 happening, despite -- first of all, you know, most
17 of these documents are signed by either family.
18 And families don't get to sign them, only
19 substitutes under the Healthcare Consent Act, which
20 may be a family member. But they're often signed
21 by people with no authority, whatsoever.

22 Even if it was a document where the
23 person knew what they were signing, understood, had
24 their wishes known, it speaks to the substitute.
25 And it would be up to the substitute to say,

1 "hey, does this wish apply to this situation?"

2 Of course, 99 percent of these
3 documents were created when COVID wasn't a thing.
4 So there was no way that it can be applicable to
5 this situation, because it's a disease that didn't
6 exist. So you can't make a future wish about
7 something that didn't even exist.

8 What these documents -- what the
9 purpose was, to count up the number of people who
10 have said, "I want to be taken to hospital." And
11 then those people who were substitutes who ticked
12 they didn't want to be taken to hospital; "oh, we
13 don't have to worry about them", and it's just the
14 people who signed.

15 So they were trying to give numbers to
16 the hospital, but the numbers were meaningless.
17 Should have been meaningless, because we don't
18 know. They weren't relevant, and we don't know
19 what the decision would be at the time.

20 Pre-COVID, these have been something
21 we've written about a lot, and that's why there's
22 the two Law Commission papers that talk about them.
23 We ran into situations like all the time with
24 respect to these documents.

25 We advise our clients not to sign them,

1 since they're not valid documents. Public guardian
2 and trustee as substitutes don't sign them. If
3 they're the substitute decision maker and last
4 resort, the reason they don't sign them is, they're
5 not valid.

6 And they're often used as consent. So
7 one of the choices, for example, is I don't want
8 antibiotics. Theory is, if you have pneumonia, you
9 don't have antibiotics, and you can slowly die and
10 it's sort of a peaceful way to die.

11 Well, what happens if you have a UTI,
12 or a tooth abscess. When you said, "I don't want
13 antibiotics"; is that what you really meant?
14 Usually it's not, but these things aren't
15 explained.

16 We've also had many times where people
17 have not been transported to hospital, or
18 questioned transported to hospital because of these
19 documents.

20 I had a client who was a non-verbal
21 resident of a long-term care home. A family member
22 came in to see her and discovered -- the family
23 member happened to be a nurse, saw bruising on the
24 leg and realized the person had a broken hip and
25 was in a great deal of pain.

1 She immediately demanded they contact
2 an ambulance. And they gave her trouble because
3 they said, "Well, four years ago when you admitted
4 your mother, you said no hospitalization."

5 And she said, "I meant when she was
6 dying, not if she was in pain."

7 And they said, "Well, we just didn't
8 call you because what was the point."

9 I've had homes call me where there was
10 a resident who had some kind of a problem, and the
11 administrator called and said, I have a resident, I
12 don't know what to do. They have X, Y, Z, and we
13 think they should probably go to the hospital. But
14 two years ago when they were admitted, they signed
15 this document and it said "no hospitalization".

16 The first question I asked is, "is the
17 person competent?"

18 "Oh, yes, they are. They're sitting
19 right here."

20 And I said, "well, you don't look at
21 the document. What do they want to do?"

22 "Oh, they want to go to the hospital."

23 "Then why are you calling me?"

24 These documents shouldn't be used.

25 It's clear whoever wrote the documents, the

1 directive and the guidelines did not understand
2 that these are not consents. Couldn't possibly be
3 applicable to the situation. There was no way to
4 know whether people wanted family members to be
5 sent to hospital.

6 I think we saw this throughout where
7 people were calling us, we're hearing it in the
8 media, they were not being sent to hospital? They
9 were being told, "oh, you signed something, we're
10 not sending you to hospital".

11 They're being told hospitals didn't
12 want them. Even though hospitals denied saying
13 that, but we know that because it happens all the
14 time.

15 But to go to documents that aren't even
16 legally valid, and should have never been signed in
17 the first place is really problematic. And I think
18 it created a situation where many people -- we were
19 talking about sending people to hospital and
20 getting them out of homes.

21 That didn't happen, because the homes
22 simply looked at these documents as the Ministry
23 told them to and said, "oh, this person said no
24 hospitalization, so we're not even going to offer
25 it."

1 I think that increased the number of
2 people in long-term care who had COVID because it
3 spread it. And I also think that people also got
4 better treatment in hospital. That's not a slam on
5 long-term care. They're not funded, we all know
6 they don't have enough funding. They don't have
7 enough expertise in infection control, and so seems
8 that in many cases people who went to hospital
9 seemed to have a better outcome. That does not
10 mean they were intubated, and that's not what we
11 were suggesting. But they do seem to have gotten
12 better more than a lot of other people.

13 And even palliative care. Long-term
14 care homes don't do palliative care well. They
15 don't have -- as we know, they didn't have doctors
16 in the homes. They're not nimble enough, they
17 don't have access to the kind of medications. They
18 don't do IVs, generally. And so people were being
19 kept in the home, and were subject to a lot of pain
20 and suffering at the end of their lives which
21 should not have occurred.

22 Yes?

23 COMMISSIONER KITTS: Can I just ask the
24 question about palliative care. And I guess not
25 that common in hospitals, or not done well.

1 Do you think that --

2 MS. MEADUS: Long-term care.

3 COMMISSIONER KITTS: Sorry, in
4 long-term care. It's kind of similar for
5 hospitals, so...

6 Do you think that the ask might be that
7 because this is their home, and you know,
8 palliative care is mostly in the home and
9 community. Instead of transferring to hospitals,
10 would you think having palliative care specialists
11 available 24-7, so that palliative care could
12 happen in the long-term care home?

13 MS. MEADUS: Well, I think in non-COVID
14 times, yes.

15 I understand that people want to stay
16 in their home. And most people when asked whether
17 they would prefer to die in their own home, and
18 that includes in long-term care, they would say
19 they would; they would want to die in their own
20 home.

21 If the question was: Do you want to
22 die in your own home, but you might be infecting
23 other people? Because they don't have the ability
24 to prevent that infection from spreading, because
25 they don't have negative, you know, air and all

1 that sort of thing, I think that's a different
2 question.

3 So again, I go back to the issue
4 around, it depends on the ability to properly
5 control that infection. Even, you know, at the
6 best of times, I don't think we do that well in
7 long-term care.

8 COMMISSIONER KITTS: In pre-COVID, is
9 palliative care much better?

10 MS. MEADUS: No.

11 COMMISSIONER KITTS: So as a rule,
12 palliative care needs to have a greater presence in
13 long-term care?

14 MS. MEADUS: Yeah, and it makes no
15 sense. There's a couple of things you would think
16 they would be experts in.

17 One would be palliative care since the
18 bulk of people who leave long-term care leave
19 because they've died.

20 And yet we've known for many, many
21 years, and there's been studies and there's been
22 attempts, that palliative care is not well-managed
23 in long-term care, and there's been a lot of
24 complaints. Of course some homes do it well, but
25 overall if you've talked to the hospice and

1 palliative care group, who I know he's been trying
2 to contact you guys.

3 COMMISSIONER KITTS: Yeah.

4 MS. MEADUS: He'll tell you about how
5 long-term care does not do palliative well.

6 COMMISSIONER KITTS: Yeah.

7 MS. MEADUS: The other area you would
8 think they would do well in is infection control,
9 because they're required by law to have certain
10 infection control programs.

11 They have flu outbreaks and gastro
12 outbreaks all the time, and people die. And so you
13 would think this would be an area they're an
14 absolute expert in, and as we found that's not the
15 case. This was not a surprise to us, and we see
16 this, you know, during flu outbreaks and things,
17 and we shake our heads and we hear from our clients
18 and families, telling us about the poor infection
19 control systems; and lack of proper hand washing,
20 and locking away PPE -- which is, by the way still
21 going on. Homes are still locking away these
22 things, there's no access to people. And misuse,
23 not knowing how to use the PPE well.

24 It sort of boggles my mind that in a
25 place where you've got congregate care, if a

1 contagious disease does get in, it does spread
2 rapidly. It just boggles your mind that they're
3 not experts in control.

4 COMMISSIONER KITTS: Thank you.

5 MS. MEADUS: Sorry. That's sort of
6 what I have to say about the Advance Care issue.
7 And that's an issue that we talk about a lot, and
8 try to do a lot of education about.

9 But it's clearly not getting to the
10 mark. We have a lot of issues around getting
11 consent to treatment in the long-term care and how
12 staff just don't understand consent to treatment,
13 including Advance Care.

14 MS. LANE: Should we move to the
15 detention issue?

16 MS. MEADUS: Yes. So the next one I'm
17 going to talk about is the issue of the detention
18 of 72,000 residents of long-term care homes.

19 So right from the beginning, the
20 Directive No. 3 stated that residents were not
21 allowed to leave long-term care homes.

22 That is continued until fairly
23 recently. So at the present time, if a home is not
24 in outbreak, residents are allowed to go out for
25 short absences and potentially overnight absences

1 as well to visit family, but there's more stringent
2 rules about that.

3 Just with respect to the rules around
4 absences, visitors, all of that. I know the
5 visitor stuff, you know, the family counsel will
6 probably talk to you about that a lot.

7 Is that, again, this is an area where
8 we have documents, we have the government coming
9 out and saying things, but they're allowing the
10 homes to make up their own rules. For example,
11 around short absences, people are being told, you
12 can go out on a short absence, but when you come
13 back, you're in isolation for five days.

14 That's not what the directives say,
15 that's not what the guidance documents say.

16 They're told that you have to book your
17 absences. That's not what it says.

18 And so we continue to have this problem
19 where the government is sort of putting up these
20 guidance documents, but they're not actually
21 enforcing what's going on.

22 So with respect to this detention
23 issue, I guess the first thing you have to
24 understand is that long-term care homes actually
25 don't have any detention authority, they're not

1 like a psych facility. Even clients who are found
2 incapable, there is no detention authority.

3 It's really questionable whether or
4 not -- so under the Healthcare Consent Act, there
5 is at present no detention authority. The
6 Long-Term Care Homes Act does not have detention
7 authority either.

8 There are sections in both of those
9 pieces of legislation which would allow some type
10 of detention, although, I don't think it would
11 apply in this situation. But that they do have
12 sections, but they have never been enacted, so
13 they've been on the books, but never enacted.

14 So the only authority that long-term
15 care homes have is under the common law in an
16 emergency. So if someone is walking out on the
17 street, going to get hit by a car, they can bring
18 them back.

19 This is really problematic. I've been
20 pushing since prior to the new legislation in 2010,
21 to get this section, which would protect both the
22 residents and the homes. The homes would know what
23 the parameters were for detention, then the
24 residents would know, and there would be an appeal
25 process which of course you have to have if you're

1 being detained, there has to be an appeal process.

2 The government has not passed that,
3 unfortunately. There's been no litigation on that,
4 probably because in most cases where we have
5 residents who are complaining about it, we usually
6 get them undetained fairly quickly, non-COVID.

7 So sometimes homes have a policy, which
8 is in one of the papers that I'll be sending the
9 bibliography to you. It was another Law Commission
10 report that we did.

11 We found that every home that we talked
12 to, detained all residents. And if a resident
13 wanted to be able to leave the home on their own,
14 they had to prove that they had the ability to do
15 that.

16 In fact, the law would be the exact
17 opposite. Everyone is allowed out, unless the home
18 provides proof that they should not be allowed out.
19 That would be the way it should go.

20 So under the pandemic, what happened
21 was, we had the directive. Now Directive No. 3 is
22 under Section 77.7 of the Health Detection and
23 Promotion Act, and it gives the Chief Medical
24 Officer of Health the authority to issue
25 directives to help practitioners. And it says

1 that:

2 "The proposed directives relate
3 to health worker safety protective
4 clothing equipment and advice."

5 The use of Directive 3 during this
6 pandemic with respect to long-term care and its
7 residents has been overly broad. It has put in
8 sections that I believe are outside the authority
9 of Section 77.7, and this includes both illegal
10 detention, as well as the restrictions on visitors
11 and absences from homes.

12 That section doesn't give the Chief
13 Medical Officer of Health that kind of authority.
14 If they want to detain, they have to use Section 22
15 of the Act. And that's what, for example, has been
16 used by the Public Officer of Health in Toronto.
17 That's what they use to say, if you've been
18 exposed, or if you have it, you have to detain for
19 two weeks. That's done under that section.

20 It is much more restrictive than what
21 these directives have said, which is basically, "we
22 don't care if your home has COVID or not, you can't
23 go out".

24 So we basically illegally detained
25 72,000 people for almost six months, with no right

1 of review. The section doesn't comply with the
2 charter. It's trying to download the rules onto
3 the homes who don't have detention authority.

4 If they had done it under Section 22,
5 it's much narrower and there would have been a
6 right of review. I think that we can't continue
7 with this. We all understand that almost 2,000
8 people died. We understand how rampant it became
9 in the long-term care homes. But detaining 72,000
10 people basically in solitary confinement for six
11 months is not, in my opinion, the proper way of
12 managing this.

13 I think that there were other ways of
14 doing this. And I think that the government has to
15 really think about how they're going to do this
16 moving forward, because I'm really afraid as we go
17 into a second wave, they're going to do a lockdown
18 again and not allow people out.

19 And COVID, obviously, had a devastating
20 effect on long-term care homes, but so did
21 detention of people. And the detention and
22 inability to have family members who assisted, have
23 family members visit, on people who have common
24 issues, especially -- and frankly, those without
25 cognitive issues, are even worse. You know, the

1 effect on their mental health has been absolutely
2 horrendous. And I think this is an area that, you
3 know, really they looked at and said, "we just
4 won't let anybody out and that will protect it".

5 I guess they could have done that for
6 the rest of society --

7 COMMISSIONER MARROCCO: Just a second.
8 Commissioner Coke, did you want to ask a question?

9 COMMISSIONER COKE: Yes. You mentioned
10 there's probably other ways they should have looked
11 at. I'm just wanting to hear you elaborate on what
12 you think they could have done instead.

13 MS. MEADUS: Well, I think there has to
14 be more than, "we have a pandemic, we're going to
15 lock everybody away". It's very different than
16 what they did with the rest of society.

17 There were many places in Ontario that
18 didn't even have COVID in the north and stuff. I
19 think that -- I had residents who wanted to go out
20 and were quite willing to do the same kind of
21 precautions that you and I do when we go out, wear
22 masks, use protection, do whatever is needed to do.

23 Staff are coming and going out of those
24 homes all the time, and that's where the infections
25 are coming in.

1 If somebody wants to go to somewhere
2 else -- you know, you don't lose your rights just
3 because you live in a long-term care home. And we
4 have to figure out a better way than just detain
5 everybody. We could have prevented it by detaining
6 all of us, too. But we didn't do that.

7 COMMISSIONER MARROCCO: And I suppose
8 one improvement implied in what you're saying is
9 that you wouldn't have the same policy for Toronto
10 as Kingston, if Kingston has no -- if there's a
11 long-term care facility in Kingston, and Kingston
12 has no cases, then you would be saying the
13 residents there should be free to go out?

14 MS. MEADUS: Yeah, I think it's a
15 balance. And I think we just -- you know, the
16 system, the government just took away all of those
17 rights of people thinking that was okay. And
18 didn't really consider the fact that they didn't
19 have the legal authority to do that.

20 Section 22 is much more prescriptive.
21 And that they, you know, had no right of review,
22 they just -- this wasn't -- I think at the
23 beginning, you know, we all kind of went, "well,
24 we're all doing our part". And I think long-term
25 care residents wanted to do their part, too.

1 But as things went on -- you know, we
2 all stayed home for the most part, I think. Many
3 of us stayed home, unless we were essential
4 workers, we tried to not go out unless we had to.
5 That was not -- that same ability was not allowed
6 for long-term care residents.

7 MR. WEBB: If I may interject to say
8 non-charter compliant detention has been a
9 longstanding concern of ours in long-term care
10 homes. Because normally we see when someone is
11 detained, there's usually a right of review in some
12 manner.

13 And we've had detention of long-term
14 care home residents with no prescribed legal
15 standards and no right of review. And, of course,
16 this is another situation where the intent sleight
17 of COVID has just made that problem more abundantly
18 clear.

19 COMMISSIONER MARROCCO: Could you bring
20 judicial review?

21 MR. WEBB: I don't have an answer to
22 that immediately at hand. I do know there has been
23 some litigation concerning that, but I am not -- I
24 don't have that fresh in mind, and I am not in a
25 position to comment on it.

1 COMMISSIONER MARROCCO: All right. And --

2 MS. MEADUS: I just wanted to comment
3 that I do believe that there are some -- certainly,
4 you know, in non-COVID times, we have -- you have
5 to deal with it sort of on a case by case basis, usually.

6 The clients that we've had, usually we
7 can get out quite quickly. During COVID, access to
8 people in long-term care, as you know, has been
9 very difficult. Families aren't necessarily who
10 might be substitutes and might assist with cases
11 aren't particularly interested in it.

12 The couple of clients that I've had --
13 I had one client who we were going to pursue
14 something and she got out anyway. So we weren't
15 able to pursue it.

16 MR. WEBB: The type of review we would
17 have in mind is something more akin to the
18 Consenting Capacity Board, where somebody is
19 detained, say, in the mental health factor, in that
20 way they would have an easy and a fast way of
21 review that would not have a lot of barriers to it.

22 MS. MEADUS: That's what's under the
23 legislation written, but we don't have it right now.

24 COMMISSIONER MARROCCO: So is there
25 anything else that you wanted to present?

1 MS. MEADUS: We have lots of other
2 things, I'd say I have pages. But maybe I'll just
3 open, if there's areas that we didn't cover and you
4 think you'd like our perspective on.

5 COMMISSIONER MARROCCO: I asked my
6 questions as we went along.

7 Any other questions?

8 COMMISSIONER COKE: No.

9 COMMISSIONER MARROCCO: It doesn't
10 sound like it.

11 Well, to repeat what I said when I
12 started. Thank you, this is very informative. We
13 would be happy to receive -- we'll leave it to your
14 discretion, but some things that we might find
15 interesting, I mentioned the one document that I
16 was interested in particularly. And I just will
17 say, apart from saying thank you, as you may hear
18 from us again.

19 MS. MEADUS: Anytime.

20 MR. WEBB: May we purchase a transcript
21 of our submissions to help us?

22 COMMISSIONER MARROCCO: Of course. It
23 should be ready within a day or so.

24 MR. WEBB: Thank you very much.

25 -- Meeting concluded at 2:50 p.m.

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REPORTER'S CERTIFICATE

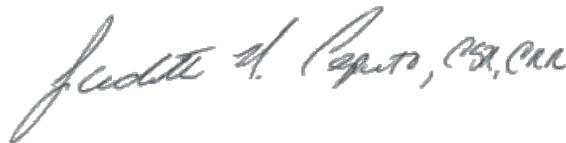
I, JUDITH M. CAPUTO, RPR, CSR, CRR,
Certified Shorthand Reporter, certify;

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 24th day of September, 2020.



NEESONS, A VERITEXT COMPANY

PER: JUDITH M. CAPUTO, RPR, CSR, CRR

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