

# **Long-Term Care COVID-19 Commission Meeting**

Dr. David Williams, Chief Medical Officer of Health  
on Monday, February 22, 2021



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

[neesonsreporting.com](https://neesonsreporting.com) | 416.413.7755

MEETING OF THE LONG-TERM CARE COVID-19 COMMISSION

-----  
--- Held via Zoom Videoconferencing, with all  
participants attending remotely, on the 22nd day of  
February, 2021, 10:00 a.m. to 2:30 p.m.  
-----

1 BEFORE:

2 The Honourable Frank N. Marrocco, Commission Chair

3 Angela Coke, Commissioner

4 Dr. Jack Kitts, Commissioner

5  
6 PRESENTERS:

7 OFFICE OF THE CHIEF MEDICAL OF HEALTH, PUBLIC

8 HEALTH

9 Dr. David Williams, Chief Medical Officer of Health

10  
11 COUNSEL:

12 Kristin Smith, Counsel, Ministry of Health/Ministry  
13 of Long-Term Care

14 Amy Leamen, Counsel, Ministry of Health/Ministry of  
15 Long-Term Care

16 Stephanie Figliomeni, Counsel, Ministry of  
17 Health/Ministry of Long-Term Care

18 Sunil Mathai, Counsel, Ministry of Attorney General

19 Eric Wagner, Counsel, Ministry of Attorney General

20 Michele Valentini, Counsel, Ministry of Attorney  
21 General

22 Ayushi Kiran, Counsel, Ministry of the Attorney  
23 General

24 Ann Christian-Brown, Ministry of the Attorney  
25 General/Crown Law Office - Civil

1 Nelly Farid, Counsel, Ministry of Health/Ministry  
2 of Long-Term Care Legal Services Branch  
3 Ayokunle Adesomoju, Articling Student, Ministry of  
4 Health/Ministry of Long-Term Care Legal Services  
5 Branch

6  
7 PARTICIPANTS:

8 Alison Drummond, Assistant Deputy Minister,  
9 Long-Term Care Commission Secretariat

10 Dawn Palin Rokosh, Director, Operations, Long-Term  
11 Care Secretariat

12 Derek Lett, Policy Director, Long-Term Care  
13 Commission Secretariat

14 Jessica Franklin, Policy Lead, Long-Term Care  
15 Commission Secretariat

16 Adriana Diaz Choconta, Senior Policy Analyst,  
17 Long-Term Care Commission Secretariat

18 Angeline Hawthorn, Senior Policy Analyst, Long-Term  
19 Care Commission Secretariat

20 Rose Bianchini, Senior Policy Analyst, Long-Term  
21 Care Commission Secretariat

22 Angela Walwyn, Senior Policy Analyst, Long-Term  
23 Care Commission Secretariat

24 John Callaghan, Co-Lead Commission Counsel, Gowling  
25 WLG

Lynn Mahoney, Counsel, Gowling WLG

Jennifer King, Counsel, Gowling WLG

Michael Finley, Counsel, Gowling WLG

Kavi Sivasothy, Counsel, Gowling WLG

Peter Gross, Counsel, Gowling WLG

Patricia Brooks, Counsel, Gowling WLG

Joshua Shoemaker, Counsel, Gowling WLG

ALSO PRESENT:

Deana Santedicola, Stenographer/Transcriptionist

1 -- Upon commencing at 10:00 a.m.

2  
3 COMMISSION CHAIR FRANK MARROCCO: All  
4 right. We are ready to go. You were here once  
5 before, Doctor. Nothing has changed. We have the  
6 same practice, with the exception of the fact that  
7 Mr. Callaghan, who is one of our Counsel, will ask  
8 some questions of you.

9 And then the three Commissioners may  
10 chime in from time to time and ask a question.

11 What I propose to do, Doctor, is we'll  
12 sit for about an hour. I don't know how long this  
13 is going to take. So we'll sit for an hour and  
14 then we'll break for five or ten minutes and then  
15 come back, so that everybody can regroup.

16 DR. DAVID WILLIAMS: Okay.

17 COMMISSION CHAIR FRANK MARROCCO: So go  
18 ahead, Mr. Callaghan. Let's get started.

19 Oh, and, Doctor, you know there is a  
20 transcript which we will eventually post on our  
21 website.

22 DR. DAVID WILLIAMS: All right.

23 COMMISSION CHAIR FRANK MARROCCO: Okay.

24 JOHN CALLAGHAN: So, good morning,  
25 Doctor. My name is John Callaghan. I'm one of the

1 co-Lead Counsels to the Commission, and thank you  
2 for coming to visit with us today.

3 As the Chair indicated, I'll ask a few  
4 questions, more topic-oriented questions, and flesh  
5 out some areas, and the Commissioners have  
6 questions as well, obviously, so they'll chime in  
7 as we go.

8 I thought probably the best way to sort  
9 of get to know you a little bit was to have you  
10 explain your background in the medical world and  
11 how it came that you became the Chief Medical  
12 Officer of Health for Ontario.

13 DR. DAVID WILLIAMS: Okay.

14 JOHN CALLAGHAN: I hope that is not too  
15 hard a question.

16 DR. DAVID WILLIAMS: No, I don't know  
17 how much -- I'll try and be concise on that.

18 I did -- as you know, did my  
19 undergraduate at the University of Toronto in  
20 biological medical sciences, and then I went and  
21 was accepted into medical school at the University  
22 of Toronto and completed the program there.

23 And then I wanted to do a northern  
24 practice. It didn't exist then. You couldn't get  
25 any training in that, and so I did a year

1 internship at the Toronto East General as it was  
2 called then.

3 And then I did an extra six months in  
4 obstetrics and gynecology, and an extra six months  
5 to become a GP anesthetist.

6 As I had been up to -- in my medical  
7 school undergrad, I had been up to the Sioux  
8 Lookout Zone Hospital, it was called then. It was  
9 under the Sick Children's Hospital and under their  
10 program by the then lead of the SickKids, Dr. Harry  
11 Bain, and I thought that is where I would like to  
12 work with, because I was very much impressed with  
13 working with the First Nation communities then,  
14 placements and that, and I told myself to go back  
15 up there and do that and --

16 JOHN CALLAGHAN: Sorry, Doctor, you  
17 faded out there.

18 COMMISSION CHAIR FRANK MARROCCO: You  
19 faded out there for a minute. No, we can't hear  
20 you now.

21 DR. DAVID WILLIAMS: Just a minute.  
22 Can you hear me now?

23 COMMISSION CHAIR FRANK MARROCCO: Yes,  
24 that is better.

25 JOHN CALLAGHAN: Perhaps, Sunil, do you



1 have two devices going? Because it may be you who  
2 is --

3 SUNIL MATHAI: Can you hear me?

4 JOHN CALLAGHAN: Yeah, you are echoing.  
5 Can you put yourself on mute?

6 SUNIL MATHAI: Yes.

7 DR. DAVID WILLIAMS: We are getting  
8 better at this technology, I think.

9 JOHN CALLAGHAN: Yeah. Well, we are  
10 certainly using it a lot.

11 DR. DAVID WILLIAMS: Yes, we are.

12 COMMISSION CHAIR FRANK MARROCCO: That  
13 is a relative observation about how much better we  
14 are getting, but anyway, carry on, Mr. Callaghan.  
15 Doctor, please.

16 JOHN CALLAGHAN: Well, let me stop you  
17 there before you talked about Sioux Lookout. Did  
18 you have a degree in public health?

19 DR. DAVID WILLIAMS: At that time, no.  
20 I was, as I said, a GP. I went and worked up in  
21 there for two and a half years, covered about five  
22 communities on a regular basis. There were only  
23 four doctors up there at the time, so we covered  
24 the town and the north.

25 And after that, I did go overseas, and

1 then worked at a hospital in Nepal, where I was the  
2 Outpatient Director and then became the Hospital  
3 Director. During that time, I felt the need for  
4 more training, especially I was seeing the impact  
5 of larger issues around management and  
6 administration and that. So I was accepted into  
7 the residency program at the University of Toronto  
8 in community medicine by Dr. Ken Shaw, and I went  
9 back and did my first full year in '85 to '86, and  
10 the first year full time course work towards my  
11 Masters in sciences and community health and  
12 epidemiology, which is like a public health degree.

13 And then I went back to Nepal where I  
14 had to complete some more work with construction  
15 projects, designing and building in rural areas, a  
16 hospital and that, and then I came back in '90 and  
17 completed my Masters, and another year of  
18 residency, so I only had a little bit left.

19 And they recruited me to go and work as  
20 the Medical Officer of Health in Thunder Bay. I  
21 started there in 1991 because I had my Masters  
22 degree, but I agreed I would go back and finish my  
23 fellowships. So I have one of the histories of  
24 being the longest resident in the U of T program,  
25 because I did go back in '95 to '96 and did another

1 year and then wrote did my fellowships in '96. So  
2 I had many cohorts that were my classmates  
3 throughout that time.

4 So I had my fellowships in what was  
5 then Community Medicine, now it is Public Health  
6 and Preventive Medicine, and a Masters of Science  
7 in Community Health and Epidemiology in that.

8 So I started my work in Thunder Bay in  
9 1991 as the Medical Officer of Health there. I had  
10 been as a child brought up in Thunder Bay, Port  
11 Arthur then, and so I knew the area as well, as  
12 well as, of course, having known the northwest with  
13 the communities.

14 And so I was there as the Medical  
15 Officer of Health until 2005. During that time, I  
16 was on a lot of provincial committees. I was the  
17 Chair of the Advisory Committee on Communicable  
18 Diseases just prior to SARS, and I remember the  
19 Minister of Health had written a letter saying, How  
20 prepared are we for a large infectious disease  
21 outbreak in Ontario? And I said, We'll review the  
22 matter and get back to you. And then within a  
23 month, SARS had occurred, and I as asked by the  
24 then Chief Medical Officer of Health, Dr. D'Cunha,  
25 to come down and assist him in carrying out the

1 response to that, and I and another veteran,  
2 Dr. Ian Gemmill, we went down as a team, and he  
3 went on to the science committee. I stayed to  
4 coordinate the public health response and --

5 JOHN CALLAGHAN: Sorry --

6 COMMISSION CHAIR FRANK MARROCCO:  
7 Mr. Callaghan, now you are breaking up.

8 JOHN CALLAGHAN: Yes, I know. Just to  
9 pause there for a second. So prior to SARS, so in  
10 2002 -- I'm just -- you are doing a great job  
11 explaining. I'm just getting a little lost. Where  
12 are you in 2002-2003 during SARS?

13 DR. DAVID WILLIAMS: I'm still the  
14 Medical Officer of Health in Thunder Bay, but in  
15 that time, medical officers -- and sometimes we sat  
16 on many provincial committees, and I chaired the  
17 Advisory Committee on Communicable Diseases that  
18 had a number of specialists on it, including  
19 some like you have interviewed already, like  
20 Dr. Allison McGeer. So we go back a long way  
21 working together, and I have always valued getting  
22 her input, and many other specialists.

23 So we were in that mode, and then --  
24 why that is important you'll hear in a moment. So  
25 I helped to coordinate. I had to relocate

1 physically and stay at a hotel for the two or three  
2 months in the first wave of SARS and to give advice  
3 and direction, assist Dr. D'Cunha and the rest of  
4 the SARS response team as we tried to make our way  
5 through that.

6           Following that -- and that was in 2003,  
7 and, of course, I was not here for the second wave  
8 because I had gone back to my job, the one at North  
9 York, and I did have some presentations at the  
10 Campbell Inquiry, as well as Naylor, et cetera.

11           And then we had...[inaudible]...when  
12 Dr. Sheela Basrur became the Chief Medical Officer  
13 of Health.

14           [Court Reporter intervenes for  
15 Clarification.]

16           MICHAEL FINLEY: Sometimes these echos  
17 are caused by people listening on a speaker mode  
18 rather than through headphones, and so for those  
19 persons who are doing that, I would suggest that  
20 you mute yourself as you listen because that is  
21 what causes the echo, and then you just unmute when  
22 you want to speak, and that may resolve some of  
23 these audio problems, other than those people who  
24 are talking to each other, obviously.

25           DR. DAVID WILLIAMS: See if that helps.

1 If it doesn't, I guess I could switch to  
2 headphones. It will be a bit challenging, but we  
3 could do that.

4 MICHAEL FINLEY: No. Well, I think for  
5 John -- for Mr. Callaghan and for you, Dr.  
6 Williams, I don't think it should be an issue, but  
7 for others listening, let's see if that fixes the  
8 problem, just a suggestion from new experience with  
9 this technology.

10 DR. DAVID WILLIAMS: Been there.

11 So in 2005, I came down -- applied to  
12 come down as the Associate Chief Medical Officer of  
13 Health to assist Dr. Sheela Basrur because she  
14 needed extra expertise in communicable diseases and  
15 infectious diseases.

16 And so I had applied and went through  
17 the interview process and was successful in  
18 obtaining the position and relocated and started in  
19 August of 2005 as the Associate Chief Medical  
20 Officer of Health for infectious disease,  
21 communicable diseases, and environmental health,  
22 and had the equivalent of being a Branch Director  
23 at that time as well with about 150 staff to work  
24 with.

25 And so we started that process of

1 implementing Operation Health Protection and a  
2 number of things we had to put in place to try and  
3 deal with some of the deficits we saw post-SARS.  
4 So I did that.

5 And then unfortunately Dr. Basrur  
6 became ill, and she had to step away. So in the  
7 fall of -- got to make sure my dates are correct  
8 here. The fall of 2007, I was asked to step up and  
9 act as the Chief Medical Officer of Health because  
10 she had to step away due to illness, and I  
11 maintained that position until the next Chief  
12 Medical Officer of Health was recruited and started  
13 in her position in June of 2009.

14 And I was then her associate. That was  
15 Dr. Arlene King. And so that was 2009 up until the  
16 fall of 2011. And then the fall, they had  
17 difficulty obtaining a Medical Officer of Health  
18 again for Thunder Bay, and they asked if I would  
19 consider coming back as the Medical Officer there  
20 with the task of training up a junior -- a person  
21 in training and equipping her to take over, seeking  
22 a deadline of around 2016 to be able to hand over.

23 So I went back in 2011, in the fall of  
24 2011, and did that for the three to four years.  
25 And then I was asked by the then Acting Chief

1 Medical Officer of Health -- because Dr. King was  
2 not renewed -- late in May and June of 2015 if I  
3 would come down and cover as Acting Chief Medical  
4 Officer of Health while Dr. David Mowat took leave.  
5 And then when I got down to start that duty on July  
6 1st of 2015, he announced he was not coming back,  
7 so I was left responsible.

8 And so I was acting from July 1st of  
9 2015, and through the application process, I was  
10 asked to put my hand in the ring for that, and  
11 through the application process was appointed as  
12 the Chief Medical Officer of Health officially in  
13 February the 16th of 2016, which I have had that  
14 post since then and, as you saw, my OIC was due to  
15 expire last week on the 16th, but they asked if I  
16 would stay on in the middle of the pandemic and  
17 continue, and that was extended to September the  
18 1st of this year, 2021.

19 So I think that -- does that give you  
20 enough, Mr. Callaghan?

21 JOHN CALLAGHAN: That is terrific. I  
22 wonder if that is me? I hope it is not me. Well,  
23 that is terrific. Just to be clear, so then you  
24 were in the Associate Chief Medical Officer of  
25 Health role or the Chief Medical Officer of Health



1 role as interim during H1N1 and Ebola, for example?

2 DR. DAVID WILLIAMS: Yes. I led the  
3 initial part of the first wave of the H1N1. I was  
4 the Acting Chief Medical Officer of Health.

5 Dr. King did the second part with the vaccination,  
6 but I assisted her in that. And then the Ebola, I  
7 came in more near the end of it after -- because  
8 Dr. David Mowat was there for the inception of it.  
9 I was a Local Medical Officer of Health during that  
10 time, and then did the latter part of it after he  
11 had stepped back.

12 JOHN CALLAGHAN: So to answer more sort  
13 of general questions, you'll appreciate that the  
14 inquiry is looking at what happened in wave one  
15 and, to the extent we can, a little bit of wave  
16 two.

17 But the Commissioners also have to deal  
18 with some structural issues and considering the  
19 structure, and you, given your length of  
20 experience, and perhaps maybe even more so because  
21 you are now departing, I think as we go, I just  
22 want to ask you if you would be kind enough to let  
23 the Commissioners know if you think there are  
24 improvements to the system, with your breadth of  
25 experience, that you can tell them about and

1 whether that is the role -- I'm not saying right  
2 now, but as we go, that is one of the functions.

3 And sometimes people lose that, because  
4 the Commissioners -- and we'll cover a bit because  
5 we'll go into various issues. I may even contrast  
6 it with what happened in SARS.

7 The other thing I would like to get  
8 your view on, we heard from one person that  
9 Ontario, more over the years and years, is training  
10 more and more Public Health positions. Is that  
11 your view, and is it your view that public health  
12 is a real specialty, and how you see the province  
13 sort of poised and for the next generation?

14 DR. DAVID WILLIAMS: That is an  
15 excellent question because I have been through the  
16 whole history of it over the years, and when I was  
17 a medical student, I remember we had a talk from  
18 one of the professors of the Public Health School  
19 at that time, and I remember leaning over to one of  
20 my friends and said, well, this is really boring  
21 and that is something I'll never get involved in.  
22 And be careful what you wish for.

23 It has changed so much in that time.  
24 And when I started in the residency program, and  
25 having been in the program over a ten-year period,

1 I saw a lot of growth and extension in there and  
2 could see the added value of a residency program  
3 because it is that much different than other  
4 clinical one, and having been a primary care  
5 physician before, a GP anesthetist, and did a lot  
6 of obstetrics and gynecology, mostly obstetrics,  
7 you can see the difference in how that works,  
8 especially when you combine the various areas of  
9 study that you want to take part in and studying  
10 population health as compared to clinical medicine,  
11 one-on-one patient type aspects.

12 And some of our -- having been -- also  
13 I was the Chair of the Public Health physician  
14 section for almost ten years with the OMA, and  
15 dealing with that issue where our counterparts  
16 would say, whatever you guys do anyways, we really  
17 don't know what you guys are up to, and so we had a  
18 lot of education to do to make it aware to our  
19 peers of what are Public Health physicians, what  
20 are community medicine specialists populations,  
21 Public Health specialists, and how can we  
22 contribute to the overall physician community.

23 And we were able to do that, so that  
24 there was a lot of education in those years,  
25 because in the past, there was just -- someone took

1 a three-month course in public health. Now with a  
2 five-year residency, it is quite different, and  
3 fellowship exams, and often we combine most of  
4 those with a Masters degree as well.

5 So it has been a journey, an evolving  
6 one. When I went in, it was the youngest. Then it  
7 became the second-youngest, because emergency  
8 medicine brought in their own specialty. So it  
9 still is relatively new in the archives of the  
10 Royal College, but I think we have made great  
11 steps, and remember, we only had, at that time when  
12 I started back then, one school of public health in  
13 Toronto. Now there is well over 11 in the Province  
14 of Ontario, and as far as residency programs, we  
15 have the one in Toronto. We have other ones with  
16 residents in Ottawa, Kingston, Hamilton, McMaster,  
17 that is, and NASM, which I was -- of course, when I  
18 was up in Thunder Bay, I was an assistant professor  
19 in the program there, as I am down here, with  
20 the -- still I am on record with the Dalla Lana  
21 School of Public Health.

22 So we still have that ongoing academic  
23 side as well. So it has evolved a lot, and we do  
24 train a lot. We have the biggest cohort of  
25 residents every year. We have lots of residents in

1 the Public Health Office and do rotations. We have  
2 one here right now, and so we give them lots of  
3 training opportunities, which is very critical, as  
4 any residency, because part of it is learning but  
5 part of it is the actual tools and working with  
6 your supervisor to carry out various  
7 investigations.

8 And that was very valuable at that  
9 time.

10 So it has been interesting to see the  
11 evolution of the specialty.

12 JOHN CALLAGHAN: So I take it that you  
13 would say that the cupboard is well stocked at the  
14 moment? As you depart, there are others there to  
15 come forward?

16 DR. DAVID WILLIAMS: Yes, I have been  
17 trying to make it aware to people. I say, Get your  
18 resumés dusted off. I think a lot are very leery  
19 just because the position in Ontario is so  
20 different than other CMOHs across the country  
21 because here, besides now, besides being a Chief  
22 Medical Officer of Health and working in the  
23 Ontario Public Health system, which is totally  
24 different than the rest of the country, and also  
25 the fact that I am an ADM and I have a department

1 of 250 staff, and outside of that we deal with a  
2 budget of \$1.4 billion, and with all the transfer  
3 agencies and also the connection with Public Health  
4 Ontario and the Public Health Ontario laboratory  
5 system, so all of those under the responsibilities,  
6 and being a member of the senior team in the  
7 Ministry of Health and Long-Term Care there then,  
8 now Ministry of Health when that was separated out,  
9 and so some of my peers across the country don't  
10 have the same complexity of structure and the same  
11 breadth of responsibilities and duties and to be a  
12 member of such a large team.

13 JOHN CALLAGHAN: So, you know, I think  
14 we'll probably cover some of that and discuss with  
15 you the pros and cons of that so that we  
16 understand, the Commissioners have an  
17 understanding.

18 Just when you got appointed, was there  
19 a panel that vetted the nominees that went to  
20 Cabinet?

21 DR. DAVID WILLIAMS: Yes.

22 JOHN CALLAGHAN: Is that how it works?

23 DR. DAVID WILLIAMS: There was a  
24 search -- there was a company, but it was you had  
25 interviews with the committee of the Cabinet --

1 with the Parliament. So it was a three-party at  
2 that time committee.

3 JOHN CALLAGHAN: So were there experts  
4 on those panels? Like were there other -- you  
5 know, those who you would expect, and maybe Public  
6 Health, infectious disease, hospital people, who  
7 would know the characteristics required for a Chief  
8 Medical Officer of Health, were they involved in  
9 the panel at all?

10 DR. DAVID WILLIAMS: They could be --  
11 they weren't in the key decision-making because it  
12 was set up by the Speaker of the House as the  
13 Chair, and then you have representatives of three  
14 parties, and they are elected officials, so -- but  
15 deputies behind could give -- not during the  
16 interviews but afterwards give advice and  
17 direction, and they could access -- I assume they  
18 would access different experts if they wanted to  
19 ask some information on that, and whatever the  
20 company was putting together, the overall vetting  
21 of the candidates through the committee. So there  
22 was resources to the committee, but I was not  
23 privileged to know all that at the time because it  
24 is a Parliamentary committee.

25 JOHN CALLAGHAN: But it is not -- I

1 just ask because there is not a public statement,  
2 for example, or a policy from the government as to  
3 how the CMOH would be vetted? I mean, I know you  
4 go back a number of years, but is it anticipated  
5 that there would be a committee this time, or do  
6 you know -- or has that been set yet?

7 DR. DAVID WILLIAMS: It still is. It  
8 is part of the aspect with Dr. Basrur because she  
9 was appointed by the Minister. And then they said,  
10 Well, we need to have the term of seeking some  
11 independence of the CMOH, so therefore the  
12 selection and the appointment should be by the  
13 legislature, not by a Minister, a Deputy Minister.

14 But the complication is that you still  
15 report to a Deputy Minister, and you still report  
16 to a Minister. So you are a quasi-officer of the  
17 legislature. So it is the only one like it in the  
18 government, where you have some levels of  
19 independence, but you have reporting, and all your  
20 budget comes through the Minister of Health in  
21 there. It doesn't come from -- like other officers  
22 of the legislature, their budget comes from the  
23 Speaker of the House.

24 JOHN CALLAGHAN: Right.

25 DR. DAVID WILLIAMS: But you are



1 appointed by the legislature, and you are dismissed  
2 by the legislature.

3 JOHN CALLAGHAN: But the current --  
4 have they set a process, for example, for your  
5 successor, or is it still as you just described it?

6 DR. DAVID WILLIAMS: I have been --  
7 well, one, is I have been pushing them saying, You  
8 need to get it going, you need to get it going.  
9 Who is counting the days? But I am saying -- we  
10 are saying you need to do it, because I know these  
11 things take time. But it still is under the  
12 auspices of a Parliamentary committee. Now there  
13 is only two parties, and how would you set that up.

14 It is still under the auspices of the  
15 Speaker of the House to do all that arrangement and  
16 that. So, of course, I am not -- again, I'm not  
17 privy to know all the details behind the scenes  
18 because they would say, Well, you are not coming  
19 in, you are going out, and so we don't need to tell  
20 you.

21 So I keep pushing them to push the  
22 process, because while there are people available,  
23 they are not -- there is not a lineup in that sense  
24 because a number are -- want to have the  
25 qualifications, and besides having the degrees, you

1 have to have -- they prefer having at least ten  
2 years' experience in a senior level in Public  
3 Health.

4 And I think it is important in this job  
5 here that they also feel you should have knowledge  
6 of the Ontario Public Health system. In essence,  
7 have you been working as an MOH in Ontario before  
8 or some level of seniority, that you have knowledge  
9 and experience of the province before you come into  
10 the job. So you have to have degrees in training  
11 and eight to ten years of experience at a senior  
12 level before you come in.

13 So you can see the scope of the  
14 applicant starts to narrow down, if you may, and  
15 one of the challenges is that if you bring someone  
16 from outside the province, some find it challenging  
17 at first to understand the complexity of the  
18 Ontario Public Health system and how it works.

19 So that is -- so how wide the  
20 candidates are, I don't know. I am encouraging. I  
21 think we have got a lot of good MOHs out there I  
22 think could do a good job. I'm always big on  
23 succession. I'm always pushing hard for succession  
24 training because -- I guess my motto always is,  
25 while everybody is valuable, no one is

1       indispensable, and that includes me.

2                   JOHN CALLAGHAN: That is a good motto.

3                   So what I would like to do is I would  
4       like to explore with you the various relationships  
5       the Chief Medical Officer of Health does, but I  
6       have to tell you before I do, during the process  
7       here I would have ordinarily sort of directed you  
8       to some of your documents. I should let you know  
9       that, you know, we received some 217,000 documents  
10      in the last week, and we were told that, on Friday,  
11      your documents from July 1st to January 31st were  
12      produced.

13                  So we haven't had an opportunity to  
14      look at those documents. So it may be that I am  
15      not in a position to help you understand what --  
16      remind you of what happened. The Commissioners  
17      will have an opportunity, if we can get through  
18      them -- it is a gargantuan task, almost impossible,  
19      but we may have an opportunity to look at them  
20      afterwards so their report may reflect some of it.

21                  We also received 2,000 pages of your  
22      notes Saturday afternoon, many of which were  
23      redacted, which we had to go to a Court -- or an  
24      arbitrator, I should say, to get them -- some of  
25      them unredacted.

1                   And so can you just tell the  
2 Commissioners when you were asked for your  
3 documents for this process?

4                   SUNIL MATHAI: So, Commissioner  
5 Marrocco, may I just jump in for a moment?

6                   JOHN CALLAGHAN: I don't know why.

7                   SUNIL MATHAI: Well, because that  
8 question may involve --

9                   COMMISSION CHAIR FRANK MARROCCO: You  
10 know, just a minute. I don't want to get bogged  
11 down in a lot of wrangling here, and so I really  
12 don't want to get into it.

13                   This is an interview and so on and  
14 consistent with the way we have conducted ourselves  
15 in the past.

16                   Mr. Mathai, if there is something you  
17 want to say that is short and brief, then by all  
18 means I'll permit you to say it, but this is not  
19 going to turn into an adversarial process. It is  
20 not that kind of process.

21                   SUNIL MATHAI: The only thing I was  
22 going to say, Justice Marrocco, is the way the  
23 question is framed, it may require the witness to  
24 advise of information that he has received from his  
25 counsel, and so it could involve revealing

1 solicitor-client privilege.

2 But it sounds like you don't want to  
3 turn this into, you know, a further investigation  
4 into when the documents were produced and why, so I  
5 don't think I need to say anything more than that.

6 COMMISSION CHAIR FRANK MARROCCO: Yes.  
7 Let me just ask you this, Mr. Mathai. At the risk  
8 of -- having told you I didn't want to hear from  
9 you for very long, now let me prolong it for a  
10 second.

11 Dr. Williams was asked, I think, when  
12 he was asked for his notes. Do you have a problem  
13 with that question?

14 SUNIL MATHAI: So yes, because it could  
15 reveal solicitor-client privilege.

16 COMMISSION CHAIR FRANK MARROCCO: All  
17 right. So, Mr. Callaghan, I'm not going to get  
18 into it.

19 Dr. Williams, on the instructions of  
20 his counsel, is not answering that question because  
21 it apparently involves solicitor-client  
22 communications.

23 I don't really want to spend a whole  
24 lot of time trying to figure that out, so let's  
25 just leave it at that. And if it becomes a

1 problem, again, Mr. Callaghan, then we'll come back  
2 to it.

3 JOHN CALLAGHAN: All right. You know,  
4 that is fine. It is a little problematic. It is a  
5 vexing issue for us to get these so late. I was  
6 just trying to find out when this process started.

7 But let me ask you this, Dr. Williams,  
8 did you get an opportunity to review your notes in  
9 preparation for today?

10 DR. DAVID WILLIAMS: My notes on the --  
11 you mean my jottings in my journals?

12 JOHN CALLAGHAN: Well, yes, jottings  
13 and the journal notes, yes.

14 DR. DAVID WILLIAMS: Well, I didn't  
15 go -- I didn't spend a lot of time reviewing them  
16 because it deals with a lot of other stuff too,  
17 so it is -- it deals with different things and --  
18 well, in meetings and stuff, you make some notes  
19 and so on to remind yourself what you have to  
20 follow up on, on different issues and that, but I  
21 haven't spent a lot of time reviewing them. I was  
22 more doing all the documents. As you know, there  
23 is quite a few documents to go over some of those,  
24 so I was trying to prepare those.

25 JOHN CALLAGHAN: Did you review any

1 documents from July 1st to January 31st, because  
2 those are the ones we haven't seen?

3 DR. DAVID WILLIAMS: That you supplied  
4 me with?

5 JOHN CALLAGHAN: Well, no, these are  
6 the documents -- your documents that we have just  
7 received on Friday.

8 DR. DAVID WILLIAMS: I would only look  
9 them up if I was looking for something to remind  
10 myself of something. Not really.

11 JOHN CALLAGHAN: Well -- and I guess  
12 you can't help me and I can't help you because  
13 neither of us have seen them. Let me just move on  
14 then.

15 We'll come back to your notes in a  
16 second, but let's talk then about your relationship  
17 with the -- and you have dealt with this somewhat,  
18 and as you indicated, it is somewhat complex.

19 So what is your relationship then with  
20 the Ministry of Health as the Chief Medical Officer  
21 of Health?

22 DR. DAVID WILLIAMS: And I have been in  
23 this for quite a few years. The relationship is  
24 the Chief Medical Officer of Health is -- because  
25 you are actually one of the equivalents of an

1 Assistant Deputy Minister in there and have a  
2 reporting relationship with the Deputy Minister of  
3 Health and then up to the Minister of Health.

4 So therefore, I sit at the table with  
5 the senior team, chaired by the Deputy Minister of  
6 Health that has all the ADMs at it, as well as  
7 others.

8 And up until 2018 -- I mean, I did sit  
9 on it back in 2006/07 when I was Acting. And I  
10 would sometimes fill in for the Chief Medical  
11 Officer of Health when she was not available after  
12 that. And then later, I was the Chief Medical  
13 Officer of Health without being an ADM from -- when  
14 I came back in 2015 until October 2018 when there  
15 was some structural changes within the Ministry,  
16 some downsizing in some sense, but I was asked to  
17 take on the ADM job as well, and the ADM had  
18 stepped away.

19 JOHN CALLAGHAN: ADM of what?

20 DR. DAVID WILLIAMS: The Assistant  
21 Deputy Minister for Population and Public Health  
22 division.

23 JOHN CALLAGHAN: So would that not  
24 ordinarily be the Chief Medical Officer of Health?

25 DR. DAVID WILLIAMS: No. When I came



1 down in 2015, that was under an Assistant Deputy  
2 Minister at that time, separate, and it was  
3 actually two who were sharing it, and they combined  
4 the two into one division. So there was two  
5 divisions. There was Health Promotion and  
6 Population Health, and there were two acting ADMs,  
7 and then they had a competition, and they selected  
8 one ADM, who became the ADM of the Population and  
9 Public Health Division. That was in about 2017 --  
10 '16 and '17. And then that was restructured and  
11 changed again, and so then they combined my  
12 position as Chief Medical Officer of Health and ADM  
13 of the Population and Public Health division. So I  
14 assumed, again, as a Director of a division.

15 JOHN CALLAGHAN: So are you under the  
16 direction of the Deputy Minister in certain  
17 respects in some of your roles?

18 DR. DAVID WILLIAMS: In the function as  
19 the ADM, that's correct.

20 JOHN CALLAGHAN: And therefore, are you  
21 under the direction of the Deputy Minister as your  
22 role as Chief Medical Officer of Health?

23 DR. DAVID WILLIAMS: Not in the same  
24 way because I have independence then. So unlike  
25 other AD Ms, I can issue reports directly to the

1 legislature, which I am legally required to do at  
2 least a once year, and I do that. I give a report  
3 on the state of public health to the legislature,  
4 as required under the HPPA, and I can then go and  
5 do media and other things without having it  
6 approved directly by the Deputy Minister or the  
7 Minister. So I can do releases and special reports  
8 as well.

9 So unlike other ADMs, I have that  
10 independence combine with it, which makes it an odd  
11 or unusual position within the structure.

12 JOHN CALLAGHAN: Right, and so when you  
13 look at the Health Protection and Promotion Act, it  
14 doesn't actually set out your duties. It provides  
15 you with powers. Have I got that right?

16 DR. DAVID WILLIAMS: That's correct.

17 JOHN CALLAGHAN: So where does one find  
18 your duties as the Chief Medical Officer of Health?

19 DR. DAVID WILLIAMS: There is a  
20 historical job description that they share with  
21 that, yes, that lays out what the Chief Medical  
22 Officer of Health is, so that is in that job  
23 description. The ADM one is a different one.

24 JOHN CALLAGHAN: So what is the job  
25 description of the Chief Medical Officer of Health

1 in your view?

2 DR. DAVID WILLIAMS: So the job  
3 description of the Chief Medical Officer of Health  
4 is to be the physician lead for Public Health in  
5 the Province of Ontario, to look at and advise the  
6 government and to work in collaboration with the  
7 field in there, and that is what is different in  
8 Ontario.

9 I don't direct the Local Medical  
10 Officer of Health. The HPPA lays that out because  
11 you have to look at the structure and historically  
12 how it has evolved over time.

13 So the Chief Medical Officer of Health  
14 sits with the Ministry and gives advice on Public  
15 Health issues. As you can see, it has evolved, and  
16 they have added and modified the HPPA over  
17 different years -- Health Protection and Promotion  
18 Act, over different years to increase some of the  
19 responsibilities, some of the powers of the Chief  
20 Medical Officer of Health that, when back in SARS,  
21 the Chief Medical Officer of Health, while being  
22 advisory and being advisory to the government and  
23 to speak to the government, did not have a lot of  
24 select powers on his or her own self. And  
25 therefore, Dr. Basrur was trying to change that to

1 put some more independence and powers in there, as  
2 later, on under Dr. Arlene King's time, made some  
3 more changes and amendments with sections that you  
4 will probably ask me about later on.

5 JOHN CALLAGHAN: Right.

6 DR. DAVID WILLIAMS: So there was a  
7 move to say how does one increase some power and  
8 authority of the Chief Medical Officer of Health,  
9 at the same time not to compromise the role of the  
10 autonomy and independence of Local Medical Officers  
11 of Health and their boards of health.

12 So there is this real balance in  
13 Ontario that you don't see in other jurisdictions.

14 JOHN CALLAGHAN: Do you have any  
15 overarching responsibility to coordinate Local  
16 Medical Officers of Health?

17 DR. DAVID WILLIAMS: In the Chief  
18 Medical Officer of Health, per se, you are to give  
19 leadership and giving some advice and direction and  
20 to try and -- and to work with that, to be in a  
21 way -- more leadership is really required to bring  
22 that forward, to talk and discuss and to help them  
23 if they want to have some issues and deal with  
24 that.

25 As the ADM, then I have their budget

1 issues, and they may be asking for funding issues  
2 and staffing resources to assist them in their  
3 duties and responsibilities on a one-on-one basis.  
4 They submit their budgets to my office on an annual  
5 basis, their annual plans, their reports of how  
6 they are doing with regards to the Ontario Public  
7 Health standards, which is a reg attached to the  
8 HPPA that lays out all the duties and  
9 responsibilities that the province expects the  
10 Local Medical Officer of Health in his or her  
11 leadership, more specifically under a Board of  
12 Health, to deliver in their respective  
13 jurisdictions.

14 So there is a lot of interface with  
15 them on an administration side, as well as being  
16 there in your seniority to give advice and to  
17 assist, especially some of the newer ones, on how  
18 they might -- there might comes time they call for  
19 advice and direction.

20 I'm also in a sense auditing. You  
21 know, are things going okay. If I'm made aware  
22 there is a health unit having a difficulty or a  
23 problem, I would talk to the Medical Officer of  
24 Health or the Board of Health, and sometimes in the  
25 past, the Chief Medical Officers of Health have had

1 to -- rarely -- intervene and to ask for changes or  
2 to -- sometimes to take over and -- control and  
3 put, like, an administrator in, which we did once  
4 in the past, and to take over a health unit while  
5 we -- because there was concerns about the public  
6 being put at risk due to a lack of quality  
7 performance in the Board and the Medical Officer of  
8 Health.

9 So that is one of the responsibilities,  
10 is to assess that, and then if there is a need, to  
11 step in and to look at solutions.

12 JOHN CALLAGHAN: So let me just break  
13 that down for a second just to make sure I  
14 understand it.

15 So by and large is your role generally  
16 advisory to the Local Medical Officers of Health?

17 DR. DAVID WILLIAMS: Yes.

18 JOHN CALLAGHAN: Is that what I am to  
19 understand?

20 DR. DAVID WILLIAMS: Right.

21 JOHN CALLAGHAN: And in a separate role  
22 as the Assistant Deputy Minister, you approve their  
23 budgets?

24 DR. DAVID WILLIAMS: Correct.

25 JOHN CALLAGHAN: And the budgets are

1 predicated on whatever the cost-sharing mechanism  
2 exists with the province at the time because --

3 DR. DAVID WILLIAMS: Correct. And  
4 hundred percent funded programs.

5 JOHN CALLAGHAN: So is it your role as  
6 an ADM because it has been assigned to you by the  
7 Deputy Minister, or is it your role as an ADM  
8 because legislation requires you to have an input  
9 into the budgets of Local Medical Officers of  
10 Health and --

11 DR. DAVID WILLIAMS: I think it is the  
12 former. You faded away there. I think it is the  
13 former, is as the -- is part of the -- as the ADM  
14 responsible for the Population and Public Health  
15 Division, which has the budgets of both the -- all  
16 the 34, at the moment, Boards of Health in the  
17 Province of Ontario and also Public Health Ontario  
18 and the Public Health laboratory system.

19 JOHN CALLAGHAN: So at the moment, if  
20 the government chose, they could put in anybody in  
21 that role and someone who isn't obviously, like the  
22 Chief Medical Officer of Health, trained in public  
23 health; correct?

24 DR. DAVID WILLIAMS: They could put an  
25 ADM to do the administration and the fiscal

1 management, which they did when I was -- when I was  
2 Acting back in 2006/'07 to '09, there was an ADM  
3 working, I would say, in a matrix relationship with  
4 me. So we both gave leadership. She was more  
5 in -- I would say handling the administration and  
6 the government processes, you know, with briefing  
7 notes and documents and materials going to getting  
8 things ready, and we would generally in pairs go to  
9 various Cabinet committees to present and put  
10 budgets forward.

11 Then that was changed back when, to the  
12 next CMOH, where that Dr. King wanted to have much  
13 more of a leadership, and she was assisted by an  
14 Executive Director.

15 And then after, when she left, then  
16 there was an Acting CMOH, but they were assisted by  
17 Acting ADMs to carry that out, because some people  
18 coming in from the field, some are not that steeped  
19 in government systems, because after all that  
20 training you are doing as a medical person, do you  
21 know how government works? Like a lot of ADMs take  
22 a number of years to get equipped and up and ready  
23 working through the process to be able to know the  
24 systems well enough, and so it does take that time  
25 to do that.



1                   And so you can see it is -- we can  
2 choose to change it. So it doesn't say that the  
3 CMOH has to be the administrative lead of the  
4 Population and Public Health Division. That is not  
5 part of what the HPPA says.

6                   JOHN CALLAGHAN: Should he be?

7                   DR. DAVID WILLIAMS: As the Chief  
8 Medical Officer of Health --

9                   JOHN CALLAGHAN: No, I'm asking you as  
10 a matter of opinion. Having been in the role,  
11 should he be?

12                  DR. DAVID WILLIAMS: Well, I think  
13 there is great value added in there. At the same  
14 time, I can understand if there is a person coming  
15 in who doesn't -- hasn't worked in government, in  
16 Ministry structures with eight to ten years, would  
17 be greatly assisted by a steeped government expert  
18 who understands that and could give advice and  
19 direction either working under as an Executive  
20 Director or working in matrix as an ADM in  
21 partnership.

22                  And I have done different ones in  
23 different areas, and I have done it now, and having  
24 a good team of directors and empower them to do a  
25 lot of work in there.

1                   So there is various ways it does work,  
2 but it is not laid out in the legislation that the  
3 Chief Medical Officer of Health has to be the ADM.

4                   JOHN CALLAGHAN: And as I say, I am  
5 going to be asking you for your personal opinion  
6 given certainly your expertise.

7                   So we have heard obviously that there  
8 are different models between Public Health Units  
9 and Local Medical Officers of Health, and some are  
10 largely controlled by local municipal councils.  
11 And is there, in your view, a model that is better  
12 or more improved for the delivery of local services  
13 between a Public Health Unit and a Local Medical  
14 Officer of Health?

15                  DR. DAVID WILLIAMS: So this has been a  
16 long discussion all the time I have been in Public  
17 Health Ontario, because you are right, we have  
18 about four models.

19                  It is the only place in the country  
20 that has municipal-led Public Health, and it is  
21 under the different municipal structures as they  
22 sit in Ontario. So you have large ones, like the  
23 City of Toronto, which is unique in itself. You  
24 have upper tier municipal structures, such as  
25 regional ones, like York and Peel, where there is a

1 Commissioner.

2 And in those two, the CMOH -- or the  
3 MOH sits as a Commissioner or as a senior staff  
4 level. They may report to another Commissioner, so  
5 they are embedded in various organizational  
6 structures. The Board of Health then tends to be a  
7 subcommittee of the council with sometimes  
8 community members participating.

9 Then you have county government  
10 structures that have a combination of the two, and  
11 then we have a large number of the smaller ones,  
12 are autonomous Boards of Health that is made up  
13 of -- usually by regulation, different members of  
14 the municipalities that do it in rotation over a  
15 four-year period that sit on the Board of Health  
16 with provincial appointees as laid down in  
17 legislation, as well as with municipal  
18 representatives in there, and that that Board is  
19 responsible for the funding, the total costs of  
20 running it, the whole budget, as the Chief Medical  
21 Officer Health, searching for a Medical Officer of  
22 Health, getting the official appointment for the  
23 Medical Officer of Health, and associates if they  
24 have them. And then you report to that Board of  
25 Health as that. You may report as the Medical

1 Officer of Health. You may be joined up with a  
2 business administrative office or a CEO, and so you  
3 may have dual reporting to the Board of Health.

4 So some MOHs are CEO and MOH combined  
5 and some are just MOH, as that. They lead the  
6 program side, but they don't deal with the HR, the  
7 financing, and the capital structure and renewal  
8 and all that kind of stuff.

9 So we have these different versions in  
10 the province. There is strengths and weaknesses in  
11 each one in there or when you are part of the  
12 larger municipal and you have got access to a lot  
13 of other resources in there. Now, it may be  
14 readily forthcoming and it may not be, but you are  
15 competing with all these in the largest context.

16 In an autonomous board, then, of  
17 course, you have the autonomy, but you have to do  
18 the whole thing on your own, including things like  
19 legal counsel and different types of supply.

20 So there is a variety in there, and  
21 there is the complexity of the changeover of board  
22 members, and with every election it changes.

23 So there is strengths and weaknesses in  
24 the different four groups.

25 JOHN CALLAGHAN: So we know that in

1 SARS that Justice Campbell recommended more  
2 independence for the Local Medical Officer of  
3 Health. You'll remember that. And we have heard  
4 about these models, and we have had some people  
5 speak to us that some of these models do not  
6 facilitate the independence of the Local Medical  
7 Officer of Health. Do you have a view as to  
8 whether that is so or not?

9 DR. DAVID WILLIAMS: I think all the  
10 models in Ontario -- and you have seen it. The  
11 Medical Officer of Health has a level of autonomy.  
12 Certainly I don't direct them. They are under  
13 their board. And how they work within the  
14 different -- the municipal government structures, I  
15 think for the most part, because of their expertise  
16 and knowledge -- and as you were aware, we are  
17 under review of the modernization of the Public  
18 Health system, and even after SARS, we did a number  
19 of reviews, including the Operation Health  
20 Protection and Capacity Review Program, looking at  
21 how we might look at those issues that you are  
22 alluding to.

23 And I think while we have a variation  
24 across there, I find most of the Medical Officers  
25 of Health have a certain level of autonomy, but at

1 the same time, you have an accountability, and you  
2 have a responsibility. You have a reportability.  
3 Because as a Medical Officer of Health, you are  
4 always asking at times for resources, and those can  
5 be funded through municipal dollars or seeking  
6 funding from the province on budget-wise,  
7 et cetera.

8 So independence is one thing, that you  
9 have an independence to make your opinion and your  
10 thing made known to report to a board without  
11 encumbrance. At the same time, you are asking the  
12 board for resources and information and material,  
13 including if you are in upper tier structures,  
14 maybe other parts of the regional and larger  
15 municipal structures, to seek resources from that  
16 group to assist you, and then you are going up and  
17 submitting to the province, of course, for  
18 resources in there to carry out your duties and  
19 responsibilities and deliver all the programs and  
20 service requirements of the regulation, which is  
21 the Ontario Public Health standards.

22 JOHN CALLAGHAN: So the Local Medical  
23 Officer of Health has powers under section 22 and  
24 29, is that right, under the HPP A?

25 DR. DAVID WILLIAMS: Well, there is a

1 whole section on basically the job description of a  
2 Medical Officer of Health. So it is more than just  
3 those. Those are some of the powers they have, but  
4 they have a whole list of duties and  
5 responsibilities, including those are there to  
6 deliver the Ontario Public Health standards. There  
7 are Public Health Inspectors and different staff.  
8 So as a Local Medical Officer of Health, you have a  
9 wide range of things that you are responsible for,  
10 but you do have some legal tools to use if you need  
11 to use them, if you need to use them and when you  
12 need to use them.

13 JOHN CALLAGHAN: And you have those  
14 same powers; correct?

15 DR. DAVID WILLIAMS: Up until recently,  
16 I didn't as the Chief Medical Officer of Health,  
17 but I have under -- now you have seen 77.1 where at  
18 times I can have -- and they felt there was a need  
19 at some times when a Chief Medical Officer of  
20 Health -- during SARS I had to coach the Chief  
21 Medical Officer of Health that when at that time he  
22 wanted to take some action at the local level, that  
23 he had no power to do so, and he found that pretty  
24 surprising. But I said that you have to go through  
25 the Local Medical Officer of Health because, as the

1 Chief Medical Officer of Health, you have no power  
2 and authority at the local level to undertake that.

3 So there was some -- through the  
4 process, the years later, they did put that in  
5 there, that when there is a need and a trigger for  
6 that, the Chief Medical Officer of Health could  
7 undertake to have some of the same powers and  
8 authority as a Local, and to issue a 22 Order, if  
9 you may.

10 JOHN CALLAGHAN: Or I think we have  
11 seen that in some jurisdictions they called -- and  
12 we'll talk about this later, they called upon  
13 hospitals to go into long-term care homes under the  
14 power of 29.2; you are familiar with that?

15 DR. DAVID WILLIAMS: Correct.

16 JOHN CALLAGHAN: And you would have  
17 that same power under the new provision under  
18 section 77; correct?

19 DR. DAVID WILLIAMS: Yes. If there was  
20 a need for it and where the Local Medical Officer  
21 of Health was not able to acquire that.

22 JOHN CALLAGHAN: And the other role you  
23 have is you have a role as it relates to Public  
24 Health Ontario. Can you tell us about what your  
25 role is with respect to Public Health Ontario?



1 DR. DAVID WILLIAMS: So the role with  
2 Public Health Ontario, going back in the  
3 development of Public Health Ontario, we were  
4 looking at as an agency -- because at that time  
5 there was a need to have a scientific advisor to  
6 the government and to the Chief Medical Officer of  
7 Health. As in SARS, we had a scientific table, if  
8 you may.

9 And one of the things we did is a --  
10 before we formed PHO -- it was the Ontario Agency  
11 for Health Protection and Promotion under its old  
12 title -- there was the Provincial Infectious  
13 Disease Advisory Committee. And as a result then,  
14 I was the first Chair of the Provincial Infectious  
15 Disease Advisory Committee, but then I quickly  
16 recruited a Co-Chair in Dr. Dick Zoutman that would  
17 emulate the Science Table that was there during  
18 SARS, and then we formed a number of subcommittees  
19 in there in a way starting to prepare for the  
20 creation of a Public Health agency.

21 And then through time, the Public  
22 Health agency was put together, and I was on some  
23 of the committees that were dealing with all the  
24 discussion, what should it be structured like, how  
25 should it work, how should it interface with the

1 government, how should it connect to the Public  
2 Health division as it was called at the time, and  
3 the Chief Medical Officer of Health, and we wanted  
4 to have very much a collegial relationship rather  
5 than a more typical government agency, one at a  
6 distance, arm's length totally, but allowing the  
7 agency to have autonomy at the same time to give  
8 its advice as openly as they felt was necessary.

9 And one of the conduits was that -- is  
10 through the Chief Medical Officer of Health and  
11 through our various joint liaison committees we had  
12 with them, and also I was a member of the Strategic  
13 Planning Committee. That is one of the things that  
14 is laid out in the Act, and I have and continue to  
15 meet on that, that lays out the general planning.

16 And then I'm an ex-officio member at  
17 the board meetings -- all the board meetings of the  
18 Public Health Ontario in that, which includes --  
19 has, of course, reporting to it, as we merged it in  
20 2007, the Public Health Laboratory System into the  
21 Ontario Agency for Health Protection and Promotion  
22 that became known as Public Health Ontario.

23 JOHN CALLAGHAN: Let's just break that  
24 down. So do you have any operational role at  
25 Public Health Ontario?

1 DR. DAVID WILLIAMS: As the ADM, we  
2 receive their business case. We approve their  
3 budget and their annual plans and then take that up  
4 and direct -- submit that to various Cabinet  
5 committees for approval.

6 JOHN CALLAGHAN: And what about with  
7 respect to the detail of it? Do you have any  
8 operational responsibility for the labs?

9 DR. DAVID WILLIAMS: The operational  
10 responsibility for the labs would come up through  
11 the reports from Public Health Ontario through  
12 their administration and management and their CEO,  
13 with part of their annual business plan that they  
14 would submit, including budgeting for the Public  
15 Health laboratories, capital projects, et cetera,  
16 that we would take through -- through my director  
17 of finance here, up and then through to our senior  
18 level table. This is an ADM function now, that I  
19 would take it up there for approvals and then if we  
20 had to submit to Treasury Board, to Cabinet and  
21 committees, et cetera, to get that approved in a  
22 regular process on an annual basis in different  
23 timelines.

24 And urgent one-time requests as well.

25 JOHN CALLAGHAN: And so that would

1 include infection and protection --

2 COMMISSION CHAIR FRANK MARROCCO:  
3 Mr. Callaghan, you are breaking up.

4 JOHN CALLAGHAN: Would that include  
5 IPAC as well, the IPAC division? You wouldn't have  
6 any operational responsibility other than reviewing  
7 documents coming out of that area?

8 DR. DAVID WILLIAMS: So do you mean  
9 under the director that was with Dr. Deeks  
10 recently, would have under that -- there was a  
11 sub-director that had infection prevention and  
12 control.

13 JOHN CALLAGHAN: Right. That is  
14 relatively new.

15 DR. DAVID WILLIAMS: That is relatively  
16 new. A lot of the infection prevention and control  
17 policies and directions came out of the Provincial  
18 Infectious Disease Advisory Committee.

19 JOHN CALLAGHAN: Right, but from an  
20 operational perspective, am I to understand that  
21 you have no --

22 DR. DAVID WILLIAMS: That, of course,  
23 was part of the business plan.

24 JOHN CALLAGHAN: Right. So we heard  
25 that Public Health Ontario's budget was flat for

1 five years, and then in 2019, it was to be cut,  
2 which was stopped, but would you have been part of  
3 the group that recommended that?

4 DR. DAVID WILLIAMS: We were given  
5 targets by the government from the Finance  
6 Committee and from Treasury Board of budget levels  
7 that we were required to come into control of and  
8 to have dialogues and discussions of how we  
9 could -- because the -- especially the  
10 newly-elected government was dealing with very much  
11 concerns of fiscal constraint and wanted to see, I  
12 guess, in a sense, a belt tightening and a  
13 sharpening of the pencils, and what kind of budget  
14 limitations and how we would do that in ways of  
15 looking at efficiencies, and we had discussions  
16 with Public Health Ontario in that regard.

17 JOHN CALLAGHAN: So you are probably  
18 aware that in their business plan they talk about  
19 the numbers of lost full-time equivalents, and we  
20 heard that 12 of 24 senior managers changed over in  
21 the last year, and did you at any time provide any  
22 advice as to whether or not the services of Public  
23 Health Ontario would be compromised in any way as a  
24 result of --

25 DR. DAVID WILLIAMS: Sorry, there was

1 noise there. I would be advised under their  
2 planning from the CEO of what they were  
3 endeavouring to do, and I would ask, of course, is  
4 that going to compromise at all in the quality of  
5 services and that, and I was reassured by the CEO  
6 that it wouldn't.

7 And so that was under the planning of  
8 their CEO and their board to make that decision.

9 JOHN CALLAGHAN: But as the Chief  
10 Medical Officer of Health for the province -- and  
11 we can go back to the SARS report that indicated  
12 the importance of having this arm's length  
13 independent agency, do you have any duty as the  
14 Chief Medical Officer of Health to speak up if it  
15 is going to compromise the health situation of the  
16 Province of Ontario through these cuts?

17 DR. DAVID WILLIAMS: I would -- both  
18 from my CMOH job and ADM, if I felt there was going  
19 to be a compromise in the delivery of critical  
20 services, we would advocate to have those dealt  
21 with and to make sure it was put in place,  
22 including our directions around laboratory services  
23 and advocating for capital, building, and renewal.

24 JOHN CALLAGHAN: So did you advocate  
25 for that?

1 DR. DAVID WILLIAMS: Yes.

2 JOHN CALLAGHAN: And so did you  
3 advocate against the cuts?

4 DR. DAVID WILLIAMS: The cuts that I  
5 thought were a concern that were raised to me by  
6 the CEO of the board, where I felt it was  
7 necessary, I would put those and advocate that we  
8 should limit those and to keep those in place.

9 JOHN CALLAGHAN: So what were those  
10 cuts that you were concerned about?

11 DR. DAVID WILLIAMS: Well, the number  
12 of laboratories, if we are going to reduce the  
13 number of laboratories, I wanted to make sure that  
14 we were ensuring that the number of laboratory cuts  
15 did not compromise the quality of the services in  
16 there, especially with the new modernization of  
17 equipment and the technological systems.

18 So I was apprised of that by their CEO.  
19 I wanted to make sure that we were advocating for a  
20 reasonable distribution of those throughout Ontario  
21 so that they wouldn't cut some of the more rural  
22 ones and compromise, because in a province the size  
23 of Ontario, the distance becomes a huge issue, and  
24 to make sure that was provided for in that.

25 And of course, I was always concerned

1 about surveillance staff, to make sure there was  
2 enough there to carry out all the data collection,  
3 as well as producing of reports in a timely fashion  
4 so that that was not compromised at all in that.

5 JOHN CALLAGHAN: So you are aware that  
6 there was concerns expressed. We have heard  
7 concerns expressed about the timeliness of lab  
8 results. We have been told about the delay in --  
9 taking to ramp up capacity. Were you concerned  
10 about those things in 2019, and did you express any  
11 view about those issues?

12 DR. DAVID WILLIAMS: In 2019, our  
13 regular laboratory services, with our lab that had  
14 moved into the MaRS Building, was one of the  
15 cutting edge ones, and I had worked very much  
16 before, during listeriosis and different things,  
17 with Dr. Vanessa Allen and having access to the  
18 high quality medical microbiologists, including  
19 genetic sequencing individuals, was great, was a  
20 great asset, and how to work with that.

21 So they had looked at a number of the  
22 things they were doing with new technologies and  
23 trying to speed up expeditiously how they would  
24 deal with the volume of testing coming in, and we  
25 were made aware, as we were trying to look at --



1 and I was advocating all the time the difference  
2 between a Public Health laboratory as composed to a  
3 hospital laboratory as compared to a private  
4 laboratory, and what is the difference between the  
5 three.

6 Even when I was a Medical Officer of  
7 Health and the Chair of the Advisory Committee way  
8 back 15, 20 years ago, they said a lab is a lab is  
9 a lab, and I never agreed with that, because a  
10 Public Health laboratory is different functionally  
11 than a hospital laboratory and a private laboratory  
12 and how it works and operates in that sense.

13 So I have always been advocating for  
14 that, and I continue to do so, to make sure that  
15 our laboratory system was maintained and had that  
16 uniqueness and was not going to be merged into a  
17 singular laboratory system.

18 It could be part of a network, that is  
19 true, but I have always strongly advocated that it  
20 has to be somewhat different and funded  
21 differently, because some of the tests that you do  
22 for Public Health laboratory is not -- financially  
23 is not as high volume as other ones. It is unique  
24 testing, and you have to have unique resources and  
25 equipment to do that, like tuberculosis testing and

1 cultures and things like that.

2 So that has always been my advocacy.  
3 That continues to be my advocacy. And it has been  
4 a critical part all the time, of course, coming  
5 from infectious diseases.

6 JOHN CALLAGHAN: So let me ask you,  
7 were you privy to or did you have any involvement  
8 in any planning for pandemics at Public Health  
9 Ontario?

10 DR. DAVID WILLIAMS: In the planning  
11 for pandemics, going way back, we were all part of  
12 the development of the Ontario pandemic planning  
13 documents, reviewing post-SARS, looking at meeting  
14 with our -- because as --

15 JOHN CALLAGHAN: Let me stop you there.  
16 We'll come to that. Let's take you from 2013  
17 forward then. Like actually in the recent past,  
18 because the evidence we have from Mr. Shingler and  
19 others is that there wasn't a great deal of  
20 finalized pandemic planning. We are going to talk  
21 about Ready and Resilient. But I'm asking  
22 specifically in 2018/2019, when the World Health  
23 Organization writes that the world is not ready for  
24 a pandemic, were you involved in any planning at  
25 Public Health Ontario as to its lab capacity?

1 DR. DAVID WILLIAMS: So in -- okay.  
2 We'll we go to 2018/2019. The pandemic planning at  
3 that stage was still -- we were working at our  
4 federal/provincial/territorial meetings at what is  
5 an updated pandemic plan. A lot of focus then was  
6 on the -- because the pandemic plan historically  
7 and up until even 2018/'19, as you'll read in the  
8 plans, was always deemed -- the only one that could  
9 cause a pandemic was influenza A, and that was the  
10 focus, and as a result, then our planning was  
11 around that.

12 And looking at our --

13 JOHN CALLAGHAN: Sorry, I don't want to  
14 stop you, just -- because we are going to get to  
15 that. I'm just asking Public Health Ontario. We  
16 are going to get to the plans. I'm just asking  
17 about Public Health Ontario and your role. So did  
18 you have a role in pandemic planning in the labs at  
19 Public Health Ontario?

20 DR. DAVID WILLIAMS: So the planning in  
21 that was always looking at the rapidity, how  
22 quickly we can do the influenza testing, as well as  
23 the rapid testing, and how we could proliferate and  
24 put that out, so we could do a lot more direct  
25 testing for influenza out in the community dealing

1 with our -- a number of outbreaks every year in  
2 influenza we experienced and how we could ascribe  
3 to that and look at our capacity to -- we were  
4 trying to drive towards could we do even more  
5 influenza testing, per se, and how do we make sure  
6 we can monitor that.

7 So that always was a discussion because  
8 that was part of the basis to say, if you do it on  
9 a seasonal basis, can you ramp up and do even more.  
10 Because during H1N1, as you recall, we had a great  
11 need to expand quickly on our testing, and I  
12 advocated for that, and we did that.

13 So again, we were having discussions on  
14 how we would increase quickly our capacity to do  
15 influenza testing in the presence of -- if a  
16 pandemic came so we could really ramp that up  
17 quickly.

18 JOHN CALLAGHAN: And were you aware of  
19 an actual plan?

20 COMMISSION CHAIR FRANK MARROCCO:  
21 Mr. Callaghan, you are breaking up from time to  
22 time.

23 JOHN CALLAGHAN: I will try to get  
24 closer.

25 DR. DAVID WILLIAMS: Yes.

1                   JOHN CALLAGHAN: So again, I come back  
2 to it. Like I hear you talk about discussions, but  
3 was there a plan, to your knowledge, to get --

4                   DR. DAVID WILLIAMS: Not any definitive  
5 revised plan on that. There was discussions at the  
6 PHO because PHO, some of the scientists were  
7 members on national committees looking at the  
8 Canadian pandemic influenza plan and looking at  
9 revisions to parts and sections of that as is going  
10 forward. There was individuals -- even experts  
11 saying at that time, I think by doing this, you are  
12 wasting your time because there is not going to be  
13 a pandemic, so it doesn't exist anymore.

14                  JOHN CALLAGHAN: Well, that certainly  
15 wasn't the advice of the World Health Organization  
16 or John Hopkins in 2019 when they told the world --

17                  DR. DAVID WILLIAMS: I didn't agree  
18 with that either, so I took flak for saying I still  
19 think we have to plan that way, but I was  
20 criticized by some experts saying I think you are  
21 spending a lot of time on something that will never  
22 occur, and I said, I can't agree with that. I  
23 think we still have to be planning for that.

24                  JOHN CALLAGHAN: But what about --

25                  COMMISSION CHAIR FRANK MARROCCO: Can I

1 just interrupt for a second.

2 Doctor, when Ebola scare occurred, did  
3 it occur -- did the discussions -- was there  
4 discussions around whether it was sufficient to  
5 simply be planning for influenza?

6 DR. DAVID WILLIAMS: It was known that  
7 Ebola was not a pandemic, but Ebola challenged us  
8 to say -- and this is what we were mostly working  
9 on in that era of 2013 to 2018/'19, that with the  
10 global mobilization of people and these infectious  
11 diseases that seem to be artifacts out in remote  
12 countries that would never impact you, it became  
13 very clear they could be on your doorstep within 12  
14 hours, and you could not assume that you had a long  
15 lead time to gradually get ready for it.

16 So Ebola brought that really to focus  
17 to say you could have Ebola cases arrive in your  
18 country in a very short order. Now, that may not  
19 be a pandemic. Nevertheless, it will be something  
20 you should be prepared to deal with.

21 And so that was a --

22 COMMISSION CHAIR FRANK MARROCCO:

23 Sorry, I didn't mean to interrupt.

24 DR. DAVID WILLIAMS: That is okay.

25 COMMISSION CHAIR FRANK MARROCCO: No.

1 Did you want to finish.

2 DR. DAVID WILLIAMS: I was just saying  
3 the focus was whether it is Ebola or other  
4 infectious diseases that could still impact your  
5 health system and your health care system, you  
6 needed to be, in the terms of Mr. Shingler, Ready  
7 and Resilient to respond to infectious disease  
8 issues, not just say focus on pandemic planning and  
9 forget the others. You need to do all of them.

10 JOHN CALLAGHAN: And not only that you  
11 need to do all of them, but that the risks can come  
12 from other than influenza?

13 DR. DAVID WILLIAMS: Oh, correct, and  
14 even though an influenza could be a pandemic, it  
15 doesn't mean to say, well, let's not worry about  
16 Ebola. You have to worry about Ebola. You have to  
17 worry about MERS. It could come. You have to  
18 worry about other infectious diseases, like  
19 Chikungunya. I'm not going to name a whole bunch.  
20 How are you going to handle these? Because you  
21 don't know how they are going to impact because  
22 there is so much global mobility now, especially  
23 for Ontario, where we are an international  
24 community and we have so much movement in and out.  
25 You have to be prepared that what may seem in some

1 isolated area, in a remote part of a country, could  
2 be presenting in your hospital in a very short  
3 order.

4 COMMISSION CHAIR FRANK MARROCCO: And  
5 if people think about that, then it would occur to  
6 them that with respect to any highly infectious  
7 disease, it can be at your doorstep within a matter  
8 of hours.

9 DR. DAVID WILLIAMS: Correct. And you  
10 have to assess, does it have the dynamics to be a  
11 pandemic; yes or no? And because we are getting  
12 alerts every month of new strains in countries that  
13 are perceived could be, and you have to look at  
14 those, and you work with your federal counterparts  
15 and WHO to say, Is this one moving? Is this one  
16 changing?

17 And because the mutations are always  
18 happening, and which ones are you going to prepare  
19 up for, and when is it going to present in your  
20 jurisdiction, because it can come fairly quickly.

21 COMMISSION CHAIR FRANK MARROCCO: Did  
22 these types of considerations affect discussions  
23 around lab capacity?

24 DR. DAVID WILLIAMS: Yes. Do you have  
25 the capacity to test for it? When we dealt with



1 some new ones from -- with Zika virus. Do you  
2 remember that? And do we have the testing for it?  
3 We had to get the testing. Is it going to be  
4 certified? How are we going to -- what is the  
5 quality of the testing? When we have a case, how  
6 can we advise? And then what is the method to  
7 inform people, and who is at risk and who is not at  
8 risk.

9 So that was a new one. We didn't have  
10 that. And then we have Chikungunya, and we had  
11 other ones like dengue, and how well are we  
12 equipped to deal with those ones. How up to date  
13 are they? Listeriosis and with Legionellosis, and  
14 all these infectious disease issues that to me are  
15 always of great concern, and you have to watch and  
16 monitor, and how is your laboratory system dealing  
17 with that? Is it current, avant-garde, and asking  
18 your experts, like your medical microbiologists,  
19 how are we doing? How do we compare to other labs?  
20 How do we compare to the national medical  
21 laboratory system? So what should we have in  
22 place?

23 So it is always a dialogue.

24 COMMISSION CHAIR FRANK MARROCCO: Apart  
25 from it being a question of whether you can test,

1 there is also a question of capacity, because if it  
2 is highly infectious, you could be doing quite a  
3 lot of testing.

4 DR. DAVID WILLIAMS: If it is highly  
5 communicable, yes.

6 COMMISSION CHAIR FRANK MARROCCO: Yes,  
7 communicable.

8 DR. DAVID WILLIAMS: Correct.

9 COMMISSION CHAIR FRANK MARROCCO: Those  
10 were considerations at the time?

11 DR. DAVID WILLIAMS: Well, we know we  
12 had to always try and build up to a surge capacity,  
13 because if you built the capacity for everything on  
14 every possibility every time, you would be wasting  
15 a lot of resources.

16 So you had to make sure, could you  
17 surge up? And that is where you have your  
18 satellite laboratories, and our network, as we did  
19 with H1N1, could you quickly access, because one of  
20 the strengths of Ontario is that we have a lot of  
21 tertiary care health centres, world leaders, and  
22 their laboratory systems are high quality. And  
23 they do a lot of stuff also.

24 So you have these potential partners  
25 that you need to always have a relationship with

1 that you could -- they get advice from them because  
2 they have experts as well. So all the infectious  
3 disease expertise is not only in PHO, but  
4 population base is more their focus.

5 So this is one of the luxuries we have  
6 in Ontario. We have a lot of these high-quality  
7 centres that you bring into your committees and  
8 stuff to discuss, and they can surge up as well.  
9 So you don't have to do it on your own, but you  
10 have to allow for that time to build that up, as we  
11 did with H1N1, and we did later now with COVID,  
12 with coronavirus.

13 COMMISSION CHAIR FRANK MARROCCO: But  
14 we have certainly heard from many people about the  
15 delays in getting test results, sometimes five,  
16 six, seven days after the test was taken.

17 Did you think that the surge capacity  
18 wasn't accessed as quickly as it should have been  
19 as far as testing results, especially in long-term  
20 care home testing results was concerned -- were  
21 concerned?

22 DR. DAVID WILLIAMS: Well, it is a  
23 good -- it was really a very important part all the  
24 way through. When we -- I mean, this is why it was  
25 so amazingly different to me from SARS. We went

1 through most of SARS without a lab test. We didn't  
2 know what the organism was, and when we finally got  
3 the test, a lot of the people who were diagnosed  
4 with SARS, 50 percent of them were negative, and we  
5 had some people outside in the rural areas that had  
6 more positivity but didn't have symptoms of SARS.

7 So the testing was really a challenge.  
8 We had to work just on case definitions, is what we  
9 do anyways.

10 When we started on this one, within  
11 three weeks -- or within two weeks, they had gene  
12 sequencing being done at our lab. That was never  
13 even thought of back in SARS. And we then  
14 developed the early stages of a polymerase chain  
15 reaction testing through our laboratory here in  
16 Ontario, in Toronto, and they were working in  
17 tandem, in partnership with the National Medical  
18 Laboratory system. Those resources were not there.

19 To have the sequencing done within  
20 three weeks and to have a PCR developed at least as  
21 a pilot was unknown of, and the question is, is it  
22 a good test? Will it work? How good is it? How  
23 reliable is it? All to be determined.

24 And so -- and the fact we had that, and  
25 the first time, all the way through February, was

1 getting the tests doubled up with NML -- sorry,  
2 National Medical Laboratory, how well was our test  
3 doing compared to their test. Were they the same  
4 level of sensitivity, specificity, because this is  
5 all pioneering. This is all new things coming  
6 forward.

7           When you are dealing with cases  
8 initially, with infectious disease cases, you  
9 develop a case definition. Not on your own. You  
10 work with your national counterparts, and you agree  
11 what makes up a case definition. And then if you  
12 get laboratory testing, it is part of it in there.

13           So once you do that, how much can that  
14 laboratory testing ramp up? When is the testing  
15 used? As always -- because you can overwhelm the  
16 system in any moment, so you got to make sure you  
17 are judicious in the use of your testing, because  
18 besides ramping up, you need not only experts in  
19 it, you need staffing. You need equipment and  
20 machinery. You need reagents. And then you need  
21 the sampling equipment and that.

22           So the testing is one thing. But the  
23 test is not just the lab testing. It is going out  
24 and getting the samples, sending them in, make sure  
25 you document them and record them and then do that.

1                   So all the way along, as in H1N1, I  
2 would like more testing all the time sooner and  
3 sooner, but there are realities that you have to  
4 work within -- in that because you do not want to  
5 compromise the quality of your testing so that you  
6 end up with having false results, lost results, in  
7 test results that have no explanation of their  
8 quality. You don't want to go there.

9                   So as you are ramping up, you want to  
10 make sure you maintain the quality all the way  
11 through. So when we were ramping up with the  
12 network of other hospitals, every time we brought a  
13 new one on board, a good portion of our lab testing  
14 was -- the central one was repeating all the  
15 testing they were doing at the local one back and  
16 forth until we did the QA until we could certify  
17 that that one came on board.

18                  So each lab that came on slowed us down  
19 on the volume we could do for the pretense of doing  
20 more future testing.

21                  COMMISSION CHAIR FRANK MARROCCO: And I  
22 take it that this concern about overwhelming the  
23 labs would affect -- I wouldn't say I take it. Did  
24 it affect your approach to whether you test  
25 symptomatic or asymptomatic individuals?

1 DR. DAVID WILLIAMS: In the first wave,  
2 as we sat down with our international people and  
3 with Health Canada, it was very clear that only  
4 symptomatic people need to be tested, and the  
5 symptoms we started with, the triad of the fever,  
6 cough, and shortness of breath, and a travel  
7 history, because the travel history was paramount  
8 as part of the case definition. Testing people  
9 outside of that was not deemed to be necessary or  
10 valuable.

11 And then we added some more symptoms  
12 over time. They were added to the list to be  
13 involved in that.

14 In the first wave, it was very much the  
15 sense of the National Committee, that if you had  
16 individuals who had a travel history or contact of  
17 a person with a travel history that had any of the  
18 three symptoms, and they were having no  
19 complications, one, you should call them an  
20 epi-link case, and you didn't need to test them,  
21 and so that was very strongly said because you  
22 needed to keep your testing for diagnostic purposes  
23 for complicated cases, for hospitalization and  
24 treatment.

25 COMMISSION CHAIR FRANK MARROCCO: And

1 was that your view as well?

2 DR. DAVID WILLIAMS: That was the view,  
3 to work in partnership with all the rest. That was  
4 the science we had at the time that said that was  
5 important. Asymptomatic transmission was not at  
6 all supported by the scientists in there because  
7 the evidence wasn't there for that.

8 And so we were advised by many tables,  
9 and including at our Special Advisory Committee  
10 with the federal/provincial/territorial committee,  
11 that the Technical Advisory Committee, which is  
12 made up of lots of experts, they had been reviewing  
13 all the data and information and did not advise us  
14 differently.

15 COMMISSION CHAIR FRANK MARROCCO: And  
16 so the decision to test asymptomatic people would  
17 be a very significant decision to take.

18 DR. DAVID WILLIAMS: Yes.

19 COMMISSION CHAIR FRANK MARROCCO: One  
20 would have to be quite deliberate before you made  
21 that decision because you could overwhelm your lab  
22 capacity by doing that.

23 DR. DAVID WILLIAMS: Easily.

24 COMMISSION CHAIR FRANK MARROCCO: Is  
25 that correct?



1 DR. DAVID WILLIAMS: Very easily.

2 Because if you are doing asymptomatic with no signs  
3 or symptoms and no history, that means the whole  
4 population, and who do you test and not test, and  
5 then after awhile you can't test the ones you  
6 really need to test that may be imperative for them  
7 to do hospital admission, ongoing to ICU admission,  
8 and care and therapy, because your specialists are  
9 looking for that definitive diagnosis. That is  
10 critical.

11 And then you are going to advise people  
12 when to quarantine and take action accordingly. So  
13 you have to be confident that the ones you are  
14 making a decision on, you are sure that you have  
15 the information and material you need, and in a  
16 timely way. It is no good doing a whole bunch of  
17 tests. And some countries, I understand,  
18 internationally, some accept the loss. If you lose  
19 10 to 20 percent of the samples, that is okay.  
20 That is not okay. If you are going to test people,  
21 you don't want a loss and misplaced samples, and  
22 you can't report back to people.

23 One of the things we found in SARS is  
24 you have to have an integrity of the system, that  
25 if you are going to do it, what you do, do well,

1 document well and report back well. And the  
2 turn-around time was very important. To do a test  
3 and say, well, we'll get the result three weeks  
4 from now, it is too late.

5 And you want to make sure on those  
6 critical core ones, the ones you really need to  
7 have the turn-around time and the diagnostics,  
8 maintain that, keep that, because it is going to  
9 have great implications on what you might want to  
10 decide on.

11 But to throw it wide open, then you  
12 start to lose the integrity of the system. You  
13 overwhelm it because there was a global competition  
14 for a number of parts of the testing system because  
15 you are not the only one involved in it globally,  
16 and you have to work within those limitations and  
17 make sure you keep a core functionality all the  
18 time and make decisions on case definitions, and  
19 who you test and don't test all the time is very  
20 important.

21 COMMISSION CHAIR FRANK MARROCCO:

22 Dr. Kitts, did you raise your hand?

23 COMMISSIONER JACK KITTS: Yes.

24 Dr. Williams, from the time you designated a  
25 hospital lab or private lab or another lab that is

1 not Public Health to start doing testing, how long  
2 did it take until they were fully functional and  
3 operational from the time you designated them?

4 DR. DAVID WILLIAMS: You would have to  
5 ask Dr. Allen that question, who was involved a lot  
6 in doing that. It was usually almost was a period  
7 of over -- anywhere from -- or the first time we  
8 asked them to take on doing it, to acquire the  
9 equipment, the reagents and the staffing and  
10 training, almost like two to three weeks, and then  
11 the QA testing, and it varied. Some were more  
12 quicker than others, but I wouldn't want to give  
13 you an exact figure. That would be coming from  
14 Dr. Allen.

15 COMMISSION CHAIR FRANK MARROCCO: I  
16 think what I will do, Doctor, is maybe we'll  
17 take -- we'll stand down for 5 minutes, 10 minutes,  
18 give everybody a short break, and then come back.

19 DR. DAVID WILLIAMS: Okay. Well, thank  
20 you. So it is 11:21.

21 COMMISSION CHAIR FRANK MARROCCO: So  
22 11:30.

23 DR. DAVID WILLIAMS: 11:30. That  
24 sounds great. Thank you very much.

25 COMMISSION CHAIR FRANK MARROCCO: Yes,

1 you should remember to mute yourself. Otherwise,  
2 everybody can hear you.

3 -- RECESSED AT 11:22 A.M.

4 -- RESUMED AT 11:30 A.M.

5 COMMISSION CHAIR FRANK MARROCCO: Okay.  
6 We are all back.

7 JOHN CALLAGHAN: Doctor, I don't want  
8 to belabour the lab point much more, but I should  
9 tell you that, you know, we have heard evidence  
10 from the hospitals that went in, and they talked  
11 about delays that they thought were unacceptable in  
12 getting test results back, and five days, seven  
13 days, almost all the way through the piece.

14 And they said, if they got in earlier,  
15 people wouldn't have died. People wouldn't have  
16 got COVID.

17 And we also heard from the families of  
18 those homes, who were all very distraught. So that  
19 is why we ask whether the lab capacity was  
20 sufficient, whether it was up and running fast  
21 enough, and what do we tell those people about the  
22 lab capacity? I know you talked about finding the  
23 test. We got that. That was done in February.  
24 But we are talking lab capacity in April, the fall.  
25 So what do we tell those families?

1 DR. DAVID WILLIAMS: So you asked a  
2 question and then you started on about three  
3 different things, hospitals and wanting to go for  
4 treatment, then you went to long-term care, then  
5 you went to families, then you went to -- can you  
6 break it down for me?

7 JOHN CALLAGHAN: Well, it is not  
8 complicated. I'm not talking about hospitals. I'm  
9 talking about hospitals that were called in to save  
10 long-term care homes, were delayed because test  
11 results took five, seven days. They said they  
12 should be back quicker, much quicker, and had they  
13 been back in 24 or 48 hours, they could have saved  
14 lives, lives of family members who this Commission  
15 has heard from, who are distraught that the delay  
16 in getting lab results caused their loved ones to  
17 get COVID and die.

18 So when we ask you these questions, I  
19 recognize there is lots to this, but that is the  
20 base route.

21 So as the Chief Medical Officer of  
22 Health, and whatever your relationship with Public  
23 Health Ontario, what do you tell them about the  
24 delays?

25 DR. DAVID WILLIAMS: So our issue all

1 along is we wanted a turn-around time, working with  
2 Toronto Health, to be less than 48 hours if we  
3 could, maximum 72 hours. So turn-around time has  
4 always been important to us.

5 I think when you are asking a question  
6 like that, there is many parts and components to  
7 it. I would say, while it is -- for people that  
8 have gone through it and with the uncertainty and  
9 wondering what is going on, especially family  
10 members, it was no doubt disconcerting to  
11 understand what is happening.

12 When you are dealing with -- because  
13 you seem to be focussing on long-term care homes.  
14 Right now the question is specifically, right?

15 JOHN CALLAGHAN: That is my job.

16 DR. DAVID WILLIAMS: That is the  
17 mission. That is what we are here for. When we  
18 deal with outbreaks in long-term care homes, which  
19 we do with Public Health all the time, there is  
20 some key parts that are very important there. One  
21 is you determine if you have an outbreak or not.  
22 Once you have a suspicion or a possibility of an  
23 outbreak, you take a number of steps to curtail its  
24 impact. You don't say, well, let's just wait until  
25 we get all the lab tests back to start to do stuff.

1                   So critical in this is the infection  
2 prevention and control practices and what you need  
3 to do to put in place to start to limit the impact  
4 of a respiratory infectious disease in your  
5 institution, which we have in our protocols because  
6 every year we deal with influenza outbreaks in  
7 long-term care facilities.

8                   It does help to have laboratory  
9 testing, but your actions should not wait until all  
10 the laboratory testing is back, and you need to be  
11 taking some steps and action there.

12                  So the laboratory testing is an adjunct  
13 and assists you in assessing how it is going and  
14 assessing how well your steps are taken to try and  
15 limit that and to try and cordon it off and contain  
16 it. So they are very important.

17                  They are initially important to tell do  
18 you have an outbreak? So an initial one of  
19 identifying a case, and an original definition of  
20 two cases, then you have an outbreak definition  
21 under our Public Health standards, and that is very  
22 important, and the turn-around time is very  
23 important.

24                  But that should not cause one to say,  
25 Well, let's just wait and do nothing until you get

1 the laboratory testing. You have to move.

2 JOHN CALLAGHAN: So by now you must be  
3 aware that a large number of the homes in  
4 significant outbreak have been described to have  
5 woefully inadequate IPAC practices. You are aware  
6 of that? Have you followed the evidence in this  
7 Commission that has repeatedly been to the effect  
8 that homes had woeful IPAC practices?

9 DR. DAVID WILLIAMS: Yes, we have been  
10 made aware that when -- even when our Public Health  
11 Units went in, and where they know they had the  
12 documents and materials, when they went in and  
13 identified an outbreak, they would say, A lot of  
14 the things that should have been in place were not  
15 in place, and the staff weren't at an adequate  
16 level of training and knowledge it would take to  
17 implement those.

18 So that was disappointing to in us in  
19 Public Health writ large.

20 JOHN CALLAGHAN: So you could  
21 appreciate there would be a greater reliance on lab  
22 results when these homes were insufficiently  
23 trained in IPAC? And I am not talking about an  
24 institution. I'm talking about specific homes.

25 DR. DAVID WILLIAMS: I think there is a



1     pretense there, if you have a lab test, does that  
2     negate the need of IPAC? I can't agree with that.

3             JOHN CALLAGHAN: I'm not suggesting it  
4     does. I'm suggesting to you, sir, that where the  
5     home hasn't got the first clue about IPAC, the one  
6     way Public Health and the hospitals who were  
7     brought in could understand the scope is by timely  
8     results, and that did not happen and people died.  
9     And I am trying to get from you whether you believe  
10    that the results -- the times of -- the results  
11    provided by labs were timely and whether more could  
12    have been done to prepare the labs so that timely  
13    results came? I'm just trying to get a straight  
14    answer from that question.

15            DR. DAVID WILLIAMS: I think the answer  
16    is that we want a rapid turn-around time. It is  
17    key and important who did the testing in the homes,  
18    who was tested, and as part of the overall IPAC  
19    policy, you have to do your cohorting and all the  
20    other steps.

21            To me, IPAC is the primary importance.  
22    The testing is an adjunct to that. How you use it,  
23    how quickly you get the results back, informs you  
24    of the quality of your infection prevention and  
25    control. To say that you are doing the testing,

1 you then decide if you are going to do IPAC, I  
2 can't agree with that.

3 JOHN CALLAGHAN: I'm not talking about  
4 IPAC as a procedure. I'm talking about people that  
5 actually understand disease control, including the  
6 monitoring, as you describe, and how to act. That  
7 did not happen. What they did is they waited for  
8 test results. Test results were late. People  
9 died. That is what happened on the ground, not  
10 theoretically.

11 You appreciate that that happened?

12 DR. DAVID WILLIAMS: I appreciate that  
13 there was some lab testing. I think different  
14 people coming in were undertaken through the  
15 infection prevention and control practices.

16 Remember, when you get the test result  
17 back -- when you get the test result back, that  
18 means someone has been infected at least seven to  
19 ten days before. It doesn't give you real time.  
20 If you wait until that laboratory test result back  
21 and not looking at signs and symptoms of patients  
22 and monitoring them and dealing with proper  
23 cohorting, proper methods of infection prevention  
24 and control practice, that is not good enough  
25 because the test is time-delayed anyways because

1 the person was already infected by time you get the  
2 test result back.

3 JOHN CALLAGHAN: So your Directive  
4 doesn't come, I don't think, until March 22nd or  
5 March 30th on cohorting. It says that you cohort  
6 the well and the unwell, right? You separate the  
7 well and unwell, that is the wording you use in  
8 your Directive?

9 DR. DAVID WILLIAMS: The Directive was  
10 to ratify what the guidance documents already said.

11 JOHN CALLAGHAN: Right, and you used  
12 the word "well" and "unwell"; do you recall that?

13 DR. DAVID WILLIAMS: Yes, well, and we  
14 defined that -- those that had signs and symptoms  
15 and those who didn't.

16 JOHN CALLAGHAN: And when you  
17 understood there was asymptomatic spread, how does  
18 one cohort?

19 DR. DAVID WILLIAMS: That was the  
20 difficulty. At that time, there was no  
21 asymptomatic spread accepted and approved by our  
22 scientists.

23 JOHN CALLAGHAN: Well, we'll come to  
24 that as to whether it was approved, whether the  
25 precautionary principle would have said you should

1 have done that anyway. But let's talk a little  
2 further about it. On cohorting, did you listen to  
3 the evidence of Mr. Lum from Hong Kong, how they  
4 dealt with things that was before this Commission?  
5 Did you read is that transcript?

6 DR. DAVID WILLIAMS: No. I mean, I  
7 have read it before, during the time, and it was  
8 reviewed by our National Committee on that. So our  
9 cohorting, laid out by our guidance documents and  
10 protocols, is that when --

11 JOHN CALLAGHAN: But I'm not asking you  
12 about that. I'm asking you about Mr. Lum.

13 DR. DAVID WILLIAMS: That is one  
14 scientist giving his input.

15 JOHN CALLAGHAN: No, he is telling you  
16 what happened in Hong Kong. In Hong Kong, they  
17 cohorted those that were positive at the hospital  
18 and those that had been exposed in a different  
19 location in long-term care where they had as many  
20 as 30 to a room, and they had de minimus deaths. I  
21 think they have had 30 in total.

22 Did you ever consider decanting them  
23 into those places where symptomatic people went one  
24 place, those exposed to them went to another, and  
25 you left the remainder in the home? Did you ever

1 do that?

2 DR. DAVID WILLIAMS: Part of the  
3 program was, if you had a patient who was quite  
4 sick, they were usually transferred to a hospital.

5 JOHN CALLAGHAN: No, I didn't ask that.  
6 I asked for a larger program dealing with those who  
7 were exposed because there was knowledge and  
8 expectations of asymptomatic spread at some point  
9 in time, and I don't know of you ever doing that.  
10 I'm asking you whether you considered it.

11 DR. DAVID WILLIAMS: We had discussions  
12 on that if we had the facilities to move them off  
13 into with staffing.

14 JOHN CALLAGHAN: Sorry, you had the  
15 facilities, or you did not have the facilities?

16 DR. DAVID WILLIAMS: We didn't have the  
17 facilities.

18 JOHN CALLAGHAN: So no one made the  
19 facilities available?

20 DR. DAVID WILLIAMS: That was later on  
21 in the discussion that talked about, if you  
22 decanted, and could you go open up new centres, and  
23 when you decant patients, you have to decant the  
24 care with them.

25 JOHN CALLAGHAN: So we have heard about

1 Bruce Power, a private company, putting up field  
2 hospitals. So it is not the facility. Surely we  
3 have the facilities; correct?

4 DR. DAVID WILLIAMS: We have  
5 facilities, but you haven't got the staff.

6 JOHN CALLAGHAN: I see. So it is  
7 staff. So we'll talk about staff surge a little  
8 later. But let's go back then. So have you read  
9 Dr. Klein's study on cohorting in long-term care?

10 DR. DAVID WILLIAMS: I remember seeing  
11 a report reviewed by Public Health -- a group did a  
12 review on it, looked at it.

13 JOHN CALLAGHAN: So he came, and he  
14 talked to the Commissioners here, and he showed in  
15 one particular home how they took your cohorting,  
16 and they moved the well and unwell, not knowing and  
17 not appreciating or not having any understanding of  
18 asymptomatic because it wasn't told to them, and  
19 they basically showed how they spread COVID around  
20 that home from an asymptomatic patient to a  
21 non-symptomatic, who then became symptomatic, and  
22 then moved them all the way around in the whole  
23 home where a large portion had become infected.  
24 Were you aware of that?

25 DR. DAVID WILLIAMS: If you move around

1 infected patients, you will spread infection.

2 JOHN CALLAGHAN: So did you ever amend  
3 the guidance on separating the well and unwell to  
4 tell them that if you separate the unwell, you may  
5 be symptomatic -- they may be symptomatic, and you  
6 may be spreading the disease around your long-term  
7 care home? Did you ever do that?

8 DR. DAVID WILLIAMS: Well, the point is  
9 that you have to separate the --

10 JOHN CALLAGHAN: Did you ever do that?

11 DR. DAVID WILLIAMS: No, we wanted to  
12 separate the infected from the uninfected.

13 JOHN CALLAGHAN: Well, no, you would  
14 say well and unwell, and I don't know how you know  
15 if they are infected if it is asymptomatic.

16 DR. DAVID WILLIAMS: They should test  
17 them.

18 JOHN CALLAGHAN: Which takes time;  
19 correct?

20 DR. DAVID WILLIAMS: We did. We did  
21 the testing. So I am more interested in separating  
22 infected from uninfected.

23 JOHN CALLAGHAN: And the only way to  
24 know that is to have prompt test results; correct?

25 DR. DAVID WILLIAMS: Yeah, when you go

1 into an outbreak testing, you test as many people  
2 as you need to do, and you need to have the results  
3 back.

4 JOHN CALLAGHAN: Were you aware that  
5 some long-term care homes were actually getting  
6 results by mail sometimes; are you aware of that?

7 DR. DAVID WILLIAMS: Yes, they had no  
8 automated system to receive it.

9 JOHN CALLAGHAN: Did you ever, as the  
10 Chief Medical Officer of Health, speak to the  
11 long-term care and say that is a danger to the  
12 safety of residents?

13 DR. DAVID WILLIAMS: When we did  
14 testing, a copy of the results usually went --  
15 always goes to the local health department.

16 JOHN CALLAGHAN: No, I mean the actual  
17 failure to provide for some automated process like  
18 a hospital has to get desktop results, did you, as  
19 the Chief Medical Officer of Health, ever complain  
20 or raise an objection -- because you obviously knew  
21 about it, you just said you did -- about the manner  
22 in which long-term care homes were getting results;  
23 yes or no?

24 DR. DAVID WILLIAMS: Before the  
25 pandemic?



1 JOHN CALLAGHAN: Yes.

2 DR. DAVID WILLIAMS: My issue was that  
3 I wanted to make sure that my MOHs got the results.

4 JOHN CALLAGHAN: All right.

5 DR. DAVID WILLIAMS: Because they --

6 JOHN CALLAGHAN: So the answer is no,  
7 just to be clear?

8 DR. DAVID WILLIAMS: No. Because I was  
9 more concerned that Public Health has the results.

10 JOHN CALLAGHAN: Fine. After. Did you  
11 ever complain after the pandemic? Because you seem  
12 to make a distinction there.

13 DR. DAVID WILLIAMS: We are not after  
14 the pandemic. It is still on.

15 JOHN CALLAGHAN: All right. Since  
16 before and current, did you object to the manner in  
17 which long-term care homes were receiving their  
18 test results?

19 DR. DAVID WILLIAMS: We wanted to make  
20 sure that everybody received the results as quickly  
21 as possible and accurately as possible.

22 JOHN CALLAGHAN: Okay. So I have not  
23 seen your objection. You would say to me you  
24 objected to the long-term care -- the Minister of  
25 Long-Term Care, the Deputy Minister of Long-Term

1 Care, or somebody in that department about the  
2 manner in which long-term care homes were receiving  
3 their results? Did you, or did you not?

4 DR. DAVID WILLIAMS: I was more  
5 interested that they receive them expeditiously to  
6 handle outbreaks.

7 JOHN CALLAGHAN: Well, you just spoke  
8 with me that you knew that they didn't have the  
9 technology to receive them expeditiously, so I'm  
10 asking you, having that knowledge in hand, knowing  
11 the risk to the patients or to the long-term care  
12 residents of not getting quick results, did you at  
13 any time raise the issue with the Ministry of  
14 Long-Term Care? I'm sensing the answer is no. A  
15 direct answer would be helpful.

16 DR. DAVID WILLIAMS: The answer is that  
17 in outbreaks, I raise the issue we want the lab  
18 test results back as promptly as possible.

19 JOHN CALLAGHAN: And did you then go on  
20 to say that it is your understanding that long-term  
21 care homes do not have the technology to receive  
22 results expeditiously? Did you go on to say that?

23 DR. DAVID WILLIAMS: No, because in the  
24 middle of it we were dealing with the outbreaks,  
25 not with the technology.

1                   JOHN CALLAGHAN: Well, they seem to go  
2 hand in hand in what you just said a moment ago,  
3 but let's move on.

4                   DR. DAVID WILLIAMS: Not exactly.

5                   JOHN CALLAGHAN: So in terms of --

6                   COMMISSION CHAIR FRANK MARROCCO:  
7 Mr. Callaghan, before you move on, we have finished  
8 with this particular line of questioning, but I  
9 just wanted to ask you, Doctor, how do you see the  
10 relationship between the Chief Medical Officer of  
11 Health, the Minister of Long-Term Care, in relation  
12 to long-term care facilities and the Local Medical  
13 Officer of Health, because it seems to me, Doctor,  
14 that at least with respect to the Local Medical  
15 Officer of Health and the Minister, they can issue  
16 orders that affect long-term care facilities, and I  
17 think you can too, quite frankly, but I'm just  
18 trying to understand from your perspective how you  
19 see the interrelation of the three of you, if you  
20 like?

21                   DR. DAVID WILLIAMS: Well, yes. Thank  
22 you, Commissioner. It is a good question.  
23 Recently we were in the Ministry of Health and  
24 Long-Term Care, we were combined, and so the  
25 Assistant Deputy Minister for Long-Term Care would

1 be at our table. We would discuss things and -- if  
2 there is issues and concerns, and one of the things  
3 always every year is how is the influenza  
4 vaccination program going, how are outbreaks going,  
5 and different aspects there. So we would compare  
6 notes on that. Because under Ontario Public Health  
7 standards, we have our outbreak protocols. So  
8 every year, Public Health is highly invested in  
9 making sure influenza planning is around and in  
10 place, making sure that they have their vaccination  
11 program ready to roll out. There are standing  
12 orders for all the residents in there, as well as  
13 to put as the top priority get our vaccinations  
14 done there and deal with any of the outbreaks and  
15 have our staff at the local health unit be prepared  
16 to move over and assist when necessary to deal with  
17 outbreaks of influenza or other outbreaks.

18 So we have always had an outbreak  
19 relationship with them. We don't actually get  
20 involved in their management and administration,  
21 per se. So ours is more on a basis of two levels:  
22 One, we would have our staff involved in outbreaks,  
23 or on a regular basis, we would have our inspectors  
24 look at food services to make sure that there was  
25 proper food handling and that kind of stuff.

1 But that was the actual day-to-day  
2 limitation of our interaction with it.

3 When the Ministry of Long-Term Care was  
4 formed, about a few weeks before the start of the  
5 pandemic we were asking questions that, as the  
6 CMOH, do I go to their table? We gave a  
7 presentation and were made aware.

8 So it was the early days of building up  
9 a relationship with the Minister of Long-Term Care,  
10 the Deputy Minister of Long-Term Care and how does  
11 that work. Because I am an ADM at the Ministry of  
12 Health table, do I -- I'm in a consulting role.  
13 Would I be part of their senior management role?  
14 And that said, No, I think you're still staying,  
15 you're with the Minister of Health, but I'm  
16 available to have advice and direction and  
17 discussions in that.

18 And then later, when we came into the  
19 pandemic, they were part of the health table and  
20 participated in there, and we have had always  
21 collegial working relationship with the Deputy,  
22 with their ADMs and others with my staff and their  
23 staff as we work through the ongoing issues  
24 throughout the whole process.

25 So it is more of an advisory and

1 consulting, and then sometimes using my powers with  
2 the directives versus the powers of the Minister  
3 and getting used to working with a Ministry of  
4 Long-Term Care, which in my time I have never seen,  
5 but it is a new thing, and it was developing at  
6 that time.

7 COMMISSION CHAIR FRANK MARROCCO: So  
8 did you see the relationship as consensual or  
9 advisory as opposed to directive?

10 DR. DAVID WILLIAMS: Right, because I  
11 reported to the Deputy Minister of Health and the  
12 Minister of Health, not to the Deputy Minister of  
13 Long-Term Care or the Minister of Long-Term Care.

14 So in a reporting direction, under my  
15 OIC, et cetera, I had a reporting one within the  
16 Ministry of Health. I had more of an advisory  
17 consulting with the Long-Term Care.

18 COMMISSION CHAIR FRANK MARROCCO: But  
19 you are the Chief Medical Officer of Health.

20 DR. DAVID WILLIAMS: Right, and I can  
21 give advice and direction, whether it is Public  
22 Health concerned. I can ask for information, ask  
23 for data, ask for reports that would help and  
24 assist me on that. So I would often ask the Deputy  
25 for, you know, what is happening here and how is

1 this and some issues like that.

2 So I can be kept informed on those  
3 public health issues, yes.

4 COMMISSION CHAIR FRANK MARROCCO: But  
5 can you not make orders when there is an infectious  
6 disease outbreak --

7 DR. DAVID WILLIAMS: Directives?

8 COMMISSION CHAIR FRANK MARROCCO:  
9 Whether the Minister of Long-Term Care or the  
10 Deputy Minister agree with you or not?

11 DR. DAVID WILLIAMS: As a Medical  
12 Officer of Health, we can write orders, and as a  
13 Chief Medical Officer of Health, I can write  
14 directives to seek to contain it and deal with it,  
15 that's correct.

16 COMMISSION CHAIR FRANK MARROCCO: So if  
17 you think it is necessary that they do something to  
18 contain, you can tell them that they have to do it,  
19 and they ought to comply with your -- they have to  
20 comply.

21 DR. DAVID WILLIAMS: My directives are  
22 towards the homes, not towards the Minister. I  
23 don't direct the Minister.

24 COMMISSION CHAIR FRANK MARROCCO: But  
25 you can direct the homes that the Minister is

1 responsible for.

2 DR. DAVID WILLIAMS: Or other health  
3 institutions where there is the proper triggers  
4 under the Health Protection and Promotion Act.

5 COMMISSION CHAIR FRANK MARROCCO: So  
6 even if -- if there was a practice that you thought  
7 was necessary to employ or that a home or the homes  
8 employ, you can tell them to do that as the Chief  
9 Medical Officer of Health?

10 DR. DAVID WILLIAMS: Right, with the  
11 proper triggers and evidence, yes, to do so, yes,  
12 and to implement that.

13 At the same time, I may ask the Deputy  
14 of Long-Term Care, is this something you might want  
15 to incorporate into your regulations, because  
16 directives at times are seen as -- they can be  
17 there for a period of time, but if they develop new  
18 regulations and legislation under their Act, the  
19 need for the directives may become less than  
20 necessary.

21 COMMISSION CHAIR FRANK MARROCCO: Okay.  
22 Thank you.

23 JOHN CALLAGHAN: So on the issue of  
24 that, you mentioned the Public Health Units, they  
25 do not inspect homes for IPAC compliance; am I



1 correct on that?

2 DR. DAVID WILLIAMS: They generally  
3 don't. They are there as a resource to give them  
4 education and information in that and to share  
5 documents and materials with them, but they don't  
6 go around and audit the IPAC practices in all the  
7 long-term care homes. If there is an outbreak, of  
8 course, they would want to see that those things  
9 are place.

10 JOHN CALLAGHAN: Given what you have  
11 heard about the state of IPAC practices in homes,  
12 do you think the Public Health Units should take  
13 over that responsibility?

14 DR. DAVID WILLIAMS: Yeah, this has  
15 been a very big part of -- when we looked at that.  
16 When we did post-SARS, there was -- one of the  
17 things from the Provincial Infectious Disease  
18 Advisory Committee, there was a lack of infection  
19 prevention and control practices throughout the  
20 whole health system, long-term care, home care, and  
21 hospitals.

22 Our concern greatly was the hospital,  
23 and we really wanted to look at that, and you have  
24 seen many documents from PIDAC, from the Provincial  
25 Infectious Disease Advisory against specificity and

1 Infection Prevention Control Committee, under their  
2 Chair, and we put out many documents that became  
3 leading ones throughout the country because a lot  
4 of places -- even when I went through medical  
5 school when I dealt with infectious diseases, the  
6 professor would say, This is more for historical  
7 purposes because you are not going to be dealing  
8 much with this in the future. And I went, Wow,  
9 okay, and as I went out and we did that, we still  
10 had some attitude, and even during SARS, I had some  
11 doctors saying, I never thought I could get  
12 infected by working in a hospital. I am going,  
13 Really? And this was very surprising.

14 So part of our task was to raise the  
15 whole bar of infection prevention and control  
16 across the whole system and saying you have to  
17 invest in this. You have to devote staff and time,  
18 many things to put that in place.

19 And you have to start training  
20 infection prevention and control practitioners to  
21 get them certified. It was very much a small  
22 group, and they came and worked with us and PIDAC,  
23 because they said, We now have an advocate in  
24 Public Health that says that infection prevention  
25 and control is valuable and should be resourced

1 accordingly.

2 So we worked hard since the SARS up  
3 until now to continue to advocate for that to be  
4 always there, and we developed through Public  
5 Health Ontario -- because, remember, the PIDAC --  
6 acronyms I know we are not supposed to use, the  
7 Provincial Infectious Disease Advisory Committee,  
8 that whole committee was moved into PHO. At the  
9 same time, we developed regional infection control  
10 networks, which had groups of infection prevention  
11 control practitioners, certified, that were  
12 available to hospitals and other ones who wanted to  
13 have that resource, if they needed to do that.

14 Over time, a lot of those initial  
15 veterans retired, and some of those resources  
16 dwindled down, because in the acuity of the urgent,  
17 with overload in hospitals and emergency department  
18 demands, and -- there is reasons that people say we  
19 don't have the time and stuff to spend on this. So  
20 we have always been pushing for IPAC to be brought  
21 back to the table, to make sure it is there. But I  
22 think over time we have seen less and less emphasis  
23 on that in various sectors, but we keep putting out  
24 our documents. We keep emphasizing it.

25 And I think some find it at times, in

1 times of peace, to be sort of things that they just  
2 say, well, there is urgent issues we need to deal  
3 with. I mean, we know it is important, but not  
4 right now. And it is hard to keep that prevention  
5 thing always at the front table because the tyranny  
6 of the urgent always pushes things aside, and that  
7 is --

8 JOHN CALLAGHAN: I think that is a good  
9 point. So then I take it then you must have  
10 been -- were you not surprised or were you  
11 surprised at the state of IPAC on these homes that  
12 had massive outbreaks? And we just heard that they  
13 didn't have any clue of what they were doing and --

14 DR. DAVID WILLIAMS: Well --

15 JOHN CALLAGHAN: Did that surprise you?  
16 I mean, it seems to us that perhaps acute care got  
17 the memo out of SARS and perhaps maybe parts of  
18 long-term care didn't get the memo out of SARS, but  
19 I don't know what your reaction is because that is  
20 what we are after, figuring out how we solve this  
21 long-term care issue.

22 DR. DAVID WILLIAMS: Yeah, I think I  
23 would say unfortunately not surprised, but I am  
24 surprised at the paucity of it. I would have  
25 expected a lot more to be available and present

1     there. We had been working with a lot of homes  
2     every year in outbreaks, so we had many times to  
3     try some out. We deal with over a thousand  
4     influenza outbreaks in long-term care homes every  
5     year, so it is not atypical.

6                 So we get a chance to keep pushing back  
7     and saying, We need it, we need it again. What I  
8     found when I was a Local Medical Officer of Health  
9     where we might have done a big outbreak the year  
10    before, and we went back and said, Okay, I guess  
11    they are ready to go. Yeah, where is so and so,  
12    the manager? Well, no, she left, and she was  
13    replaced by another one, who was replaced by  
14    another one. And okay, is any of the staff here  
15    that were there a year ago? And the answer is not  
16    many.

17                So that core expertise that we trained  
18    was changing very quickly, and it is how do you  
19    maintain that with the turnover in there.

20                And the same with our hospitals. We  
21    would look for our point person who was our  
22    infection prevention and control practitioner, the  
23    champion, if you may, to be there to keep raising  
24    the banner and keep pushing the agenda.

25                But some of those have retired and

1 moved on. So it has always been for us -- and even  
2 now during the pandemic, we have asked one of my  
3 directors, Can we start to look at how to develop  
4 an even stronger infection prevention and control  
5 practitioner training program back up again in our  
6 colleges and universities and look for that  
7 certification to raise that core strength back up  
8 again.

9 So I guess it was to me disappointing  
10 to find the lack of depth and breadth of infection  
11 prevention and control expertise that was available  
12 out there to deal with it.

13 So I see this is one of the systematic  
14 things, if you are looking for system solutions,  
15 that needs to be raised in all sectors. Even if it  
16 isn't urgently necessary every moment all yearlong,  
17 you need it there in your backdrop to be keeping  
18 that there, because unlike our professor said back  
19 in medical school, infectious diseases are not a  
20 historical phenomena, they are here, and they are  
21 in our face, and we have to deal with that.

22 JOHN CALLAGHAN: So --

23 COMMISSION CHAIR FRANK MARROCCO:

24 Mr. Callaghan, before you go on, did I understand,  
25 as a result of the work you were doing with

1 preventing and controlling infectious diseases like  
2 the flu, it became clear that one of the barriers  
3 to effective infectious prevention and control  
4 practices in individual homes was the high turnover  
5 of staff?

6 DR. DAVID WILLIAMS: At the local level  
7 I found that to be, as a Medical Officer of Health,  
8 and our staff found it perplexing because we had  
9 groomed someone in the past to be our local  
10 champion, because you need a -- in a long-term care  
11 home, we deal with a lot of part-time staff and  
12 turnover. You need one of your more managerial  
13 people who have a longer history in the  
14 organization to be that expert, that our lead of  
15 our infectious disease, our Public Health Nurse was  
16 the lead there, would be able to maintain a  
17 relationship with and to monitor that over time.  
18 And time and time again, we found where is that  
19 person? And who is now the lead? And we hadn't  
20 met the person before.

21 And so the changeover was at times  
22 disconcerting because you invested in the training  
23 of that person, because it is really the person you  
24 want to train up on who can do that, I would say,  
25 organizational and structural and systematic and

1 engineering diagnostic of infection prevention and  
2 control practices that are applicable to that  
3 setting that is so critical.

4 COMMISSION CHAIR FRANK MARROCCO: Would  
5 you agree that given that difficulty, it makes  
6 sense to vest the hospitals with the challenge of  
7 training infection control or introducing infection  
8 control practices, because there is an element, it  
9 seems to me, of consistency and permanence in the  
10 hospitals that apparently you did not find in the  
11 long-term care homes.

12 DR. DAVID WILLIAMS: There is a yes and  
13 no there. We had worked hard to increase that in  
14 our hospitals, and not every hospital has all of  
15 that. Some of the smaller ones don't. So that is  
16 why we had our regional infection control networks  
17 so they could avail themselves of that expertise,  
18 and some of those were hospital-based ICPs,  
19 infection control practitioners, that they could  
20 come in and ask for some advice on.

21 I think what happened over time is that  
22 the more permanent jobs and better paying jobs were  
23 in the hospital, and they would tend to move over  
24 to there. And we really need them in the hospital,  
25 so that is very -- that is critically important.



1                   At the same time, what I found  
2 sometimes -- because in the hospital, if you have  
3 only been working in the hospital, you build it on  
4 the basis of the infrastructure that you are aware  
5 is in the hospital. And when you go out to a  
6 long-term care home, you start to say, Well, this  
7 is not very hospital-like.

8                   And the answer is no, it isn't. It is  
9 a home. And therefore, they would say, Well, where  
10 is the anteroom where you can put on the gowns and  
11 go in? There isn't one. Where is this and where  
12 is that and all these other things that you would  
13 expect to have in a hospital, that we had raised  
14 the bar that they should put in a hospital, are not  
15 in a long-term care home.

16                  So how does one run a quality infection  
17 control program in a home as compared -- like a  
18 residence, a home, as compared to a hospital?

19                  And to be able to translate that, you  
20 would have to be doing that on a regular basis all  
21 the time. It is part of your expertise. So if you  
22 had them doing that, would they avail themselves on  
23 a regular basis to be going out and meeting with  
24 the staff and looking at it, because part of  
25 infection prevention and control is doing it before

1 it happens, not when it happens, and setting up all  
2 those -- looking for the compromise and the things  
3 that are missing and what is not in place and that,  
4 it is a constant auditing.

5 And I think if you are going to set  
6 that up, it would be a good process but you are  
7 going to have to make it part of the job  
8 description if they said, Okay, now you have --  
9 responsible for these five, these ten, and are you  
10 meeting on a regular basis with them? But they  
11 say, Well, my contract, I work for the hospital, I  
12 don't work for the long-term care home. Where is  
13 the liability? Should I be doing that or not doing  
14 that?

15 And so it really behooves us, and I  
16 would like to see in that systematic review, the  
17 same as you did with the hospitals, to raise the  
18 bar of infection prevention and control. Even when  
19 we did all the work with PIDAC around building and  
20 design where we were recommending through our PIDAC  
21 committee with the Dew Drop Foundation and staff  
22 saying, There is logic in building new hospitals  
23 that every room is a private room. It is separate.  
24 And you say, Well, what is the cost of that?

25 So we are trying to raise the overall

1 infection prevention and control policy and  
2 practices even in the capital building and design  
3 stuff, and we weren't involved and asked to do that  
4 in long-term care homes in there, but that is  
5 something that could be looked at in a proactive  
6 basis, is that what things might one consider in  
7 capital building, even building and layout and, you  
8 know, staffing, those system things that I really  
9 think are very critical and important that need to  
10 be there before you have any pandemics, before you  
11 have outbreaks, that has to be looked at day in and  
12 day out.

13 And I know even hospital staff at times  
14 get frustrated with the infection control teams  
15 coming around and saying, well, here they come  
16 again. They are going to demand this. They are  
17 going to demand that. Yes, they are going to  
18 demand that. That is what it is about.

19 COMMISSION CHAIR FRANK MARROCCO: And I  
20 guess my question was more directed to this. You  
21 perceive a significant challenge in raising the  
22 level of knowledge about infection practices and  
23 control in long-term care homes caused by the high  
24 turnover of staff.

25 So Public Health going to a long-term

1 care home and training someone or some group,  
2 depending on how you did the training, training  
3 them doesn't always work because there is a high  
4 turnover of staff. It is hard to have an expert  
5 there because the expert leaves, and frequently the  
6 person you have invested the time and money and  
7 training leaves.

8 So that is a reality. We have been  
9 told that 70 to 80 percent in some homes are  
10 part-time, and that the excessive number of  
11 part-time people is a real problem.

12 So given that reality, isn't really the  
13 only alternative then to ask the hospitals to take  
14 on the responsibility of training and obviously  
15 paying them for it, but I don't know who else --  
16 who else could do it?

17 DR. DAVID WILLIAMS: You are correct.  
18 That would be your logical go-to. Public Health,  
19 some had infection control practitioners. We  
20 always usually went in mostly for outbreaks, but if  
21 you were making that part of someone -- some  
22 agency, an organization, I think, should have that  
23 responsibility to do that on a regular basis and  
24 do -- much like you do with inspections for food  
25 services, you go in on a regular basis, look at

1 deficits, give them advice, give them direction to  
2 improve this, improve that, so they have to not  
3 only have the training capabilities but the ability  
4 to give some direction to the organization to say,  
5 this is not in place; that is not in place; you  
6 need to do this; you need to do that.

7           So I agree with you, Commissioner, I  
8 think looking at that system approach is an  
9 important one to maintain that quality of infection  
10 prevention and control in times of peace so it is  
11 there during times of outbreaks.

12           COMMISSION CHAIR FRANK MARROCCO: And  
13 the other side of it, do you agree -- and please,  
14 if you don't, please said so, but the hospitals  
15 have some sense of civil liability, so the need to  
16 make sure that this is effectively done is going to  
17 resonate with whoever is on the compliance end in  
18 the hospital because they recognize there can be  
19 civil suits and the government is not always going  
20 to try to pass legislation to protect the hospital  
21 from civil liability.

22           So there is an internal incentive to  
23 making sure that these practices are known and  
24 don't fall into the situation where there is nobody  
25 there that knows how to put the equipment on.

1 Nobody knows how to take it off. We have heard of,  
2 you know, people wearing the same PPE from room to  
3 room. Crazy practices. A hospital would  
4 appreciate the significant civil consequences of  
5 permitting that to go on.

6 Does that seem reasonable to you or no?

7 DR. DAVID WILLIAMS: There is a yes and  
8 no.

9 One of the things I found about  
10 hospitals is they are very reluctant to do things  
11 outside their walls because they have a great sense  
12 of liability and their areas of responsibility  
13 under the Public Hospitals Act.

14 So I think what you are asking for, is  
15 there some way -- and this is what we ran into at  
16 the outset with the 29.2s and that, how do we ease  
17 off that liability issue that allows hospital staff  
18 to go outside their workplace to do that and what  
19 is the liability and different issues. What  
20 regulations permit to do that?

21 So I think what you are asking is, is  
22 there a need for some change in the legislation and  
23 powers and authority that would not only allow that  
24 but permit it and in a way that interface that has  
25 not been there would be there, so whoever is going

1 to do it is legislatively enabled to do it and  
2 covered in that area and equipped and financed and  
3 funded.

4 So it is creating an infrastructure, a  
5 system, that I think would -- in answer to your  
6 question, would be most helpful. Whoever is going  
7 to do it, because then they are not only going to  
8 do it because they feel it is nice to do, they need  
9 to do it because they are supposed to do it. And  
10 they have to be audited also and saying, Did you go  
11 around and do this training. Because there is  
12 accountability in the system up there. You have to  
13 build that in. And hospitals up until now have  
14 been very careful to make sure that what is offered  
15 is within their jurisdiction and their  
16 responsibilities, and that is understandable under  
17 the legislation Acts that are there now.

18 But I think what you are asking for,  
19 Commissioner, is that should be something that  
20 needs to be thought of as a system approach and how  
21 would that be put in place.

22 COMMISSION CHAIR FRANK MARROCCO: Well,  
23 I have to take issue a bit with the idea that the  
24 hospitals won't do it unless they are directed to  
25 do it, although I'm sure that that's a preferable

1 way of going about this.

2 But we have heard remarkable stories of  
3 hospitals going in to long-term care homes in  
4 response to a request for help and simply helping  
5 on top of their responsibilities they had at the  
6 hospital.

7 We have heard no suggestion that they  
8 had a shortage of people willing to do what was  
9 necessary in a crisis to get through the crisis.

10 DR. DAVID WILLIAMS: Yes, I wasn't  
11 inferring that morally they had to be directed.  
12 More than willing to do that, I think what they  
13 said, if we are directed, then we have the legal  
14 and the liability aspects covered that allow our  
15 people to go in and do it, as they so do want to do  
16 it and take part in that.

17 So it is more of an administration and  
18 management thing behind the scenes, that by giving  
19 directives and that allows that to occur and to let  
20 them do what they feel they want to do and know how  
21 to do. So we want to free them up to do that.

22 And that is what we had to face in the  
23 middle, because based on need -- and they did want  
24 to help. Now, they were also under pressure too  
25 because they are hospitals, and we heard some



1 saying we have got cases, and we have some  
2 outbreaks in our own institution. We can spare  
3 some in different -- but we have to be sensitive to  
4 that because that is not something that was built  
5 into their normal operations.

6 But I think what you are getting at,  
7 Commissioner, is maybe something that would be  
8 built in there in the future.

9 COMMISSION CHAIR FRANK MARROCCO: So,  
10 sorry, Mr. Callaghan, to interrupt.

11 JOHN CALLAGHAN: So you spoke about  
12 peacetime, and we are talking about IPAC, and we  
13 heard evidence that there was a deterioration of  
14 IPAC at Public Health Ontario in 2019 to 2020. We  
15 heard comments that it was in part related to  
16 Ontario Health and a takeover by Ontario Health.

17 Do you agree that there was a decline?  
18 We have heard the numbers. Was there a decline in  
19 IPAC consideration at Public Health Ontario and was  
20 there concern about Ontario Health taking over  
21 Public Health Ontario, some of their segments?

22 DR. DAVID WILLIAMS: I think from the  
23 IPAC standpoint, the people leading the portfolio,  
24 we had some retirees. We still had the Provincial  
25 Infectious Diseases Advisory Committee that reports

1 in, so they were getting lots of advice in there.

2 As far as the staffing and aspects  
3 there, as I said, that was under the CEO to deal  
4 with the budget issues. There was some initial  
5 consideration in looking at early in 2019 of a  
6 restructuring, how we should deal with it. Should  
7 we deal with it like other provinces and just have  
8 one large agency, if you may, that has many parts  
9 and components, and should this be part of it; yes  
10 or no. That was postulated. How should that be,  
11 because other agencies that had been combined under  
12 Ontario Health, the new entity of Ontario Health  
13 that just was put together in the early parts of  
14 late 2019 and 2020, and is there efficiencies  
15 gained by that.

16 These questions were being asked and --

17 JOHN CALLAGHAN: Was there -- let me  
18 just show you a note that you did on December 2nd,  
19 2019. Can you put that up, Michael?

20 MICHAEL FINLEY: Sorry, John. Can you  
21 say that one again? You just broke up on me a  
22 little bit.

23 JOHN CALLAGHAN: December 2nd, 2019,  
24 note.

25 So the reason why I'm going to show you

1 this is because, if you can move it across -- I  
2 think I'm reading your handwriting, and I apologize  
3 if I'm not. It says:

4 "Need to do PHO shift ASAP to  
5 avoid an OH takeover."

6 And it caught us when someone read it  
7 last night because we heard testimony from somebody  
8 else who said almost exactly the same thing.

9 So what did you mean by that?

10 DR. DAVID WILLIAMS: My position was --  
11 my position, and I still feel that a public health  
12 agency in my opinion needs to be separate from an  
13 acute care hospital sector in that, and the same as  
14 the laboratory, is the same.

15 So I have always felt that way. I have  
16 always been -- that is why I supported developing a  
17 Public Health agency from the get-go.

18 And I said that we need to make sure  
19 that Public Health, in its presentation and its  
20 materials it is putting forward, has to be able to  
21 have that frank conversation of why it is best not  
22 to be put under an overall agency because there is  
23 some unique --

24 JOHN CALLAGHAN: No, I get the  
25 rationale, Doctor. I get the rationale. I'm

1 asking you whether the sentiment that there was a  
2 concern of Ontario Health takeover -- I say that  
3 because we have heard other evidence to that effect  
4 and that it had an impact on the IPAC performance  
5 of Public Health Ontario.

6 So was that a concern, and I hear you,  
7 the rationale why there ought not to be a takeover.  
8 But I have taken you to the note, because it seems  
9 to me that you are saying at the end of 2019 that  
10 is a concern; correct?

11 DR. DAVID WILLIAMS: Well, because it  
12 had been postulated to us that -- sorry about the  
13 noise, postulated to us and as myself to say we  
14 need to think about developing one agency for the  
15 Province of Ontario and to put that into  
16 consideration and deal with that, and so that was  
17 part of the dialogue and discussion at that time.

18 So it wasn't a sentiment. It was  
19 actually to be considered as a possibility looking  
20 at other jurisdictions that had done something  
21 similar.

22 JOHN CALLAGHAN: So let me show you a  
23 note of January 7th, a couple of weeks later,  
24 before the pandemic, and it says:

25 "Matt Anderson CEO OH".

1                   Can you help me out reading that for me  
2                   because it is hard for me to --

3                   DR. DAVID WILLIAMS: It is on the  
4                   corner of my page, so I guess that gray bar. It  
5                   says -- I really didn't know Matt that well at the  
6                   time because he had just been in the job, so I  
7                   wanted to get to know him better and to understand  
8                   how does he see it or not.

9                   JOHN CALLAGHAN: All right. There  
10                  is -- I think the way it goes on, it goes on to  
11                  say:

12                               "Hand over to the new shiny  
13                               bauble."

14                  And I guess what I -- we have heard  
15                  from somebody who was very adamant that Ontario  
16                  Health coming in to do a takeover had an adverse  
17                  impact on the IPAC division of Public Health  
18                  Ontario, and so I'm hearing from you that the  
19                  Ontario Health "takeover", as you noted, was a  
20                  concern by many; correct?

21                  DR. DAVID WILLIAMS: We had a concern  
22                  if you merge Ontario Health into the overall  
23                  Ontario Health agency, there was concerns by a  
24                  number of people on that. There was some people  
25                  felt it might be a better thing to do.

1                   JOHN CALLAGHAN: And your view was it  
2 wasn't?

3                   DR. DAVID WILLIAMS: My point is always  
4 I think a Public Health thing is different, and the  
5 risk I had seen before when Public Health was  
6 incorporated into these larger structures, it gets  
7 lost in the busyness of it. The other ones are  
8 huge and demanding, and I have seen where before in  
9 other structures it gets a smaller and smaller  
10 enterprise because prevention at times doesn't seem  
11 to be as efficient at the moment, dealing with, as  
12 I said, the tyranny of the urgent, and then it gets  
13 set aside.

14                   So I have always believed Public Health  
15 is different. It needs to be kept separated out,  
16 both laboratory and in its science and bodies and  
17 that. So I --

18                   JOHN CALLAGHAN: And that would be one  
19 of the lessons from SARS; correct? I mean, that is  
20 what Justice Campbell said; correct?

21                   DR. DAVID WILLIAMS: It is the same,  
22 and that is why I like to see that Medical Officers  
23 of Health still maintain an entity on that, and if  
24 they are going to be involved in any other  
25 structures, have that autonomy still, because in

1 the overall picture, they tend to get set aside  
2 sometimes under the urgency of other health crises,  
3 health system crises.

4 JOHN CALLAGHAN: Let's talk a moment  
5 about preparedness for a pandemic. As the Chief  
6 Medical Officer of Health, did you have a role or  
7 responsibility to make sure the province was ready  
8 for a pandemic?

9 DR. DAVID WILLIAMS: Part of it is the  
10 pandemic planning, that's correct.

11 JOHN CALLAGHAN: Was that your role as  
12 the Chief Medical Officer of Health, or was that  
13 your role as an Assistant Deputy Minister?

14 DR. DAVID WILLIAMS: There is an answer  
15 yes to both of those. Either as the CMOH, I  
16 advocate for it, and as the ADM, I try to look for  
17 the system things to address that.

18 JOHN CALLAGHAN: I'll tell you why,  
19 because it is a little confusing, and as -- we were  
20 provided a slide deck, and I'll just go through it,  
21 but it has you responsible, because they were  
22 talking about the stockpile, which we'll talk about  
23 in a minute, but a stockpile from 2018 through to  
24 August of 2020, but I take it you have a separate  
25 responsibility for preparedness independent of

1 that, independent of the stockpile?

2 DR. DAVID WILLIAMS: Yes.

3 JOHN CALLAGHAN: So the stockpile --  
4 why wouldn't the stockpile responsibility go to  
5 that person who is responsible for the  
6 preparedness --

7 DR. DAVID WILLIAMS: Before 2018, it  
8 would be the Assistant Deputy Minister.

9 JOHN CALLAGHAN: Well, yes. Before you  
10 say that, in August 2020, we were told that  
11 responsibility was taken away from you, and that is  
12 ADM Blair's now. So it is not with the -- it is  
13 not with you at the moment, according to the  
14 evidence we heard.

15 DR. DAVID WILLIAMS: ADM Blair had a  
16 reporting relationship with myself and the Deputy,  
17 to me and the Deputy.

18 JOHN CALLAGHAN: That is not what it  
19 says. That is not what we were told. We were told  
20 that she reports to the Deputy Minister.

21 Can we put up slide "A", please.

22 So this is what we were told. We were  
23 told from 2016 to January 2008, an Executive  
24 Director who reported to the Public Health  
25 Division, and it is not clear to me in what role.



1                   And then from 2008 to 2011, it was ADM  
2 Stuart reporting to Deputy Minister Sapsford.

3                   And 2011 to 2014, Executive Director  
4 Martino to the ADM/CMOH.

5                   And then from 2014 to 2018, ADM now  
6 reporting to the Deputy Minister.

7                   And now from 2018 to 2020, you have it  
8 and you are reporting to the Deputy Minister.

9                   And then from August 2020, we were told  
10 it was ADM Blair reporting to the Deputy Minister.

11                  So leave aside the issue with the  
12 stockpile, we'll talk about in a minute, but as a  
13 matter of structure, why isn't the person  
14 responsible for preparedness not also responsible  
15 for the stockpile? Why does it get moved around?  
16 I'm not suggesting it is your responsibility. I'm  
17 just asking, as a matter of theory, do you think it  
18 should happen, and if you know why it happened, you  
19 could let us know that too.

20                  DR. DAVID WILLIAMS: So to be clear,  
21 the one you are talking about, the '20 to the  
22 current, that is not preparedness. That is  
23 pandemic response and Public Health modernization.  
24 It is not pandemic preparedness.

25                  JOHN CALLAGHAN: So this was talking

1 about -- this evidence was about the stockpile,  
2 so --

3 DR. DAVID WILLIAMS: Yes, I know, but  
4 you are mixing that in, and you are saying that  
5 Alison Blair is now responsible for pandemic  
6 preparedness and --

7 JOHN CALLAGHAN: No, I thought you said  
8 you were.

9 DR. DAVID WILLIAMS: No, you said she  
10 got the job now. I said I had it.

11 JOHN CALLAGHAN: Give me a moment then.  
12 Let me get it straight.

13 DR. DAVID WILLIAMS: Okay. Please.

14 JOHN CALLAGHAN: What is your role for  
15 pandemic preparedness?

16 DR. DAVID WILLIAMS: In my role in  
17 pandemic preparedness, as a CMOH -- and I have an  
18 associate CMOH, we sit on various  
19 federal/provincial/territorial committees looking  
20 at the development and change of the federal  
21 Canadian pandemic influenza plan. We then  
22 incorporate those into our Ontario pandemic  
23 influenza plans, and we look at the different  
24 components and aspects to see how prepared we are  
25 for a pandemic. In that, part is having the

1 framework of the plan in place so we have it  
2 updated as necessary if it needs to be done.

3 JOHN CALLAGHAN: So let me be clear.  
4 The buck stops with you? If the plan isn't  
5 prepared, that is your responsibility?

6 DR. DAVID WILLIAMS: The plan, as far  
7 as the Ontario one, is to make sure that it is as  
8 up to date as mine.

9 JOHN CALLAGHAN: All right.

10 DR. DAVID WILLIAMS: And my team, yes.

11 JOHN CALLAGHAN: And the stockpile, we  
12 have read documents back to 2006. The stockpile is  
13 integral to preparedness, but that responsibility  
14 does not belong to you. It belongs to whoever is  
15 assigned by the Deputy Minister?

16 DR. DAVID WILLIAMS: The stockpile is  
17 one component of the plan, and because it requires  
18 purchase and procurement, is usually under a  
19 Director. In this case, it was under the Director  
20 of the Health Services Emergency Measures branch,  
21 which was, up until 2018, reporting to the ADM,  
22 Martino. And then it switched over to reporting to  
23 me.

24 JOHN CALLAGHAN: So that is as an ADM,  
25 not as the Chief Medical Officer of Health?

1 DR. DAVID WILLIAMS: Correct.

2 JOHN CALLAGHAN: So the Chief Medical  
3 Officer of Health can prepare a plan but has no  
4 authority or responsibility to ensure the necessary  
5 supplies are available to execute the plan; is that  
6 what I am understanding?

7 DR. DAVID WILLIAMS: Yes, there is a  
8 number of components in there that hospitals are  
9 required to do and different things that ask them  
10 to put in place, but you don't actually are  
11 responsible for delivering those. They are  
12 responsible to put those actions in place, and one  
13 is the stockpile and different components of it in  
14 there.

15 JOHN CALLAGHAN: So can you tell me  
16 then, going back to preparedness, what document do  
17 I look at to find the provincial plan?

18 DR. DAVID WILLIAMS: So you have the  
19 initial one, the one we did a lot of work on, the  
20 2006, and then you have the one -- the updated one  
21 on 2013. And we had discussions at the  
22 federal/provincial/territorial level on some  
23 components of it in there.

24 Most of it was on the discussion --  
25 ongoing discussions of antivirals and vaccines.

1                   JOHN CALLAGHAN: So I am looking for --  
2   if you were going to tell me what the plan was,  
3   what documents am I looking at? It is a plan,  
4   right? It is supposed to be written. So what is  
5   the plan? You have got the 2006 you say.

6                   DR. DAVID WILLIAMS: Correct.

7                   JOHN CALLAGHAN: What else?

8                   DR. DAVID WILLIAMS: And the 2013  
9   update on that.

10                  JOHN CALLAGHAN: Right.

11                  DR. DAVID WILLIAMS: And then we have  
12   it incorporated in our Ontario Influenza Plan. And  
13   then we have other ones that don't deal with a  
14   pandemic such as Ebola, et cetera.

15                  JOHN CALLAGHAN: Okay. Well, so you  
16   would have failed the test.

17                  DR. DAVID WILLIAMS: No --

18                  JOHN CALLAGHAN: Mr. Shingler gave us  
19   about five other documents we had to look at to  
20   find the plan, including the Ebola Step-Down Plan,  
21   the Ready and Resilient slide deck, another one.  
22   Like there are about five of them.

23                  DR. DAVID WILLIAMS: They are not  
24   pandemic plans.

25                  JOHN CALLAGHAN: Did you know that?

1 DR. DAVID WILLIAMS: They are not  
2 pandemic plans.

3 JOHN CALLAGHAN: I asked for the COVID.  
4 So you are saying for the COVID pandemic, that  
5 wasn't what we were supposed to look at, because  
6 that is what he told us to look at when he  
7 testified.

8 DR. DAVID WILLIAMS: We didn't have a  
9 COVID pandemic plan because I know --

10 JOHN CALLAGHAN: I understand that.

11 DR. DAVID WILLIAMS: And what you  
12 referred to, the Ebola one, is not a pandemic plan.

13 JOHN CALLAGHAN: Okay. So when he told  
14 us that was the plan, he was wrong?

15 DR. DAVID WILLIAMS: That was the plan  
16 for the Ebola, that's correct.

17 JOHN CALLAGHAN: It had no bearing on  
18 this. Okay. Are you aware that even Shelley  
19 Deeks, who was the head of pandemic preparedness at  
20 Public Health Ontario, had no idea what plan you  
21 were operating under?

22 DR. DAVID WILLIAMS: She was not the  
23 head of pandemic preparedness. She was the VP, and  
24 her original job was vaccinations.

25 JOHN CALLAGHAN: I think she said she

1 was responsible for preparedness, but we'll check  
2 the record. I might be wrong.

3 DR. DAVID WILLIAMS: She has the Public  
4 Health Ontario's aspect, and she would be involved  
5 in various committees looking at pandemic planning,  
6 and she had been on some federal ones in the past.

7 JOHN CALLAGHAN: Well, okay. So let's  
8 assume the Commissioners accept what she said. Do  
9 you think she should have an understanding of what  
10 the pandemic plan was before we went into COVID?

11 DR. DAVID WILLIAMS: Yes.

12 JOHN CALLAGHAN: And what plan -- okay.  
13 So she doesn't. You differ with Mr. Shingler. So  
14 I'm just trying to figure out how did you expect  
15 other people in the health sector or other people  
16 who might be interested because they are going to  
17 be exposed to in this in the province to understand  
18 what plan the province was acting on? How was that  
19 to happen?

20 DR. DAVID WILLIAMS: Well, I mean, even  
21 if you look at the 2006, the details, the detailing  
22 down to it is still quite applicable, and we had  
23 followed a lot of the stuff in there and a number  
24 of aspects.

25 The stockpile is a very small part of

1 it, but it is --

2 JOHN CALLAGHAN: I'm not talking about  
3 the stockpile. I'm talking about --

4 DR. DAVID WILLIAMS: So the plan was  
5 reviewed and says it is still value. Look at the  
6 Public Health measures. Look at the data  
7 calculations on the attack rates. Look at the  
8 forecasts, you know, what the number of  
9 hospitalizations and death rates would be and how  
10 that is done, the component of what is the use of  
11 different Public Health measures. You'll see that  
12 we emulate a number of those in our plan with the  
13 pandemic.

14 So we did not ignore those. We used  
15 them.

16 JOHN CALLAGHAN: I am not saying you  
17 ignored any of them. I am just saying that it  
18 doesn't appear to have been a plan. And what I am  
19 asking about is -- we heard evidence about Ready  
20 and Resilient. Are you familiar with Ready and  
21 Resilient?

22 DR. DAVID WILLIAMS: That is an aspect  
23 that Mr. Shingler brought in to say, as we go  
24 forward in the health system, dealing with  
25 infectious disease impacts, such as Ebola and



1 others, not pandemic in particular, we need a Ready  
2 and Resilient system.

3 JOHN CALLAGHAN: So this Commission has  
4 heard from the expert from the European Union on  
5 pandemic preparedness who says -- he generally  
6 agrees that you need to have an all-purpose plan,  
7 which is what Mr. Shingler was talking about. And  
8 that, he said, was Ready and Resilient. And he  
9 told us that in 2016 the then Minister started  
10 phase one, and it never got completed.

11 So do you have any knowledge about the  
12 Ready and Resilient plan and why it wasn't  
13 completed in four years before COVID?

14 DR. DAVID WILLIAMS: In 2016, I was not  
15 part of those discussions. But the Ready and  
16 Resilient is how does one prepare for the inflow of  
17 a number of infectious diseases, not necessarily a  
18 pandemic, but also included in that, but as was  
19 raised by awareness by Ebola, and that is where a  
20 lot of that --

21 JOHN CALLAGHAN: I am not asking you to  
22 describe the plan. I'm asking as a matter of  
23 process.

24 DR. DAVID WILLIAMS: The process was in  
25 place, and they were doing reviews on it.

1                   JOHN CALLAGHAN: For four years?

2                   DR. DAVID WILLIAMS: At different  
3 times, changeover of different individuals and  
4 aspects there and structure.

5                   JOHN CALLAGHAN: Did you ever go to the  
6 Minister and say, We don't have a cohesive plan?

7                   DR. DAVID WILLIAMS: We presented the  
8 Ready and Resilient to the Deputy Minister.

9                   JOHN CALLAGHAN: And did she reject it?

10                  DR. DAVID WILLIAMS: No, she  
11 understood --

12                  JOHN CALLAGHAN: Why in your opinion  
13 did the province have planning for four years in  
14 respect of something so important as a pandemic  
15 plan?

16                  DR. DAVID WILLIAMS: Ready and  
17 Resilient is not a pandemic plan.

18                  JOHN CALLAGHAN: Well, it was the plan  
19 that Mr. Shingler said would have responded to the  
20 pandemic had it been finished. So why was it not  
21 done?

22                  DR. DAVID WILLIAMS: Because it was not  
23 completed.

24                  JOHN CALLAGHAN: All right. So there  
25 was no -- this was peacetime, no priority?

1 DR. DAVID WILLIAMS: Yes.

2 JOHN CALLAGHAN: So if you go to tab

3 5 --

4 SUNIL MATHAI: Commissioner Marrocco,  
5 it is Sunil. I just want to make sure one thing.  
6 And it is a factual inquiry. I have no concerns  
7 with this line of inquiry.

8 Mr. Callaghan, there has been a number  
9 of times that you have suggested that the  
10 stockpile -- sorry, the Ready and Resilient review  
11 began in 2016, but I think the evidence that you  
12 heard was that -- and I apologize, I was away  
13 because my son was born during this period of time,  
14 so I didn't attend that presentation, but I think  
15 you are misspeaking, that the Ready and Resilient  
16 began in 2008 -- sorry, 2018.

17 JOHN CALLAGHAN: Okay. Well, let's  
18 take that up. Can we put up document 4.

19 COMMISSION CHAIR FRANK MARROCCO: Just  
20 hold on a minute. What were you saying? So it is  
21 the date?

22 SUNIL MATHAI: Yes, just the date,  
23 Commissioner Marrocco. Mr. Callaghan was  
24 suggesting it started in 2016. But I think the  
25 evidence that he heard was that it started in 2018,

1 that there was a stockpile review that began in  
2 2016. I think there may be just some confusion of  
3 that date. But I just wanted to -- and maybe I  
4 stand to be corrected, and Mr. Callaghan can do  
5 that now, as I understand he is going to bring up a  
6 document.

7 COMMISSION CHAIR FRANK MARROCCO:  
8 Mr. Callaghan, when did Mr. Shingler say this  
9 started?

10 JOHN CALLAGHAN: The project started in  
11 2016 when phase one was done. I don't plan to  
12 spend a lot of time because we are losing time  
13 here. I can show you the document, tab 4. He said  
14 it started with the Ebola Step-Down Plan, and the  
15 planning phases were three phases.

16 And if you go to page 15, this is July  
17 of 2016, and his evidence was -- and we had slide  
18 decks to this effect because we had slide decks  
19 saying it would have been ordinarily done in 2016.  
20 They had just been doing phase one. And they were  
21 going to do phase two and three, which never got  
22 done.

23 In 2018, there was another portion of  
24 it done, another report done, and that is tab --  
25 here we go. And we'll take you to page 3, which

1 outlined the existing problems and challenges with  
2 the system.

3 So I'm not suggesting it didn't  
4 continue in 2018. It started in 2016 with the  
5 Ebola Step-Down Plan, and they got through phase  
6 one. And what I understood Mr. Shingler said,  
7 there was not -- and maybe I'm hearing the same  
8 from Dr. Williams, there wasn't the political will  
9 to get it done in peacetime. Am I right on that,  
10 Dr. Williams?

11 COMMISSION CHAIR FRANK MARROCCO: Well,  
12 before you ask Dr. Williams a question, I think,  
13 Mr. Mathai, that that corresponds with the evidence  
14 that I recollected we heard about dates.

15 So I am not going to get into it any  
16 further.

17 SUNIL MATHAI: Yes, that is fine,  
18 Commissioner Marrocco.

19 COMMISSION CHAIR FRANK MARROCCO: All  
20 right. Thank you.

21 So now, Mr. Callaghan, you were going  
22 to pose a question to Dr. Williams.

23 JOHN CALLAGHAN: Well, Doctor, I  
24 understood you said that this was an element of  
25 peacetime. Was there no political will to complete

1 this project between 2016 and the end of 2019 and  
2 beginning of 2020?

3 COMMISSION CHAIR FRANK MARROCCO: Just  
4 a second. Deana, did you get the question?

5 THE COURT REPORTER: Yes, I heard it.

6 COMMISSION CHAIR FRANK MARROCCO: Okay.  
7 Thank you. Doctor, did you get the question?

8 DR. DAVID WILLIAMS: I did get the  
9 question. I would have to say, when I first heard  
10 about the Ready and Resilient system that came to  
11 my attention, it was more when I had resumed the  
12 ADM responsibilities. I had seen some concepts  
13 around it following the Ebola that we looked at  
14 where the key issue there was, if we are going to  
15 respond, we need a health care system that is Ready  
16 and Resilient to respond to these issues.

17 It was not dealing with pandemic, per  
18 se, where we were talking about having -- we  
19 realized that with Ebola, not every hospital could  
20 cope with it. How do we have a tiered structure  
21 where cases identified could be moved from one to  
22 the other. So there was a desire to have a health  
23 care system that was Ready and Resilient to respond  
24 to these infectious disease agents, that Ebola made  
25 us only but aware of and to bring in there.

1                   So part of that was -- the ongoing  
2 discussion is how does one look at the structuring  
3 of a health care system with its various regional  
4 structures, referral systems, the LHIN system at  
5 the time, so that one can --

6                   JOHN CALLAGHAN: I hear this. I am not  
7 really interested in the theory. I'm interested in  
8 the process. So, you know, we heard evidence, when  
9 we heard about the stockpile, which suggested the  
10 plan was the 2013 plan. The plan hadn't been  
11 actually upgraded or practiced would have been the  
12 evidence.

13                   And then we heard that really what was  
14 these other plans -- and we were given a whole  
15 bunch of them as to what the plan was, and we were  
16 told that this is what was in the works to address  
17 all the things you say a general plan but was  
18 intended to address a pandemic.

19                   And so the question is -- and I am not  
20 going to take you through because we have been  
21 through this. You see on the screen a lot of the  
22 problems that are identified by Mr. Shingler that  
23 have to be fixed.

24                   And what I am suggesting is it wasn't  
25 fixed, and I am asking you, was that the failure on

1 your part, or was that the failure on the political  
2 establishment and the people higher than you who  
3 didn't push this through?

4 DR. DAVID WILLIAMS: So as I said  
5 before, this was not part of a pandemic plan, which  
6 is what I was concerned with. A lot had thought  
7 about at that stage that probably a pandemic might  
8 never occur.

9 This was dealing with -- the real issue  
10 they were dealing with at the time is do you have a  
11 health care system that can deal with invading  
12 infectious diseases that would give impacts on the  
13 health care system such as that Ebola demonstrated  
14 the need for.

15 So as you see, you don't see pandemic  
16 in there, referring to that in particular. So  
17 therefore, I think you are mixing the two  
18 together --

19 JOHN CALLAGHAN: Explain --

20 DR. DAVID WILLIAMS: Excuse me, I  
21 haven't finished yet. This was dealing with the  
22 issue of how do you make sure that the health care  
23 system can deal with these incoming infectious  
24 disease issues in all these different components  
25 there coming out of the Ebola, because we did the



1 whole service, and this was the early planning  
2 process that would go towards policy formulation  
3 that would go towards system-wide implementation.

4 So these take a number of steps to get  
5 there. So this was the early discussions and how  
6 to put all these things in place, a rationale for  
7 doing that, the necessity to do that, and all these  
8 aspects to deal with to be Ready and Resilient to  
9 deal with invasive infectious disease entities that  
10 might come into our hospital health care system.

11 JOHN CALLAGHAN: Like a pandemic.

12 DR. DAVID WILLIAMS: No, like Ebola.

13 JOHN CALLAGHAN: Okay. So that is  
14 different evidence than we got from Mr. Shingler.

15 DR. DAVID WILLIAMS: A pandemic is a  
16 different thing altogether, in my mind.

17 JOHN CALLAGHAN: So your evidence is we  
18 are back to the 2013 plan that was never updated in  
19 seven years? Is that what you are saying?

20 DR. DAVID WILLIAMS: Plans are updated  
21 as the need is for them.

22 JOHN CALLAGHAN: So for seven years  
23 under your entire -- for seven years you never felt  
24 the need to increase your pandemic plan, your  
25 influenza pandemic plan?

1 DR. DAVID WILLIAMS: Because the  
2 pandemic plan -- and even now, you look at the  
3 2006, a lot of the steps we have taken are  
4 consistent with that because we did quality work  
5 back in 2006.

6 JOHN CALLAGHAN: We'll talk about how  
7 consistent it is, but you are saying, in your  
8 opinion, it was your decision not to upgrade the  
9 2013 plan; that is your decision; correct?

10 DR. DAVID WILLIAMS: No, I was not  
11 asked to update the plan until we looked at it, and  
12 we were on national committees doing different  
13 annexes and subsections. So those annexes and  
14 things were looked at and reviewed at our FPT  
15 levels.

16 JOHN CALLAGHAN: As the Chief Medical  
17 Officer of Health, you told me you had the  
18 responsibility for preparedness, so I take it --

19 DR. DAVID WILLIAMS: To make sure it is  
20 consistent with the Canadian plan, that's correct.

21 JOHN CALLAGHAN: Well, the Canadian  
22 plan, that was updated over time; correct?

23 DR. DAVID WILLIAMS: Annexes were  
24 changed and updated, and we had committees working  
25 on that.

1 JOHN CALLAGHAN: The Canadian plan?

2 DR. DAVID WILLIAMS: And our plan has  
3 to be consistent with the Canadian plan.

4 JOHN CALLAGHAN: Well, you'll have to  
5 provide them to me, because we were given the 2013  
6 plan and all the documents were 2013, and we were  
7 told that it wasn't updated, so you are telling us  
8 something different now.

9 DR. DAVID WILLIAMS: If it was  
10 necessary to update, we would, but you see the  
11 Ontario plan for 2013 is a synopsis of how the plan  
12 status is at the time.

13 JOHN CALLAGHAN: So I don't know. It  
14 is not that complicated. I mean, we were told the  
15 2013 plan was not updated. We were then told,  
16 Well, in fact, there are all these other things,  
17 the Ebola Step-Down Plan, the Ready and Resilient,  
18 and now you are saying the 2013 plan wasn't. And  
19 we'll take the record as it is, but that is your  
20 evidence. Your evidence was it was updated, okay.

21 DR. DAVID WILLIAMS: As necessary and  
22 as needed for an influenza pandemic.

23 JOHN CALLAGHAN: Was it in fact  
24 updated. Not as needed. Was it in fact updated  
25 from 2013 to your knowledge?

1 DR. DAVID WILLIAMS: Not to my  
2 knowledge. I didn't see a new typed-up version  
3 signed off, no.

4 COMMISSION CHAIR FRANK MARROCCO: All  
5 right. We have exhausted this topic.

6 JOHN CALLAGHAN: Yes, let's move --

7 COMMISSION CHAIR FRANK MARROCCO: I did  
8 want to ask Dr. Williams, though, we have heard  
9 that the shortage of personal protective equipment  
10 was a serious problem at the beginning of this  
11 pandemic, and we have heard about it as a serious  
12 problem in the context of long-term care homes and  
13 the access that workers there, staff there, had to  
14 personal protective equipment.

15 And I guess I wanted to ask you, as the  
16 Chief Medical Officer of Health, you weren't  
17 responsible you said for the stockpile, but did you  
18 know that the stockpile was being destroyed and not  
19 replaced?

20 DR. DAVID WILLIAMS: Yes, I had been  
21 made aware that -- even before I assumed the ADM  
22 function that there was a lot of expired materials,  
23 and they were going about the process of removing  
24 them, instead of storing them, and to deal with  
25 that issue. So that process had already been set

1 in place.

2 COMMISSION CHAIR FRANK MARROCCO: Did  
3 you have a view on whether or not it was important  
4 to replenish the stockpile?

5 DR. DAVID WILLIAMS: Yes, I had a view.  
6 I wanted to replenish, especially the antiviral  
7 stockpile.

8 COMMISSION CHAIR FRANK MARROCCO: And I  
9 take it that was -- because the stockpile wasn't  
10 replaced, that your view was not accepted by --  
11 what? The Deputy Minister?

12 DR. DAVID WILLIAMS: No, we put  
13 submissions in to the financial planning for the  
14 replenishment of the antiviral stockpile. I had  
15 discussions with the Deputy and with the Minister,  
16 because in the initial plan, the federal government  
17 agreed they would maintain up to 60 percent of the  
18 stockpile, and that had waned away, so they weren't  
19 giving us anything. So could we open that  
20 discussion again, just because for everyone to  
21 maintain that on a real basis, enough to supply, it  
22 was going to be an ongoing issue and maybe at a  
23 federal, like we do with our vaccines, to have a  
24 national purchasing process, we could do it much  
25 more efficiently.

1 But we had put in budget amounts for  
2 the next coming three years of how we would buy  
3 volumes of antivirals to replenish our stockpile.

4 COMMISSION CHAIR FRANK MARROCCO: And  
5 that was not accepted?

6 DR. DAVID WILLIAMS: It was still in  
7 the process. We were going to start purchasing in  
8 the year 2021 and going on to '21/'22 and '22/'23.

9 COMMISSION CHAIR FRANK MARROCCO: When  
10 was it destroyed?

11 DR. DAVID WILLIAMS: They started  
12 destroying some back in 2017 and '18, some expired  
13 materials, yes, because it expired long ago.

14 COMMISSION CHAIR FRANK MARROCCO: And  
15 you sounded the alarm when they started destroying  
16 or when the decision was made to destroy it?

17 DR. DAVID WILLIAMS: No, that decision  
18 was already made before. I understood that expired  
19 equipment, you really can't be using it, because if  
20 you are going to give staff expired equipment, that  
21 is really not proper. You need to buy approved and  
22 certified and current materials.

23 So you needed to replace them, if you  
24 need to do that in that.

25 So we knew that NIOSH and groups like

1 that would not at all back you up for using expired  
2 products.

3 COMMISSION CHAIR FRANK MARROCCO: Well,  
4 I wasn't suggesting that you would think it was a  
5 good idea for people to use expired health  
6 products. I can assure you I was not suggesting  
7 that.

8 DR. DAVID WILLIAMS: Thank you.

9 COMMISSION CHAIR FRANK MARROCCO: So  
10 when you find out that the decision is made not to  
11 replenish the stockpile, that is when you raise --  
12 that is when you sound the alarm that this is not a  
13 good idea; have I got that correct?

14 DR. DAVID WILLIAMS: The alarm -- my  
15 main focus was on the antiviral stockpile. So we  
16 needed to get that replenished just because it was  
17 so vital to us every year to contain outbreaks,  
18 especially in long-term care homes, is the use of  
19 antivirals, which over time we felt were as equal,  
20 if not maybe superior, to vaccination alone. So we  
21 really had put -- and we had many over the time  
22 meetings at the federal level, FPT levels, looking  
23 at how we might replace this and get this properly  
24 handled.

25 COMMISSION CHAIR FRANK MARROCCO: So

1 when there is a decision made not to replace the  
2 stockpile immediately, then what happens is the  
3 pandemic hits before any decision -- any different  
4 decision is put in place.

5 DR. DAVID WILLIAMS: Correct.

6 COMMISSION CHAIR FRANK MARROCCO: And  
7 did you agree that the shortage of personal  
8 protective equipment was a critical problem in the  
9 early days in March and even perhaps earlier as  
10 this pandemic tidal wave is heading our direction?

11 DR. DAVID WILLIAMS: So when we  
12 declared it, for the month of February, because we  
13 had not a lot of cases, it was -- in the first few  
14 weeks, it was not seen as an issue, but as it  
15 escalated, we became aware that the supply chain  
16 management was having difficulty at all sectors of  
17 purchasing, and it became a global shortage.

18 And so I became aware more in, like,  
19 the second or third week of February that this was  
20 a big problem, and it was escalating especially  
21 because not only even before we had cases, a lot of  
22 cases in our facilities, we were having a lot of  
23 uptake and usage, burn-through rates of PPE by some  
24 of our facilities.

25 So we became aware that we were already



1 into a supply management issue and challenge we had  
2 to really work at stridently.

3 COMMISSION CHAIR FRANK MARROCCO: And I  
4 don't think it is particularly difficult, but I am  
5 just asking you whether I have got it right. The  
6 whole world is trying to buy personal protective  
7 equipment at the same time.

8 DR. DAVID WILLIAMS: Correct.

9 COMMISSION CHAIR FRANK MARROCCO: And  
10 there is a shortage.

11 DR. DAVID WILLIAMS: Correct. And I  
12 think what was surprising to me is that in the  
13 globalization of things, we assumed that our  
14 companies that supplied us made it onshore, and  
15 that big companies located in Canada and the United  
16 States were making it. And we found out in the  
17 overall global thing a lot of it had moved offshore  
18 and some components, critical components. And that  
19 was startling and shocking to me that that had  
20 happened in there because it is something that I  
21 thought we had in-house, anyways. In North America  
22 at least.

23 COMMISSION CHAIR FRANK MARROCCO: So a  
24 lot of it was being made in China?

25 DR. DAVID WILLIAMS: And it really

1 became shocking to me that N95s in particular, the  
2 main place worldwide, the global centre making it,  
3 was in this place called Wuhan, which I didn't even  
4 know the name of Wuhan before this whole thing  
5 started, but then to find that out, that was very  
6 perplexing.

7                   JOHN CALLAGHAN: Can I ask, Doctor,  
8 that seems at odds with some of the documents we  
9 have seen. There was a 2006 Cabinet submission  
10 that followed SARS that basically said you had to  
11 be careful about supply chain because a lot of  
12 these products were made in Asia. So you weren't  
13 aware of that?

14                   DR. DAVID WILLIAMS: I was aware that  
15 some of the products were there, and we thought the  
16 supply chain was robust enough to deal with that  
17 and that you weren't -- as we said, to be not  
18 dependent on that.

19                   JOHN CALLAGHAN: So exactly -- I have  
20 not seen any records because they may not have been  
21 produced, but what did you do to verify your  
22 assumption?

23                   DR. DAVID WILLIAMS: That wasn't -- the  
24 procurement issue wasn't and the companies wasn't  
25 that. That was our committee had raised that as a

1 broad issue for the procurement sectors of our  
2 governments and other groups to look at, mostly  
3 with health care sectors too to look at their  
4 supply chain management.

5 JOHN CALLAGHAN: But in fairness, you  
6 weren't buying anything for the stockpile, so what  
7 supply chain did you have for purposes of a  
8 pandemic supply?

9 DR. DAVID WILLIAMS: Well, in 2006, we  
10 did buy --

11 JOHN CALLAGHAN: No, I'm talking  
12 afterwards. You say --

13 DR. DAVID WILLIAMS: We kept buying the  
14 small volume of material for us.

15 JOHN CALLAGHAN: I understand, and  
16 basically I think the evidence we have, but for  
17 Ebola, from about 2016 or 2014 on, there wasn't  
18 much purchased, and it was all rotting, as it were,  
19 going bad and --

20 DR. DAVID WILLIAMS: A large volume of  
21 the stockpile was not being replaced, that's  
22 correct. We kept our side, because our volume  
23 was for -- hospital sectors and other institutions  
24 were required to have a four-week supply.

25 JOHN CALLAGHAN: Right, and from your

1 perspective, you weren't dealing with a supply  
2 chain because, as the person responsible for the  
3 stockpile, you weren't buying any; correct?

4 DR. DAVID WILLIAMS: Because our people  
5 said they had enough stock, and the government was  
6 looking at a whole new supply chain management to  
7 be much more efficient and effective, so our  
8 stockpile --

9 JOHN CALLAGHAN: Right, so you had --

10 DR. DAVID WILLIAMS: And we didn't use  
11 much -- sorry?

12 JOHN CALLAGHAN: So you had no --

13 COMMISSION CHAIR FRANK MARROCCO: No,  
14 just a minute, Mr. Callaghan. Let Dr. Williams  
15 finish what he was saying.

16 DR. DAVID WILLIAMS: Our experience  
17 with the H1N1, we didn't have to use much of the  
18 stockpile, and including also with Ebola around  
19 those materials such as gloves and some of the  
20 materials in that. We used more for buying  
21 products with our large vaccine campaign in there  
22 because our supplies were more to help doctors'  
23 offices, whereas the hospitals and institutions  
24 were to maintain their supply for the first four  
25 weeks, so that -- we should have enough to last us

1 for the month of February in that sense.

2 So we were looking at how much we  
3 should buy and procure, but it was more important  
4 that we have access to a very effective and  
5 efficient supply chain because of the turnover and  
6 the materials necessary. We found in Ebola there  
7 was some things we didn't have that were much more  
8 important to deal with that, such as PAPRs, more  
9 ventilators, and the overalls and those type of  
10 equipment that are more specific for Ebola that we  
11 needed to pick up on those, and we probably have to  
12 keep being aware of new things that might come in  
13 that normally hospitals and other institutions  
14 don't buy a lot because it only comes once in  
15 awhile, but we want to be Ready and Resilient, and  
16 that was part of that process, and we needed to buy  
17 those things as well. So we did put those ones  
18 into our system.

19 JOHN CALLAGHAN: That was in 2016, as I  
20 understand it.

21 DR. DAVID WILLIAMS: Yes, in 2016 and  
22 2017 --

23 JOHN CALLAGHAN: Right. So nothing in  
24 the subsequent years, but did you have any insight  
25 in terms of the state of PPE at long-term care

1 homes?

2 DR. DAVID WILLIAMS: Myself, no. I  
3 assumed they were supposed to have their four-week  
4 supply.

5 JOHN CALLAGHAN: Right, and you weren't  
6 aware that the Auditor General, the last time she  
7 looked in 2007, less than 50 percent had -- I have  
8 forgotten the number, but a significant number  
9 didn't have anywhere near that. Were you aware of  
10 that, or was that something that you would have  
11 left to long-term care?

12 DR. DAVID WILLIAMS: I was aware that  
13 it was to long-term care to resolve the issue, and  
14 I assumed that with that warning, they would pick  
15 back up and put that in place.

16 JOHN CALLAGHAN: Well, the models that  
17 were used in 2016 was an influenza pandemic with  
18 18,000 deaths. Were you aware of that? That was  
19 the plan.

20 DR. DAVID WILLIAMS: That is the data,  
21 the calculation of the 2006 as well, yes.

22 JOHN CALLAGHAN: And you are aware that  
23 they modelled the necessary PPE for various  
24 sectors, including the long-term care sector?

25 DR. DAVID WILLIAMS: I didn't see the

1 long-term care sector in particular.

2 JOHN CALLAGHAN: So they did, and we  
3 have had evidence on it. It has been in the  
4 record.

5 And we were told -- and maybe you would  
6 appreciate that -- that if that stockpile had been  
7 purchased as planned in 2006, we wouldn't have any  
8 shortage of PPE; were you aware of that?

9 DR. DAVID WILLIAMS: If the long-term  
10 care homes had purchased that?

11 JOHN CALLAGHAN: No, if the stockpile  
12 that the province was required to have, then we  
13 would not have had a problem.

14 DR. DAVID WILLIAMS: That wouldn't have  
15 assisted the long-term care. It was not for the  
16 long-term care.

17 JOHN CALLAGHAN: I'm sorry, you are  
18 saying that the provincial stockpile wasn't to help  
19 the province, including the long-term care sector?  
20 They were excluded from using the stockpile?

21 DR. DAVID WILLIAMS: If it was  
22 unusual -- our stockpile was to equip primary care  
23 physicians in their offices.

24 JOHN CALLAGHAN: Okay. So the province  
25 never had a plan, notwithstanding the age and

1 illness level of people in long-term care, to have  
2 a stopgap for PPE in the event that they ran out?  
3 That was never the plan for the province? I just  
4 want to make sure we understand.

5 DR. DAVID WILLIAMS: The plan was that  
6 they were to have their own stockpile for four  
7 weeks.

8 JOHN CALLAGHAN: So that is all. So  
9 the documents we have seen that specifically  
10 suggest that the province was to have a four-week  
11 stockpile and the long-term care homes were to have  
12 a four-week stockpile, those are documents you are  
13 not familiar with?

14 DR. DAVID WILLIAMS: That the long-term  
15 care homes and hospitals were supposed to have a  
16 four-week stockpile.

17 JOHN CALLAGHAN: But also the province  
18 was to have some eight weeks of stock. Eight  
19 weeks, that was the plan. But you are saying you  
20 don't think the province's stockpile was to apply  
21 to long-term care, and they were supposed to only  
22 have four weeks?

23 DR. DAVID WILLIAMS: If you look at the  
24 volume in 2006, if you look at the purchase volume,  
25 that would only supply doctors' offices and other



1 smaller health clinics and stuff like that. That  
2 was what it was purchased for.

3 COMMISSION CHAIR FRANK MARROCCO: So,  
4 Doctor, if we were told that there was four  
5 weeks -- the long-term care facilities were to have  
6 four weeks, and the province would have four weeks  
7 of supplies, which were available to the long-term  
8 care homes when their supplies ran out, you are  
9 saying that is not correct; that is not what the  
10 stockpile was for?

11 DR. DAVID WILLIAMS: My understanding  
12 is the stockpiles we have in our plan was that we  
13 had -- if you look at the volume that we purchased,  
14 that would give enough to give doctors' offices,  
15 and that is one of the things we ran into right  
16 into the pandemic, that we didn't have enough to  
17 give them, the IPAC materials to all the doctors'  
18 offices to keep all the primary care physician  
19 offices open and running. We had to hold that back  
20 for others because they ran out.

21 And so that -- my understanding is we  
22 had to purchase, even the 40 million back in that  
23 time, if you have 15,000 physicians, and you are  
24 going to supply them for 30 days, there goes all  
25 your money. If you are going to do the whole

1 thing, you need about -- probably a \$2 billion  
2 stockpile in that to do that. And that is in 2006  
3 dollars, not in 2020.

4 So the sense was that if you had that  
5 for three to four weeks, by then you have got your  
6 supply chain up and running, and the new orders are  
7 coming in and people are meeting that, but it is  
8 harder for physicians in their offices in smaller  
9 centers to acquire that very quickly. They don't  
10 have the ordering procurement systems that other of  
11 these larger institutions have or should have put  
12 in place.

13 So that was one of the things we felt  
14 right from the get-go. Physician offices were  
15 saying we are not getting this. How are we  
16 supposed to run our practice in these early days  
17 and see people without the proper IPAC, but we had  
18 to hold back on that because already some others  
19 were needing them, such as long-term care, and we  
20 had to make a decision to make sure we kept it for  
21 the ones that are the most high priority, whatever  
22 we had left, not much. But it was never meant to  
23 supply the whole health care system for 4 to 8  
24 weeks. We would need a huge stockpile.

25 COMMISSION CHAIR FRANK MARROCCO:

1 I agree with you the absolutely  
2 unbelievable fact that the N95 masks are made in  
3 Wuhan and that North America has no capability to  
4 speak of to produce PPE. Once you get over that,  
5 did you also find out that we shipped -- Canada  
6 shipped PPE to China in February? Did you become  
7 aware of that?

8 DR. DAVID WILLIAMS: I understood that  
9 there was some decision by the federal authorities  
10 to do that to assist, because that was -- the WHO  
11 was looking for some assistance to help out on that  
12 because the sense was if you -- and they had real  
13 clear ideas that it could be contained within --  
14 not only within China but within the Wuhan province  
15 and prevent a pandemic.

16 COMMISSION CHAIR FRANK MARROCCO: In  
17 February?

18 DR. DAVID WILLIAMS: Yes, early  
19 February.

20 COMMISSION CHAIR FRANK MARROCCO: And  
21 did you find out about the shipment after or  
22 before, like the decision to ship a plane load of,  
23 you know, personal protective equipment in February  
24 when everybody is obviously getting ready for the  
25 virus to hit here?

1 DR. DAVID WILLIAMS: I found out  
2 afterwards, of course.

3 COMMISSION CHAIR FRANK MARROCCO:  
4 Afterwards, yes.

5 DR. DAVID WILLIAMS: But we were very  
6 much under the travel link that the source was, in  
7 early February, just from Wuhan city and then Wuhan  
8 province, and we were affirmed by the Chinese  
9 government and by WHO and by Health Canada that  
10 even centres like Beijing and Shanghai and others  
11 were not getting impacted, and they had it under  
12 control. And there was a sense --

13 COMMISSION CHAIR FRANK MARROCCO: And  
14 as well -- we were talking about this a little  
15 earlier. You know, as well as everybody knows,  
16 that with air travel, that can be all over in a  
17 matter of a few hours.

18 DR. DAVID WILLIAMS: Oh, we were very  
19 concerned about the travel.

20 COMMISSION CHAIR FRANK MARROCCO: Sure.  
21 And in any event, I don't want to go any further.

22 DR. DAVID WILLIAMS: Yes.

23 COMMISSION CHAIR FRANK MARROCCO: I  
24 thought, Doctor, we might take half an hour or so  
25 for lunch and a break now.

1                   JOHN CALLAGHAN: Mr. Commissioner, can  
2 I just finish one point, so I don't have to come  
3 back to the stockpile.

4                   COMMISSION CHAIR FRANK MARROCCO: Yes,  
5 by all means, if we can finish the stockpile.

6                   JOHN CALLAGHAN: And then it will be  
7 done. So can you just put up document 8, please.  
8 This is a presentation that this Commission was  
9 given in January. This is on the provincial  
10 stockpile. If we could go to page 8, and what we  
11 were told -- and I just want to make sure we are a  
12 hundred percent, that we don't have a  
13 misunderstanding, and we could take you to the  
14 Cabinet document that would seem to verify this,  
15 but it says:

16                               "The following guided the  
17 determination of volume of PPE  
18 needed for LTCHs:

19                               Numbers are based on a projected  
20 number of beds for 2006."

21                               And it goes through the number of  
22 interactions, the number of masks needed, and then  
23 it says:

24                               "Purchases were made between  
25 2006 and 2011 to align with these

1                   assumptions."

2                   We were told that was the stockpile,  
3                   and it is verified by Cabinet documents that that  
4                   was the intent, and your evidence is that is not  
5                   the case; is that correct?

6                   DR. DAVID WILLIAMS: Yes, because we  
7                   had another document on -- it was actually an  
8                   internal one reviewing the update on stockpile  
9                   review. The date of this one is -- I'm sorry, I  
10                  missed the date.

11                  JOHN CALLAGHAN: January of this year.

12                  DR. DAVID WILLIAMS: And I had one in  
13                  December of 2019.

14                  JOHN CALLAGHAN: Okay. Well, I am  
15                  talking about evidence that your department or  
16                  somebody on behalf of the government has given to  
17                  this Commission just last month.

18                  DR. DAVID WILLIAMS: And that may be  
19                  what they presented, that the 2006 -- as I said, if  
20                  you do the metrics in numbers, that amount that we  
21                  purchased in 2006 would not have been adequate to  
22                  supply the long-term care homes for four to eight  
23                  weeks.

24                  COMMISSION CHAIR FRANK MARROCCO: If I  
25                  may, Mr. Callaghan, I don't think we need to --

1 Doctor, if we were told that, that was not correct?

2 JOHN CALLAGHAN: Well --

3 DR. DAVID WILLIAMS: If you just do the  
4 math, it won't work out. And there was reviews  
5 back in 2019 that the scientific evidence said the  
6 use of stockpiles was actually not evidence and  
7 scientifically supported, and one should look at --  
8 you should move out of the old modality of  
9 stockpiles into the much more robust,  
10 multi-factored supply chain management, that  
11 obviously when it came into the issue,  
12 as Commissioner Marrocco, it was very much a key  
13 issue, just having a stockpile and then it is gone  
14 in three weeks. You need to have a much more  
15 better system of production of supply and demand, a  
16 supply chain management, was more the way we should  
17 be going in, and we were asked to address that  
18 early in 2019.

19 JOHN CALLAGHAN: So the evidence we  
20 heard was the stockpile in 2006 was a static  
21 stockpile. They didn't move it, that there was a  
22 stockpile. We were told that money was  
23 requisitioned and the money stopped in peacetime.

24 We were then told that in 2018/2019 Ms.  
25 Baumann was asked -- in 2018, I think, was asked to

1 look at it after things were being destroyed, and  
2 she said that, you know, her recommendation was  
3 they should do a supply chain management when we  
4 have a stockpile, but we rotate it out.

5 And so are you confusing the two, that  
6 there would still be a -- that the current modality  
7 is that there be a stockpile, just that it be a  
8 rotating stockpile, that there always be a safety  
9 net?

10 DR. DAVID WILLIAMS: Therefore, what  
11 you are getting at - and I think it is a good  
12 point - a stockpile is not a bottomless pit that  
13 you can get to depend on. You need to have a  
14 certain -- and you might make sure you have a  
15 warehouse, but you don't have -- everything on the  
16 shelf is all you have got. You have got a supply  
17 chain and a key system, and you move it through.  
18 Instead of having it sit there, can we have a  
19 system where we could buy and keep rotating, and so  
20 our stockpile is always being continually renewed  
21 and sent out to other ones to be used up so we are  
22 not going to sit with stuff for five years on the  
23 shelf.

24 The same as the anti-virals. We are  
25 saying that instead of us buying stuff that over



1 time expires, can we buy some, and is there a way  
2 we could use it to then go out to the wider sector  
3 that they could utilize as they need and so we can  
4 keep purchasing and updating.

5 So that is the supply chain that  
6 Ms. Baumann was talking about, and we were trying  
7 to drive towards that.

8 But those other sectors, such as  
9 hospitals and long-term care saying that we have  
10 our procurement systems and we have our things, we  
11 can't just interchange them like that and --

12 JOHN CALLAGHAN: Well --

13 DR. DAVID WILLIAMS: -- thought we  
14 could do that.

15 JOHN CALLAGHAN: All right. Well, I'm  
16 not sure I'm understanding your evidence, but we'll  
17 take a hard look at it when it comes.

18 That is fine, Mr. Commissioner.

19 COMMISSION CHAIR FRANK MARROCCO: So,  
20 Doctor, I thought we would take a half an hour for  
21 lunch. So 1:30.

22 SUNIL MATHAI: Sorry, Commissioner, it  
23 is Sunil Mathai here. Sorry, one thing I should  
24 flag is that the witness has a commitment at 2:30  
25 that he has to attend to. Originally this was

1 scheduled for 10:00 to 2:00. I don't know what the  
2 plan is for Mr. Callaghan and how far he wants to  
3 go. But all that was to say, while it might be a  
4 bit taxing, I'm wondering if we shortened this to a  
5 ten-minute break, and then continue on.

6 COMMISSION CHAIR FRANK MARROCCO: So,  
7 Doctor, we could shorten this to 10 minutes and  
8 continue on to 2:30 or just -- do you have to be  
9 somewhere at 2:30, or if we stop at 2:30, is that  
10 convenient for your purposes?

11 DR. DAVID WILLIAMS: Yes, 2:30 we have  
12 to go up, and we do have our press conference.

13 COMMISSION CHAIR FRANK MARROCCO: Oh.

14 DR. DAVID WILLIAMS: At Queen's Park.

15 COMMISSION CHAIR FRANK MARROCCO: Well,  
16 I guess if we are trying to demonstrate to the  
17 public that we are working, we could try to keep  
18 you here so you can't show up. But I don't think  
19 we'll do that. So we'll break for 10, come back at  
20 1:20, and then we'll go through to 2:30.

21 DR. DAVID WILLIAMS: Yes, I'll eat  
22 quickly. Thank you, Commissioner.

23 COMMISSION CHAIR FRANK MARROCCO: Thank  
24 you.

25 -- RECESSED AT 1:08 P.M.

1                   -- RESUMED AT 1:20 P.M.

2                   COMMISSION CHAIR FRANK MARROCCO: Let's  
3 carry on, Mr. Callaghan, and we'll stop at 2:30.

4                   JOHN CALLAGHAN: Moving on then,  
5 Doctor, just so that we are all on the same page  
6 here, I take it you subscribe to the precautionary  
7 principle, as articulated by Archie Campbell in his  
8 report?

9                   DR. DAVID WILLIAMS: I am aware of the  
10 precautionary principle, and I have worked at it  
11 and working with it for many years.

12                  JOHN CALLAGHAN: Right, so we can agree  
13 that particularly in the earlier stages of a  
14 pandemic, when evidence-informed decision-making is  
15 not possible due to the lack of data and  
16 uncertainty of an evolving event, that one should  
17 use the precautionary principle?

18                  DR. DAVID WILLIAMS: Knowing that it is  
19 not definitely defined what that means, my aspect  
20 is that when you don't have the evidence, you seek  
21 a consensus of expert opinion to give you advice  
22 and direction while you are waiting for evidence to  
23 be developed.

24                  JOHN CALLAGHAN: All right, but if  
25 evidence isn't possible due to the lack of data and

1     uncertainty of an evolving event, you take the most  
2     precautionary road; correct?

3             DR. DAVID WILLIAMS:   Well, on the  
4     extension -- in the lack of evidence, you go to the  
5     next best level up, which is expert opinion and  
6     consensus of expert opinion and to seek that,  
7     because the case control studies aren't done, all  
8     that kind of stuff, because the science doesn't  
9     turn things around that quickly.  So that is why  
10    you have various scientific advisory bodies to give  
11    you the best they can at that time.  And even if  
12    the evidence isn't solid, if they feel that is on a  
13    precautionary basis, if that is the level it should  
14    go to, that would be good.

15            But it doesn't mean ignore science  
16    totally, but it still has to be considered.

17            JOHN CALLAGHAN:   So if you have a  
18    difference of opinion, do you weigh them and take  
19    the one you think is best or do you default to the  
20    one that if you don't take will cause the most  
21    damage?

22            DR. DAVID WILLIAMS:   It is a  
23    combination of both there.  You listen to what --  
24    as any table of experts, they don't agree on every  
25    item exactly, but you seek to get that to -- well,

1 we seek to get that advice as much as possible, and  
2 then they balance that out, because of course some  
3 actions will have consequences if you don't take  
4 action there and that of course would be part of  
5 the expert opinion on the matter, on how to  
6 proceed, yes.

7 JOHN CALLAGHAN: I am not sure I fully  
8 understand it, but you are aware that a big issue  
9 here is when you take precautionary principles  
10 because there is the possibility that there could  
11 be asymptomatic spread? You realize that is a big  
12 issue in this situation?

13 DR. DAVID WILLIAMS: Do you mean in the  
14 latter half?

15 JOHN CALLAGHAN: The latter half of  
16 what?

17 DR. DAVID WILLIAMS: Of the pandemic,  
18 of where we are now in wave two?

19 JOHN CALLAGHAN: No, I mean at the  
20 beginning.

21 DR. DAVID WILLIAMS: There was no  
22 asymptomatic spread by scientific evidence at that  
23 time.

24 JOHN CALLAGHAN: At what time? When  
25 did you believe --

1 DR. DAVID WILLIAMS: At the beginning.

2 JOHN CALLAGHAN: When did you -- when  
3 do we take from your actions that you accepted that  
4 there was asymptomatic spread? What is the date?

5 DR. DAVID WILLIAMS: It would be more  
6 later in the summer, because as we looked at the  
7 data and the information there, even now some of  
8 our Public Health officials say that what is  
9 asymptomatic is someone who just doesn't recall  
10 exactly if they had any symptoms, mild ones, so it  
11 could be very mild symptoms.

12 JOHN CALLAGHAN: So what about  
13 community spread?

14 DR. DAVID WILLIAMS: Community spread  
15 is a different issue altogether.

16 JOHN CALLAGHAN: So you are saying it  
17 is not until the scientists tell you, and that is  
18 when you accept it?

19 DR. DAVID WILLIAMS: Of course.

20 JOHN CALLAGHAN: So when did you start  
21 to act like there was asymptomatic and community  
22 spread?

23 DR. DAVID WILLIAMS: Well, community  
24 spread and asymptomatic are different things.

25 JOHN CALLAGHAN: All right, so tell me

1 what the difference is in your planning and your  
2 execution.

3 DR. DAVID WILLIAMS: Community spread,  
4 when we started off in February, the mainstay of  
5 any infectious disease control mechanism is case  
6 contact management. That means everyone gets it  
7 from someone. Therefore, if you are going to try  
8 and control it, you need to identify who the person  
9 might or got it from and follow that person up and  
10 where they got it from, and also you are going to  
11 follow up whoever they contacted afterwards during  
12 their period of communicability to make sure you  
13 isolate them and control it, so if you are going to  
14 do case contact management.

15 If during that time you come to a level  
16 where you say that we can no longer get a sense of  
17 who got it from who, it just seems to be rising,  
18 and you move over from being epi-linked to saying  
19 more and more cases are now not epidemiologically  
20 linked. So the Public Health system is saying that  
21 there are so many cases occurring, and when we  
22 interview the people, we can't get any idea of it,  
23 so we are going to say it is community spread  
24 because it is out there and people say I can't  
25 remember where I got it from and I don't know who I

1 had contact with.

2 And so community spread does not mean  
3 asymptomatic. It means that you got it from  
4 someone who was harbouring it who was symptomatic  
5 that you can't remember talking to and doing  
6 whatever. That started to really become apparent  
7 in the second to third week of March, as our cases  
8 escalated from a few with travel history to more  
9 and more where the Public Health people in  
10 different areas started saying we are finding more  
11 and more cases. We can't identify their travel  
12 history and their contact history. And we just  
13 have to assume it has gone community-wide because  
14 we can't -- we are losing that case contact  
15 management capacity. And we said, okay, that is  
16 what we call community spread, because you are  
17 saying, in essence, the epidemiological evidence is  
18 lacking.

19 JOHN CALLAGHAN: So when in mid-March  
20 did you -- how did you describe your thoughts in  
21 mid-March and when?

22 DR. DAVID WILLIAMS: In mid-March --  
23 and let me see if I can get the chronology here.

24 As you see in the early part of March,  
25 all during February we had done an excellent job of



1 anyone who came in with a travel history, we  
2 contacted them and their contacts and that and we  
3 tested and ruled it out fairly quickly, so we were  
4 doing that.

5 All of a sudden in about the second or  
6 the third week of March, as you will see when our  
7 cases went from a few and they started almost  
8 tripling within a week, from an epi standpoint  
9 something has happened. And I started getting more  
10 and more reports after the second -- or the second  
11 week and third week of March that our health people  
12 were saying we can't get the epi-link. It has gone  
13 community-wide. We are losing it because we can't  
14 follow up on them.

15 And then I said, okay. And one Health  
16 Unit would say it and then another one, and I said,  
17 okay, it has got enough evidence now. We are going  
18 to have to take a different strategy here because  
19 you are no longer able to maintain case contact and  
20 control. And basically that is what they are  
21 saying, we can't -- we are not able to do it.

22 JOHN CALLAGHAN: So does that change  
23 your philosophy then at that time?

24 DR. DAVID WILLIAMS: Then you have to  
25 change your Public Health measure. You have to go

1 from case contact to wider Public Health measures,  
2 such as closing schools, such as limiting travel  
3 and different things like that, and start changing  
4 things, because if it has gone around and people  
5 don't know who they got it from and can't tell what  
6 contacts, you have to start limiting contacts. You  
7 have to put social distancing. You have to put in  
8 other things as you bring in there, as we find more  
9 and more information that people were saying, I  
10 don't know who I spoke to. I don't know what  
11 happened.

12 JOHN CALLAGHAN: So you end up chasing  
13 the virus rather than being ahead of it?

14 DR. DAVID WILLIAMS: You end up trying  
15 to contain the public's exposure as compared to  
16 exposure due to Public Health measures as compared  
17 to exposure due to case contact notification and  
18 saying, we understand you were talking to so and so  
19 five days ago. You were exposed to COVID and  
20 didn't know it. We need to test you. That is the  
21 case contact method.

22 If we can't do that, then we have to  
23 say -- we are going to have to say in broad  
24 measures that if you have signs or symptoms, go and  
25 get tested. If you are sick, stay home. If you

1 need hand hygiene, stay 2 metre distancing. And  
2 you started to put all this stuff in place saying  
3 right now you can't tell who you might be coming in  
4 contact with, so therefore, you are going to have  
5 to take personal measures to limit that. At the  
6 same time, if you think you have exposure, let us  
7 know. Some people still had a travel history.  
8 Some, a lot didn't have travel history.

9 So you change your strategy from case  
10 contact management to personal health measures,  
11 until the time you can get things back under  
12 control and bring it back into case contact  
13 management again, as in dealing with outbreak  
14 settings and locations.

15 JOHN CALLAGHAN: So let's just go  
16 there. I want to make sure I understand the flow  
17 of this.

18 So if we can go to document 13, this is  
19 one of the earlier documents that we seem to see  
20 the concept of asymptomatic spread, and this comes  
21 out of -- it is an email that makes its way to you,  
22 I believe, at some point. This goes to Barbara  
23 Yaffe for sure, because you are at the top. But it  
24 says, if you go down, this is an international --  
25 go down, Michael. So go down a little further

1 please. It says:

2 "The Australian Public Health  
3 authorities have articulated that:

4 'New international evidence  
5 suggests that asymptomatic or  
6 minimally symptomatic infection can  
7 occur, and that pre-symptomatic  
8 transmission has occurred in at  
9 least one case cluster'."

10 So that would be reliable information,  
11 I take it, from the Australian Public Health  
12 authorities?

13 DR. DAVID WILLIAMS: It is something  
14 that needs to be looked at.

15 JOHN CALLAGHAN: And at this time, you  
16 are aware then of things like the Diamond Princess  
17 and the other cruise ships?

18 DR. DAVID WILLIAMS: Yes.

19 JOHN CALLAGHAN: So I take it you are  
20 aware that -- are you cognizant of the fact that it  
21 will spread in a congregate setting?

22 DR. DAVID WILLIAMS: We are cognizant  
23 of the fact that it did spread in the passengers on  
24 the ship and staff.

25 JOHN CALLAGHAN: Would that make you

1     aware that it spreads in congregate settings?

2             DR. DAVID WILLIAMS:   If you have people  
3     coming in close contact with each other, it  
4     spreads, that's correct.

5             JOHN CALLAGHAN:   Right.   And the reason  
6     why we ask is because we are trying to figure out  
7     when people were thinking about long-term care  
8     homes.   So long-term care homes, you would agree,  
9     are a congregate setting; correct?

10            DR. DAVID WILLIAMS:   Yes.   And I mean,  
11     we agree that it is droplet spread, or enhanced  
12     droplet spread, much as we had before.   And so when  
13     people are in close contact over periods of time  
14     with each other without any barrier you can spread  
15     that from person to person.   That was our thesis  
16     from the get-go with influenza, and we assumed that  
17     was our case with coronavirus as well.

18            JOHN CALLAGHAN:   So let's go to tab 15  
19     for a second.   So this is a surveillance screening  
20     and testing meeting that you Chair, I think.

21            DR. DAVID WILLIAMS:   Uhm-hmm.

22            JOHN CALLAGHAN:   And it says there:

23                    "Most expert attendees agreed  
24                    that the widespread incidence of  
25                    COVID-19 is imminent and essentially

1                   inevitable."

2                   This is February 27th. So what did  
3 that mean then?

4                   DR. DAVID WILLIAMS: That "the  
5 widespread evidence of COVID-19 is imminent and  
6 essentially inevitable"?

7                   Our experts were saying that the way it  
8 was happening at that time in late in February,  
9 they are saying that it seems from other countries  
10 that had started experiencing this, that they moved  
11 quickly and they were seeing it happen in their  
12 jurisdictions, and we should consider this.

13                  JOHN CALLAGHAN: Right, so does that  
14 inform your decision-making?

15                  DR. DAVID WILLIAMS: Everything informs  
16 the decision-making, and so that means then we have  
17 to say those reviews in those areas and their  
18 public health infrastructure and system, how does  
19 it fit ours, yes or no. And then how does we take  
20 advice and direction accordingly.

21                  So all sources of things have to be  
22 vetted through and reviewed and seeing what is it  
23 based on. So we would say let's look at that, and  
24 we need to understand that really well.

25                  JOHN CALLAGHAN: Okay, and if we could

1 just go to, we have a set of notes of yours that  
2 someone has pulled last night for us.

3 I don't know what number they are,  
4 Michael. They are the ones in March.

5 Okay, so what I am going to go down to  
6 is if you go to the next page, and this is a note  
7 and it says, "Pre Brief". I can't read your notes,  
8 but it says:

9 "Pre-cautionary - where  
10 evidence is lacking.

11 Campbell."

12 So you are having regard to Archie  
13 Campbell's report?

14 DR. DAVID WILLIAMS: Yes, I am  
15 referring to the concept of the precautionary  
16 principle.

17 JOHN CALLAGHAN: And it says:

18 "Now we have the evidence.

19 Suggest limiting visitors"?

20 DR. DAVID WILLIAMS: Yes, from talking  
21 with the consultant Maureen Cividino.

22 JOHN CALLAGHAN: Who is she?

23 DR. DAVID WILLIAMS: She was one of the  
24 IPAC leads at -- she just retired last week. I  
25 worked for many years on PIDAC and stuff, so she is

1 one of the valuable infection prevention and  
2 control experts that I utilized.

3 And so as far as she was concerned,  
4 there was evidence that visitors could be a source  
5 of infection in the long-term care homes.

6 JOHN CALLAGHAN: Right. And did you  
7 also hear from the Local Medical Officer of Health  
8 from Ottawa to same effect at about that time?

9 DR. DAVID WILLIAMS: We were given good  
10 information coming in from various individuals,  
11 yes. That is one of the things that is important,  
12 is to hear all the different voices coming in with  
13 their various concepts and theses and ideas. It is  
14 part of the validity of the response, hearing all  
15 the --

16 JOHN CALLAGHAN: Well, if you go down a  
17 little further, it says:

18 "No evidence that it is not  
19 airborne?

20 What evidence is then necessary.

21 SARS - not airborne - but later  
22 proved it was.

23 SARS Commission - precautionary  
24 process."

25 Did I read that right?



1 DR. DAVID WILLIAMS: Yes, this person I  
2 wrote asked me that and posing those questions.

3 JOHN CALLAGHAN: Well, when you knew,  
4 you know that that was one of the reasons why  
5 Justice Campbell went with the precautionary  
6 principle, right, because it had an impact in not  
7 doing so in that case?

8 DR. DAVID WILLIAMS: Well, not in  
9 particular this one in there, but he had on a  
10 general basis. So I am saying that this person  
11 raised it, so we have to continue to look at the  
12 evidence and the science.

13 JOHN CALLAGHAN: Who was the person?

14 DR. DAVID WILLIAMS: I am going to  
15 guess, I have to look back at the concept -- oh,  
16 that is the head of CUPE.

17 JOHN CALLAGHAN: Sorry, I am not sure I  
18 can tell you which is the name. Is that the  
19 Michael?

20 DR. DAVID WILLIAMS: If you go above  
21 "Michael", you see up on the right "Michael -  
22 CUPE".

23 JOHN CALLAGHAN: Right.

24 DR. DAVID WILLIAMS: He is the lead of  
25 CUPE. We were at a meeting and he raised the

1 issue.

2 JOHN CALLAGHAN: So your expert is  
3 telling you that there is -- even where evidence is  
4 lack, and he is telling you that he believes we  
5 have evidence?

6 DR. DAVID WILLIAMS: That's correct.

7 JOHN CALLAGHAN: All right. And if we  
8 go over to the next page, and it says:

9 "Need discussion on shortage."

10 Is that "shortage"?

11 DR. DAVID WILLIAMS: Shortage.

12 JOHN CALLAGHAN: So we understand that  
13 the unions were concerned about the shortage of  
14 PPE. Was that your understanding?

15 DR. DAVID WILLIAMS: Yes, we were all  
16 concerned.

17 JOHN CALLAGHAN: All right. And so  
18 then it goes down, and who is Maureen then?

19 DR. DAVID WILLIAMS: Back to Maureen  
20 Cividino.

21 JOHN CALLAGHAN: Okay. And then it  
22 says:

23 "Justice Campbell - heart  
24 wrenching.

25 Separating political/science.

1 Evidence - has come in very  
2 rapidly."

3 What does that mean?

4 DR. DAVID WILLIAMS: I think someone  
5 said that they -- my understanding is that, again,  
6 I think it was the CUPE rep was telling us how he  
7 had been there back in the Justice Campbell time  
8 and he had stories of people and fellow staff  
9 members, because he is a worker, not necessarily a  
10 nurse, and had seen how people had been infected.  
11 And this was I think a strong passion to him, and  
12 he was really strong on the issue. So I was  
13 talking his concerns and issues seriously because  
14 this was very important to him.

15 JOHN CALLAGHAN: Because he was  
16 actually witnessing it, as far as he was concerned?

17 DR. DAVID WILLIAMS: Back in SARS, he  
18 said he did, yes, and he said it was a strong  
19 component of his, and he wanted to make sure that  
20 he was going to bring it to the table and always  
21 bring it to the table because he said it was  
22 important for him. And that is why I made a note  
23 of that, yes.

24 JOHN CALLAGHAN: And so if you go over  
25 then to another couple of pages here, and we don't

1 have time to go through them all, I'm afraid, so  
2 there was discussion about being worried about the  
3 provincial stock, as you said, and I take it CUPE  
4 and those were aware by now that the stockpile had  
5 been not replenished?

6 DR. DAVID WILLIAMS: They were aware  
7 that all around we had a problem with supply,  
8 management and delivery, because in their own  
9 respective jurisdictions -- and so this is the  
10 comments they are making, and they are aware that  
11 it doesn't matter stockpile or not, there is a  
12 supply issue writ large. And the provincial  
13 stockpile inventory, they thought it was supposed  
14 to hold this.

15 JOHN CALLAGHAN: Right, and did you  
16 advise them that there was no stockpile?

17 DR. DAVID WILLIAMS: We had -- what we  
18 had we were giving out and using as best we could  
19 in that time.

20 JOHN CALLAGHAN: We were told you had  
21 10 percent by 2020, and it was mostly, as you  
22 indicated, material that was for Ebola.

23 But anyway, let's go further down, and  
24 it says -- let's go a little further down, I think.  
25 At the bottom here -- I am not sure. If we can go

1 up to the next one, to the one on the right there,  
2 Michael, please. Okay, and a little further up.

3 Who are we talking to here? Do you  
4 know?

5 DR. DAVID WILLIAMS: Back to Michael  
6 again.

7 JOHN CALLAGHAN: Okay.

8 DR. DAVID WILLIAMS: I'm sorry, which  
9 one? Are you up above this page or --

10 JOHN CALLAGHAN: No, I'm at  
11 "Recommending - employers", and it is Brenda. Is  
12 this the same meeting?

13 DR. DAVID WILLIAMS: Yes, and Brenda --

14 JOHN CALLAGHAN: And then if you go  
15 further down --

16 DR. DAVID WILLIAMS: Yes.

17 JOHN CALLAGHAN: -- it says:

18 "Agreement on the science not  
19 possible.

20 Wuhan not possible - full suits  
21 - when jurisdictions - USA??"

22 Were you saying that there was no  
23 agreement on the science at this point?

24 DR. DAVID WILLIAMS: Yes.

25 JOHN CALLAGHAN: So if we go to

1 document 46 in the same time period, this is a  
2 document from March 9th from Public Health Ontario,  
3 and if we go to the next page, it says:

4 "Additionally, evidence on the  
5 relative role of asymptomatic and  
6 pre-symptomatic infectiousness and  
7 its contributions to transmission is  
8 still emerging [...]"

9 Is that the advice you were getting  
10 from Public Health Ontario?

11 DR. DAVID WILLIAMS: Correct, and there  
12 was materials and anecdotal reports. They were  
13 still gathering it to see well the validity of the  
14 information.

15 JOHN CALLAGHAN: All right. So just so  
16 I am clear, when that happens, are you applying the  
17 precautionary principle to say it is symptomatic --  
18 asymptomatic spread?

19 DR. DAVID WILLIAMS: The precautionary  
20 principle would be what does the evidence tell me,  
21 and as this document, the title, is there anything  
22 different in the Public Health measures that by  
23 consensus they have committees meeting and then  
24 this is their scientific table. They are making  
25 the recommendations in that, because you haven't

1 got the whole document open here, but anyways, that  
2 was their basis for that.

3 So they are my scientific table and  
4 they have a consensus of expert opinion.

5 JOHN CALLAGHAN: But you don't believe  
6 that Justice Campbell's precautionary principle was  
7 directly related to not waiting for scientific  
8 proof?

9 DR. DAVID WILLIAMS: No, his aspect was  
10 that if you are waiting for the case control  
11 studies and all the science to get formulated, that  
12 is too late. You need to take some steps before  
13 that. But it doesn't say throw science out the  
14 door and just wing it. He didn't mean that either.

15 And what he meant to say is that if you  
16 need to take steps, you should look at how you can  
17 best do those. And my interpretation always is  
18 that if you haven't got the case control studies,  
19 all the peer science evidence and peer review, you  
20 go with your experts. You put as much information  
21 in front of them and ask them do we have a  
22 consensus on what we need to do at this moment, not  
23 waiting for all the scientific journals to be  
24 published.

25 And that is what we do. So that is how

1 I do the precautionary principle. So I don't  
2 abandon the science totally. I depend on experts  
3 to give me advice.

4 JOHN CALLAGHAN: But if it turns out in  
5 this case it did, that it was asymptomatic spread,  
6 if you made a decision waiting for the science or  
7 waiting for the balancing of a scientific view by  
8 your scientific table, haven't you waited too late?

9 DR. DAVID WILLIAMS: In March there was  
10 not asymptomatic spread. There is no evidence of  
11 it.

12 JOHN CALLAGHAN: Well, I think what  
13 they are saying, "evidence on the relative role of  
14 asymptomatic" --

15 DR. DAVID WILLIAMS: Still emerging.

16 JOHN CALLAGHAN: Right, still emerging.

17 DR. DAVID WILLIAMS: Yes, you are not  
18 there yet.

19 JOHN CALLAGHAN: Right.

20 DR. DAVID WILLIAMS: Even now there is  
21 some debate that it doesn't occur.

22 JOHN CALLAGHAN: Well, in fact, it did  
23 occur, but it just didn't occur in March. It  
24 occurred later, in June or whatever that you just  
25 referred me to.



1 DR. DAVID WILLIAMS: Well, there is  
2 still some people that are saying that what you  
3 call asymptomatic transmission is basically -- I  
4 mean, I have a whole bunch of people writing me  
5 saying that your lab test is artificially labelling  
6 those cases when they are not. I mean, there is  
7 still a lot of debate going on.

8 JOHN CALLAGHAN: So are you accepting  
9 at this point, by March 8th, there is community  
10 spread yet?

11 DR. DAVID WILLIAMS: Shortly after  
12 that, because at the 8th -- just a minute, let me  
13 get back here.

14 On the 8th we went from 32 cases to  
15 146 -- no, 15 to 146. We started hearing from some  
16 Health Units in some areas that had more than  
17 others. We were wondering if there is. We  
18 discussed that at a federal level, and they yet  
19 were not -- they were saying, you know, giving  
20 advice and direction.

21 So as that proceeded in that week of  
22 the 8th to the 14th, there was a lot of robust  
23 discussion about switching over to community-wide  
24 spread because the next week we went from 146 new  
25 cases to 445.

1 JOHN CALLAGHAN: Right, and this --

2 DR. DAVID WILLIAMS: So losing -- when  
3 I talked to our consultant with my MOHs, more and  
4 more were saying we can't do the case contact  
5 management. It has gone -- you know, just because  
6 one Health Unit -- because if you have a problem  
7 with one Health Unit, does that mean every 34 has  
8 it? The answer is no.

9 So do we have a local issue or do we  
10 have a province-wide issue? And it was accruing  
11 fairly quickly that we are moving towards that it  
12 is a province-wide issue.

13 [Court Reporter intervenes for  
14 clarification.]

15 MICHAEL FINLEY: May I make a further  
16 suggestion that follows on from my technical advice  
17 from the morning.

18 For those that don't have headsets  
19 available and are listening, if you turn your  
20 volume down a little bit, that may reduce the  
21 feedback back and forth between the speakers. That  
22 may make the reporter's life a little bit easier.

23 DR. DAVID WILLIAMS: And I will speak  
24 slower. Apologies.

25 JOHN CALLAGHAN: So moving ahead then,

1 so I am not sure we got the answer, but what I was  
2 going to say was that you are talking about 140  
3 cases. In all of SARS, there were only about 344  
4 cases. So you were going to wait until the results  
5 get to 144 before you change your view about  
6 community spread?

7 DR. DAVID WILLIAMS: Well, the week  
8 before -- 344 for SARS was over 6 months.

9 JOHN CALLAGHAN: I understand --

10 DR. DAVID WILLIAMS: We are talking  
11 that the week before that, the 1st to 7th we only  
12 had 15 new cases in all of the province, and the  
13 week before that we only had 13 and they were all  
14 being case contact managed.

15 And if you used the epi stuff in person  
16 to person, how did those 15 spread it to 146 so  
17 quickly? Remember, these people already had it  
18 back -- they had been incubating, right, before  
19 they got tested.

20 And so when you go from 15 to 146, you  
21 have to ask yourself, is your system able to  
22 maintain case contact tracing? And some of the  
23 Health Units that had the most numbers were saying  
24 we are not able to find the epidemiological link of  
25 our cases. More and more we are losing it.

1                   And then if you go into the next week,  
2 when it even goes up even further to 445, and so  
3 from an epidemiological standpoint, you can see you  
4 are moving from - and I don't know if I am getting  
5 too complicated here - from an R-naught of 1.2 to 3  
6 to a huge number, or there is something else going  
7 on, as in you are having multiple -- that all of a  
8 sudden you have an inflow of multiple infected  
9 people that you weren't aware of, and so therefore  
10 then it is happening through community spread  
11 because people say, I didn't travel to China. I  
12 didn't travel to Thailand. I didn't go to all  
13 these other high risk areas. And they are adamant  
14 we didn't travel to those places. We went to the  
15 States, that is true, but we didn't travel anywhere  
16 that is high risk.

17                   JOHN CALLAGHAN: So if we could go to  
18 document "F", so this is -- we are going to get  
19 into the way you addressed some of the concerns.  
20 This is a letter dated March 19th. We don't have a  
21 lot of time, so we'll just do the single-site issue  
22 which you are no doubt aware of.

23                   But this is a letter, and you  
24 subsequently do a Directive, and then there is  
25 subsequent to that there is an Emergency Order.

1                   And I guess the question is, why do you  
2     issue a letter as opposed to a Directive by March  
3     19th where you, I appreciate now, appreciate there  
4     is community spread. So why just a letter?

5                   DR. DAVID WILLIAMS: So the letter  
6     is -- as always in Public Health, we first put  
7     out -- one of the key things we learned from SARS  
8     is communicate, communicate, communicate. We found  
9     most of the time our stakeholders and others are  
10    more than willing, if you give them the information  
11    and give it to them, so we do it through  
12    teleconferences and we do it through letters and  
13    that.

14                  One moves from that to a compilation of  
15    a guidance document when you need a product put out  
16    that the stakeholders and everybody agrees on and  
17    to move forward on. So you don't need to write a  
18    Directive if everybody is saying, just give us the  
19    updated information and we'll handle it and we can  
20    deal with it. So you are looking at the overall  
21    delivery and compliance of the field at that time.

22                  So this is related to -- having to do  
23    with health worker illness and their return to  
24    work. This is what --

25                  JOHN CALLAGHAN: Well, if we can go

1 down, the one I'm interested in for this is just by  
2 way of illustration, so I am not trying to -- we  
3 are going to talk about multiple locations. Just  
4 up one page, there, multiple locations at the  
5 bottom there.

6 And I am not too interested -- we'll  
7 talk about that, but you give a Directive about not  
8 working in different places. And I take it you  
9 were aware, and I think I have a statement in here  
10 which I won't take you to unless I need to, where  
11 you were aware that multiple -- this was an issue  
12 about spreading the disease because of part-time  
13 employees working in different locations. You were  
14 aware of that problem?

15 DR. DAVID WILLIAMS: In Ontario?

16 JOHN CALLAGHAN: In Ontario.

17 DR. DAVID WILLIAMS: No, I had not  
18 heard that was a problem up to that time. It was  
19 in other provinces. We hadn't seen cases of where  
20 infected workers from one long-term care went to  
21 another one and caused an outbreak.

22 JOHN CALLAGHAN: No, I am not talking  
23 about evidence. You keep on talking about the  
24 evidence. I am saying were you --

25 DR. DAVID WILLIAMS: And this is all --

1                   JOHN CALLAGHAN: Well, were you aware  
2 of the Walker report specifically alerted that the  
3 part-time employment in long-term care and other  
4 settings would result in people taking disease from  
5 one location to another posing a risk? Were you  
6 aware of that?

7                   DR. DAVID WILLIAMS: I was.

8                   JOHN CALLAGHAN: All right. So you  
9 were aware that where people are working in  
10 multiple locations, there is a risk of spreading  
11 disease in the face of a pandemic; correct?

12                  DR. DAVID WILLIAMS: In the face of an  
13 outbreak any time. We already put that in our  
14 directions, so we already had that in place.

15                  JOHN CALLAGHAN: Then it was an easy  
16 question. So this is what you are trying to  
17 articulate here; correct?

18                  DR. DAVID WILLIAMS: Correct.

19                  JOHN CALLAGHAN: Right. And you  
20 then --

21                  DR. DAVID WILLIAMS: To identify our  
22 position, yes.

23                  JOHN CALLAGHAN: Right. So if we then  
24 go to March 22nd, tab 25, you issue a direction  
25 under your authority, and this direction has the

1       compulsion of law; correct?

2                   DR. DAVID WILLIAMS:   Correct.

3                   JOHN CALLAGHAN:   Right.   So why did you  
4       then issue a direction three days later?

5                   DR. DAVID WILLIAMS:   Because in the  
6       Directive, you want to ratify -- if it is a legal  
7       requirement, that allows institutions to take steps  
8       further and get compensated and deal with issues  
9       that might assist them in doing that activity and  
10      undertake that.

11                   One of the aspects was that throughout  
12      our guidance, right from the get-go, and our  
13      guidance in our Ontario Public Health Standards is  
14      that if you have an outbreak, you need to check to  
15      see if your employee is working at some other  
16      institutions and notify other institutions of this  
17      aspect and not have that.   So right from the  
18      get-go, we had this in place.

19                   Now, if you are going to make this in  
20      here and employees who only have a part-time job  
21      and you tell them they can't go elsewhere, who is  
22      going to compensate them for that?

23                   JOHN CALLAGHAN:   Well, let's just go  
24      and take a look at it, because I don't think you --  
25      you didn't compensate them.



1 DR. DAVID WILLIAMS: No, this is not a  
2 compensation letter. This means - this is a  
3 Directive - there is an intent to deal with the  
4 issue.

5 JOHN CALLAGHAN: And the province  
6 didn't compensate them?

7 DR. DAVID WILLIAMS: There was a sense  
8 that they had to work towards that, so that they  
9 would say you cannot work at this place and this  
10 place at the same time.

11 JOHN CALLAGHAN: So can we go down a  
12 bit there and just get to the paragraph here.

13 So this paragraph says:

14 "Whenever possible, employers  
15 should work with employees to limit  
16 the number of different work  
17 locations that employees are working  
18 at, to minimize risks to patients of  
19 exposure to COVID-19."

20 What did this compel anybody to do?

21 DR. DAVID WILLIAMS: So it said, again,  
22 and ratified our position from the get-go that  
23 where your employees, if they are part-time people,  
24 and others are coming in from say they are OTs -  
25 occupational therapists, sorry - and they are

1 coming in and going from place to place, you have  
2 to be aware that that could be a possibility.

3 We know that some of the people who did  
4 the work in these places were also working at  
5 grocery stores and other things and aspects there.  
6 So we knew that just because you work at  
7 institution "A", I can't say, well, you can no  
8 longer work at the grocery store on Friday nights.  
9 They'll say that the last time I checked it is a  
10 free country, and I guess I could choose to work  
11 there if I want to.

12 So we are trying to say that you should  
13 work with them to have them not do that because  
14 they could be picking up infection and bringing it  
15 in and exposing potentially COVID-19 to the  
16 patients or the --

17 JOHN CALLAGHAN: So you don't feel your  
18 emergency powers are strong enough to stop someone  
19 to spread virus by working in more than one  
20 location?

21 DR. DAVID WILLIAMS: To stop someone in  
22 their civil freedoms to stop working in multiple  
23 places outside of health care?

24 JOHN CALLAGHAN: Yes.

25 DR. DAVID WILLIAMS: No, I can't do

1 that.

2 JOHN CALLAGHAN: And did you have  
3 discussions with people who have the emergency  
4 power that you had that restriction at that time?

5 DR. DAVID WILLIAMS: Our legal counsel  
6 on that, when we do a Directive, it is reviewed by  
7 many groups on that, and they'll say here is the  
8 scope of your Directive and here is what you can  
9 say and can't say.

10 JOHN CALLAGHAN: I appreciate that, but  
11 did you have discussions saying this may not be  
12 strong enough and we should probably get an  
13 Emergency Order?

14 DR. DAVID WILLIAMS: Up until that  
15 time, as I said, we had not had the evidence  
16 that -- I mean, there was no evidence to me that  
17 employees working at one long-term care home had  
18 carried it to an adjacent one and caused an  
19 outbreak.

20 JOHN CALLAGHAN: You keep on waiting  
21 for evidence. Is that what you needed? You needed  
22 evidence for it to happen before you acted, is that  
23 it, just to be clear? Because you keep talking  
24 like that.

25 DR. DAVID WILLIAMS: Yes, evidence is

1 critical.

2 JOHN CALLAGHAN: Okay.

3 DR. DAVID WILLIAMS: Because people  
4 keep throwing out ascertations and even sometimes  
5 union members saying, why are you blaming staff?  
6 And it is legitimate. And they say, you know, you  
7 have to have some proof that it is the staff that  
8 are doing it. You just can't make that assumption.

9 JOHN CALLAGHAN: Well, when did you  
10 conclude that was the case?

11 DR. DAVID WILLIAMS: Which is the case?

12 JOHN CALLAGHAN: That staff were taking  
13 the virus from home to home?

14 DR. DAVID WILLIAMS: We never found  
15 home to home. We found staff were coming in  
16 infected from the community, and when we started to  
17 test them and asked them questions, they had not  
18 picked it up on the job. They had contacts back at  
19 the household and became infected, because when it  
20 is community-wide spread, they are community  
21 members as well when they are not on the job, and  
22 so they can infect -- and visitors too.

23 JOHN CALLAGHAN: And wasn't the point  
24 not really whether they got it from one place, but  
25 whether they took it from place to place?

1 DR. DAVID WILLIAMS: No, whether they  
2 got it at home and brought it into the home, that  
3 is what --

4 JOHN CALLAGHAN: Well, weren't you  
5 trying to limit the number of places they could  
6 bring it into. Wasn't that the purpose?

7 DR. DAVID WILLIAMS: We already had  
8 that in place.

9 JOHN CALLAGHAN: From what?

10 DR. DAVID WILLIAMS: From what I asked  
11 them to do early in January and through Ontario  
12 Public Health Standards to say if you are in an  
13 outbreak situation, then your staff cannot go from  
14 place to place. And as I said, I don't have anyone  
15 documenting that that had occurred, so therefore,  
16 it means that it was working. But --

17 JOHN CALLAGHAN: So why --

18 DR. DAVID WILLIAMS: But if you do the  
19 Directive in saying -- let's say I'm in a part of  
20 Ontario where there is no cases and I say  
21 throughout Ontario the fact that you work at two  
22 long-term care homes, that your staff do, you can  
23 only work at one, and they say now we've lost a  
24 third of our staff and residents are not being  
25 looked after. And they say, well, you have created

1 a crisis and --

2 JOHN CALLAGHAN: Well, I appreciate  
3 that that will be the next issue, but I am just a  
4 little confused --

5 COMMISSION CHAIR FRANK MARROCCO: I'm  
6 sorry, just a second. Doctor, what were you going  
7 to say?

8 DR. DAVID WILLIAMS: I'm saying part of  
9 our issue here is when you are putting out these  
10 Directives, because it is province-wide and because  
11 the impact of the pandemic was not homogeneous  
12 throughout the province, by doing a Directive  
13 province-wide, you could in fact make some areas  
14 make it worse, because if you put this restriction  
15 in place that was a law and order and then staff  
16 who would work say part-time in two or three  
17 long-term care homes in an area where there was no  
18 cases reported and no outbreaks, all of a sudden  
19 you limit them all and they now haven't got enough  
20 staff to look after the residents.

21 And so you have to keep that in  
22 consideration. And the managers and administration  
23 would say, you know, weren't you aware that this  
24 could happen and give us some latitude to work at  
25 it. And this is why this says "wherever possible"

1 you should work with this, and this is just  
2 ratifying what we put out in our guidance, what I  
3 communicated verbally, and what I had been  
4 persuaded -- I kept asking all the way along, can  
5 you give me an example, like in British Columbia,  
6 where you had an outbreak at one and the staff  
7 member went to another one and caused an outbreak?  
8 And we hadn't seen that yet. And that makes me  
9 sense that both workers and the administrators had  
10 taken those recommendations seriously.

11 JOHN CALLAGHAN: So were you then  
12 surprised that the government felt the need to  
13 issue an Emergency Order to back up your Directive?

14 DR. DAVID WILLIAMS: The Emergency  
15 Order was totally independent of this.

16 JOHN CALLAGHAN: I understand. So if  
17 we can go to "H", what I am trying to get at,  
18 though, is they then make it an offence to work at  
19 more than one long-term care home. If we go down a  
20 bit -- you are aware of that?

21 DR. DAVID WILLIAMS: Yes.

22 JOHN CALLAGHAN: So this is the Cabinet  
23 notes of the Minister. It says:

24 "This new emergency order would  
25 require long-term care staff to work

1 in only one long-term care home, and  
2 to not work for any other health  
3 service provider or retirement home.

4 The evidence is increasingly  
5 clear that many outbreaks are the  
6 result of asymptomatic staff  
7 unknowingly introducing the virus  
8 into homes. We know that a  
9 considerable number of long-term  
10 care staff work part-time, often in  
11 more than one job - at another  
12 long-term care home, a retirement  
13 home, or elsewhere - to create full  
14 time employment."

15 So are you aware that your directive  
16 was turned into an order essentially?

17 DR. DAVID WILLIAMS: Basically it is  
18 Cabinet ratifies that position, and it deals with  
19 employment out, not only from place to place but  
20 added in elsewhere, which I --

21 JOHN CALLAGHAN: Well, it didn't  
22 actually add in elsewhere. It dealt with home to  
23 home. That is another issue.

24 DR. DAVID WILLIAMS: No, it says "or  
25 elsewhere", if you read it.



1                   JOHN CALLAGHAN: That is what that  
2 says. That is not what the order says. The order  
3 refers to working at long-term care homes and  
4 health sectors, not working at a grocery store, for  
5 example. So I mean, I recognize this isn't your  
6 order --

7                   DR. DAVID WILLIAMS: Well, I think you  
8 have to read the order.

9                   JOHN CALLAGHAN: Right. Are you  
10 familiar with the order? Would they have shown you  
11 the order, or would they do this independent of  
12 you?

13                  DR. DAVID WILLIAMS: They can do it  
14 independently. They don't have to show it to me,  
15 no.

16                  JOHN CALLAGHAN: So who gives them the  
17 advice that there is asymptomatic staff, since you  
18 didn't come to that conclusion until June?

19                  DR. DAVID WILLIAMS: That could be an  
20 assertion by the Minister or the Deputy of  
21 Long-Term Care.

22                  JOHN CALLAGHAN: Well, they don't rely  
23 on your advice?

24                  DR. DAVID WILLIAMS: I give the advice,  
25 and we had undertaken to do testing in the

1 long-term care homes, the Public Health Department,  
2 and we did a series of ten and we checked where  
3 there was -- where we had no cases of outbreaks,  
4 and we found very little evidence of COVID among  
5 the staff or among the residents.

6 So we didn't see asymptomatic  
7 positivity in those in that study. It took quite a  
8 bit of work. We did the study and we didn't find  
9 any.

10 JOHN CALLAGHAN: Right, and we have  
11 heard about that study, but that study dealt with  
12 homes, and I think the conclusion that somebody  
13 described it is in the homes it is where you  
14 believe it is, but that doesn't answer the question  
15 of how it got there in the first place and were  
16 there employees working at more than one home.

17 DR. DAVID WILLIAMS: Well, it does. I  
18 mean, you can't say you believe or where you  
19 believe it is. It is not a belief thing. I mean,  
20 the thing is that if you are saying asymptomatic,  
21 that means it is probably in there and the  
22 assertion is that it is probably there and you  
23 don't know it. That was the assertion. So we went  
24 and looked for it and we didn't find it.

25 JOHN CALLAGHAN: Well, let's be clear.

1 Your study was done after this Directive was turned  
2 into an Order effective April 22nd. Your study I  
3 believe was done in May, wasn't it, with the  
4 long-term care? That is when the results came out?

5 DR. DAVID WILLIAMS: It was later  
6 more -- we did our earlier one with the Health  
7 Units in -- are you talking about the full one or  
8 the partial one by Health Units?

9 JOHN CALLAGHAN: Well, we were told  
10 about the full one I think by Dr. Johnstone.

11 DR. DAVID WILLIAMS: Yeah, we didn't do  
12 the -- we did the full one, but ours was more --  
13 the better study was done -- the Health Units did  
14 10 to 12 homes and did the full testing and  
15 investigation.

16 JOHN CALLAGHAN: So the reason why I  
17 ask again is that Revera did an investigation by  
18 Dr. Bell, the Former Deputy Minister, and  
19 Dr. McGeer and Dr. Sinha --

20 COMMISSION CHAIR FRANK MARROCCO:

21 Mr. Callaghan, could you speak into the  
22 mic a little. It is getting a little hard for the  
23 reporter I think to hear.

24 JOHN CALLAGHAN: All right, I'll do a  
25 little better then. I'm always trying to do

1 better.

2 What I was saying was Revera did a  
3 report about wave one, and we have heard evidence  
4 about it. In the report, and the reason why I ask,  
5 is they attribute a number of deaths to  
6 asymptomatic spread coming in the homes through  
7 staff, and they say that the vast majority of those  
8 were infections before I believe April 15th. So  
9 this is the period where you have a Directive but  
10 we don't have an Order yet because the Order wasn't  
11 effective until April 22nd.

12 So I am just wondering, it doesn't  
13 sound like you were involved in the order, but did  
14 you get any feedback about the impact of your  
15 Directive?

16 DR. DAVID WILLIAMS: The feedback about  
17 the Directive in what aspect of it? There is a  
18 whole bunch of things in that Directive.

19 JOHN CALLAGHAN: Well, I think that the  
20 point we are trying to talk about is whether people  
21 abided by it because the --

22 DR. DAVID WILLIAMS: Again, we have  
23 feedback --

24 JOHN CALLAGHAN: Because clearly --  
25 sorry.

1 DR. DAVID WILLIAMS: The feedback of  
2 whether we had staff working in one outbreak place  
3 and going to another outbreak, I had no reports of  
4 that. So the sense is that it was effective.

5 JOHN CALLAGHAN: Well, you never heard  
6 from, for example, the Deputy Minister that there  
7 was an issue?

8 DR. DAVID WILLIAMS: Helen Angus?

9 JOHN CALLAGHAN: No, Mr. Steele.

10 DR. DAVID WILLIAMS: Richard Steele,  
11 yes, we talked many times. About what?

12 JOHN CALLAGHAN: Well, I am trying to  
13 find it. I don't know, Michael, if you can find  
14 it. There is an April 3rd email where I believe he  
15 asks you about it. I am not sure I can put my  
16 finger on it at the moment, Doctor, so I don't  
17 want --

18 DR. DAVID WILLIAMS: I think it was  
19 more of a discussion of testing.

20 COMMISSION CHAIR FRANK MARROCCO:

21 Doctor, just before we move on, just  
22 help me with this. So who makes the final  
23 decisions concerning outbreak policy?

24 DR. DAVID WILLIAMS: Outbreak policy,  
25 Commissioner, do you mean different aspects of it

1 or --

2 COMMISSION CHAIR FRANK MARROCCO: Well,  
3 you know, this seems to me to be -- what you were  
4 just talking about with Mr. Callaghan seems to be  
5 related to how the province is responding to an  
6 outbreak, and what is the policy response will  
7 limit where people can work, just to use a  
8 shorthand. So who sets that policy? Who has the  
9 final say on that policy?

10 DR. DAVID WILLIAMS: Well, if it is the  
11 EMCPA, it is the Cabinet and the legal counsel  
12 advising Cabinet accordingly, and then you have got  
13 Ministry of Labour. You have got many different  
14 Ministries weighing into it that would give the  
15 different informative components that would assist  
16 them in making the Order as the Cabinet decided on.

17 COMMISSION CHAIR FRANK MARROCCO: But  
18 if it is a matter of public health, you know, that  
19 we don't want people working at multiple sites  
20 because they are going to convey the disease from  
21 site to site inadvertently, then shouldn't that be  
22 the Chief Medical Officer of Health that makes that  
23 decision?

24 DR. DAVID WILLIAMS: We already, from  
25 the outset, already advised them not to have

1 people, if you are in any outbreak or any cases, to  
2 have any of your staff working in multiple sites.  
3 If you did, you should inform and take some steps  
4 to eliminate that. And we watched very carefully  
5 all along to see if that was -- were there cases  
6 occurring like that that would support that it was  
7 not being adhered to or followed.

8 And when we do our case contact  
9 management with the staff, we didn't find and say,  
10 well, I was working over there and there and I  
11 didn't want to tell you, or whatever. We knew that  
12 they were working off-site doing some other  
13 part-time jobs because they didn't pay a large  
14 amount and they were looking to supplement income  
15 that they needed desperately, so they were doing --  
16 I don't know, working in a kitchen making pizzas or  
17 something like that outside. So we only had  
18 authority within the health care system to deal  
19 with that. Whereas the EMCPA could go beyond that  
20 if they so wished.

21 JOHN CALLAGHAN: I thought your  
22 authority extended to anybody who was going to  
23 cause or contribute to disease, no?

24 DR. DAVID WILLIAMS: My order goes  
25 to -- the Directive goes to institutions, not to

1 individual people. So this was a Directive to the  
2 institutions.

3 JOHN CALLAGHAN: No, but your  
4 authority. I am talking your authority. Does your  
5 authority extend to directing an individual to do  
6 something or not do something so as to avoid the  
7 spread of disease?

8 DR. DAVID WILLIAMS: In a section 22  
9 order, yes, that's correct.

10 JOHN CALLAGHAN: Right.

11 DR. DAVID WILLIAMS: Not this order you  
12 are talking about, not the Directive. That is a  
13 different power. So you have to write it to the  
14 individual.

15 JOHN CALLAGHAN: Right.

16 COMMISSION CHAIR FRANK MARROCCO:

17 Doctor, when the Cabinet is making a  
18 decision under the emergency legislation, are you  
19 at the Cabinet table?

20 DR. DAVID WILLIAMS: I'm at the Cabinet  
21 table on areas that pertain to mine and asked to  
22 present, and then with all the different groups  
23 that present, so they have my input of what I am  
24 looking for. But then that is a recommendation.  
25 Then they can go to Ministers only and they can



1 have their discussion where I'm not privy to be at  
2 the table. That's correct.

3 So I'm in, therefore, on invitation to  
4 present and answer questions and to make any  
5 recommendations if I have them known, but then we  
6 are excused from the table and then the Cabinet  
7 meets. That is Ministers only.

8 JOHN CALLAGHAN: So this is the  
9 reference that I was pointing to, and you will see  
10 that you get a letter on April 2nd -- or pardon me,  
11 an email, and they are talking about PPE and they  
12 are talking about surgical masks, but he says:

13 "One point that is striking is  
14 the number of instances where  
15 infection has been introduced,  
16 apparently, through a staff member."

17 Did you have discussions with the  
18 Deputy about that, or is that --

19 DR. DAVID WILLIAMS: We arranged it  
20 with them that when we did our outbreak  
21 investigation and asked staff members who -- some  
22 of them who said they had reported to the  
23 administration that they were asymptomatic where,  
24 when our nurses interviewed them, said, well, okay,  
25 I might have had a sore throat or a cold a bit,

1 whatever, but it is not a big deal, and I had to  
2 come to work, so I came to work. And then when we  
3 tested some of those ones -- well, we interviewed  
4 them because we tested them and they were positive.  
5 So they had purported to be asymptomatic, but some  
6 had very mild symptoms and thought it was not a big  
7 deal, and they needed the work and they thought it  
8 was okay. But we raised this issue to him, and he  
9 wondered, okay, what can we do about that.

10 And so it was something that we had  
11 asked them to think about what we should do with  
12 this issue in there with staff potentially bringing  
13 infection into the home, sometimes -- not intending  
14 to. They weren't trying to do it -- there wasn't  
15 anything malicious. It is just that they thought  
16 it wasn't a big deal. They weren't that sick.

17 JOHN CALLAGHAN: Well, I mean, that is  
18 one of the studies we heard of was pretty popular  
19 that people who even are sick go to work in any  
20 event, but that is why --

21 DR. DAVID WILLIAMS: Yes, I was aware  
22 of that.

23 JOHN CALLAGHAN: But just to go back to  
24 the Chair 's point, I am just going to read you  
25 what Archie Campbell wrote:

1 "SARS showed us that while  
2 cooperation and team work are  
3 important, it is essential that one  
4 person be in overall charge of our  
5 public health defence against  
6 infectious outbreaks. The Chief  
7 Officer of Health should be in  
8 charge of public health emergency  
9 planning and public health emergency  
10 management."

11 And as I understand it -- and I  
12 recognize that you are not there to implement the  
13 statute. You have your certain powers. But it is  
14 not all with you, as we have seen, right? The  
15 management of the emergency, we have other  
16 Ministers and we have the Cabinet and Emergency  
17 Orders; correct?

18 DR. DAVID WILLIAMS: Correct.

19 JOHN CALLAGHAN: So if we read Justice  
20 Campbell, we shouldn't take it that that was  
21 accepted in 2006?

22 DR. DAVID WILLIAMS: Correct.

23 JOHN CALLAGHAN: And do you have a view  
24 about whether now that there should be one point of  
25 contact?

1 DR. DAVID WILLIAMS: I think if you had  
2 one point of contact and everything had to come  
3 across my desk, that would not be a very good  
4 response.

5 I think that one of the things that  
6 Ontario has an advantage, and that is why we built  
7 it into our plan, even in 2006, even after Justice  
8 Campbell's report, is that we created the emergency  
9 service, the Emergency Measures Branch that was put  
10 with the CMOH at that time, and we put in there  
11 that when you have an outbreak, you form a  
12 committee and you activate your -- we created the  
13 medical, the MEOC which was not in there before and  
14 with the Director then, which was Allison Stuart  
15 initially, she became an ADM later, and a number of  
16 other Directors, and the last one that you talked  
17 to, well, Justine Hartley is acting and Clint  
18 Shingler was.

19 And so you then, as we did in January,  
20 we activated the MEOC, and we started having our  
21 HIRA reports and that, so that is all part of the  
22 process.

23 If during that time you start to see  
24 where the issue is starting to impact the health  
25 care system writ large that, that means, as we

1 predicted in our model, if you get a number of  
2 staff signing off sick, the health care system  
3 starts to fade, then you form a so-called  
4 coordinated or command table that you ask, and we  
5 asked and I asked, and that is under the leadership  
6 of the Deputy Minister and reports -- it can be the  
7 Minister, if she wants to or he wants to. In this  
8 case, the emissary of the Minister, which is the  
9 Deputy Minister, who runs the health -- who is the  
10 main bureaucrat for the health care system writ  
11 large.

12 And so we asked that to be formed, and  
13 so that gets together and then you start having  
14 other subcommittees and tables off that because if  
15 it is going to start to impact more and more parts  
16 of the health care system, you have to have more  
17 and more input, especially in a place like Ontario  
18 where you have got 14.8 million people and you have  
19 got a lot of huge health institutions that are not  
20 only provincial but they are actually national  
21 centres and some are international centres. So you  
22 have a huge decision-making that has to take place  
23 very quickly and adeptly with full consultation.

24 So where the general advice is mine,  
25 the detail of that and all the work that has to be

1 done, which expanded rapidly where not only -- in  
2 some of the SARS, we had a couple of ADMs, but we  
3 didn't have a lot. This one I was very surprised  
4 that many ADMs jumped in, and ADMs and their staff  
5 were putting in 7 days a week and on certain  
6 portfolios, and the night, and that was only  
7 necessary because we had such a huge machine and it  
8 had to move that way.

9 So I would disagree that it has to all  
10 come across my desk. If we were a small province,  
11 we might get away with it, but we have a big  
12 machine here. And I was very pleased with the  
13 all-of-government response. It was excellent.

14 JOHN CALLAGHAN: But you weren't at the  
15 head of it?

16 DR. DAVID WILLIAMS: The head of it,  
17 no, I don't run the health care system.

18 JOHN CALLAGHAN: No, but -- --

19 DR. DAVID WILLIAMS: I'm the Public  
20 Health lead, and all the time my advice is readily  
21 sought and they incorporate it into that.

22 But all the detailing about putting  
23 together implementation and planning and policy  
24 development and the fiscal and stuff, it all has to  
25 be done. You have to keep it going. You can't --

1 as you'll hear from the Deputy, the workload didn't  
2 abate. Her workload went up immensely, as well as  
3 everybody else.

4 JOHN CALLAGHAN: So let me give you an  
5 example. We have heard and we have talked about it  
6 and we have heard you speak about the value of  
7 asymptomatic testing, and we have had Dr. Johnstone  
8 who was the head of the Testing Table testify to  
9 it, and there seems to have been -- and she talked  
10 about, just as you did, that it could overwhelm the  
11 capacity, and she said exactly what you said pretty  
12 much.

13 DR. DAVID WILLIAMS: This is Dr.  
14 Johnstone, right?

15 JOHN CALLAGHAN: Dr. Jennie Johnstone.

16 DR. DAVID WILLIAMS: Jennie Johnstone,  
17 yes, thank you.

18 JOHN CALLAGHAN: But we know that the  
19 advice that she gave, and Dr. Vanessa Allen  
20 testified to it, was that there shouldn't be  
21 asymptomatic testing.

22 And then on May 24th the province  
23 announced asymptomatic testing, and then before  
24 that they put Dirk Huyer in charge of the testing  
25 who was a Coroner.

1                   So I am trying to understand, if you  
2 are the Chief Medical Officer of Health who is  
3 supposed to be the Executive Lead, how does that  
4 happen that, first of all, they are putting the  
5 Coroner as head of testing when you yourself didn't  
6 agree with asymptomatic testing and the head of the  
7 Testing Table didn't agree with asymptomatic  
8 testing?

9                   DR. DAVID WILLIAMS: Correct, because  
10 the Cabinet had asked to start doing wide testing  
11 of anyone who wanted one and it didn't matter, so  
12 just that the more testing you do, the better.

13                  Dr. Huyer was brought in. And I have  
14 worked with Dr. Huyer for many years. He was  
15 brought in to look at specifically the testing  
16 related to transient farm workers in that aspect  
17 down in Southwest Ontario, because we had a lot of  
18 outbreaks occurring and there was major issues  
19 around that matter and how to coordinate doing some  
20 what he thought was asymptomatic testing, but what  
21 he realized very soon when we went out and started  
22 doing it is that it was actually outbreak  
23 investigation because some of the homes had cases  
24 already. So instead of going in and testing and  
25 finding nothing, he was finding all sorts of cases



1 who were symptomatic actually and were not being  
2 picked up.

3 So he quickly understood that down in  
4 that area he was not really truly doing  
5 asymptomatic testing. He was helping very much to  
6 set up a method of doing mobile I would say and  
7 assisting the MOH in that area and a couple of the  
8 MOHs to do a lot more testing in farm settings that  
9 needed more resources to do that.

10 And so we found more and more cases in  
11 outbreaks and found --

12 JOHN CALLAGHAN: But this is  
13 provincially wide, not just in that area. And what  
14 I am asking is --

15 DR. DAVID WILLIAMS: He didn't do  
16 provincial, because some places don't have  
17 transient farm workers.

18 JOHN CALLAGHAN: No, but May 24th, the  
19 Premier, contrary to the advice of the Testing  
20 Table, as testified here by Dr. Johnstone and  
21 Dr. Vanessa Allen, and I am assuming given what you  
22 have already said, contrary to your advice, set out  
23 asymptomatic testing when there was a concern about  
24 lab capacities and --

25 DR. DAVID WILLIAMS: It was a desire by

1 the Premier and Cabinet that anyone who wanted to  
2 get tested could go to an assessment centre and ask  
3 for a test, whether they had symptoms or not.

4 JOHN CALLAGHAN: So that is just the  
5 process.

6 DR. DAVID WILLIAMS: Correct.

7 JOHN CALLAGHAN: Notwithstanding the  
8 advice of the scientists, that is the process,  
9 right? Is that what you are saying?

10 DR. DAVID WILLIAMS: Correct.

11 JOHN CALLAGHAN: And so then we know in  
12 the fall, because we have heard from Shelley Deeks,  
13 and I could show you the documents and you know the  
14 story, that on the prevalence testing, Public  
15 Health Ontario advised you that the highest should  
16 be 25 to 100,000, that then in September and  
17 October --

18 DR. DAVID WILLIAMS: No, wait a minute,  
19 you are talking about the prevalence testing or the  
20 framework?

21 JOHN CALLAGHAN: The testing --

22 DR. DAVID WILLIAMS: You are talking  
23 about the framework?

24 JOHN CALLAGHAN: Yes.

25 DR. DAVID WILLIAMS: Oh, and not the

1 testing. Okay, I got confused.

2 JOHN CALLAGHAN: Sorry, the framework.  
3 Sorry, the framework --

4 DR. DAVID WILLIAMS: You are on the  
5 framework now, okay.

6 JOHN CALLAGHAN: Sorry, I meant  
7 prevalence of exposure, you are quite right, thank  
8 you.

9 DR. DAVID WILLIAMS: Cases.

10 JOHN CALLAGHAN: But you know the  
11 story. Public Health Ontario - and we have got the  
12 documents, we just don't have time to put them to  
13 you - advised you that the highest red at that time  
14 should be 25 to 100.

15 DR. DAVID WILLIAMS: Incidence of --

16 JOHN CALLAGHAN: And it eventually goes  
17 to one of the tables and it gets moved to 40 to  
18 100,000.

19 DR. DAVID WILLIAMS: Correct.

20 JOHN CALLAGHAN: And then the Premier  
21 announces 100 to 100,000. Is that again a  
22 political decision, or was that a recommendation by  
23 you?

24 DR. DAVID WILLIAMS: The Public Health  
25 Measures Table had met with Dr. Deeks who was at

1 the table, and we wanted the feedback from them and  
2 they had two or three options. We put those  
3 options to the Cabinet, and the Cabinet picked one  
4 of the three options.

5 And then Dr. Deeks came back later and  
6 said, well, we didn't get a chance to put ours in  
7 before the decision was made, but then later when  
8 we went back and reviewed it, she said she was okay  
9 with the different decisions.

10 So as all of these, some directions we  
11 put options towards the Cabinet that they can  
12 choose from.

13 JOHN CALLAGHAN: I am not sure that is  
14 quite how it worked.

15 COMMISSION CHAIR FRANK MARROCCO: Just  
16 before you go on to that, I am trying to  
17 understand, Doctor, if I can go back for a second.  
18 How is it that the Coroner is recruited in this  
19 context, in the context that you have described?  
20 Who does that? Who did that?

21 DR. DAVID WILLIAMS: I think in that  
22 case, it was the -- as far as I understand, it was  
23 probably the Premier with the Solicitor General.

24 COMMISSION CHAIR FRANK MARROCCO: So  
25 this has nothing to do with being the Coroner. It

1 is just a recruitment of him to do this.

2 DR. DAVID WILLIAMS: It was part of  
3 the -- one of the aspects they said in a  
4 government-wide approach under an emergency, as it  
5 went on, people were getting overloaded and they  
6 needed to go with experts wherever they could find  
7 them and to see if they could undertake to do that.

8 So there was only so many physicians  
9 employed in this kind of role in the government, so  
10 they asked Dr. Huyer if he could participate and he  
11 agreed to.

12 JOHN CALLAGHAN: But Public Health  
13 Ontario has lots of public health physicians.

14 DR. DAVID WILLIAMS: Yeah, but they  
15 don't work in the government. They are not a  
16 government employee. He is like an ADM equivalent.

17 JOHN CALLAGHAN: Is that document up  
18 then, Michael?

19 So this is advice from the Public  
20 Health table to you?

21 DR. DAVID WILLIAMS: Correct.

22 JOHN CALLAGHAN: And the advice, as I  
23 understand it, was that you could modify -- a  
24 return to modification would be greater than 40 per  
25 100,000. The recommendation we were told by

1 Shelley Deeks from Public Health Ontario was less  
2 than 25 -- or greater than 25 per 100,000. And you  
3 are telling me did you make the recommendation to  
4 Cabinet that they could go to 100 per 100,000?

5 DR. DAVID WILLIAMS: We made this  
6 recommendation, and a different number was chosen.

7 JOHN CALLAGHAN: Right, so a number  
8 that wasn't recommended by Public Health Ontario,  
9 wasn't recommended by the Public Health Measures  
10 Table and not recommended by you; correct?

11 DR. DAVID WILLIAMS: We gave this  
12 recommendation to the Cabinet.

13 JOHN CALLAGHAN: Right. But just to be  
14 clear, you didn't recommend it, the 100 to 100,000,  
15 you personally, Dr. Williams, as the Chief Medical  
16 Officer of Health?

17 DR. DAVID WILLIAMS: We recommended 25  
18 to 100,000, and then 40, another one there. And  
19 then we wondered about a new gray zone above there.  
20 So they asked if we put one over 100,000, say if  
21 you didn't have a modified Stage 2, could there be  
22 a level above the red level.

23 JOHN CALLAGHAN: And the reason I ask,  
24 and I am asking quickly, because it is part of the  
25 wave two --

1 DR. DAVID WILLIAMS: Yes.

2 JOHN CALLAGHAN: And we have been told  
3 the prevalence in the community was the biggest  
4 driver of COVID entering a long-term care home,  
5 which I take it you would agree with.

6 DR. DAVID WILLIAMS: Correct, the  
7 incidence -- incidence is not prevalence. Well,  
8 prevalence is the same thing, but when we saw the  
9 new cases come in, that when there is evidence of  
10 lots of transmission in the community, we found  
11 more and more people were coming into the long-term  
12 care home, either visitors or staff, positive  
13 because they got infected in the community.

14 JOHN CALLAGHAN: And the concern at  
15 this point was that the 100 to 100,000 would result  
16 in not severe enough measures to lockdown the virus  
17 so as to stop the spread, right? That was the fear  
18 of 100 to 100,000?

19 DR. DAVID WILLIAMS: The level of the  
20 100 per 100,000 as a top level for lockdown,  
21 because we didn't have one yet, was that some felt  
22 that was too high, that it should be dropped down  
23 lower, that the range of 40 to 100 per 100,000 was  
24 too wide and we should have some other intermediary  
25 in there or a lower one, and some felt even some of

1 the other ones should be moved down even lower.

2 So there was debate about from the  
3 Public Health Measures Table what is the best level  
4 to do a staged -- remember that we staged out of  
5 lockdown with Stage 1, 2 and 3.

6 JOHN CALLAGHAN: Right.

7 DR. DAVID WILLIAMS: And then if we put  
8 this back in reverse, how do we stage back up again  
9 and what is reasonable in that.

10 And that is where the debate with the  
11 Public Health Measures and coming up with the  
12 different numbers with incidence rates and that,  
13 and so this was one of the proposals and agreed  
14 upon. And then when we put that in and found those  
15 concerns, then it was revised again later. And it  
16 can be revised any time if the Public Health  
17 Measures Table wants to.

18 JOHN CALLAGHAN: So let me ask you.  
19 Dr. Deeks went to the press to advise that the  
20 advice wasn't as represented, and there is some  
21 newspaper articles here, but that it wasn't as  
22 represented. And you didn't go to the press.

23 Is there a role for the Chief Medical  
24 Officer of Health and the scientific community to  
25 be able to have their opinions made public? And



1 certainly the politicians can consider them, but  
2 should the public have these recommendations so  
3 that they can assess the decisions being made?

4 DR. DAVID WILLIAMS: I mean,  
5 individuals can go. The value of having an  
6 in-public debate between scientists that have  
7 different opinions, as we have seen, we get lots of  
8 that going on now, and it gets the public, at best,  
9 confused. I think if they are going to have that  
10 debate, it should be robustly held at the table,  
11 and to agree what they can agree upon and, if they  
12 can't agree, then they make it known to that extent  
13 in there.

14 And so what you are trying to do is get  
15 a consensus and the table thought they had this  
16 information, and Dr. Deeks was preparing a PHO  
17 document and got it in the day after Cabinet made  
18 the decision.

19 JOHN CALLAGHAN: Well, I mean, I won't  
20 show you now, but I can -- the levels there are  
21 levels that seem to have been acted upon even by  
22 you in giving advice to Cabinet, that is, that the  
23 highest at that point was greater than 25 per  
24 100,000.

25 But I take it then your view is that

1 the advice the CMOH gives to Cabinet or to the  
2 Premier or the advice Public Health Ontario gives  
3 ought not to be made public? That is your view?

4 DR. DAVID WILLIAMS: Well, the view is  
5 that the advice we give to Cabinet is, as in any  
6 Cabinet process, confidential until they make a  
7 decision.

8 So that is our usual method in there.  
9 If you are not involved in the government system, I  
10 guess on the outside you can make comments as you  
11 wish, which many so-called experts are doing.

12 JOHN CALLAGHAN: So if you weren't  
13 going to recommend 100 to 100,000 and the  
14 prevalence of COVID in the community was likely to  
15 go up and enter a long-term care home - and we know  
16 because after December there was a lot in long-term  
17 care - and imperil the lives of long-term care  
18 residents, you don't think as a Chief Medical  
19 Officer of Health that you ought to go and speak  
20 publicly that they were going to risk lives?

21 DR. DAVID WILLIAMS: There was no sense  
22 that that itself was risking lives. The protection  
23 of residents in place has to deal with proper  
24 assessment of staff, screening and proper IPAC and  
25 principles in that.

1                   Just because you have got out in the  
2 street some issue, does that mean invariably that  
3 it is in the community or into the home? You have  
4 got to put your protections. Even if you have  
5 it lower down, if you don't do your other  
6 aspects -- so the key thing with long-term care  
7 homes was back again to the vigilance and  
8 stringence of monitoring and assessing and limiting  
9 access into it, and of course, we were dealing with  
10 the other side all during the fall of people felt  
11 that the steps were over-bound or over-stepping and  
12 inhumane and people were left without family  
13 members.

14                   So we went to pushing hard and I pushed  
15 all along to bring in the idea of essential  
16 visitors because there is -- beyond dropping the  
17 infection, there is things that are very important  
18 to these individuals. These are their homes, and  
19 these individuals are impacted by all of these  
20 things. And that is okay for four to six weeks,  
21 but if it goes on month after month after month,  
22 that is not the interest there.

23                   And so I see these different things.  
24 The staging, we didn't do the staging, per se, to  
25 say this is only to deal with long-term care homes.

1 That is not what we did it for only. That was not  
2 the main intent.

3 JOHN CALLAGHAN: But I guess what I  
4 would say to you, sir, is that by November wave one  
5 has demonstrated that the IPAC in long-term care  
6 was not where it ought to be, that this is the  
7 number one risk of COVID getting into homes. And I  
8 would suggest to you that it was known that if  
9 COVID got into the homes, there was a good  
10 likelihood, as was demonstrated, that 20 to 30  
11 percent of those who get COVID would die.

12 So what I --

13 DR. DAVID WILLIAMS: So --

14 JOHN CALLAGHAN: So what I am saying is  
15 you don't think you have any role to stand up and  
16 say this was our advice so the public knows? I  
17 just want that to be clear.

18 DR. DAVID WILLIAMS: Because the advice  
19 and that we wanted the framework introduced and the  
20 framework was re-introduced, and so that is the  
21 main thing. And so we said -- because it isn't  
22 affecting every part of the province all at the  
23 same time.

24 The ideal solution was we needed to put  
25 in something that would stop all infections in the

1 community instantaneously. I don't have that kind  
2 of power. And what can you do? Because the  
3 pandemic plan has two goals, remember: the first  
4 goal is reduce morbidity and mortality; and the  
5 second one, and it is important, is minimize  
6 social disruption.

7 JOHN CALLAGHAN: Right.

8 DR. DAVID WILLIAMS: And people seem to  
9 forget about the second, because we know, as Public  
10 Health officials, if you come down too much, you  
11 are going to get other consequences - people not  
12 getting surgery, mental health issues, domestic  
13 violence. These are issues that, while they don't  
14 impact some of the intensives who work in areas, it  
15 does come back to an issue we have to consider.

16 So this was an attempt by the Public  
17 Health management to reintroduce ways to try and  
18 keep the community spread under control, which the  
19 models did demonstrate by putting these in place,  
20 that what they were projecting we were going to end  
21 up with was far less than we ended up with.

22 And so that, in fact, by doing these  
23 things, we said we did save lives and we did reduce  
24 the incidence of cases and the number of outbreaks  
25 in these homes.

1 JOHN CALLAGHAN: Because the --

2 COMMISSION CHAIR FRANK MARROCCO:

3 Mr. Callaghan --

4 JOHN CALLAGHAN: Because it was moved  
5 back to 40?

6 DR. DAVID WILLIAMS: No, by instituting  
7 the framework.

8 JOHN CALLAGHAN: I understand, but the  
9 framework --

10 DR. DAVID WILLIAMS: And then the  
11 Public Health measures to go up to the lockdown and  
12 then go up to the stay-at-home orders.

13 JOHN CALLAGHAN: Right, and what I am  
14 saying is that at this point in time the government  
15 introduced a prevalence for lockdown two and a half  
16 times what was being recommended by yourself and  
17 all your scientists, and I am not hearing you have  
18 any appetite to provide that statement publicly  
19 outside of Cabinet; correct?

20 DR. DAVID WILLIAMS: Well, we wanted to  
21 recommend that there could be consideration of a  
22 lockdown. The levels for the green, the yellow and  
23 the red I felt were good.

24 When we do a lockdown or not a  
25 lockdown, we hadn't had a firm answer on that,

1 because basically, if you are going to do a  
2 lockdown, it involves more than just the staging.  
3 And even where we were aware that in the first wave  
4 the lockdown wasn't a true hard lockdown, and  
5 modelers said, no, it wasn't, and so what is a  
6 lockdown and what does that consist of?

7 And so when we did change it and went  
8 to a lockdown, it still wasn't good enough. Then  
9 we went to a stronger lockdown on Boxing Day, and  
10 that still wasn't good enough. So we went to a  
11 stay-at-home order, which is even stronger.

12 So there is different things you can  
13 do. And even with those in place, we still had  
14 some outbreaks occurring. Why? It is a virus and  
15 how it works and how it changes, and the variants  
16 started coming in as well.

17 So there is things you know and there  
18 is things you can control, but you try with  
19 mitigating that. And as the modelers said, each  
20 time we have done some steps, we have met the curve  
21 and brought it down. Did we eliminate it?  
22 Unfortunately, no. It would have been nice to  
23 eliminate it.

24 COMMISSION CHAIR FRANK MARROCCO: I  
25 just want to -- Doctor, you said that you have a

1 hard commitment at 2:30 AND it is now 2:34.

2 DR. DAVID WILLIAMS: Yes.

3 COMMISSION CHAIR FRANK MARROCCO:

4 So I think we should end the  
5 questioning where it is at, just in order to avoid  
6 interfering with your commitment and your press  
7 conference.

8 DR. DAVID WILLIAMS: I appreciate that.

9 COMMISSION CHAIR FRANK MARROCCO: So we  
10 will stop and you can go up there. I know you are  
11 late, so go ahead.

12 DR. DAVID WILLIAMS: Okay, well, thank  
13 you very much.

14 JOHN CALLAGHAN: Thank you.

15 COMMISSION CHAIR FRANK MARROCCO: Thank  
16 you, Doctor, for coming.

17 DR. DAVID WILLIAMS: Yes, thank you.

18 COMMISSION CHAIR FRANK MARROCCO: I  
19 think we'll end for today, Mr. Callaghan.

20 JOHN CALLAGHAN: Yes, that is fine.

21 COMMISSION CHAIR FRANK MARROCCO: Sorry  
22 to cut you off like that, but it is what it is.

23 JOHN CALLAGHAN: Yes, time is what it  
24 is.

25 Thank you.



1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

-- Adjourned at 2:35 p.m.

REPORTER'S CERTIFICATE

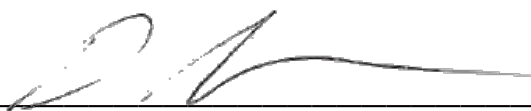
I, DEANA SANTEDICOLA, RPR, CRR,  
CSR, Certified Shorthand Reporter, certify:

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

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

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

Dated this 22nd day of February, 2021.



NEESONS, A VERITEXT COMPANY

PER: DEANA SANTEDICOLA, RPR, CRR, CSR

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

Page 10, line 23: "I was asked" not "I as asked"

Page 17, line 22: "Be careful what you wish for"  
not "And be careful what you  
wish for"

Page 19, line 17: "NOSM" not "NASM"

Page 25, line 7: "MOH in Ontario" refers to  
Medical Officer of Health in  
Ontario.

Page 25, line 21: "MOHs" refers to Medical  
Officers of Health.

Page 32, line 25: "ADMs" not "AD Ms"

Page 33, line 2: "pnce a year" not "a once year"

Page 36, line 18: "there might come times" not  
"there might comes time"

Page 39, line 4: "So we were both in leadership."  
not "So we both gave  
leadership."

Page 43, line 2: "administration officer" not  
"administrative office"

Page 43, lines 4-5: "MOHs" refers to Medical  
Officers of Health and "MOH"  
refers to Medical Officer of  
Health.

Page 43, line 15: "larger context" not "largest  
context"

Page 45, line 24: "HPPA" not "HPP A"

Page 72, line 2: "doing asymptomatic testing" not  
"doing asymptomatic"

Page 72, line 21: "lost and misplaced samples" not  
"a loss and misplaced samples"

Page 79, line 18: "to us in" not "to in us in"

1 Page 81, line 19: "real time results" not "real  
2 time"

3  
4 Page 88, line 3: "MOHs" refers to Medical  
5 Officers of Health.

6  
7 Page 96, line 25: "Infectious Disease Advisory  
8 Committee against" not  
9 "Infectious Disease Advisory  
10 against"

11  
12 Page 163, line 11: "the best advice they can" not  
13 "the best they can"

14  
15 Page 185, line 3: "MOHs" refers to Medical  
16 Officers of Health.

17  
18 Page 193, line 21: "stop someone and" not "stop  
19 someone in"

20  
21 Page 196, line 11: "early in January" not "early IN  
22 January"

23  
24 Page 215, line 6: "asymptomatic testing" not  
25 "asymptomatic tasting"

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25

Page 216, line 7: "MOH" refers to Medical Officer  
of Health.

Page 216, line 8: "MOHs" refers to Medical  
Officers of Health.

Page 228, line 5: "minimize" not "minimalize"

Page 228, line 14: "intensivists" not "intensives"

## WORD INDEX

< \$ >

\$1.4 21:2

\$2 153:1

< 0 >

09 39:2

< 1 >

1 223:5

1.2 187:5

1:08 161:25

1:20 161:20

162:1

1:30 160:21

10 72:19 74:17

161:7, 19

179:21 202:14

234:3

10:00 1:16 5:1

161:1

100 218:14, 21

221:4, 14

222:15, 18, 20,

23 225:13

100,000 217:16

218:18, 21

220:25 221:2, 4,

14, 18, 20

222:15, 18, 20,

23 224:24

225:13

11 19:13

236:12, 21

11:21 74:20

11:22 75:3

11:30 74:22, 23

75:4

12 52:20 61:13

202:14

13 170:18

186:13

14 237:10

14.8 212:18

140 186:2

144 186:5

146 184:15, 24

186:16, 20

14th 184:22

15 56:8 131:16

172:18 184:15

186:12, 16, 20

235:13

15,000 152:23

150 13:23

15th 203:8

16 32:10

163 236:12

16th 15:13, 15

17 32:10 234:5,

9

18 141:12

234:22 235:24

18,000 149:18

185 236:15

19 234:9 236:1

193 236:18

196 236:21

1991 9:21 10:9

19th 187:20

188:3

1st 15:6, 8, 18

26:11 30:1

186:11

< 2 >

2 170:1 221:21

223:5 234:20

235:5, 18

2,000 26:21

2:00 161:1

2:30 1:16

160:24 161:8, 9,

11, 20 162:3

231:1

2:34 231:1

2:35 232:3

20 56:8 72:19

120:21 227:10

2002 11:10

2002-2003 11:12

2003 12:6

2005 10:15

13:11, 19

2006 122:12

123:20 124:5

126:21 137:3, 5

145:9 146:9

149:21 150:7

151:24 153:2

156:20, 25

157:19, 21

158:20 210:21

211:7

2006/07 31:9

2006/07 39:2

2007 14:8

49:20 149:7

2008 119:23

120:1 130:16

2009 14:13, 15

2011 14:16, 23,

24 120:1, 3

156:25

2013 57:16

61:9 123:21

124:8 134:10

136:18 137:9

138:5, 6, 11, 15,

18, 25

2014 120:3, 5

146:17

2015 15:2, 6, 9

31:14 32:1

2016 14:22

15:13 119:23

128:9, 14

130:11, 24

131:2, 11, 17, 19

132:4 133:1

146:17 148:19,

21 149:17

2017 32:9

141:12 148:22

2018 31:8, 14

118:23 119:7

120:5, 7 122:21

130:16, 25

131:23 132:4

158:25

2018/19 58:7

61:9

2018/2019 57:22

58:2 158:24

2019 52:1

55:10, 12 60:16

112:14 113:5,

14, 19, 23 115:9

133:1 157:13

158:5, 18

2020 112:14

113:14 118:24

119:10 120:7, 9

133:2 153:3

179:21

2021 1:16

15:18 141:8

233:16

21 234:15

235:21 236:18

21/22 141:8

215 236:24

216 237:2, 5

217,000 26:9

22 45:23 47:8

207:8 234:5

22/23 141:8

228 237:8, 10

22nd 1:15 82:4

190:24 202:2

203:11 233:16

23 234:3

24 52:20 76:13

235:16

24th 214:22

216:18

25 190:24

217:16 218:14

221:2, 17

224:23 234:11,

15, 18 236:7

250 21:1

27th 173:2

29 45:24

29.2 47:14

29.2s 109:16

2nd 113:18, 23

208:10

< 3 >

3 131:25 187:5

223:5 236:4, 15

30 83:20, 21

152:24 227:10

30th 82:5

31st 26:11 30:1

32 184:14

234:18

33 234:20

34 38:16 185:7

344 186:3, 8

36 234:22

39 235:1

3rd 204:14

< 4 >

4 130:18

131:13 153:23

235:1

40 152:22

218:17 220:24

221:18 222:23

229:5

43 235:5, 8, 13

445 184:25

187:2

45 235:16

4-5 235:8

46 181:1

48 76:13 77:2

< 5 >

5 74:17 130:3

237:8

50 67:4 149:7

< 6 >

6 186:8 236:24

60 140:17

< 7 >

7 213:5 234:11

237:2

70 107:9

72 77:3 235:18,

21

77 47:18

77.1 46:17

79 235:24

7th 115:23

186:11

< 8 >

8 153:23 156:7,

10 237:5

80 107:9

81 236:1

85 9:9

86 9:9

88 236:4

8th 184:9, 12,

14, 22

< 9 >

90 9:16

95 9:25

96 9:25 10:1

236:7

9th 181:2

< A >

a.m. 1:16 5:1

75:3, 4

abandon 183:2

abate 214:2

abided 203:21

ability 108:3

absolutely 154:1

academic 19:22

accept 72:18

126:8 165:18

<p><b>accepted</b> 6:21 9:6 82:21 140:10 141:5 165:3 210:21 <b>accepting</b> 184:8 <b>access</b> 22:17, 18 43:12 55:17 65:19 139:13 148:4 226:9 <b>accessed</b> 66:18 <b>accountability</b> 45:1 110:12 <b>accruing</b> 185:10 <b>accurately</b> 88:21 <b>acquire</b> 47:21 74:8 153:9 <b>acronyms</b> 98:6 <b>act</b> 14:9 33:13 34:18 49:14 81:6 95:4, 18 109:13 165:21 <b>acted</b> 194:22 224:21 <b>Acting</b> 14:25 15:3, 8 16:4 31:9 32:6 39:2, 16, 17 126:18 211:17 <b>action</b> 46:22 72:12 78:11 164:4 <b>actions</b> 78:9 123:12 164:3 165:3 <b>activate</b> 211:12 <b>activated</b> 211:20 <b>activity</b> 191:9 <b>Acts</b> 110:17 <b>actual</b> 20:5 59:19 87:16 92:1 <b>acuity</b> 98:16 <b>acute</b> 99:16 114:13 <b>AD</b> 32:25 234:18 <b>adamant</b> 116:15 187:13 <b>add</b> 199:22 <b>added</b> 18:2 34:16 40:13 70:11, 12 199:20 <b>Additionally</b> 181:4</p>	<p><b>address</b> 118:17 134:16, 18 158:17 <b>addressed</b> 187:19 <b>adeptly</b> 212:23 <b>adequate</b> 79:15 157:21 <b>Adesomoju</b> 3:3 <b>adhered</b> 206:7 <b>adjacent</b> 194:18 <b>Adjourned</b> 232:3 <b>adjunct</b> 78:12 80:22 <b>ADM</b> 20:25 31:13, 17, 19 32:8, 12, 19 33:23 35:25 38:6, 7, 13, 25 39:2 40:20 41:3 50:1, 18 53:18 92:11 118:16 119:12, 15 120:1, 5, 10 122:21, 24 133:12 139:21 211:15 220:16 <b>ADM/CMOH</b> 120:4 <b>administration</b> 9:6 36:15 38:25 39:5 50:12 91:20 111:17 197:22 208:23 235:5 <b>administrative</b> 40:3 43:2 235:6 <b>administrator</b> 37:3 <b>administrators</b> 198:9 <b>admission</b> 72:7 <b>ADMs</b> 31:6 32:6 33:9 39:17, 21 92:22 213:2, 4 234:18 <b>Adriana</b> 3:16 <b>advantage</b> 211:6 <b>adversarial</b> 27:19 <b>adverse</b> 116:16 <b>advice</b> 12:2 22:16 34:14 35:19 36:16, 19 40:18 49:8</p>	<p>52:22 60:15 66:1 92:16 93:21 103:20 108:1 113:1 162:21 164:1 173:20 181:9 183:3 184:20 185:16 200:17, 23, 24 212:24 213:20 214:19 216:19, 22 217:8 220:19, 22 223:20 224:22 225:1, 2, 5 227:16, 18 236:12 <b>advise</b> 27:24 34:5 64:6 71:13 72:11 179:16 223:19 <b>advised</b> 53:1 71:8 205:25 217:15 218:13 <b>advising</b> 205:12 <b>advisor</b> 48:5 <b>Advisory</b> 10:17 11:17 34:22 37:16 48:13, 15 51:18 56:7 71:9, 11 92:25 93:9, 16 96:18, 25 98:7 112:25 163:10 236:7, 9 <b>advocacy</b> 57:2, 3 <b>advocate</b> 53:20, 24 54:3, 7 97:23 98:3 118:16 <b>advocated</b> 56:19 59:12 <b>advocating</b> 53:23 54:19 56:1, 13 <b>affect</b> 63:22 69:23, 24 90:16 <b>affirmed</b> 155:8 <b>afraid</b> 179:1 <b>after</b> 8:25 16:7, 10 31:11 39:15, 19 44:18 66:16 72:5 88:10, 11, 13 99:20 154:21 159:1 168:10 184:11</p>	<p>196:25 197:20 202:1 211:7 224:17 225:16 226:21 <b>afternoon</b> 26:22 <b>age</b> 150:25 <b>agencies</b> 21:3 113:11 <b>agency</b> 48:4, 10, 20, 22 49:5, 7, 21 53:13 107:22 113:8 114:12, 17, 22 115:14 116:23 <b>agenda</b> 100:24 <b>agents</b> 133:24 <b>ago</b> 56:8 90:2 100:15 141:13 169:19 <b>agree</b> 60:17, 22 68:10 80:2 81:2 94:10 103:5 108:7, 13 112:17 143:7 154:1 162:12 163:24 172:8, 11 215:6, 7 222:5 224:11, 12 <b>agreed</b> 9:22 56:9 140:17 172:23 220:11 223:13 <b>Agreement</b> 180:18, 23 <b>agrees</b> 128:6 188:16 <b>ahead</b> 5:18 169:13 185:25 231:11 <b>air</b> 155:16 <b>airborne</b> 175:19, 21 <b>alarm</b> 141:15 142:12, 14 <b>alerted</b> 190:2 <b>alerts</b> 63:12 <b>align</b> 156:25 <b>Alison</b> 3:8 121:5 <b>Allen</b> 55:17 74:5, 14 214:19 216:21 <b>Allison</b> 11:20 211:14</p>	<p><b>all-of- government</b> 213:13 <b>allow</b> 66:10 109:23 111:14 <b>allowing</b> 49:6 <b>allows</b> 109:17 111:19 191:7 <b>all-purpose</b> 128:6 <b>alluding</b> 44:22 <b>alternative</b> 107:13 <b>altogether</b> 136:16 165:15 <b>amazingly</b> 66:25 <b>amend</b> 86:2 <b>amendments</b> 35:3 <b>America</b> 144:21 154:3 <b>amount</b> 157:20 206:14 <b>amounts</b> 141:1 <b>Amy</b> 2:14 <b>Analyst</b> 3:16, 18, 20, 22 <b>Anderson</b> 115:25 <b>anecdotal</b> 181:12 <b>anesthetist</b> 7:5 18:5 <b>Angela</b> 2:3 3:22 <b>Angeline</b> 3:18 <b>Angus</b> 204:8 <b>Ann</b> 2:24 <b>annexes</b> 137:13, 23 <b>announced</b> 15:6 214:23 <b>announces</b> 218:21 <b>annual</b> 36:4, 5 50:3, 13, 22 <b>answering</b> 28:20 <b>anteroom</b> 104:10 <b>anticipated</b> 23:4 <b>antiviral</b> 140:6, 14 142:15 <b>antivirals</b> 123:25 141:3 142:19</p>
--	--	---	--	---



<p><b>anti-virals</b> 159:24</p> <p><b>anybody</b> 38:20 192:20 206:22</p> <p><b>anymore</b> 60:13</p> <p><b>anyway</b> 8:14 83:1 179:23</p> <p><b>anyways</b> 18:16 67:9 81:25 144:21 182:1</p> <p><b>Apart</b> 64:24</p> <p><b>Apologies</b> 185:24</p> <p><b>apologize</b> 114:2 130:12</p> <p><b>apparent</b> 167:6</p> <p><b>apparently</b> 28:21 103:10 208:16</p> <p><b>appear</b> 127:18</p> <p><b>appetite</b> 229:18</p> <p><b>applicable</b> 103:2 126:22</p> <p><b>applicant</b> 25:14</p> <p><b>application</b> 15:9, 11</p> <p><b>applied</b> 13:11, 16</p> <p><b>apply</b> 151:20</p> <p><b>applying</b> 181:16</p> <p><b>appointed</b> 15:11 21:18 23:9 24:1</p> <p><b>appointees</b> 42:16</p> <p><b>appointment</b> 23:12 42:22</p> <p><b>appreciate</b> 16:13 79:21 81:11, 12 109:4 150:6 188:3 194:10 197:2 231:8</p> <p><b>appreciating</b> 85:17</p> <p><b>apprised</b> 54:18</p> <p><b>approach</b> 69:24 108:8 110:20 220:4</p> <p><b>approval</b> 50:5</p> <p><b>approvals</b> 50:19</p> <p><b>approve</b> 37:22 50:2</p>	<p><b>approved</b> 33:6 50:21 82:21, 24 141:21</p> <p><b>April</b> 75:24 202:2 203:8, 11 204:14 208:10</p> <p><b>arbitrator</b> 26:24</p> <p><b>Archie</b> 162:7 174:12 209:25</p> <p><b>archives</b> 19:9</p> <p><b>area</b> 10:11 51:7 63:1 110:2 197:17 216:4, 7, 13</p> <p><b>areas</b> 6:5 9:15 18:8 40:23 67:5 109:12 167:10 173:17 184:16 187:13 197:13 207:21 228:14</p> <p><b>Arlene</b> 14:15 35:2</p> <p><b>arm's</b> 49:6 53:12</p> <p><b>arranged</b> 208:19</p> <p><b>arrangement</b> 24:15</p> <p><b>arrive</b> 61:17</p> <p><b>Arthur</b> 10:11</p> <p><b>articles</b> 223:21</p> <p><b>Articling</b> 3:3</p> <p><b>articulate</b> 190:17</p> <p><b>articulated</b> 162:7 171:3</p> <p><b>artifacts</b> 61:11</p> <p><b>artificially</b> 184:5</p> <p><b>ASAP</b> 114:4</p> <p><b>ascertations</b> 195:4</p> <p><b>ascribe</b> 59:2</p> <p><b>Asia</b> 145:12</p> <p><b>aside</b> 99:6 117:13 118:1 120:11</p> <p><b>asked</b> 10:23 14:8, 18, 25 15:10, 15 27:2 28:11, 12 31:16 74:8 76:1 84:6 101:2 106:3 113:16 125:3 137:11 158:17, 25 176:2 195:17 196:10</p>	<p>207:21 208:21 209:11 212:5, 12 215:10 220:10 221:20 234:3</p> <p><b>asking</b> 36:1 40:9 41:5 45:4, 11 57:21 58:15, 16 64:17 77:5 83:11, 12 84:10 89:10 92:5 109:14, 21 110:18 115:1 120:17 127:19 128:21, 22 134:25 144:5 198:4 216:14 221:24</p> <p><b>asks</b> 204:15</p> <p><b>aspect</b> 23:8 126:4 127:22 162:19 182:9 191:17 203:17 215:16</p> <p><b>aspects</b> 18:11 91:5 111:14 113:2 121:24 126:24 129:4 136:8 191:11 193:5 204:25 220:3 226:6</p> <p><b>assertion</b> 200:20 201:22, 23</p> <p><b>assess</b> 37:10 63:10 224:3</p> <p><b>assessing</b> 78:13, 14 226:8</p> <p><b>assessment</b> 217:2 225:24</p> <p><b>asset</b> 55:20</p> <p><b>assigned</b> 38:6 122:15</p> <p><b>assist</b> 10:25 12:3 13:13 36:2, 17 45:16 91:16 93:24 154:10 191:9 205:15</p> <p><b>assistance</b> 154:11</p> <p><b>Assistant</b> 3:8 19:18 31:1, 20 32:1 37:22</p>	<p>90:25 118:13 119:8</p> <p><b>assisted</b> 16:6 39:13, 16 40:17 150:15</p> <p><b>assisting</b> 216:7</p> <p><b>assists</b> 78:13</p> <p><b>Associate</b> 13:12, 19 14:14 15:24 121:18</p> <p><b>associates</b> 42:23</p> <p><b>assume</b> 22:17 61:14 126:8 167:13</p> <p><b>assumed</b> 32:14 139:21 144:13 149:3, 14 172:16</p> <p><b>assuming</b> 216:21</p> <p><b>assumption</b> 145:22 195:8</p> <p><b>assumptions</b> 157:1</p> <p><b>assure</b> 142:6</p> <p><b>asymptomatic</b> 69:25 71:5, 16 72:2 82:17, 21 84:8 85:18, 20 86:15 164:11, 22 165:4, 9, 21, 24 167:3 170:20 171:5 181:5, 18 183:5, 10, 14 184:3 199:6 200:17 201:6, 20 203:6 208:23 209:5 214:7, 21, 23 215:6, 7, 20 216:5, 23 235:18, 19 236:24, 25</p> <p><b>attached</b> 36:7</p> <p><b>attack</b> 127:7</p> <p><b>attempt</b> 228:16</p> <p><b>attend</b> 130:14 160:25</p> <p><b>attendees</b> 172:23</p> <p><b>attending</b> 1:15</p> <p><b>attention</b> 133:11</p> <p><b>attitude</b> 97:10</p> <p><b>Attorney</b> 2:18,</p>	<p>19, 20, 22, 24</p> <p><b>attribute</b> 203:5</p> <p><b>atypical</b> 100:5</p> <p><b>audio</b> 12:23</p> <p><b>audit</b> 96:6</p> <p><b>audited</b> 110:10</p> <p><b>auditing</b> 36:20 105:4</p> <p><b>Auditor</b> 149:6</p> <p><b>August</b> 13:19 118:24 119:10 120:9</p> <p><b>auspices</b> 24:12, 14</p> <p><b>Australian</b> 171:2, 11</p> <p><b>authorities</b> 154:9 171:3, 12</p> <p><b>authority</b> 35:8 47:2, 8 109:23 123:4 190:25 206:18, 22 207:4, 5</p> <p><b>automated</b> 87:8, 17</p> <p><b>autonomous</b> 42:12 43:16</p> <p><b>autonomy</b> 35:10 43:17 44:11, 25 49:7 117:25</p> <p><b>avail</b> 103:17 104:22</p> <p><b>available</b> 24:22 31:11 84:19 92:16 98:12 99:25 101:11 123:5 152:7 185:19</p> <p><b>avant-garde</b> 64:17</p> <p><b>avoid</b> 114:5 207:6 231:5</p> <p><b>aware</b> 18:18 20:17 36:21 44:16 52:18 55:5, 25 59:18 79:3, 5, 10 85:24 87:4, 6 92:7 104:4 125:18 133:25 139:21 143:15, 18, 25 145:13, 14 148:12 149:6, 9, 12, 18,</p>
--	--	---	--	--

22 150:8 154:7  
162:9 164:8  
171:16, 20  
172:1 179:4, 6,  
10 187:9, 22  
189:9, 11, 14  
190:1, 6, 9  
193:2 197:23  
198:20 199:15  
209:21 230:3  
**awareness**  
128:19  
**awhile** 72:5  
148:15  
**Ayokunle** 3:3  
**Ayushi** 2:22

< B >

**back** 5:15 7:14  
9:9, 13, 16, 22,  
25 10:22 11:20  
12:8 14:19, 23  
15:6 16:11  
19:12 23:4  
29:1 30:15  
31:9, 14 34:20  
39:2, 11 48:2  
53:11 56:8  
57:11 60:1  
67:13 69:15  
72:22 73:1  
74:18 75:6, 12  
76:12, 13 77:25  
78:10 80:23  
81:17, 20 82:2  
85:8 87:3  
89:18 98:21  
100:6, 10 101:5,  
7, 18 122:12  
123:16 136:18  
137:5 141:12  
142:1 149:15  
152:19, 22  
153:18 156:3  
158:5 161:19  
170:11, 12  
176:15 177:19  
178:7, 17 180:5  
184:13 185:21  
186:18 195:18  
198:13 209:23  
219:5, 8, 17  
223:8 226:7  
228:15 229:5

**backdrop**  
101:17  
**background**  
6:10  
**bad** 146:19  
**Bain** 7:11  
**balance** 35:12  
164:2  
**balancing** 183:7  
**banner** 100:24  
**bar** 97:15  
104:14 105:18  
116:4  
**Barbara** 170:22  
**barrier** 172:14  
**barriers** 102:2  
**base** 66:4  
76:20  
**based** 111:23  
156:19 173:23  
**basically** 46:1  
85:19 145:10  
146:16 168:20  
184:3 199:17  
230:1  
**basis** 8:22  
36:3, 5 50:22  
59:8, 9 91:21,  
23 104:4, 20, 23  
105:10 106:6  
107:23, 25  
140:21 163:13  
176:10 182:2  
**Basrur** 12:12  
13:13 14:5  
23:8 34:25  
**bauble** 116:13  
**Baumann**  
158:25 160:6  
**Bay** 9:20 10:8,  
10 11:14 14:18  
19:18  
**bearing** 125:17  
**beds** 156:20  
**began** 130:11,  
16 131:1  
**beginning**  
133:2 139:10  
164:20 165:1  
**behalf** 157:16  
**behooves**  
105:15  
**Beijing** 155:10  
**belabour** 75:8  
**belief** 201:19

**believe** 80:9  
164:25 170:22  
182:5 201:14,  
18, 19 202:3  
203:8 204:14  
**believed** 117:14  
**believes** 177:4  
**Bell** 202:18  
**belong** 122:14  
**belongs** 122:14  
**belt** 52:12  
**best** 6:8  
114:21 163:5,  
11, 19 179:18  
182:17 223:3  
224:8 236:12, 13  
**better** 7:24 8:8,  
13 41:11  
103:22 116:7,  
25 158:15  
202:13, 25  
203:1 215:12  
**Bianchini** 3:20  
**big** 25:22  
96:15 100:9  
143:20 144:15  
164:8, 11 209:1,  
6, 16 213:11  
**biggest** 19:24  
222:3  
**billion** 21:2  
153:1  
**biological** 6:20  
**bit** 6:9 9:18  
13:2 16:15  
17:4 110:23  
113:22 161:4  
185:20, 22  
192:12 198:20  
201:8 208:25  
**Blair** 119:15  
120:10 121:5  
**Blair's** 119:12  
**blaming** 195:5  
**Board** 36:11, 24  
37:7 42:6, 15,  
18, 24 43:3, 16,  
21 44:13 45:10,  
12 49:17 50:20  
52:6 53:8 54:6  
69:13, 17  
**boards** 35:11  
38:16 42:12  
**bodies** 117:16

163:10  
**bogged** 27:10  
**boring** 17:20  
**born** 130:13  
**bottom** 179:25  
189:5  
**bottomless**  
159:12  
**Boxing** 230:9  
**Branch** 3:2, 5  
13:22 122:20  
211:9  
**breadth** 16:24  
21:11 101:10  
**break** 5:14  
37:12 49:23  
74:18 76:6  
155:25 161:5, 19  
**breaking** 11:7  
51:3 59:21  
**breath** 70:6  
**Brenda** 180:11,  
13  
**brief** 27:17  
174:7  
**briefing** 39:6  
**bring** 25:15  
35:21 66:7  
131:5 133:25  
169:8 170:12  
178:20, 21  
196:6 226:15  
**bringing** 193:14  
209:12  
**British** 198:5  
**broad** 146:1  
169:23  
**broke** 113:21  
**Brooks** 4:6  
**brought** 10:10  
19:8 61:16  
69:12 80:7  
98:20 127:23  
196:2 215:13,  
15 230:21  
**Bruce** 85:1  
**buck** 122:4  
**budget** 21:2  
23:20, 22 35:25  
42:20 50:3  
51:25 52:6, 13  
113:4 141:1  
**budgeting** 50:14

**budgets** 36:4  
37:23, 25 38:9,  
15 39:10  
**budget-wise**  
45:6  
**build** 65:12  
66:10 104:3  
110:13  
**building** 9:15  
53:23 55:14  
92:8 105:19, 22  
106:2, 7  
**built** 65:13  
112:4, 8 211:6  
**bunch** 62:19  
72:16 134:15  
184:4 203:18  
**bureaucrat**  
212:10  
**burn-through**  
143:23  
**business** 43:2  
50:2, 13 51:23  
52:18  
**busyness** 117:7  
**buy** 141:2, 21  
144:6 146:10  
148:3, 14, 16  
159:19 160:1  
**buying** 146:6,  
13 147:3, 20  
159:25  
  
< C >  
**Cabinet** 21:20,  
25 39:9 50:4,  
20 145:9  
156:14 157:3  
198:22 199:18  
205:11, 12, 16  
207:17, 19, 20  
208:6 210:16  
215:10 217:1  
219:3, 11 221:4,  
12 224:17, 22  
225:1, 5, 6  
229:19  
**calculation**  
149:21  
**calculations**  
127:7  
**call** 36:18  
70:19 167:16  
184:3

<p><b>Callaghan</b> 3:24 5:7, 18, 24, 25 6:14 7:16, 25 8:4, 9, 14, 16 11:5, 7, 8 13:5 15:20, 21 16:12 20:12 21:13, 22 22:3, 25 23:24 24:3 26:2 27:6 28:17 29:1, 3, 12, 25 30:5, 11 31:19, 23 32:15, 20 33:12, 17, 24 35:5, 14 37:12, 18, 21, 25 38:5, 19 40:6, 9 41:4 43:25 45:22 46:13 47:10, 16, 22 49:23 50:6, 25 51:3, 4, 13, 19, 24 52:17 53:9, 24 54:2, 9 55:5 57:6, 15 58:13 59:18, 21, 23 60:1, 14, 24 62:10 75:7 76:7 77:15 79:2, 20 80:3 81:3 82:3, 11, 16, 23 83:11, 15 84:5, 14, 18, 25 85:6, 13 86:2, 10, 13, 18, 23 87:4, 9, 16 88:1, 4, 6, 10, 15, 22 89:7, 19 90:1, 5, 7 95:23 96:10 99:8, 15 101:22, 24 112:10, 11 113:17, 23 114:24 115:22 116:9 117:1, 18 118:4, 11, 18 119:3, 9, 18 120:25 121:7, 11, 14 122:3, 9, 11, 24 123:2, 15 124:1, 7, 10, 15, 18, 25 125:3, 10, 13, 17, 25 126:7, 12 127:2, 16 128:3, 21 129:1, 5, 9, 12, 18, 24 130:2, 8, 17, 23 131:4, 8, 10</p>	<p>132:21, 23 134:6 135:19 136:11, 13, 17, 22 137:6, 16, 21 138:1, 4, 13, 23 139:6 145:7, 19 146:5, 11, 15, 25 147:9, 12, 14 148:19, 23 149:5, 16, 22 150:2, 11, 17, 24 151:8, 17 156:1, 6 157:11, 14, 25 158:2, 19 160:12, 15 161:2 162:3, 4, 12, 24 163:17 164:7, 15, 19, 24 165:2, 12, 16, 20, 25 167:19 168:22 169:12 170:15 171:15, 19, 25 172:5, 18, 22 173:13, 25 174:17, 22 175:6, 16 176:3, 13, 17, 23 177:2, 7, 12, 17, 21 178:15, 24 179:15, 20 180:7, 10, 14, 17, 25 181:15 182:5 183:4, 12, 16, 19, 22 184:8 185:1, 25 186:9 187:17 188:25 189:16, 22 190:1, 8, 15, 19, 23 191:3, 23 192:5, 11 193:17, 24 194:2, 10, 20 195:2, 9, 12, 23 196:4, 9, 17 197:2 198:11, 16, 22 199:21 200:1, 9, 16, 22 201:10, 25 202:9, 16, 21, 24 203:19, 24 204:5, 9, 12 205:4 206:21 207:3, 10, 15 208:8 209:17, 23 210:19, 23</p>	<p>213:14, 18 214:4, 15, 18 216:12, 18 217:4, 7, 11, 21, 24 218:2, 6, 10, 16, 20 219:13 220:12, 17, 22 221:7, 13, 23 222:2, 14 223:6, 18 224:19 225:12 227:3, 14 228:7 229:1, 3, 4, 8, 13 231:14, 19, 20, 23 <b>called</b> 7:2, 8 47:11, 12 49:2 76:9 145:3 <b>campaign</b> 147:21 <b>Campbell</b> 12:10 44:1 117:20 162:7 174:11 176:5 177:23 178:7 209:25 210:20 <b>Campbell's</b> 174:13 182:6 211:8 <b>Canada</b> 70:3 144:15 154:5 155:9 <b>Canadian</b> 60:8 121:21 137:20, 21 138:1, 3 <b>candidates</b> 22:21 25:20 <b>capabilities</b> 108:3 <b>capability</b> 154:3 <b>capacities</b> 216:24 <b>Capacity</b> 44:20 55:9 57:25 59:3, 14 63:23, 25 65:1, 12, 13 66:17 71:22 75:19, 22, 24 167:15 214:11 <b>capital</b> 43:7 50:15 53:23 106:2, 7 <b>CARE</b> 1:7 2:13, 15, 17 3:2, 4, 9, 11, 12, 14, 17, 19, 21, 23 18:4</p>	<p>21:7 47:13 62:5 65:21 66:20 72:8 76:4, 10 77:13, 18 78:7 83:19 84:24 85:9 86:7 87:5, 11, 22 88:17, 24, 25 89:1, 2, 11, 14, 21 90:11, 12, 16, 24, 25 92:3, 9, 10 93:4, 13, 17 94:9 95:14 96:7, 20 99:16, 18, 21 100:4 102:10 103:11 104:6, 15 105:12 106:4, 23 107:1 111:3 114:13 133:15, 23 134:3 135:11, 13, 22 136:10 139:12 142:18 146:3 148:25 149:11, 13, 24 150:1, 10, 15, 16, 19, 22 151:1, 11, 15, 21 152:5, 8, 18 153:19, 23 157:22 160:9 172:7, 8 175:5 189:20 190:3 193:23 194:17 196:22 197:17 198:19, 25 199:1, 10, 12 200:3, 21 201:1 202:4 206:18 211:25 212:2, 10, 16 213:17 222:4, 12 225:15, 17 226:6, 25 227:5 <b>careful</b> 17:22 110:14 145:11 234:5, 6 <b>carefully</b> 206:4 <b>carried</b> 194:18 <b>carry</b> 8:14 20:6 39:17 45:18 55:2 162:3 <b>carrying</b> 10:25 <b>case</b> 50:2 64:5 67:8 68:9, 11</p>	<p>70:8, 20 73:18 78:19 122:19 157:5 163:7 166:5, 14 167:14 168:19 169:1, 17, 21 170:9, 12 171:9 172:17 176:7 182:10, 18 183:5 185:4 186:14, 22 195:10, 11 206:8 212:8 219:22 <b>cases</b> 61:17 68:7, 8 70:23 78:20 112:1 133:21 143:13, 21, 22 166:19, 21 167:7, 11 168:7 184:6, 14, 25 186:3, 4, 12, 25 189:19 196:20 197:18 201:3 206:1, 5 215:23, 25 216:10 218:9 222:9 228:24 <b>caught</b> 114:6 <b>caused</b> 12:17 76:16 106:23 189:21 194:18 198:7 <b>centers</b> 153:9 <b>central</b> 69:14 <b>centre</b> 145:2 217:2 <b>centres</b> 65:21 66:7 84:22 155:10 212:21 <b>CEO</b> 43:2, 4 50:12 53:2, 5, 8 54:6, 18 113:3 115:25 <b>certain</b> 32:16 44:25 159:14 210:13 213:5 <b>certainly</b> 8:10 41:6 44:12 60:14 66:14 224:1 <b>CERTIFICATE</b> 233:1 <b>certification</b> 101:7</p>
--	---	--	---	--

<p><b>certified</b> 64:4 97:21 98:11 141:22 233:4 <b>certify</b> 69:16 233:4 <b>cetera</b> 12:10 45:7 50:15, 21 93:15 124:14 <b>chain</b> 67:14 143:15 145:11, 16 146:4, 7 147:2, 6 148:5 153:6 158:10, 16 159:3, 17 160:5 <b>Chair</b> 2:2 5:3, 17, 23 6:3 7:18, 23 8:12 10:17 11:6 18:13 22:13 27:9 28:6, 16 48:14 51:2 56:7 59:20 60:25 61:22, 25 63:4, 21 64:24 65:6, 9 66:13 69:21 70:25 71:15, 19, 24 73:21 74:15, 21, 25 75:5 90:6 93:7, 18 94:4, 8, 16, 24 95:5, 21 97:2 101:23 103:4 106:19 108:12 110:22 112:9 130:19 131:7 132:11, 19 133:3, 6 139:4, 7 140:2, 8 141:4, 9, 14 142:3, 9, 25 143:6 144:3, 9, 23 147:13 152:3 153:25 154:16, 20 155:3, 13, 20, 23 156:4 157:24 160:19 161:6, 13, 15, 23 162:2 172:20 197:5 202:20 204:20 205:2, 17 207:16 209:24 219:15, 24 229:2 230:24</p>	<p>231:3, 9, 15, 18, 21 <b>chaired</b> 11:16 31:5 <b>challenge</b> 67:7 103:6 106:21 144:1 <b>challenged</b> 61:7 <b>challenges</b> 25:15 132:1 <b>challenging</b> 13:2 25:16 <b>champion</b> 100:23 102:10 <b>chance</b> 100:6 219:6 <b>change</b> 34:25 40:2 109:22 121:20 168:22, 25 170:9 186:5 230:7 <b>changed</b> 5:5 17:23 32:11 39:11 52:20 137:24 <b>changeover</b> 43:21 102:21 129:3 <b>changes</b> 31:15 35:3 37:1 43:22 230:15 <b>changing</b> 63:16 100:18 169:3 <b>characteristics</b> 22:7 <b>charge</b> 210:4, 8 214:24 <b>chasing</b> 169:12 <b>check</b> 126:1 191:14 <b>checked</b> 193:9 201:2 <b>CHIEF</b> 2:7, 9 6:11 10:24 12:12 13:12, 19 14:9, 11, 25 15:3, 12, 24, 25 16:4 20:21 22:7 26:5 30:20, 24 31:10, 12, 24 32:12, 22 33:18, 21, 25 34:3, 13, 19, 21 35:8, 17 36:25 38:22 40:7</p>	<p>41:3 42:20 46:16, 19, 20 47:1, 6 48:6 49:3, 10 53:9, 14 76:21 87:10, 19 90:10 93:19 94:13 95:8 118:5, 12 122:25 123:2 137:16 139:16 205:22 210:6 215:2 221:15 223:23 225:18 <b>Chikungunya</b> 62:19 64:10 <b>child</b> 10:10 <b>Children's</b> 7:9 <b>chime</b> 5:10 6:6 <b>China</b> 144:24 154:6, 14 187:11 <b>Chinese</b> 155:8 <b>Choconta</b> 3:16 <b>choose</b> 40:2 193:10 219:12 <b>chose</b> 38:20 <b>chosen</b> 221:6 <b>Christian-Brown</b> 2:24 <b>chronology</b> 167:23 <b>City</b> 41:23 155:7 <b>Cividino</b> 174:21 177:20 <b>Civil</b> 2:25 108:15, 19, 21 109:4 193:22 <b>Clarification</b> 12:15 185:14 <b>classmates</b> 10:2 <b>clear</b> 15:23 61:13 70:3 88:7 102:2 119:25 120:20 122:3 154:13 181:16 194:23 199:5 201:25 221:14 227:17 <b>clearly</b> 203:24 <b>clinical</b> 18:4, 10 <b>clinics</b> 152:1 <b>Clint</b> 211:17 <b>close</b> 172:3, 13 <b>closer</b> 59:24</p>	<p><b>closing</b> 169:2 <b>clue</b> 80:5 99:13 <b>cluster</b> 171:9 <b>CMOH</b> 23:3, 11 39:12, 16 40:3 42:2 53:18 92:6 118:15 121:17, 18 211:10 225:1 <b>CMOHs</b> 20:20 <b>coach</b> 46:20 <b>Co-Chair</b> 48:16 <b>cognizant</b> 171:20, 22 <b>cohesive</b> 129:6 <b>cohort</b> 19:24 82:5, 18 <b>cohorted</b> 83:17 <b>cohorting</b> 80:19 81:23 82:5 83:2, 9 85:9, 15 <b>cohorts</b> 10:2 <b>Coke</b> 2:3 <b>cold</b> 208:25 <b>Co-Lead</b> 3:24 6:1 <b>collaboration</b> 34:6 <b>collection</b> 55:2 <b>College</b> 19:10 <b>colleges</b> 101:6 <b>collegial</b> 49:4 92:21 <b>Columbia</b> 198:5 <b>combination</b> 42:10 163:23 <b>combine</b> 18:8 19:3 33:10 <b>combined</b> 32:3, 11 43:4 90:24 113:11 <b>come</b> 5:15 10:25 13:12 15:3 20:15 23:21 25:9, 12 29:1 30:15 50:10 52:7 57:16 60:1 62:11, 17 63:20 74:18 82:4, 23 103:20 106:15 136:10 148:12 156:2 161:19 166:15 178:1 200:18 209:2</p>	<p>211:2 213:10 222:9 228:10, 15 234:22 <b>comes</b> 23:20, 22 36:18 148:14 160:17 170:20 234:23 <b>coming</b> 6:2 14:19 15:6 24:18 39:18 40:14 51:7 55:24 57:4 68:5 74:13 81:14 106:15 116:16 135:25 141:2 153:7 170:3 172:3 175:10, 12 192:24 193:1 195:15 203:6 222:11 223:11 230:16 231:16 <b>command</b> 212:4 <b>commencing</b> 5:1 <b>comments</b> 112:15 179:10 225:10 <b>COMMISSION</b> 1:7 2:2 3:9, 13, 15, 17, 19, 21, 23, 24 5:3, 17, 23 6:1 7:18, 23 8:12 11:6 27:9 28:6, 16 51:2 59:20 60:25 61:22, 25 63:4, 21 64:24 65:6, 9 66:13 69:21 70:25 71:15, 19, 24 73:21 74:15, 21, 25 75:5 76:14 79:7 83:4 90:6 93:7, 18 94:4, 8, 16, 24 95:5, 21 101:23 103:4 106:19 108:12 110:22 112:9 128:3 130:19 131:7 132:11, 19 133:3, 6 139:4, 7 140:2, 8 141:4, 9, 14 142:3, 9, 25</p>
--	---	---	---	--

<p>143:6 144:3, 9, 23 147:13 152:3 153:25 154:16, 20 155:3, 13, 20, 23 156:4, 8 157:17, 24 160:19 161:6, 13, 15, 23 162:2 175:23 197:5 202:20 204:20 205:2, 17 207:16 219:15, 24 229:2 230:24 231:3, 9, 15, 18, 21 <b>Commissioner</b> 2:3, 4 27:4 42:1, 3, 4 73:23 90:22 108:7 110:19 112:7 130:4, 23 132:18 156:1 158:12 160:18, 22 161:22 204:25 <b>Commissioners</b> 5:9 6:5 16:17, 23 17:4 21:16 26:16 27:2 85:14 126:8 <b>commitment</b> 160:24 231:1, 6 <b>Committee</b> 10:17 11:3, 17 21:25 22:2, 21, 22, 24 23:5 24:12 48:13, 15 49:13 51:18 52:6 56:7 70:15 71:9, 10, 11 83:8 96:18 97:1 98:7, 8 105:21 112:25 145:25 211:12 236:8 <b>committees</b> 10:16 11:16 39:9 48:23 49:11 50:5, 21 60:7 66:7 121:19 126:5 137:12, 24 181:23</p>	<p><b>communicability</b> 166:12 <b>Communicable</b> 10:17 11:17 13:14, 21 65:5, 7 <b>communicate</b> 188:8 <b>communicated</b> 198:3 <b>communications</b> 28:22 <b>communities</b> 7:13 8:22 10:13 <b>community</b> 9:8, 11 10:5, 7 18:20, 22 42:8 58:25 62:24 165:13, 14, 21, 23 166:3, 23 167:2, 16 184:9 186:6 187:10 188:4 195:16, 20 222:3, 10, 13 223:24 225:14 226:3 228:1, 18 <b>community-wide</b> 167:13 168:13 184:23 195:20 <b>companies</b> 144:14, 15 145:24 <b>company</b> 21:24 22:20 85:1 233:22 <b>compare</b> 64:19, 20 91:5 <b>compared</b> 18:10 56:3 68:3 104:17, 18 169:15, 16 <b>compel</b> 192:20 <b>compensate</b> 191:22, 25 192:6 <b>compensated</b> 191:8 <b>compensation</b> 192:2 <b>competing</b> 43:15 <b>competition</b> 32:7 73:13 <b>compilation</b> 188:14 <b>complain</b> 87:19 88:11</p>	<p><b>complete</b> 9:14 132:25 <b>completed</b> 6:22 9:17 128:10, 13 129:23 <b>complex</b> 30:18 <b>complexity</b> 21:10 25:17 43:21 <b>compliance</b> 95:25 108:17 188:21 <b>complicated</b> 70:23 76:8 138:14 187:5 <b>complication</b> 23:14 <b>complications</b> 70:19 <b>comply</b> 94:19, 20 <b>component</b> 122:17 127:10 178:19 <b>components</b> 77:6 113:9 121:24 123:8, 13, 23 135:24 144:18 205:15 <b>composed</b> 56:2 <b>compromise</b> 35:9 53:4, 15, 19 54:15, 22 69:5 105:2 <b>compromised</b> 52:23 55:4 <b>compulsion</b> 191:1 <b>concept</b> 170:20 174:15 176:15 <b>concepts</b> 133:12 175:13 <b>concern</b> 54:5 64:15 69:22 96:22 112:20 115:2, 6, 10 116:20, 21 216:23 222:14 <b>concerned</b> 54:10, 25 55:9 66:20, 21 88:9 93:22 135:6 155:19 175:3 177:13, 16 178:16</p>	<p><b>concerning</b> 204:23 <b>concerns</b> 37:5 52:11 55:6, 7 91:2 116:23 130:6 178:13 187:19 223:15 <b>concise</b> 6:17 <b>conclude</b> 195:10 <b>conclusion</b> 200:18 201:12 <b>conducted</b> 27:14 <b>conduits</b> 49:9 <b>conference</b> 161:12 231:7 <b>confident</b> 72:13 <b>confidential</b> 225:6 <b>confused</b> 197:4 218:1 224:9 <b>confusing</b> 118:19 159:5 <b>confusion</b> 131:2 <b>congregate</b> 171:21 172:1, 9 <b>connect</b> 49:1 <b>connection</b> 21:3 <b>cons</b> 21:15 <b>consensual</b> 93:8 <b>consensus</b> 162:21 163:6 181:23 182:4, 22 224:15 <b>consequences</b> 109:4 164:3 228:11 <b>consider</b> 14:19 83:22 106:6 173:12 224:1 228:15 <b>considerable</b> 199:9 <b>consideration</b> 112:19 113:5 115:16 197:22 229:21 <b>considerations</b> 63:22 65:10 <b>considered</b> 84:10 115:19 163:16 <b>considering</b> 16:18 <b>consist</b> 230:6</p>	<p><b>consistency</b> 103:9 <b>consistent</b> 27:14 137:4, 7, 20 138:3 <b>constant</b> 105:4 <b>constraint</b> 52:11 <b>construction</b> 9:14 <b>consultant</b> 174:21 185:3 <b>consultation</b> 212:23 <b>consulting</b> 92:12 93:1, 17 <b>contact</b> 70:16 166:6, 14 167:1, 12, 14 168:19 169:1, 17, 21 170:4, 10, 12 172:3, 13 185:4 186:14, 22 206:8 210:25 211:2 <b>contacted</b> 166:11 168:2 <b>contacts</b> 168:2 169:6 195:18 <b>contain</b> 78:15 94:14, 18 142:17 169:15 <b>contained</b> 154:13 <b>context</b> 43:15 139:12 219:19 235:13, 14 <b>continually</b> 159:20 <b>continue</b> 15:17 49:14 56:14 98:3 132:4 161:5, 8 176:11 <b>continues</b> 57:3 <b>contract</b> 105:11 <b>contrary</b> 216:19, 22 <b>contrast</b> 17:5 <b>contribute</b> 18:22 206:23 <b>contributions</b> 181:7 <b>control</b> 37:2 51:12, 16 52:7 78:2 80:25 81:5, 15, 24</p>
--	---	--	---	---

<p>96:19 97:1, 15, 20, 25 98:9, 11 100:22 101:4, 11 102:3 103:2, 7, 8, 16, 19 104:17, 25 105:18 106:1, 14, 23 107:19 108:10 155:12 163:7 166:5, 8, 13 168:20 170:12 175:2 182:10, 18 228:18 230:18 <b>controlled</b> 41:10 <b>controlling</b> 102:1 <b>convenient</b> 161:10 <b>conversation</b> 114:21 <b>convey</b> 205:20 <b>cooperation</b> 210:2 <b>coordinate</b> 11:4, 25 35:15 215:19 <b>coordinated</b> 212:4 <b>cope</b> 133:20 <b>copy</b> 87:14 <b>cordon</b> 78:15 <b>core</b> 73:6, 17 100:17 101:7 <b>corner</b> 116:4 <b>coronavirus</b> 66:12 172:17 <b>Coroner</b> 214:25 215:5 219:18, 25 <b>correct</b> 14:7 32:19 33:16 37:24 38:3, 23 46:14 47:15, 18 62:13 63:9 65:8 71:25 85:3 86:19, 24 94:15 96:1 107:17 115:10 116:20 117:19, 20 118:10 123:1 124:6 125:16 137:9, 20, 22 142:13 143:5 144:8, 11 146:22 147:3 152:9 157:5</p>	<p>158:1 163:2 172:4, 9 177:6 181:11 190:11, 17, 18 191:1, 2 207:9 208:2 210:17, 18, 22 215:9 217:6, 10 218:19 220:21 221:10 222:6 229:19 233:12 <b>corrected</b> 131:4 <b>corresponds</b> 132:13 <b>cost</b> 105:24 <b>costs</b> 42:19 <b>cost-sharing</b> 38:1 <b>cough</b> 70:6 <b>council</b> 42:7 <b>councils</b> 41:10 <b>COUNSEL</b> 2:11, 12, 14, 16, 18, 19, 20, 22 3:1, 24 4:1, 2, 3, 4, 5, 6, 7 5:7 27:25 28:20 43:19 194:5 205:11 <b>Counsels</b> 6:1 <b>counterparts</b> 18:15 63:14 68:10 <b>counting</b> 24:9 <b>countries</b> 61:12 63:12 72:17 173:9 <b>country</b> 20:20, 24 21:9 41:19 61:18 63:1 97:3 193:10 <b>county</b> 42:9 <b>couple</b> 115:23 178:25 213:2 216:7 <b>course</b> 9:10 10:12 12:7 19:1, 17 24:16 43:17 45:17 49:19 51:22 53:3 54:25 57:4 96:8 155:2 164:2, 4 165:19 226:9 <b>Court</b> 12:14 26:23 133:5 185:13</p>	<p><b>cover</b> 15:3 17:4 21:14 <b>covered</b> 8:21, 23 110:2 111:14 <b>COVID</b> 66:11 75:16 76:17 85:19 125:3, 4, 9 126:10 128:13 169:19 201:4 222:4 225:14 227:7, 9, 11 <b>COVID-19</b> 1:7 172:25 173:5 192:19 193:15 <b>Crazy</b> 109:3 <b>create</b> 199:13 <b>created</b> 196:25 211:8, 12 <b>creating</b> 110:4 <b>creation</b> 48:20 <b>crises</b> 118:2, 3 <b>crisis</b> 111:9 197:1 <b>critical</b> 20:3 53:19 57:4 72:10 73:6 78:1 103:3 106:9 143:8 144:18 195:1 <b>critically</b> 103:25 <b>criticized</b> 60:20 <b>CRR</b> 233:3, 23 <b>cruise</b> 171:17 <b>CSR</b> 233:4, 23 <b>cultures</b> 57:1 <b>cupboard</b> 20:13 <b>CUPE</b> 176:16, 22, 25 178:6 179:3 <b>current</b> 24:3 64:17 88:16 120:22 141:22 159:6 <b>curtail</b> 77:23 <b>curve</b> 230:20 <b>cut</b> 52:1 54:21 231:22 <b>cuts</b> 53:16 54:3, 4, 10, 14 <b>cutting</b> 55:15  &lt; D &gt; <b>Dalla</b> 19:20</p>	<p><b>damage</b> 163:21 <b>danger</b> 87:11 <b>data</b> 55:2 71:13 93:23 127:6 149:20 162:15, 25 165:7 <b>date</b> 64:12 122:8 130:21, 22 131:3 157:9, 10 165:4 <b>dated</b> 187:20 233:16 <b>dates</b> 14:7 132:14 <b>David</b> 2:9 5:16, 22 6:13, 16 7:21 8:7, 11, 19 11:13 12:25 13:10 15:4 16:2, 8 17:14 20:16 21:21, 23 22:10 23:7, 25 24:6 29:10, 14 30:3, 8, 22 31:20, 25 32:18, 23 33:16, 19 34:2 35:6, 17 37:17, 20, 24 38:3, 11, 24 40:7, 12 41:15 44:9 45:25 46:15 47:15, 19 48:1 50:1, 9 51:8, 15, 22 52:4, 25 53:17 54:1, 4, 11 55:12 57:10 58:1, 20 59:25 60:4, 17 61:6, 24 62:2, 13 63:9, 24 65:4, 8, 11 66:22 70:1 71:2, 18, 23 72:1 74:4, 19, 23 76:1, 25 77:16 79:9, 25 80:15 81:12 82:9, 13, 19 83:6, 13 84:2, 11, 16, 20 85:4, 10, 25 86:8, 11, 16, 20, 25 87:7, 13, 24 88:2, 5, 8, 13, 19 89:4, 16, 23 90:4, 21</p>	<p>93:10, 20 94:7, 11, 21 95:2, 10 96:2, 14 99:14, 22 102:6 103:12 107:17 109:7 111:10 112:22 114:10 115:11 116:3, 21 117:3, 21 118:9, 14 119:2, 7, 15 120:20 121:3, 9, 13, 16 122:6, 10, 16 123:1, 7, 18 124:6, 8, 11, 17, 23 125:1, 8, 11, 15, 22 126:3, 11, 20 127:4, 22 128:14, 24 129:2, 7, 10, 16, 22 130:1 133:8 135:4, 20 136:12, 15, 20 137:1, 10, 19, 23 138:2, 9, 21 139:1, 20 140:5, 12 141:6, 11, 17 142:8, 14 143:5, 11 144:8, 11, 25 145:14, 23 146:9, 13, 20 147:4, 10, 16 148:21 149:2, 12, 20, 25 150:9, 14, 21 151:5, 14, 23 152:11 154:8, 18 155:1, 5, 18, 22 157:6, 12, 18 158:3 159:10 160:13 161:11, 14, 21 162:9, 18 163:3, 22 164:13, 17, 21 165:1, 5, 14, 19, 23 166:3 167:22 168:24 169:14 171:13, 18, 22 172:2, 10, 21 173:4, 15 174:14, 20, 23 175:9 176:1, 8, 14, 20, 24 177:6, 11, 15, 19 178:4, 17 179:6, 17 180:5, 8, 13, 16,</p>
---	---	--	--	--

<p>24 181:11, 19 182:9 183:9, 15, 17, 20 184:1, 11 185:2, 23 186:7, 10 188:5 189:15, 17, 25 190:7, 12, 18, 21 191:2, 5 192:1, 7, 21 193:21, 25 194:5, 14, 25 195:3, 11, 14 196:1, 7, 10, 18 197:8 198:14, 21 199:17, 24 200:7, 13, 19, 24 201:17 202:5, 11 203:16, 22 204:1, 8, 10, 18, 24 205:10, 24 206:24 207:8, 11, 20 208:19 209:21 210:18, 22 211:1 213:16, 19 214:13, 16 215:9 216:15, 25 217:6, 10, 18, 22, 25 218:4, 9, 15, 19, 24 219:21 220:2, 14, 21 221:5, 11, 17 222:1, 6, 19 223:7 224:4 225:4, 21 227:13, 18 228:8 229:6, 10, 20 231:2, 8, 12, 17 <b>Dawn</b> 3:10 <b>day</b> 1:15 106:11, 12 224:17 230:9 233:16 <b>days</b> 24:9 66:16 75:12, 13 76:11 81:19 92:8 143:9 152:24 153:16 169:19 191:4 213:5 <b>day-to-day</b> 92:1 <b>D'Cunha</b> 10:24 12:3 <b>de</b> 83:20 <b>deadline</b> 14:22</p>	<p><b>deal</b> 14:3 16:17 21:1 35:23 43:6 55:24 57:19 61:20 64:12 77:18 78:6 91:14, 16 94:14 99:2 100:3 101:12, 21 102:11 113:3, 6, 7 115:16 124:13 135:11, 23 136:8, 9 139:24 145:16 148:8 188:20 191:8 192:3 206:18 209:1, 7, 16 225:23 226:25 <b>dealing</b> 18:15 48:23 52:10 58:25 64:16 68:7 77:12 81:22 84:6 89:24 97:7 117:11 127:24 133:17 135:9, 10, 21 147:1 170:13 226:9 <b>deals</b> 29:16, 17 199:18 <b>dealt</b> 30:17 53:20 63:25 83:4 97:5 199:22 201:11 <b>Deana</b> 4:10 133:4 233:3, 23 <b>death</b> 127:9 <b>deaths</b> 83:20 149:18 203:5 <b>debate</b> 183:21 184:7 223:2, 10 224:6, 10 <b>decant</b> 84:23 <b>decanted</b> 84:22 <b>decanting</b> 83:22 <b>December</b> 113:18, 23 157:13 225:16 <b>decide</b> 73:10 81:1 <b>decided</b> 205:16 <b>decision</b> 53:8 71:16, 17, 21 72:14 137:8, 9</p>	<p>141:16, 17 142:10 143:1, 3, 4 153:20 154:9, 22 183:6 205:23 207:18 218:22 219:7 224:18 225:7 <b>decision-making</b> 22:11 162:14 173:14, 16 212:22 <b>decisions</b> 73:18 204:23 219:9 224:3 <b>deck</b> 118:20 124:21 <b>decks</b> 131:18 <b>declared</b> 143:12 <b>decline</b> 112:17, 18 <b>Deeks</b> 51:9 125:19 217:12 218:25 219:5 221:1 223:19 224:16 <b>deemed</b> 58:8 70:9 <b>default</b> 163:19 <b>defence</b> 210:5 <b>deficits</b> 14:3 108:1 <b>defined</b> 82:14 162:19 <b>definitely</b> 162:19 <b>definition</b> 68:9, 11 70:8 78:19, 20 <b>definitions</b> 67:8 73:18 <b>definitive</b> 60:4 72:9 <b>degree</b> 8:18 9:12, 22 19:4 <b>degrees</b> 24:25 25:10 <b>delay</b> 55:8 76:15 <b>delayed</b> 76:10 <b>delays</b> 66:15 75:11 76:24 <b>deliberate</b> 71:20 <b>deliver</b> 36:12 45:19 46:6 <b>delivering</b> 123:11</p>	<p><b>delivery</b> 41:12 53:19 179:8 188:21 <b>demand</b> 106:16, 17, 18 158:15 <b>demanding</b> 117:8 <b>demands</b> 98:18 <b>demonstrate</b> 161:16 228:19 <b>demonstrated</b> 135:13 227:5, 10 <b>dengue</b> 64:11 <b>depart</b> 20:14 <b>departing</b> 16:21 <b>department</b> 20:25 87:15 89:1 98:17 157:15 201:1 <b>depend</b> 159:13 183:2 <b>dependent</b> 145:18 <b>depending</b> 107:2 <b>depth</b> 101:10 <b>deputies</b> 22:15 <b>Deputy</b> 3:8 23:13, 15 31:1, 2, 5, 21 32:1, 16, 21 33:6 37:22 38:7 88:25 90:25 92:10, 21 93:11, 12, 24 94:10 95:13 118:13 119:8, 16, 17, 20 120:2, 6, 8, 10 122:15 129:8 140:11, 15 200:20 202:18 204:6 208:18 212:6, 9 214:1 <b>Derek</b> 3:12 <b>describe</b> 81:6 128:22 167:20 <b>described</b> 24:5 79:4 201:13 219:19 <b>description</b> 33:20, 23, 25 34:3 46:1 105:8 <b>design</b> 105:20 106:2</p>	<p><b>designated</b> 73:24 74:3 <b>designing</b> 9:15 <b>desire</b> 133:22 216:25 <b>desk</b> 211:3 213:10 <b>desktop</b> 87:18 <b>desperately</b> 206:15 <b>destroy</b> 141:16 <b>destroyed</b> 139:18 141:10 159:1 <b>destroying</b> 141:12, 15 <b>detail</b> 50:7 212:25 <b>detailing</b> 126:21 213:22 <b>details</b> 24:17 126:21 <b>deterioration</b> 112:13 <b>determination</b> 156:17 <b>determine</b> 77:21 <b>determined</b> 67:23 <b>develop</b> 68:9 95:17 101:3 <b>developed</b> 67:14, 20 98:4, 9 162:23 <b>developing</b> 93:5 114:16 115:14 <b>development</b> 48:3 57:12 121:20 213:24 <b>devices</b> 8:1 <b>devote</b> 97:17 <b>Dew</b> 105:21 <b>diagnosed</b> 67:3 <b>diagnosis</b> 72:9 <b>diagnostic</b> 70:22 103:1 <b>diagnostics</b> 73:7 <b>dialogue</b> 64:23 115:17 <b>dialogues</b> 52:8 <b>Diamond</b> 171:16 <b>Diaz</b> 3:16 <b>Dick</b> 48:16 <b>die</b> 76:17 227:11</p>
---	---	--	---	---

<p><b>died</b> 75:15 80:8 81:9 <b>differ</b> 126:13 <b>difference</b> 18:7 56:1, 4 163:18 166:1 <b>different</b> 18:3 19:2 20:20, 24 22:18 29:17, 20 33:23 34:7, 17, 18 40:22, 23 41:8, 21 42:13 43:9, 19, 24 44:14 46:7 50:22 55:16 56:10, 20 66:25 76:3 81:13 83:18 91:5 109:19 112:3 117:4, 15 121:23 123:9, 13 127:11 129:2, 3 135:24 136:14, 16 137:12 138:8 143:3 165:15, 24 167:10 168:18 169:3 175:12 181:22 189:8, 13 192:16 204:25 205:13, 15 207:13, 22 219:9 221:6 223:12 224:7 226:23 230:12 <b>differently</b> 56:21 71:14 <b>difficult</b> 144:4 <b>difficulty</b> 14:17 36:22 82:20 103:5 143:16 <b>direct</b> 34:9 44:12 50:4 58:24 89:15 94:23, 25 <b>directed</b> 26:7 106:20 110:24 111:11, 13 <b>directing</b> 207:5 <b>direction</b> 12:3 22:17 32:16, 21 35:19 36:19 40:19 92:16 93:14, 21 108:1,</p>	<p>4 143:10 162:22 173:20 184:20 190:24, 25 191:4 <b>directions</b> 51:17 53:22 190:14 219:10 <b>Directive</b> 82:3, 8, 9 93:9 187:24 188:2, 18 189:7 191:6 192:3 194:6, 8 196:19 197:12 198:13 199:15 202:1 203:9, 15, 17, 18 206:25 207:1, 12 <b>directives</b> 93:2 94:7, 14, 21 95:16, 19 111:19 197:10 <b>directly</b> 32:25 33:6 182:7 <b>Director</b> 3:10, 12 9:2, 3 13:22 32:14 39:14 40:20 50:16 51:9 119:24 120:3 122:19 211:14 <b>directors</b> 40:24 101:3 211:16 <b>Dirk</b> 214:24 <b>disagree</b> 213:9 <b>disappointing</b> 79:18 101:9 <b>disconcerting</b> 77:10 102:22 <b>discuss</b> 21:14 35:22 66:8 91:1 <b>discussed</b> 184:18 <b>discussion</b> 41:16 48:24 59:7 84:21 115:17 123:24 134:2 140:20 177:9 179:2 184:23 204:19 208:1 <b>discussions</b> 52:8, 15 59:13 60:2, 5 61:3, 4 63:22 84:11 92:17 123:21,</p>	<p>25 128:15 136:5 140:15 194:3, 11 208:17 <b>disease</b> 10:20 13:20 22:6 48:13, 15 51:18 62:7 63:7 64:14 66:3 68:8 78:4 81:5 86:6 94:6 96:17, 25 98:7 102:15 127:25 133:24 135:24 136:9 166:5 189:12 190:4, 11 205:20 206:23 207:7 236:7, 9 <b>Diseases</b> 10:18 11:17 13:14, 15, 21 57:5 61:11 62:4, 18 97:5 101:19 102:1 112:25 128:17 135:12 <b>dismissed</b> 24:1 <b>disruption</b> 228:6 <b>distance</b> 49:6 54:23 <b>distancing</b> 169:7 170:1 <b>distinction</b> 88:12 <b>distraught</b> 75:18 76:15 <b>distribution</b> 54:20 <b>division</b> 31:22 32:4, 9, 13, 14 38:15 40:4 49:2 51:5 116:17 119:25 <b>divisions</b> 32:5 <b>Doctor</b> 5:5, 11, 19, 25 7:16 8:15 61:2 74:16 75:7 90:9, 13 114:25 132:23 133:7 145:7 152:4 155:24 158:1 160:20 161:7 162:5 197:6 204:16, 21</p>	<p>207:17 219:17 230:25 231:16 <b>doctors</b> 8:23 97:11 147:22 151:25 152:14, 17 <b>document</b> 68:25 73:1 123:16 130:18 131:6, 13 156:7, 14 157:7 170:18 181:1, 2, 21 182:1 187:18 188:15 220:17 224:17 <b>documenting</b> 196:15 <b>documents</b> 26:8, 9, 11, 14 27:3 28:4 29:22, 23 30:1, 6 39:7 51:7 57:13 79:12 82:10 83:9 96:5, 24 97:2 98:24 122:12 124:3, 19 138:6 145:8 151:9, 12 157:3 170:19 217:13 218:12 <b>doing</b> 11:10 12:19 29:22 36:6 39:20 55:22 60:11 64:19 65:2 68:3 69:15, 19 71:22 72:2, 16 74:1, 6, 8 80:25 84:9 99:13 101:25 104:20, 22, 25 105:13 128:25 131:20 136:7 137:12 167:5 168:4 176:7 191:9 195:8 197:12 206:12, 15 215:10, 19, 22 216:4, 6 225:11 228:22 235:18, 19 <b>dollars</b> 45:5 153:3 <b>domestic</b> 228:12 <b>door</b> 182:14</p>	<p><b>doorstep</b> 61:13 63:7 <b>doubled</b> 68:1 <b>doubt</b> 77:10 187:22 <b>downsizing</b> 31:16 <b>drive</b> 59:4 160:7 <b>driver</b> 222:4 <b>Drop</b> 105:21 <b>droplet</b> 172:11, 12 <b>dropped</b> 222:22 <b>dropping</b> 226:16 <b>Drummond</b> 3:8 <b>dual</b> 43:3 <b>due</b> 14:10 15:14 37:6 162:15, 25 169:16, 17 <b>dusted</b> 20:18 <b>duties</b> 21:11 33:14, 18 36:3, 8 45:18 46:4 <b>duty</b> 15:5 53:13 <b>dwindled</b> 98:16 <b>dynamics</b> 63:10  &lt; E &gt; <b>earlier</b> 75:14 143:9 155:15 162:13 170:19 202:6 <b>early</b> 67:14 92:8 113:5, 13 136:1, 5 143:9 153:16 154:18 155:7 158:18 167:24 196:11 236:21 <b>ease</b> 109:16 <b>easier</b> 185:22 <b>Easily</b> 71:23 72:1 <b>East</b> 7:1 <b>easy</b> 190:15 <b>eat</b> 161:21 <b>Ebola</b> 16:1, 6 61:2, 7, 16, 17 62:3, 16 124:14, 20 125:12, 16 127:25 128:19 131:14 132:5 133:13, 19, 24</p>
--	---	---	--	--



<p>135:13, 25 136:12 138:17 146:17 147:18 148:6, 10 179:22 <b>echo</b> 12:21 <b>echoing</b> 8:4 <b>echos</b> 12:16 <b>edge</b> 55:15 <b>education</b> 18:18, 24 96:4 <b>effect</b> 79:7 115:3 131:18 175:8 <b>effective</b> 102:3 147:7 148:4 202:2 203:11 204:4 <b>effectively</b> 108:16 <b>efficiencies</b> 52:15 113:14 <b>efficient</b> 117:11 147:7 148:5 <b>efficiently</b> 140:25 <b>elected</b> 22:14 <b>election</b> 43:22 <b>element</b> 103:8 132:24 <b>eliminate</b> 206:4 230:21, 23 <b>email</b> 170:21 204:14 208:11 <b>embedded</b> 42:5 <b>EMCPA</b> 205:11 206:19 <b>emergency</b> 19:7 98:17 122:20 187:25 193:18 194:3, 13 198:13, 14, 24 207:18 210:8, 9, 15, 16 211:8, 9 220:4 <b>emerging</b> 181:8 183:15, 16 <b>emissary</b> 212:8 <b>emphasis</b> 98:22 <b>emphasizing</b> 98:24 <b>employ</b> 95:7, 8 <b>employed</b> 220:9 <b>employee</b> 191:15 220:16</p>	<p><b>employees</b> 189:13 191:20 192:15, 17, 23 194:17 201:16 <b>employers</b> 180:11 192:14 <b>employment</b> 190:3 199:14, 19 <b>empower</b> 40:24 <b>emulate</b> 48:17 127:12 <b>enabled</b> 110:1 <b>encouraging</b> 25:20 <b>encumbrance</b> 45:11 <b>endeavouring</b> 53:3 <b>ended</b> 228:21 <b>engineering</b> 103:1 <b>enhanced</b> 172:11 <b>ensure</b> 123:4 <b>ensuring</b> 54:14 <b>enter</b> 225:15 <b>entering</b> 222:4 <b>enterprise</b> 117:10 <b>entire</b> 136:23 <b>entities</b> 136:9 <b>entity</b> 113:12 117:23 <b>environmental</b> 13:21 <b>epi</b> 168:8 186:15 <b>epidemiological</b> 167:17 186:24 187:3 <b>epidemiological</b> <b>y</b> 166:19 <b>epidemiology</b> 9:12 10:7 <b>epi-link</b> 70:20 168:12 <b>epi-linked</b> 166:18 <b>equal</b> 142:19 <b>equip</b> 150:22 <b>equipment</b> 54:17 56:25 68:19, 21 74:9 108:25 139:9, 14 141:19, 20</p>	<p>143:8 144:7 148:10 154:23 <b>equipped</b> 39:22 64:12 110:2 <b>equipping</b> 14:21 <b>equivalent</b> 13:22 220:16 <b>equivalents</b> 30:25 52:19 <b>era</b> 61:9 <b>Eric</b> 2:19 <b>escalated</b> 143:15 167:8 <b>escalating</b> 143:20 <b>especially</b> 9:4 18:8 36:17 52:9 54:16 62:22 66:19 77:9 140:6 142:18 143:20 212:17 <b>essence</b> 25:6 167:17 <b>essential</b> 210:3 226:15 <b>essentially</b> 172:25 173:6 199:16 <b>establishment</b> 135:2 <b>European</b> 128:4 <b>event</b> 151:2 155:21 162:16 163:1 209:20 <b>eventually</b> 5:20 218:16 <b>everybody</b> 5:15 25:25 74:18 75:2 88:20 154:24 155:15 188:16, 18 214:3 <b>evidence</b> 57:18 71:7 75:9 79:6 83:3 95:11 112:13 115:3 119:14 121:1 127:19 130:11, 25 131:17 132:13 134:8, 12 136:14, 17 138:20 146:16 150:3 157:4, 15 158:5, 6, 19 160:16 162:20,</p>	<p>22, 25 163:4, 12 164:22 167:17 168:17 171:4 173:5 174:10, 18 175:4, 18, 20 176:12 177:3, 5 178:1 181:4, 20 182:19 183:10, 13 189:23, 24 194:15, 16, 21, 22, 25 199:4 201:4 203:3 222:9 <b>evidence-</b> <b>informed</b> 162:14 <b>evolution</b> 20:11 <b>evolved</b> 19:23 34:12, 15 <b>evolving</b> 19:5 162:16 163:1 <b>exact</b> 74:13 <b>exactly</b> 90:4 114:8 145:19 163:25 165:10 214:11 <b>example</b> 16:1 23:2 24:4 198:5 200:5 204:6 214:5 <b>exams</b> 19:3 <b>excellent</b> 17:15 167:25 213:13 <b>exception</b> 5:6 <b>excessive</b> 107:10 <b>excluded</b> 150:20 <b>Excuse</b> 135:20 <b>excused</b> 208:6 <b>execute</b> 123:5 <b>execution</b> 166:2 <b>Executive</b> 39:14 40:19 119:23 120:3 215:3 <b>exhausted</b> 139:5 <b>exist</b> 6:24 60:13 <b>existing</b> 132:1 <b>exists</b> 38:2 <b>ex-officio</b> 49:16 <b>expand</b> 59:11 <b>expanded</b> 213:1 <b>expect</b> 22:5 104:13 126:14 <b>expectations</b></p>	<p>84:8 <b>expected</b> 99:25 <b>expects</b> 36:9 <b>expeditiously</b> 55:23 89:5, 9, 22 <b>experience</b> 13:8 16:20, 25 25:2, 9, 11 147:16 <b>experienced</b> 59:2 <b>experiencing</b> 173:10 <b>expert</b> 40:17 102:14 107:4, 5 128:4 162:21 163:5, 6 164:5 172:23 177:2 182:4 <b>expertise</b> 13:14 41:6 44:15 66:3 100:17 101:11 103:17 104:21 <b>experts</b> 22:3, 18 60:10, 20 64:18 66:2 68:18 71:12 163:24 173:7 175:2 182:20 183:2 220:6 225:11 <b>expire</b> 15:15 <b>expired</b> 139:22 141:12, 13, 18, 20 142:1, 5 <b>expires</b> 160:1 <b>explain</b> 6:10 135:19 <b>explaining</b> 11:11 <b>explanation</b> 69:7 <b>explore</b> 26:4 <b>exposed</b> 83:18, 24 84:7 126:17 169:19 <b>exposing</b> 193:15 <b>exposure</b> 169:15, 16, 17 170:6 192:19 218:7 <b>express</b> 55:10 <b>expressed</b> 55:6, 7 <b>extend</b> 207:5 <b>extended</b> 15:17 206:22</p>
---	--	---	--	---

<p><b>extension</b> 18:1 163:4</p> <p><b>extent</b> 16:15 224:12</p> <p><b>extra</b> 7:3, 4 13:14</p> <p>&lt; F &gt;</p> <p><b>face</b> 101:21 111:22 190:11, 12</p> <p><b>facilitate</b> 44:6</p> <p><b>facilities</b> 78:7 84:12, 15, 17, 19 85:3, 5 90:12, 16 143:22, 24 152:5</p> <p><b>facility</b> 85:2</p> <p><b>fact</b> 5:6 20:25 67:24 138:16, 23, 24 154:2 171:20, 23 183:22 196:21 197:13 228:22</p> <p><b>factual</b> 130:6</p> <p><b>fade</b> 212:3</p> <p><b>faded</b> 7:17, 19 38:12</p> <p><b>failed</b> 124:16</p> <p><b>failure</b> 87:17 134:25 135:1</p> <p><b>fairly</b> 63:20 168:3 185:11</p> <p><b>fairness</b> 146:5</p> <p><b>fall</b> 14:7, 8, 16, 23 75:24 108:24 217:12 226:10</p> <p><b>false</b> 69:6</p> <p><b>familiar</b> 47:14 127:20 151:13 200:10</p> <p><b>families</b> 75:17, 25 76:5</p> <p><b>family</b> 76:14 77:9 226:12</p> <p><b>Farid</b> 3:1</p> <p><b>farm</b> 215:16 216:8, 17</p> <p><b>fashion</b> 55:3</p> <p><b>fast</b> 75:20</p> <p><b>fear</b> 222:17</p> <p><b>February</b> 1:16 15:13 67:25 75:23 143:12,</p>	<p>19 148:1 154:6, 17, 19, 23 155:7 166:4 167:25 173:2, 8 233:16</p> <p><b>federal</b> 63:14 121:20 126:6 140:16, 23 142:22 154:9 184:18</p> <p><b>federal/provincial /territorial</b> 58:4 71:10 121:19 123:22</p> <p><b>feedback</b> 185:21 203:14, 16, 23 204:1 219:1</p> <p><b>feel</b> 25:5 110:8 111:20 114:11 163:12 193:17</p> <p><b>fellow</b> 178:8</p> <p><b>fellowship</b> 19:3</p> <p><b>fellowships</b> 9:23 10:1, 4</p> <p><b>felt</b> 9:3 46:18 49:8 53:18 54:6 114:15 116:25 136:23 142:19 153:13 198:12 222:21, 25 226:10 229:23</p> <p><b>fever</b> 70:5</p> <p><b>field</b> 34:7 39:18 85:1 188:21</p> <p><b>Figliomeni</b> 2:16</p> <p><b>figure</b> 28:24 74:13 126:14 172:6</p> <p><b>figuring</b> 99:20</p> <p><b>fill</b> 31:10</p> <p><b>final</b> 204:22 205:9</p> <p><b>finalized</b> 57:20</p> <p><b>finally</b> 67:2</p> <p><b>finance</b> 50:17 52:5</p> <p><b>financed</b> 110:2</p> <p><b>financial</b> 140:13</p> <p><b>financially</b> 56:22</p> <p><b>financing</b> 43:7</p> <p><b>find</b> 25:16 29:6 33:17 44:24 98:25 101:10</p>	<p>103:10 123:17 124:20 142:10 145:5 154:5, 21 169:8 186:24 201:8, 24 204:13 206:9 220:6</p> <p><b>finding</b> 75:22 167:10 215:25</p> <p><b>fine</b> 29:4 88:10 132:17 160:18 231:20</p> <p><b>finger</b> 204:16</p> <p><b>finish</b> 9:22 62:1 147:15 156:2, 5</p> <p><b>finished</b> 90:7 129:20 135:21</p> <p><b>Finley</b> 4:3 12:16 13:4 113:20 185:15</p> <p><b>firm</b> 229:25</p> <p><b>fiscal</b> 38:25 52:11 213:24</p> <p><b>fit</b> 173:19</p> <p><b>five-year</b> 19:2</p> <p><b>fixed</b> 134:23, 25</p> <p><b>fixes</b> 13:7</p> <p><b>flag</b> 160:24</p> <p><b>flak</b> 60:18</p> <p><b>flat</b> 51:25</p> <p><b>flesh</b> 6:4</p> <p><b>flow</b> 170:16</p> <p><b>flu</b> 102:2</p> <p><b>focus</b> 58:5, 10 61:16 62:3, 8 66:4 142:15</p> <p><b>focussing</b> 77:13</p> <p><b>follow</b> 29:20 166:9, 11 168:14</p> <p><b>followed</b> 79:6 126:23 145:10 206:7</p> <p><b>Following</b> 12:6 133:13 156:16</p> <p><b>follows</b> 185:16</p> <p><b>food</b> 91:24, 25 107:24</p> <p><b>forecasts</b> 127:8</p> <p><b>foregoing</b> 233:5, 11</p> <p><b>forget</b> 62:9 228:9</p> <p><b>forgotten</b> 149:8</p>	<p><b>form</b> 211:11 212:3</p> <p><b>formed</b> 48:10, 18 92:4 212:12</p> <p><b>former</b> 38:12, 13 202:18</p> <p><b>formulated</b> 182:11</p> <p><b>formulation</b> 136:2</p> <p><b>forth</b> 69:16 185:21 233:7</p> <p><b>forthcoming</b> 43:14</p> <p><b>forward</b> 20:15 35:22 39:10 57:17 60:10 68:6 114:20 127:24 188:17</p> <p><b>found</b> 46:23 72:23 100:8 102:7, 8, 18 104:1 109:9 144:16 148:6 155:1 188:8 195:14, 15 201:4 216:10, 11 222:10 223:14</p> <p><b>Foundation</b> 105:21</p> <p><b>four-week</b> 146:24 149:3 151:10, 12, 16</p> <p><b>four-year</b> 42:15</p> <p><b>FPT</b> 137:14 142:22</p> <p><b>framed</b> 27:23</p> <p><b>framework</b> 122:1 217:20, 23 218:2, 3, 5 227:19, 20 229:7, 9</p> <p><b>Frank</b> 2:2 5:3, 17, 23 7:18, 23 8:12 11:6 27:9 28:6, 16 51:2 59:20 60:25 61:22, 25 63:4, 21 64:24 65:6, 9 66:13 69:21 70:25 71:15, 19, 24 73:21 74:15, 21, 25 75:5 90:6 93:7, 18</p>	<p>94:4, 8, 16, 24 95:5, 21 101:23 103:4 106:19 108:12 110:22 112:9 114:21 130:19 131:7 132:11, 19 133:3, 6 139:4, 7 140:2, 8 141:4, 9, 14 142:3, 9, 25 143:6 144:3, 9, 23 147:13 152:3 153:25 154:16, 20 155:3, 13, 20, 23 156:4 157:24 160:19 161:6, 13, 15, 23 162:2 197:5 202:20 204:20 205:2, 17 207:16 219:15, 24 229:2 230:24 231:3, 9, 15, 18, 21</p> <p><b>Franklin</b> 3:14</p> <p><b>frankly</b> 90:17</p> <p><b>free</b> 111:21 193:10</p> <p><b>freedoms</b> 193:22</p> <p><b>frequently</b> 107:5</p> <p><b>Friday</b> 26:10 30:7 193:8</p> <p><b>friends</b> 17:20</p> <p><b>front</b> 99:5 182:21</p> <p><b>frustrated</b> 106:14</p> <p><b>full</b> 9:9, 10 180:20 199:13 202:7, 10, 12, 14 212:23</p> <p><b>full-time</b> 52:19</p> <p><b>fully</b> 74:2 164:7</p> <p><b>function</b> 32:18 50:18 139:22</p> <p><b>functional</b> 74:2</p> <p><b>functionality</b> 73:17</p> <p><b>functionally</b> 56:10</p> <p><b>functions</b> 17:2</p>
--	---	---	---	--

<p><b>funded</b> 38:4 45:5 56:20 110:3</p> <p><b>funding</b> 36:1 42:19 45:6</p> <p><b>future</b> 69:20 97:8 112:8</p> <p>&lt; G &gt;</p> <p><b>gained</b> 113:15</p> <p><b>gargantuan</b> 26:18</p> <p><b>gathering</b> 181:13</p> <p><b>Gemmill</b> 11:2</p> <p><b>gene</b> 67:11</p> <p><b>General</b> 2:18, 19, 21, 23 7:1 16:13 49:15 134:17 149:6 176:10 212:24 219:23</p> <p><b>General/Crown</b> 2:25</p> <p><b>generally</b> 37:15 39:8 96:2 128:5</p> <p><b>generation</b> 17:13</p> <p><b>genetic</b> 55:19</p> <p><b>get-go</b> 114:17 153:14 172:16 191:12, 18 192:22</p> <p><b>give</b> 12:2 15:19 20:2 22:15, 16 33:2 35:18 36:16 40:18 49:7 74:12, 18 81:19 93:21 96:3 108:1, 4 121:11 135:12 141:20 152:14, 17 162:21 163:10 183:3 188:10, 11, 18 189:7 197:24 198:5 200:24 205:14 214:4 225:5</p> <p><b>given</b> 16:19 41:6 52:4 96:10 103:5 107:12 134:14 138:5 156:9</p>	<p>157:16 175:9 216:21</p> <p><b>gives</b> 34:14 200:16 225:1, 2</p> <p><b>giving</b> 35:19 83:14 111:18 140:19 179:18 184:19 224:22</p> <p><b>global</b> 61:10 62:22 73:13 143:17 144:17 145:2</p> <p><b>globalization</b> 144:13</p> <p><b>globally</b> 73:15</p> <p><b>gloves</b> 147:19</p> <p><b>goal</b> 228:4</p> <p><b>goals</b> 228:3</p> <p><b>good</b> 5:24 25:21, 22 26:2 40:24 66:23 67:22 69:13 72:16 81:24 90:22 99:8 105:6 142:5, 13 159:11 163:14 175:9 211:3 227:9 229:23 230:8, 10</p> <p><b>go-to</b> 107:18</p> <p><b>government</b> 23:2, 18 34:6, 22, 23 38:20 39:6, 19, 21 40:15, 17 42:9 44:14 48:6 49:1, 5 52:5, 10 108:19 140:16 147:5 155:9 157:16 198:12 220:9, 15, 16 225:9 229:14</p> <p><b>governments</b> 146:2</p> <p><b>government- wide</b> 220:4</p> <p><b>Gowling</b> 3:24 4:1, 2, 3, 4, 5, 6, 7</p> <p><b>gowns</b> 104:10</p> <p><b>GP</b> 7:5 8:20 18:5</p> <p><b>gradually</b> 61:15</p> <p><b>gray</b> 116:4 221:19</p>	<p><b>great</b> 11:10 19:10 40:13 55:19, 20 57:19 59:10 64:15 73:9 74:24 109:11</p> <p><b>greater</b> 79:21 220:24 221:2 224:23</p> <p><b>greatly</b> 40:17 96:22</p> <p><b>green</b> 229:22</p> <p><b>grocery</b> 193:5, 8 200:4</p> <p><b>groomed</b> 102:9</p> <p><b>Gross</b> 4:5</p> <p><b>ground</b> 81:9</p> <p><b>group</b> 45:16 52:3 85:11 97:22 107:1</p> <p><b>groups</b> 43:24 98:10 141:25 146:2 194:7 207:22</p> <p><b>growth</b> 18:1</p> <p><b>guess</b> 13:1 25:24 30:11 52:12 100:10 101:9 106:20 116:4, 14 139:15 161:16 176:15 188:1 193:10 225:10 227:3</p> <p><b>guidance</b> 82:10 83:9 86:3 188:15 191:12, 13 198:2</p> <p><b>guided</b> 156:16</p> <p><b>guys</b> 18:16, 17</p> <p><b>gynecology</b> 7:4 18:6</p> <p>&lt; H &gt;</p> <p><b>H1N1</b> 16:1, 3 59:10 65:19 66:11 69:1 147:17</p> <p><b>had...[inaudible].. .when</b> 12:11</p> <p><b>half</b> 8:21 155:24 160:20 164:14, 15 229:15</p> <p><b>Hamilton</b> 19:16</p>	<p><b>hand</b> 14:22 15:10 73:22 89:10 90:2 116:12 170:1</p> <p><b>handle</b> 62:20 89:6 188:19</p> <p><b>handled</b> 142:24</p> <p><b>handling</b> 39:5 91:25</p> <p><b>handwriting</b> 114:2</p> <p><b>happen</b> 80:8 81:7 120:18 126:19 173:11 194:22 197:24 215:4</p> <p><b>happened</b> 16:14 17:6 26:16 81:9, 11 83:16 103:21 120:18 144:20 168:9 169:11</p> <p><b>happening</b> 63:18 77:11 93:25 173:8 187:10</p> <p><b>happens</b> 105:1 143:2 181:16</p> <p><b>harbouring</b> 167:4</p> <p><b>hard</b> 6:15 25:23 98:2 99:4 103:13 107:4 116:2 160:17 202:22 226:14 230:4 231:1</p> <p><b>harder</b> 153:8</p> <p><b>Harry</b> 7:10</p> <p><b>Hartley</b> 211:17</p> <p><b>Hawthorn</b> 3:18</p> <p><b>head</b> 125:19, 23 176:16 213:15, 16 214:8 215:5, 6</p> <p><b>heading</b> 143:10</p> <p><b>headphones</b> 12:18 13:2</p> <p><b>headsets</b> 185:18</p> <p><b>HEALTH</b> 2:7, 8, 9 6:12 8:18 9:11, 12, 20 10:5, 7, 9, 15, 19, 24 11:4, 14 12:13 13:13, 20,</p>	<p>21 14:1, 9, 12, 17 15:1, 4, 12, 25 16:4, 9 17:10, 11, 18 18:10, 13, 19, 21 19:1, 12, 21 20:1, 22, 23 21:3, 4, 7, 8 22:6, 8 23:20 25:3, 6, 18 26:5 30:20, 21, 24 31:3, 6, 11, 13, 21, 24 32:5, 6, 9, 12, 13, 22 33:3, 13, 18, 22, 25 34:3, 4, 10, 13, 15, 17, 20, 21 35:8, 11, 16, 18 36:7, 10, 12, 22, 24, 25 37:4, 8, 16 38:10, 14, 16, 17, 18, 22, 23 40:4, 8 41:3, 8, 9, 13, 14, 17, 20 42:6, 12, 15, 21, 22, 23, 25 43:1, 3 44:3, 7, 11, 18, 19, 25 45:3, 21, 23 46:2, 6, 7, 8, 16, 20, 21, 25 47:1, 6, 21, 24, 25 48:2, 3, 7, 11, 20, 22 49:2, 3, 10, 18, 20, 21, 22, 25 50:11, 15 51:25 52:16, 23 53:10, 14, 15 56:2, 7, 10, 22 57:8, 22, 25 58:15, 17, 19 60:15 62:5 65:21 70:3 74:1 76:22, 23 77:2, 19 78:21 79:10, 19 80:6 85:11 87:10, 15, 19 88:9 90:11, 13, 15, 23 91:6, 8, 15 92:12, 15, 19 93:11, 12, 16, 19, 22 94:3, 12, 13 95:2, 4, 9, 24 96:12, 20 97:24 98:5 100:8 102:7, 15</p>
---	--	--	--	--

106:25 107:18 112:14, 16, 19, 20, 21 113:12 114:11, 17, 19 115:2, 5 116:16, 17, 19, 22, 23 117:4, 5, 14, 23 118:2, 3, 6, 12 119:24 120:23 122:20, 25 123:3 125:20 126:4, 15 127:6, 11, 24 133:15, 22 134:3 135:11, 13, 22 136:10 137:17 139:16 142:5 146:3 152:1 153:23 155:9 165:8 166:20 167:9 168:11, 15, 25 169:1, 16 170:10 171:2, 11 173:18 175:7 181:2, 10, 22 184:16 185:6, 7 186:23 188:6, 23 191:13 193:23 196:12 199:2 200:4 201:1 202:6, 8, 13 205:18, 22 206:18 210:5, 7, 8, 9 211:24 212:2, 9, 10, 16, 19 213:17, 20 215:2 217:15 218:11, 24 220:12, 13, 20 221:1, 8, 9, 16 223:3, 11, 16, 24 225:2, 19 228:10, 12, 17 229:11 234:12, 16 235:9, 11 236:5, 16 237:3, 6 <b>Health/Ministry</b> 2:12, 14, 17 3:1, 4 <b>hear</b> 7:19, 22 8:3 11:24 28:8 60:2 75:2 115:6 134:6	175:7, 12 202:23 214:1 <b>heard</b> 17:8 41:7 44:3 51:24 52:20 55:6 66:14 75:9, 17 76:15 84:25 96:11 99:12 109:1 111:2, 7, 25 112:13, 15, 18 114:7 115:3 116:14 119:14 127:19 128:4 130:12, 25 132:14 133:5, 9 134:8, 9, 13 139:8, 11 158:20 189:18 201:11 203:3 204:5 209:18 214:5, 6 217:12 <b>hearing</b> 116:18 132:7 175:14 184:15 229:17 <b>heart</b> 177:23 <b>Held</b> 1:14 224:10 <b>Helen</b> 204:8 <b>help</b> 26:15 30:12 35:22 78:8 93:23 111:4, 24 116:1 147:22 150:18 154:11 204:22 <b>helped</b> 11:25 <b>helpful</b> 89:15 110:6 <b>helping</b> 111:4 216:5 <b>helps</b> 12:25 <b>high</b> 55:18 56:23 65:22 102:4 106:23 107:3 153:21 187:13, 16 222:22 <b>higher</b> 135:2 <b>highest</b> 217:15 218:13 224:23 <b>highly</b> 63:6 65:2, 4 91:8 <b>high-quality</b> 66:6 <b>HIRA</b> 211:21	<b>historical</b> 33:20 97:6 101:20 <b>historically</b> 34:11 58:6 <b>histories</b> 9:23 <b>history</b> 17:16 70:7, 16, 17 72:3 102:13 167:8, 12 168:1 170:7, 8 <b>hit</b> 154:25 <b>hits</b> 143:3 <b>hold</b> 130:20 152:19 153:18 179:14 <b>home</b> 66:20 80:5 83:25 85:15, 20, 23 86:7 95:7 96:20 102:11 104:6, 9, 15, 17, 18 105:12 107:1 169:25 194:17 195:13, 15 196:2 198:19 199:1, 3, 12, 13, 22, 23 201:16 209:13 222:4, 12 225:15 226:3 <b>homes</b> 47:13 75:18 76:10 77:13, 18 79:3, 8, 22, 24 80:17 87:5, 22 88:17 89:2, 21 94:22, 25 95:7, 25 96:7, 11 99:11 100:1, 4 102:4 103:11 106:4, 23 107:9 111:3 139:12 142:18 149:1 150:10 151:11, 15 152:8 157:22 172:8 175:5 196:22 197:17 199:8 200:3 201:1, 12, 13 202:14 203:6 215:23 226:7, 18, 25 227:7, 9 228:25 <b>homogeneous</b>	197:11 <b>Hong</b> 83:3, 16 <b>Honourable</b> 2:2 <b>hope</b> 6:14 15:22 <b>Hopkins</b> 60:16 <b>Hospital</b> 7:8, 9 9:1, 2, 16 22:6 56:3, 11 63:2 72:7 73:25 83:17 84:4 87:18 96:22 97:12 103:14, 23, 24 104:2, 3, 5, 13, 14, 18 105:11 106:13 108:18, 20 109:3, 17 111:6 114:13 133:19 136:10 146:23 <b>hospital-based</b> 103:18 <b>hospitalization</b> 70:23 <b>hospitalizations</b> 127:9 <b>hospital-like</b> 104:7 <b>hospitals</b> 47:13 69:12 75:10 76:3, 8, 9 80:6 85:2 96:21 98:12, 17 100:20 103:6, 10, 14 105:17, 22 107:13 108:14 109:10, 13 110:13, 24 111:3, 25 123:8 147:23 148:13 151:15 160:9 <b>hotel</b> 12:1 <b>hour</b> 5:12, 13 155:24 160:20 <b>hours</b> 61:14 63:8 76:13 77:2, 3 155:17 <b>House</b> 22:12 23:23 24:15 <b>household</b> 195:19 <b>HPP</b> 45:24 235:16	<b>HPA</b> 33:4 34:10, 16 36:8 40:5 235:16 <b>HR</b> 43:6 <b>huge</b> 54:23 117:8 153:24 187:6 212:19, 22 213:7 <b>hundred</b> 38:4 156:12 <b>Huyer</b> 214:24 215:13, 14 220:10 <b>hygiene</b> 170:1  < I > <b>Ian</b> 11:2 <b>ICPs</b> 103:18 <b>ICU</b> 72:7 <b>idea</b> 110:23 125:20 142:5, 13 166:22 226:15 <b>ideal</b> 227:24 <b>ideas</b> 154:13 175:13 <b>identified</b> 79:13 133:21 134:22 <b>identify</b> 166:8 167:11 190:21 <b>identifying</b> 78:19 <b>ignore</b> 127:14 163:15 <b>ignored</b> 127:17 <b>ill</b> 14:6 <b>illness</b> 14:10 151:1 188:23 <b>illustration</b> 189:2 <b>immediately</b> 143:2 <b>immensely</b> 214:2 <b>imminent</b> 172:25 173:5 <b>impact</b> 9:4 61:12 62:4, 21 77:24 78:3 115:4 116:17 176:6 197:11 203:14 211:24 212:15 228:14 <b>impacted</b> 155:11 226:19
--	---	---	---	--

<p><b>impacts</b> 127:25 135:12</p> <p><b>imperative</b> 72:6</p> <p><b>imperial</b> 225:17</p> <p><b>implement</b> 79:17 95:12 210:12</p> <p><b>implementation</b> 136:3 213:23</p> <p><b>implementing</b> 14:1</p> <p><b>implications</b> 73:9</p> <p><b>importance</b> 53:12 80:21</p> <p><b>important</b> 11:24 25:4 66:23 71:5 73:2, 20 77:4, 20 78:16, 17, 22, 23 80:17 99:3 103:25 106:9 108:9 129:14 140:3 148:3, 8 175:11 178:14, 22 210:3 226:17 228:5</p> <p><b>impossible</b> 26:18</p> <p><b>impressed</b> 7:12</p> <p><b>improve</b> 108:2</p> <p><b>improved</b> 41:12</p> <p><b>improvements</b> 16:24</p> <p><b>inadequate</b> 79:5</p> <p><b>inadvertently</b> 205:21</p> <p><b>incentive</b> 108:22</p> <p><b>inception</b> 16:8</p> <p><b>incidence</b> 172:24 218:15 222:7 223:12 228:24</p> <p><b>include</b> 51:1, 4</p> <p><b>included</b> 128:18</p> <p><b>includes</b> 26:1 49:18</p> <p><b>including</b> 11:18 43:18 44:19 45:13 46:5 50:14 53:22 55:18 71:9 81:5 124:20 147:18 149:24</p>	<p>150:19</p> <p><b>income</b> 206:14</p> <p><b>incoming</b> 135:23</p> <p><b>incorporate</b> 95:15 121:22 213:21</p> <p><b>incorporated</b> 117:6 124:12</p> <p><b>increase</b> 34:18 35:7 59:14 103:13 136:24</p> <p><b>increasingly</b> 199:4</p> <p><b>incubating</b> 186:18</p> <p><b>independence</b> 23:11, 19 32:24 33:10 35:1, 10 44:2, 6 45:8, 9</p> <p><b>independent</b> 53:13 118:25 119:1 198:15 200:11</p> <p><b>independently</b> 200:14</p> <p><b>indicated</b> 6:3 30:18 53:11 179:22</p> <p><b>indispensable</b> 26:1</p> <p><b>individual</b> 102:4 207:1, 5, 14</p> <p><b>individuals</b> 55:19 60:10 69:25 70:16 129:3 175:10 224:5 226:18, 19</p> <p><b>inevitable</b> 173:1, 6</p> <p><b>infect</b> 195:22</p> <p><b>infected</b> 81:18 82:1 85:23 86:1, 12, 15, 22 97:12 178:10 187:8 189:20 195:16, 19 222:13</p> <p><b>infection</b> 51:1, 11, 16 78:1 80:24 81:15, 23 86:1 96:18 97:1, 15, 20, 24 98:9, 10 100:22 101:4, 10 103:1, 7, 16, 19 104:16,</p>	<p>25 105:18 106:1, 14, 22 107:19 108:9 171:6 175:1, 5 193:14 208:15 209:13 226:17</p> <p><b>infections</b> 203:8 227:25</p> <p><b>infectious</b> 10:20 13:15, 20 22:6 48:12, 14 51:18 57:5 61:10 62:4, 7, 18 63:6 64:14 65:2 66:2 68:8 78:4 94:5 96:17, 25 97:5 98:7 101:19 102:1, 3, 15 112:25 127:25 128:17 133:24 135:12, 23 136:9 166:5 210:6 236:7, 9</p> <p><b>infectiousness</b> 181:6</p> <p><b>inferring</b> 111:11</p> <p><b>inflow</b> 128:16 187:8</p> <p><b>influenza</b> 58:9, 22, 25 59:2, 5, 15 60:8 61:5 62:12, 14 78:6 91:3, 9, 17 100:4 121:21, 23 124:12 136:25 138:22 149:17 172:16</p> <p><b>inform</b> 64:7 173:14 206:3</p> <p><b>information</b> 22:19 27:24 45:12 71:13 72:15 93:22 96:4 165:7 169:9 171:10 175:10 181:14 182:20 188:10, 19 224:16</p> <p><b>informative</b> 205:15</p> <p><b>informed</b> 94:2</p> <p><b>informs</b> 80:23 173:15</p>	<p><b>infrastructure</b> 104:4 110:4 173:18</p> <p><b>in-house</b> 144:21</p> <p><b>inhumane</b> 226:12</p> <p><b>initial</b> 16:3 78:18 98:14 113:4 123:19 140:16</p> <p><b>initially</b> 68:8 78:17 211:15</p> <p><b>in-public</b> 224:6</p> <p><b>input</b> 11:22 38:8 83:14 207:23 212:17</p> <p><b>Inquiry</b> 12:10 16:14 130:6, 7</p> <p><b>insight</b> 148:24</p> <p><b>inspect</b> 95:25</p> <p><b>inspections</b> 107:24</p> <p><b>Inspectors</b> 46:7 91:23</p> <p><b>instances</b> 208:14</p> <p><b>instantaneously</b> 228:1</p> <p><b>instituting</b> 229:6</p> <p><b>institution</b> 78:5 79:24 112:2 193:7</p> <p><b>institutions</b> 95:3 146:23 147:23 148:13 153:11 191:7, 16 206:25 207:2 212:19</p> <p><b>instructions</b> 28:19</p> <p><b>insufficiently</b> 79:22</p> <p><b>integral</b> 122:13</p> <p><b>integrity</b> 72:24 73:12</p> <p><b>intended</b> 134:18</p> <p><b>intending</b> 209:13</p> <p><b>intensives</b> 228:14 237:10</p> <p><b>intensivists</b> 237:10</p> <p><b>intent</b> 157:4 192:3 227:2</p> <p><b>interaction</b> 92:2</p>	<p><b>interactions</b> 156:22</p> <p><b>interchange</b> 160:11</p> <p><b>interest</b> 226:22</p> <p><b>interested</b> 86:21 89:5 126:16 134:7 189:1, 6</p> <p><b>interesting</b> 20:10</p> <p><b>interface</b> 36:14 48:25 109:24</p> <p><b>interfering</b> 231:6</p> <p><b>interim</b> 16:1</p> <p><b>intermediary</b> 222:24</p> <p><b>internal</b> 108:22 157:8</p> <p><b>international</b> 62:23 70:2 170:24 171:4 212:21</p> <p><b>internationally</b> 72:18</p> <p><b>internship</b> 7:1</p> <p><b>interpretation</b> 182:17</p> <p><b>interrelation</b> 90:19</p> <p><b>interrupt</b> 61:1, 23 112:10</p> <p><b>intervene</b> 37:1</p> <p><b>intervenes</b> 12:14 185:13</p> <p><b>interview</b> 13:17 27:13 166:22</p> <p><b>interviewed</b> 11:19 208:24 209:3</p> <p><b>interviews</b> 21:25 22:16</p> <p><b>introduced</b> 208:15 227:19 229:15</p> <p><b>introducing</b> 103:7 199:7</p> <p><b>invading</b> 135:11</p> <p><b>invariably</b> 226:2</p> <p><b>invasive</b> 136:9</p> <p><b>inventory</b> 179:13</p> <p><b>invest</b> 97:17</p> <p><b>invested</b> 91:8 102:22 107:6</p>
---	--	---	--	---

<p><b>investigation</b> 28:3 202:15, 17 208:21 215:23</p> <p><b>investigations</b> 20:7</p> <p><b>invitation</b> 208:3</p> <p><b>involve</b> 27:8, 25</p> <p><b>involved</b> 17:21 22:8 57:24 70:13 73:15 74:5 91:20, 22 106:3 117:24 126:4 203:13 225:9</p> <p><b>involvement</b> 57:7</p> <p><b>involves</b> 28:21 230:2</p> <p><b>IPAC</b> 51:5 79:5, 8, 23 80:2, 5, 18, 21 81:1, 4 95:25 96:6, 11 98:20 99:11 112:12, 14, 19, 23 115:4 116:17 152:17 153:17 174:24 225:24 227:5</p> <p><b>isolate</b> 166:13</p> <p><b>isolated</b> 63:1</p> <p><b>issue</b> 13:6 18:15 29:5 32:25 47:8 54:23 76:25 88:2 89:13, 17 90:15 95:23 99:21 109:17 110:23 120:11 133:14 135:9, 22 139:25 140:22 143:14 144:1 145:24 146:1 149:13 158:11, 13 164:8, 12 165:15 177:1 178:12 179:12 185:9, 10, 12 187:21 188:2 189:11 190:24 191:4 192:4 197:3, 9 198:13 199:23 204:7 209:8, 12</p>	<p>211:24 226:2 228:15</p> <p><b>issues</b> 9:5 16:18 17:5 29:20 34:15 35:23 36:1 44:21 55:11 62:8 64:14 91:2 92:23 94:1, 3 99:2 109:19 113:4 133:16 135:24 178:13 191:8 215:18 228:12, 13</p> <p><b>item</b> 163:25</p> <p><b>&lt; J &gt;</b></p> <p><b>Jack</b> 2:4 73:23</p> <p><b>January</b> 26:11 30:1 115:23 119:23 156:9 157:11 196:11 211:19 236:21, 22</p> <p><b>Jennie</b> 214:15, 16</p> <p><b>Jennifer</b> 4:2</p> <p><b>Jessica</b> 3:14</p> <p><b>job</b> 11:10 12:8 25:4, 10, 22 31:17 33:20, 22, 24 34:2 46:1 53:18 77:15 105:7 116:6 121:10 125:24 167:25 191:20 195:18, 21 199:11</p> <p><b>jobs</b> 103:22 206:13</p> <p><b>John</b> 3:24 5:24, 25 6:14 7:16, 25 8:4, 9, 16 11:5, 8 13:5 15:21 16:12 20:12 21:13, 22 22:3, 25 23:24 24:3 26:2 27:6 29:3, 12, 25 30:5, 11 31:19, 23 32:15, 20 33:12, 17, 24 35:5, 14 37:12, 18, 21, 25 38:5,</p>	<p>19 40:6, 9 41:4 43:25 45:22 46:13 47:10, 16, 22 49:23 50:6, 25 51:4, 13, 19, 24 52:17 53:9, 24 54:2, 9 55:5 57:6, 15 58:13 59:18, 23 60:1, 14, 16, 24 62:10 75:7 76:7 77:15 79:2, 20 80:3 81:3 82:3, 11, 16, 23 83:11, 15 84:5, 14, 18, 25 85:6, 13 86:2, 10, 13, 18, 23 87:4, 9, 16 88:1, 4, 6, 10, 15, 22 89:7, 19 90:1, 5 95:23 96:10 99:8, 15 101:22 112:11 113:17, 20, 23 114:24 115:22 116:9 117:1, 18 118:4, 11, 18 119:3, 9, 18 120:25 121:7, 11, 14 122:3, 9, 11, 24 123:2, 15 124:1, 7, 10, 15, 18, 25 125:3, 10, 13, 17, 25 126:7, 12 127:2, 16 128:3, 21 129:1, 5, 9, 12, 18, 24 130:2, 17 131:10 132:23 134:6 135:19 136:11, 13, 17, 22 137:6, 16, 21 138:1, 4, 13, 23 139:6 145:7, 19 146:5, 11, 15, 25 147:9, 12 148:19, 23 149:5, 16, 22 150:2, 11, 17, 24 151:8, 17 156:1, 6 157:11, 14 158:2, 19 160:12, 15 162:4, 12, 24 163:17 164:7,</p>	<p>15, 19, 24 165:2, 12, 16, 20, 25 167:19 168:22 169:12 170:15 171:15, 19, 25 172:5, 18, 22 173:13, 25 174:17, 22 175:6, 16 176:3, 13, 17, 23 177:2, 7, 12, 17, 21 178:15, 24 179:15, 20 180:7, 10, 14, 17, 25 181:15 182:5 183:4, 12, 16, 19, 22 184:8 185:1, 25 186:9 187:17 188:25 189:16, 22 190:1, 8, 15, 19, 23 191:3, 23 192:5, 11 193:17, 24 194:2, 10, 20 195:2, 9, 12, 23 196:4, 9, 17 197:2 198:11, 16, 22 199:21 200:1, 9, 16, 22 201:10, 25 202:9, 16, 24 203:19, 24 204:5, 9, 12 206:21 207:3, 10, 15 208:8 209:17, 23 210:19, 23 213:14, 18 214:4, 15, 18 216:12, 18 217:4, 7, 11, 21, 24 218:2, 6, 10, 16, 20 219:13 220:12, 17, 22 221:7, 13, 23 222:2, 14 223:6, 18 224:19 225:12 227:3, 14 228:7 229:1, 4, 8, 13 231:14, 20, 23</p> <p><b>Johnstone</b> 202:10 214:7,</p>	<p>14, 15, 16 216:20</p> <p><b>joined</b> 43:1</p> <p><b>joint</b> 49:11</p> <p><b>Joshua</b> 4:7</p> <p><b>jottings</b> 29:11, 12</p> <p><b>journal</b> 29:13</p> <p><b>journals</b> 29:11 182:23</p> <p><b>journey</b> 19:5</p> <p><b>judicious</b> 68:17</p> <p><b>July</b> 15:5, 8 26:11 30:1 131:16</p> <p><b>jump</b> 27:5</p> <p><b>jumped</b> 213:4</p> <p><b>June</b> 14:13 15:2 183:24 200:18</p> <p><b>junior</b> 14:20</p> <p><b>jurisdiction</b> 63:20 110:15</p> <p><b>jurisdictions</b> 35:13 36:13 47:11 115:20 173:12 179:9 180:21</p> <p><b>Justice</b> 27:22 44:1 117:20 176:5 177:23 178:7 182:6 210:19 211:7</p> <p><b>Justine</b> 211:17</p> <p><b>&lt; K &gt;</b></p> <p><b>Kavi</b> 4:4</p> <p><b>keeping</b> 101:17</p> <p><b>Ken</b> 9:8</p> <p><b>kept</b> 94:2 117:15 146:13, 22 153:20 198:4</p> <p><b>key</b> 22:11 77:20 80:17 133:14 158:12 159:17 188:7 226:6</p> <p><b>kind</b> 16:22 27:20 43:8 52:13 91:25 163:8 220:9 228:1</p> <p><b>King</b> 4:2 14:15 15:1 16:5 39:12</p> <p><b>King's</b> 35:2</p>
---	---	--	---	---

**Kingston** 19:16  
**Kiran** 2:22  
**kitchen** 206:16  
**Kitts** 2:4 73:22, 23  
**Klein's** 85:9  
**knew** 10:11  
87:20 89:8  
141:25 176:3  
193:6 206:11  
**knowing** 85:16  
89:10 162:18  
**knowledge** 25:5, 8 44:16 60:3  
79:16 84:7  
89:10 106:22  
128:11 138:25  
139:2  
**known** 10:12  
45:10 49:22  
61:6 108:23  
208:5 224:12  
227:8  
**knows** 108:25  
109:1 155:15  
227:16  
**Kong** 83:3, 16  
**Kristin** 2:12

# **< L >**

**lab** 55:7, 13  
56:8, 9 57:25  
63:23 67:1, 12  
68:23 69:13, 18  
71:21 73:25  
75:8, 19, 22, 24  
76:16 77:25  
79:21 80:1  
81:13 89:17  
184:5 216:24  
**labelling** 184:5  
**laboratories**  
50:15 54:12, 13  
65:18  
**laboratory** 21:4  
38:18 49:20  
53:22 54:14  
55:13 56:2, 3, 4,  
10, 11, 15, 17, 22  
64:16, 21 65:22  
67:15, 18 68:2,  
12, 14 78:8, 10,  
12 79:1 81:20  
114:14 117:16  
**Labour** 205:13

**labs** 50:8, 10  
58:18 64:19  
69:23 80:11, 12  
**lack** 37:6 96:18  
101:10 162:15,  
25 163:4 177:4  
**lacking** 167:18  
174:10  
**laid** 41:2 42:16  
49:14 83:9  
**Lana** 19:20  
**large** 10:20  
21:12 37:15  
41:22 42:11  
79:3, 19 85:23  
113:8 146:20  
147:21 179:12  
206:13 211:25  
212:11  
**largely** 41:10  
**larger** 9:5  
43:12 45:14  
84:6 117:6  
153:11 235:13  
**largest** 43:15  
235:13  
**late** 15:2 29:5  
73:4 81:8  
113:14 173:8  
182:12 183:8  
231:11  
**latitude** 197:24  
**Law** 2:25 191:1  
197:15  
**layout** 106:7  
**lays** 33:21  
34:10 36:8  
49:15  
**Lead** 3:14 7:10  
34:4 40:3 43:5  
61:15 102:14,  
16, 19 176:24  
213:20 215:3  
**leaders** 65:21  
**leadership**  
35:19, 21 36:11  
39:4, 13 212:5  
235:1, 3  
**leading** 97:3  
112:23  
**leads** 174:24  
**Leamen** 2:14  
**leaning** 17:19  
**learned** 188:7  
**learning** 20:4

**leave** 15:4  
28:25 120:11  
**leaves** 107:5, 7  
**led** 16:2  
**leery** 20:18  
**left** 9:18 15:7  
39:15 83:25  
100:12 149:11  
153:22 226:12  
**Legal** 3:2, 4  
43:19 46:10  
111:13 191:6  
194:5 205:11  
**legally** 33:1  
**Legionellosis**  
64:13  
**legislation** 38:8  
41:2 42:17  
95:18 108:20  
109:22 110:17  
207:18  
**legislatively**  
110:1  
**legislature**  
23:13, 17, 22  
24:1, 2 33:1, 3  
**legitimate** 195:6  
**length** 16:19  
49:6 53:12  
**lessons** 117:19  
**Lett** 3:12  
**letter** 10:19  
187:20, 23  
188:2, 4, 5  
192:2 208:10  
**letters** 188:12  
**level** 25:2, 8, 12  
42:4 44:11, 25  
46:22 47:2  
50:18 68:4  
79:16 102:6  
106:22 123:22  
142:22 151:1  
163:5, 13  
166:15 184:18  
221:22 222:19,  
20 223:3  
**levels** 23:18  
52:6 91:21  
137:15 142:22  
224:20, 21  
229:22  
**LHIN** 134:4  
**liability** 105:13  
108:15, 21

109:12, 17, 19  
111:14  
**liaison** 49:11  
**life** 185:22  
**likelihood**  
227:10  
**limit** 54:8 78:3,  
15 170:5  
192:15 196:5  
197:19 205:7  
**limitation** 92:2  
**limitations**  
52:14 73:16  
**limiting** 169:2, 6  
174:19 226:8  
**lines** 235:8  
**lineup** 24:23  
**link** 155:6  
186:24  
**linked** 166:20  
**listen** 12:20  
83:2 163:23  
**listening** 12:17  
13:7 185:19  
**listeriosis** 55:16  
64:13  
**lives** 76:14  
225:17, 20, 22  
228:23  
**load** 154:22  
**Local** 16:9  
34:9 35:10, 15  
36:10 37:16  
38:9 41:9, 10,  
12, 13 44:2, 6  
45:22 46:8, 22,  
25 47:2, 8, 20  
69:15 87:15  
90:12, 14 91:15  
100:8 102:6, 9  
175:7 185:9  
**located** 144:15  
**location** 83:19  
190:5 193:20  
**locations**  
170:14 189:3, 4,  
13 190:10  
192:17  
**lockdown**  
222:16, 20  
223:5 229:11,  
15, 22, 24, 25  
230:2, 4, 6, 8, 9  
**logic** 105:22  
**logical** 107:18

**long** 5:12  
11:20 28:9  
41:16 61:14  
74:1 141:13  
**longer** 102:13  
166:16 168:19  
193:8  
**longest** 9:24  
**LONG-TERM**  
1:7 2:13, 15, 17  
3:2, 4, 9, 10, 12,  
14, 17, 18, 20, 22  
21:7 47:13  
66:19 76:4, 10  
77:13, 18 78:7  
83:19 85:9  
86:6 87:5, 11,  
22 88:17, 24, 25  
89:2, 11, 14, 20  
90:11, 12, 16, 24,  
25 92:3, 9, 10  
93:4, 13, 17  
94:9 95:14  
96:7, 20 99:18,  
21 100:4  
102:10 103:11  
104:6, 15  
105:12 106:4,  
23, 25 111:3  
139:12 142:18  
148:25 149:11,  
13, 24 150:1, 9,  
15, 16, 19 151:1,  
11, 14, 21 152:5,  
7 153:19  
157:22 160:9  
172:7, 8 175:5  
189:20 190:3  
194:17 196:22  
197:17 198:19,  
25 199:1, 9, 12  
200:3, 21 201:1  
202:4 222:4, 11  
225:15, 16, 17  
226:6, 25 227:5  
**looked** 55:21  
85:12 96:15  
106:5, 11  
133:13 137:11,  
14 149:7 165:6  
171:14 196:25  
201:24  
**looking** 16:14  
30:9 44:20  
48:4 52:15

57:13 58:12, 21 60:7, 8 72:9 81:21 101:14 104:24 105:2 108:8 113:5 115:19 121:19 124:1, 3 126:5 142:22 147:6 148:2 154:11 188:20 206:14 207:24 <b>Lookout</b> 7:8 8:17 <b>lose</b> 17:3 72:18 73:12 <b>losing</b> 131:12 167:14 168:13 185:2 186:25 <b>loss</b> 72:18, 21 235:22 <b>lost</b> 11:11 52:19 69:6 117:7 196:23 235:21 <b>lot</b> 8:10 10:16 18:1, 5, 18, 24 19:23, 24 20:18 25:21 27:11 28:24 29:15, 16, 21 34:23 36:14 39:21 40:25 43:12 51:16 58:5, 24 60:21 65:3, 15, 20, 23 66:6 67:3 74:5 79:13 97:3 98:14 99:25 100:1 102:11 123:19 126:23 128:20 131:12 134:21 135:6 137:3 139:22 143:13, 21, 22 144:17, 24 145:11 148:14 170:8 184:7, 22 187:21 212:19 213:3 215:17 216:8 225:16 <b>lots</b> 19:25 20:2 71:12 76:19 113:1 220:13 222:10 224:7 <b>loved</b> 76:16	<b>lower</b> 222:23, 25 223:1 226:5 <b>LTCHs</b> 156:18 <b>Lum</b> 83:3, 12 <b>lunch</b> 155:25 160:21 <b>luxuries</b> 66:5 <b>Lynn</b> 4:1  < M > <b>machine</b> 213:7, 12 <b>machinery</b> 68:20 <b>made</b> 19:10 35:2 36:21 42:12 45:10 55:25 71:12, 20 79:10 84:18 92:7 133:24 139:21 141:16, 18 142:10 143:1 144:14, 24 145:12 154:2 156:24 178:22 183:6 219:7 221:5 223:25 224:3, 17 225:3 233:8 <b>Mahoney</b> 4:1 <b>mail</b> 87:6 <b>main</b> 142:15 145:2 212:10 227:2, 21 <b>mainstay</b> 166:4 <b>maintain</b> 69:10 73:8 100:19 102:16 108:9 117:23 140:17, 21 147:24 168:19 186:22 <b>maintained</b> 14:11 56:15 <b>major</b> 215:18 <b>majority</b> 203:7 <b>making</b> 72:14 91:9, 10 107:21 108:23 144:16 145:2 179:10 181:24 205:16 206:16 207:17 <b>malicious</b> 209:15 <b>managed</b> 186:14 <b>management</b> 9:5 39:1 50:12	91:20 92:13 111:18 143:16 144:1 146:4 147:6 158:10, 16 159:3 166:6, 14 167:15 170:10, 13 179:8 185:5 206:9 210:10, 15 228:17 <b>manager</b> 100:12 <b>managerial</b> 102:12 <b>managers</b> 52:20 197:22 <b>manner</b> 87:21 88:16 89:2 <b>March</b> 82:4, 5 143:9 167:7, 24 168:6, 11 174:4 181:2 183:9, 23 184:9 187:20 188:2 190:24 <b>Marrocco</b> 2:2 5:3, 17, 23 7:18, 23 8:12 11:6 27:5, 9, 22 28:6, 16 51:2 59:20 60:25 61:22, 25 63:4, 21 64:24 65:6, 9 66:13 69:21 70:25 71:15, 19, 24 73:21 74:15, 21, 25 75:5 90:6 93:7, 18 94:4, 8, 16, 24 95:5, 21 101:23 103:4 106:19 108:12 110:22 112:9 130:4, 19, 23 131:7 132:11, 18, 19 133:3, 6 139:4, 7 140:2, 8 141:4, 9, 14 142:3, 9, 25 143:6 144:3, 9, 23 147:13 152:3 153:25 154:16, 20 155:3, 13, 20, 23 156:4 157:24 158:12 160:19 161:6, 13, 15, 23 162:2 197:5	202:20 204:20 205:2, 17 207:16 219:15, 24 229:2 230:24 231:3, 9, 15, 18, 21 <b>MaRS</b> 55:14 <b>Martino</b> 120:4 122:22 <b>masks</b> 154:2 156:22 208:12 <b>massive</b> 99:12 <b>Masters</b> 9:11, 17, 21 10:6 19:4 <b>material</b> 45:12 72:15 146:14 179:22 <b>materials</b> 39:7 79:12 96:5 114:20 139:22 141:13, 22 147:19, 20 148:6 152:17 181:12 <b>math</b> 158:4 <b>Mathai</b> 2:18 8:3, 6 27:4, 7, 16, 21 28:7, 14 130:4, 22 132:13, 17 160:22, 23 <b>matrix</b> 39:3 40:20 <b>Matt</b> 115:25 116:5 <b>matter</b> 10:22 40:10 63:7 120:13, 17 128:22 155:17 164:5 179:11 205:18 215:11, 19 <b>Maureen</b> 174:21 177:18, 19 <b>maximum</b> 77:3 <b>McGeer</b> 11:20 202:19 <b>McMaster</b> 19:16 <b>means</b> 27:18 72:3 81:18 156:5 162:19 166:6 167:3 173:16 192:2 196:16 201:21 211:25	<b>meant</b> 153:22 182:15 218:6 <b>measure</b> 168:25 <b>Measures</b> 122:20 127:6, 11 169:1, 16, 24 170:5, 10 181:22 211:9 218:25 221:9 222:16 223:3, 11, 17 229:11 <b>mechanism</b> 38:1 166:5 <b>media</b> 33:5 <b>MEDICAL</b> 2:7, 9 6:10, 11, 20, 21 7:6 9:20 10:9, 14, 24 11:14, 15 12:12 13:12, 19 14:9, 12, 17, 19 15:1, 3, 12, 24, 25 16:4, 9 17:17 20:22 22:8 26:5 30:20, 24 31:10, 12, 24 32:12, 22 33:18, 21, 25 34:3, 9, 13, 20, 21 35:8, 10, 16, 18 36:10, 23, 25 37:7, 16 38:9, 22 39:20 40:8 41:3, 9, 13 42:20, 21, 23, 25 44:2, 6, 11, 24 45:3, 22 46:2, 8, 16, 19, 21, 25 47:1, 6, 20 48:6 49:3, 10 53:10, 14 55:18 56:6 64:18, 20 67:17 68:2 76:21 87:10, 19 90:10, 12, 14 93:19 94:11, 13 95:9 97:4 100:8 101:19 102:7 117:22 118:6, 12 122:25 123:2 137:16 139:16 175:7 205:22 211:13 215:2 221:15 223:23 225:18 234:12, 15
---	---	---	---	---



<p>235:8, 10 236:4, 15 237:2, 5  <b>medicine</b> 9:8  10:5, 6 18:10, 20 19:8  <b>meet</b> 49:15  <b>MEETING</b> 1:7  57:13 104:23  105:10 153:7  172:20 176:25  180:12 181:23  <b>meetings</b> 29:18  49:17 58:4  142:22  <b>meets</b> 208:7  <b>member</b> 21:6,  12 49:12, 16  198:7 208:16  <b>members</b> 42:8,  13 43:22 60:7  76:14 77:10  178:9 195:5, 21  208:21 226:13  <b>memo</b> 99:17, 18  <b>mental</b> 228:12  <b>mentioned</b>  95:24  <b>MEOC</b> 211:13,  20  <b>merge</b> 116:22  <b>merged</b> 49:19  56:16  <b>MERS</b> 62:17  <b>met</b> 102:20  218:25 230:20  <b>method</b> 64:6  169:21 216:6  225:8  <b>methods</b> 81:23  <b>metre</b> 170:1  <b>metrics</b> 157:20  <b>mic</b> 202:22  <b>Michael</b> 4:3  12:16 13:4  113:19, 20  170:25 174:4  176:19, 21  180:2, 5 185:15  204:13 220:18  <b>Michele</b> 2:20  <b>microbiologists</b>  55:18 64:18  <b>middle</b> 15:16  89:24 111:23</p>	<p><b>mid-March</b>  167:19, 21, 22  <b>mild</b> 165:10, 11  209:6  <b>million</b> 152:22  212:18  <b>mind</b> 136:16  <b>mine</b> 122:8  207:21 212:24  <b>minimalize</b>  228:5 237:8  <b>minimally</b> 171:6  <b>minimize</b>  192:18 237:8  <b>minimus</b> 83:20  <b>Minister</b> 3:8  10:19 23:9, 13,  15, 16, 20 31:1,  2, 3, 5, 21 32:2,  16, 21 33:6, 7  37:22 38:7  88:24, 25 90:11,  15, 25 92:9, 10,  15 93:2, 11, 12,  13 94:9, 10, 22,  23, 25 118:13  119:8, 20 120:2,  6, 8, 10 122:15  128:9 129:6, 8  140:11, 15  198:23 200:20  202:18 204:6  212:6, 7, 8, 9  <b>Ministers</b>  207:25 208:7  210:16  <b>Ministries</b>  205:14  <b>Ministry</b> 2:12,  14, 16, 18, 19, 20,  22, 24 3:1, 3  21:7, 8 30:20  31:15 34:14  40:16 89:13  90:23 92:3, 11  93:3, 16 205:13  <b>minute</b> 7:19, 21  27:10 118:23  120:12 130:20  147:14 184:12  217:18  <b>minutes</b> 5:14  74:17 161:7  <b>misplaced</b></p>	<p>72:21 235:21, 22  <b>missed</b> 157:10  <b>missing</b> 105:3  <b>mission</b> 77:17  <b>misspeaking</b>  130:15  <b>misunderstandin</b>  <b>g</b> 156:13  <b>mitigating</b>  230:19  <b>mixing</b> 121:4  135:17  <b>mobile</b> 216:6  <b>mobility</b> 62:22  <b>mobilization</b>  61:10  <b>modality</b> 158:8  159:6  <b>mode</b> 11:23  12:17  <b>model</b> 41:11  212:1  <b>modelers</b> 230:5,  19  <b>modelled</b> 149:23  <b>models</b> 41:8, 18  44:4, 5, 10  149:16 228:19  <b>modernization</b>  44:17 54:16  120:23  <b>modification</b>  220:24  <b>modified</b> 34:16  221:21  <b>modify</b> 220:23  <b>MOH</b> 25:7 42:3  43:4, 5 216:7  234:11 235:9  237:2  <b>MOHs</b> 25:21  43:4 88:3  185:3 216:8  234:15 235:8  236:4, 15 237:5  <b>moment</b> 11:24  20:14 27:5  38:16, 19 68:16  90:2 101:16  117:11 118:4  119:13 121:11  182:22 204:16  <b>money</b> 107:6  152:25 158:22,  23</p>	<p><b>monitor</b> 59:6  64:16 102:17  <b>monitoring</b> 81:6,  22 226:8  <b>month</b> 10:23  63:12 143:12  148:1 157:17  226:21  <b>months</b> 7:3, 4  12:2 186:8  <b>morally</b> 111:11  <b>morbidity</b> 228:4  <b>morning</b> 5:24  185:17  <b>mortality</b> 228:4  <b>motto</b> 25:24  26:2  <b>move</b> 30:13  35:7 79:1  84:12 85:25  90:3, 7 91:16  103:23 114:1  139:6 158:8, 21  159:17 166:18  188:17 204:21  213:8  <b>moved</b> 55:14  85:16, 22 98:8  101:1 120:15  133:21 144:17  173:10 218:17  223:1 229:4  <b>movement</b> 62:24  <b>moves</b> 188:14  <b>moving</b> 63:15  162:4 185:11,  25 187:4  <b>Mowat</b> 15:4  16:8  <b>multi-factored</b>  158:10  <b>multiple</b> 187:7,  8 189:3, 4, 11  190:10 193:22  205:19 206:2  <b>municipal</b> 41:10,  21, 24 42:17  43:12 44:14  45:5, 15  <b>municipalities</b>  42:14  <b>municipal-led</b>  41:20  <b>mutations</b> 63:17</p>	<p><b>mute</b> 8:5 12:20  75:1    <b>&lt; N &gt;</b>  <b>N95</b> 154:2  <b>N95s</b> 145:1  <b>narrow</b> 25:14  <b>NASM</b> 19:17  234:9  <b>Nation</b> 7:13  <b>national</b> 60:7  64:20 67:17  68:2, 10 70:15  83:8 137:12  140:24 212:20  <b>Naylor</b> 12:10  <b>near</b> 16:7 149:9  <b>necessarily</b>  128:17 178:9  <b>necessary</b> 49:8  54:7 70:9  91:16 94:17  95:7, 20 101:16  111:9 122:2  123:4 138:10,  21 148:6  149:23 175:20  213:7  <b>necessity</b> 136:7  <b>needed</b> 13:14  62:6 70:22  98:13 138:22,  24 141:23  142:16 148:11,  16 156:18, 22  194:21 206:15  209:7 216:9  220:6 227:24  <b>needing</b> 153:19  <b>needs</b> 101:15  110:20 114:12  117:15 122:2  171:14  <b>NEESONS</b>  233:22  <b>negate</b> 80:2  <b>negative</b> 67:4  <b>neither</b> 30:13  <b>Nelly</b> 3:1  <b>Nepal</b> 9:1, 13  <b>net</b> 159:9  <b>network</b> 56:18  65:18 69:12  <b>networks</b> 98:10  103:16</p>
--	--	---	--	---

<p><b>Nevertheless</b> 61:19</p> <p><b>new</b> 13:8 19:9 47:17 51:14, 16 54:16 55:22 63:12 64:1, 9 68:5 69:13 84:22 93:5 95:17 105:22 113:12 116:12 139:2 147:6 148:12 153:6 171:4 184:24 186:12 198:24 221:19 222:9</p> <p><b>newer</b> 36:17</p> <p><b>newly-elected</b> 52:10</p> <p><b>newspaper</b> 223:21</p> <p><b>nice</b> 110:8 230:22</p> <p><b>night</b> 114:7 174:2 213:6</p> <p><b>nights</b> 193:8</p> <p><b>NIOSH</b> 141:25</p> <p><b>NML</b> 68:1</p> <p><b>noise</b> 53:1 115:13</p> <p><b>nominees</b> 21:19</p> <p><b>non-symptomatic</b> 85:21</p> <p><b>normal</b> 112:5</p> <p><b>normally</b> 148:13</p> <p><b>north</b> 8:24 12:8 144:21 154:3</p> <p><b>northern</b> 6:23</p> <p><b>northwest</b> 10:12</p> <p><b>NOSM</b> 234:9</p> <p><b>note</b> 113:18, 24 115:8, 23 174:6 178:22</p> <p><b>noted</b> 116:19</p> <p><b>notes</b> 26:22 28:12 29:8, 10, 13, 18 30:15 39:7 91:6 174:1, 7 198:23 233:12</p> <p><b>notification</b> 169:17</p> <p><b>notify</b> 191:16</p>	<p><b>notwithstanding</b> 150:25 217:7</p> <p><b>November</b> 227:4</p> <p><b>number</b> 11:18 14:2 23:4 24:24 39:22 42:11 44:18 48:18 54:11, 13, 14 55:21 59:1 73:14 77:23 79:3 107:10 116:24 123:8 126:23 127:8, 12 128:17 130:8 136:4 149:8 156:20, 21, 22 174:3 187:6 192:16 196:5 199:9 203:5 208:14 211:15 212:1 221:6, 7 227:7 228:24</p> <p><b>numbers</b> 52:19 112:18 156:19 157:20 186:23 223:12</p> <p><b>Nurse</b> 102:15 178:10</p> <p><b>nurses</b> 208:24</p> <p><b>&lt; O &gt;</b></p> <p><b>object</b> 88:16</p> <p><b>objected</b> 88:24</p> <p><b>objection</b> 87:20 88:23</p> <p><b>observation</b> 8:13</p> <p><b>obstetrics</b> 7:4 18:6</p> <p><b>obtaining</b> 13:18 14:17</p> <p><b>occupational</b> 192:25</p> <p><b>occur</b> 60:22 61:3 63:5 111:19 135:8 171:7 183:21, 23</p> <p><b>occurred</b> 10:23 61:2 171:8 183:24 196:15</p> <p><b>occurring</b> 166:21 206:6 215:18 230:14</p>	<p><b>October</b> 31:14 217:17</p> <p><b>odd</b> 33:10</p> <p><b>odds</b> 145:8</p> <p><b>offence</b> 198:18</p> <p><b>offered</b> 110:14</p> <p><b>OFFICE</b> 2:7, 25 20:1 36:4 43:2 235:6</p> <p><b>Officer</b> 2:9 6:12 9:20 10:9, 15, 24 11:14 12:12 13:12, 20 14:9, 12, 17, 19 15:1, 4, 12, 24, 25 16:4, 9 20:22 22:8 26:5 30:20, 24 31:11, 13, 24 32:12, 22 33:18, 22, 25 34:3, 10, 13, 20, 21 35:8, 18 36:10, 23 37:7 38:22 40:8 41:3, 14 42:21, 23 43:1 44:2, 7, 11 45:3, 23 46:2, 8, 16, 19, 21, 25 47:1, 6, 20 48:6 49:3, 10 53:10, 14 56:6 76:21 87:10, 19 90:10, 13, 15 93:19 94:12, 13 95:9 100:8 102:7 118:6, 12 122:25 123:3 137:17 139:16 175:7 205:22 210:7 215:2 221:16 223:24 225:19 234:12 235:5, 10 237:2</p> <p><b>officers</b> 11:15 23:21 35:10, 16 36:25 37:16 38:9 41:9 44:24 117:22 234:16 235:9 236:5, 16 237:6</p> <p><b>offices</b> 147:23 150:23 151:25 152:14, 18, 19</p>	<p>153:8, 14</p> <p><b>official</b> 42:22</p> <p><b>officially</b> 15:12</p> <p><b>officials</b> 22:14 165:8 228:10</p> <p><b>offshore</b> 144:17</p> <p><b>off-site</b> 206:12</p> <p><b>OIC</b> 15:14 93:15</p> <p><b>old</b> 48:11 158:8</p> <p><b>OMA</b> 18:14</p> <p><b>one-on-one</b> 18:11 36:3</p> <p><b>ones</b> 19:15 30:2 36:17 40:22 41:22, 25 42:11 54:22 55:15 56:23 63:18 64:1, 11, 12 72:5, 13 73:6 76:16 97:3 98:12 103:15 117:7 124:13 126:6 148:17 153:21 159:21 165:10 174:4 209:3 223:1</p> <p><b>one-time</b> 50:24</p> <p><b>ongoing</b> 19:22 72:7 92:23 123:25 134:1 140:22</p> <p><b>onshore</b> 144:14</p> <p><b>Ontario</b> 6:12 10:21 17:9 19:14 20:19, 23 21:4 25:6, 7, 18 34:5, 8 35:13 36:6 38:17 41:17, 22 44:10 45:21 46:6 47:24, 25 48:2, 3, 10 49:18, 21, 22, 25 50:11 52:16, 23 53:16 54:20, 23 57:9, 12, 25 58:15, 17, 19 62:23 65:20 66:6 67:16 76:23 91:6 98:5 112:14, 16, 19, 20, 21 113:12 115:2, 5, 15 116:15, 18,</p>	<p>19, 22, 23 121:22 122:7 124:12 125:20 138:11 181:2, 10 189:15, 16 191:13 196:11, 20, 21 211:6 212:17 215:17 217:15 218:11 220:13 221:1, 8 225:2 234:11, 13</p> <p><b>Ontario's</b> 51:25 126:4</p> <p><b>open</b> 73:11 84:22 140:19 152:19 182:1</p> <p><b>openly</b> 49:8</p> <p><b>operates</b> 56:12</p> <p><b>operating</b> 125:21</p> <p><b>Operation</b> 14:1 44:19</p> <p><b>operational</b> 49:24 50:8, 9 51:6, 20 74:3</p> <p><b>Operations</b> 3:10 112:5</p> <p><b>opinion</b> 40:10 41:5 45:9 114:12 129:12 137:8 162:21 163:5, 6, 18 164:5 182:4</p> <p><b>opinions</b> 223:25 224:7</p> <p><b>opportunities</b> 20:3</p> <p><b>opportunity</b> 26:13, 17, 19 29:8</p> <p><b>opposed</b> 93:9 188:2</p> <p><b>options</b> 219:2, 3, 4, 11</p> <p><b>Order</b> 47:8 61:18 63:3 187:25 194:13 197:15 198:13, 15, 24 199:16 200:2, 6, 8, 10, 11 202:2 203:10, 13 205:16 206:24 207:9, 11</p>
--	---	---	--	--

230:11 231:5 <b>ordering</b> 153:10 <b>orders</b> 90:16 91:12 94:5, 12 153:6 210:17 229:12 <b>ordinarily</b> 26:7 31:24 131:19 <b>organism</b> 67:2 <b>Organization</b> 57:23 60:15 102:14 107:22 108:4 <b>organizational</b> 42:5 102:25 <b>original</b> 78:19 125:24 <b>Originally</b> 160:25 <b>OTs</b> 192:24 <b>Ottawa</b> 19:16 175:8 <b>ought</b> 94:19 115:7 225:3, 19 227:6 <b>outbreak</b> 10:21 77:21, 23 78:18, 20 79:4, 13 87:1 91:7, 18 94:6 96:7 100:9 170:13 189:21 190:13 191:14 194:19 196:13 198:6, 7 204:2, 3, 23, 24 205:6 206:1 208:20 211:11 215:22 <b>outbreaks</b> 59:1 77:18 78:6 89:6, 17, 24 91:4, 14, 17, 22 99:12 100:2, 4 106:11 107:20 108:11 112:2 142:17 197:18 199:5 201:3 210:6 215:18 216:11 228:24 230:14 <b>outlined</b> 132:1 <b>Outpatient</b> 9:2 <b>outset</b> 109:16 205:25	<b>outside</b> 21:1 25:16 67:5 70:9 109:11, 18 193:23 206:17 225:10 229:19 <b>overall</b> 18:22 22:20 80:18 105:25 114:22 116:22 118:1 144:17 188:20 210:4 <b>overalls</b> 148:9 <b>overarching</b> 35:15 <b>over-bound</b> 226:11 <b>overload</b> 98:17 <b>overloaded</b> 220:5 <b>overseas</b> 8:25 <b>over-stepping</b> 226:11 <b>overwhelm</b> 68:15 71:21 73:13 214:10 <b>overwhelming</b> 69:22  < P > <b>p.m</b> 1:16 161:25 162:1 232:3 <b>pages</b> 26:21 178:25 <b>pairs</b> 39:8 <b>Palin</b> 3:10 <b>pandemic</b> 15:16 57:12, 20, 24 58:2, 5, 6, 9, 18 59:16 60:8, 13 61:7, 19 62:8, 14 63:11 87:25 88:11, 14 92:5, 19 101:2 115:24 118:5, 8, 10 120:23, 24 121:5, 15, 17, 21, 22, 25 124:14, 24 125:2, 4, 9, 12, 19, 23 126:5, 10 127:13 128:1, 5, 18 129:14, 17, 20 133:17 134:18 135:5, 7, 15	136:11, 15, 24, 25 137:2 138:22 139:11 143:3, 10 146:8 149:17 152:16 154:15 162:14 164:17 190:11 197:11 228:3 <b>pandemics</b> 57:8, 11 106:10 <b>panel</b> 21:19 22:9 <b>panels</b> 22:4 <b>PAPRs</b> 148:8 <b>paragraph</b> 192:12, 13 <b>paramount</b> 70:7 <b>pardon</b> 208:10 <b>Park</b> 161:14 <b>Parliament</b> 22:1 <b>Parliamentary</b> 22:24 24:12 <b>part</b> 16:3, 5, 10 18:9 20:4, 5 23:8 38:13 40:5 43:11 44:15 50:13 51:23 52:2 56:18 57:4, 11 59:8 63:1 66:23 68:12 70:8 80:18 84:2 92:13, 19 96:15 97:14 104:21, 24 105:7 107:21 111:16 112:15 113:9 115:17 118:9 121:25 126:25 128:15 134:1 135:1, 5 148:16 164:4 167:24 175:14 196:19 197:8 211:21 220:2 221:24 227:22 <b>partial</b> 202:8 <b>participants</b> 1:15 3:7 <b>participate</b> 220:10 <b>participated</b> 92:20 <b>participating</b> 42:8	<b>particular</b> 85:15 90:8 128:1 135:16 145:1 150:1 176:9 <b>particularly</b> 144:4 162:13 <b>parties</b> 22:14 24:13 <b>partners</b> 65:24 <b>partnership</b> 40:21 67:17 71:3 <b>parts</b> 45:14 60:9 73:14 77:6, 20 99:17 113:8, 13 212:15 <b>part-time</b> 102:11 107:10, 11 189:12 190:3 191:20 192:23 197:16 199:10 206:13 <b>pass</b> 108:20 <b>passengers</b> 171:23 <b>passion</b> 178:11 <b>patient</b> 18:11 84:3 85:20 <b>patients</b> 81:21 84:23 86:1 89:11 192:18 193:16 <b>Patricia</b> 4:6 <b>paucity</b> 99:24 <b>pause</b> 11:9 <b>pay</b> 206:13 <b>paying</b> 103:22 107:15 <b>PCR</b> 67:20 <b>peace</b> 99:1 108:10 <b>peacetime</b> 112:12 129:25 132:9, 25 158:23 <b>Peel</b> 41:25 <b>peer</b> 182:19 <b>peers</b> 18:19 21:9 <b>pencils</b> 52:13 <b>people</b> 12:17, 23 17:3 20:17 22:6 24:22 39:17 44:4 61:10 63:5 64:7 66:14	67:3, 5 70:2, 4, 8 71:16 72:11, 20, 22 75:15, 21 77:7 80:8 81:4, 8, 14 83:23 87:1 98:18 102:13 107:11 109:2 111:8, 15 112:23 116:24 126:15 135:2 142:5 147:4 151:1 153:7, 17 166:22, 24 167:9 168:11 169:4, 9 170:7 172:2, 7, 13 178:8, 10 184:2, 4 186:17 187:9, 11 190:4, 9 192:23 193:3 194:3 195:3 203:20 205:7, 19 206:1 207:1 209:19 212:18 220:5 222:11 226:10, 12 228:8, 11 <b>perceive</b> 106:21 <b>perceived</b> 63:13 <b>percent</b> 38:4 67:4 72:19 107:9 140:17 149:7 156:12 179:21 227:11 <b>performance</b> 37:7 115:4 <b>period</b> 17:25 42:15 74:6 95:17 130:13 166:12 181:1 203:9 <b>periods</b> 172:13 <b>permanence</b> 103:9 <b>permanent</b> 103:22 <b>permit</b> 27:18 109:20, 24 <b>permitting</b> 109:5 <b>perplexing</b> 102:8 145:6 <b>person</b> 14:20 17:8 39:20 40:14 70:17 82:1 100:21
--	---	---	---	---

<p>102:19, 20, 23 107:6 119:5 120:13 147:2 166:8, 9 172:15 176:1, 10, 13 186:15, 16 210:4 <b>personal</b> 41:5 139:9, 14 143:7 144:6 154:23 170:5, 10 <b>personally</b> 221:15 <b>persons</b> 12:19 <b>perspective</b> 51:20 90:18 147:1 <b>persuaded</b> 198:4 <b>pertain</b> 207:21 <b>Peter</b> 4:5 <b>phase</b> 128:10 131:11, 20, 21 132:5 <b>phases</b> 131:15 <b>phenomena</b> 101:20 <b>philosophy</b> 168:23 <b>PHO</b> 48:10 60:6 66:3 98:8 114:4 224:16 <b>physically</b> 12:1 <b>physician</b> 18:5, 13, 22 34:4 152:18 153:14 <b>physicians</b> 18:19 150:23 152:23 153:8 220:8, 13 <b>pick</b> 148:11 149:14 <b>picked</b> 195:18 216:2 219:3 <b>picking</b> 193:14 <b>picture</b> 118:1 <b>PIDAC</b> 96:24 97:22 98:5 105:19, 20 174:25 <b>piece</b> 75:13 <b>pilot</b> 67:21 <b>pioneering</b> 68:5 <b>pit</b> 159:12 <b>pizzas</b> 206:16</p>	<p><b>place</b> 14:2 41:19 53:21 54:8 64:22 78:3 79:14, 15 83:24 91:10 96:9 97:18 105:3 108:5 110:21 122:1 123:10, 12 128:25 136:6 140:1 143:4 145:2, 3 149:15 153:12 170:2 190:14 191:18 192:9, 10 193:1 195:24, 25 196:8, 14 197:15 199:19 201:15 204:2 212:17, 22 225:23 228:19 230:13 233:6 <b>placements</b> 7:14 <b>places</b> 83:23 97:4 187:14 189:8 193:4, 23 196:5 216:16 <b>plan</b> 50:13 51:23 52:18 58:5, 6 59:19 60:3, 5, 8, 19 121:21 122:1, 4, 6, 17 123:3, 5, 17 124:2, 3, 5, 12, 20 125:9, 12, 14, 15, 20 126:10, 12, 18 127:4, 12, 18 128:6, 12, 22 129:6, 15, 17, 18 131:11, 14 132:5 134:10, 15, 17 135:5 136:18, 24, 25 137:2, 9, 11, 20, 22 138:1, 2, 3, 6, 11, 15, 17, 18 140:16 149:19 150:25 151:3, 5, 19 152:12 161:2 211:7 228:3 <b>plane</b> 154:22 <b>planned</b> 150:7</p>	<p><b>Planning</b> 49:13, 15 53:2, 7 57:8, 10, 12, 20, 24 58:2, 10, 18, 20 60:23 61:5 62:8 91:9 118:10 126:5 129:13 131:15 136:1 140:13 166:1 210:9 213:23 <b>plans</b> 36:5 50:3 58:8, 16 121:23 124:24 125:2 134:14 136:20 <b>pleased</b> 213:12 <b>pnce</b> 234:20 <b>point</b> 75:8 84:8 86:8 99:9 100:21 117:3 156:2 159:12 170:22 180:23 184:9 195:23 203:20 208:13 209:24 210:24 211:2 222:15 224:23 229:14 <b>pointing</b> 208:9 <b>poised</b> 17:13 <b>policies</b> 51:17 <b>Policy</b> 3:12, 14, 16, 18, 20, 22 23:2 80:19 106:1 136:2 204:23, 24 205:6, 8, 9 213:23 <b>political</b> 132:8, 25 135:1 218:22 <b>political/science</b> 177:25 <b>politicians</b> 224:1 <b>polymerase</b> 67:14 <b>popular</b> 209:18 <b>population</b> 18:10 31:21 32:6, 8, 13 38:14 40:4 66:4 72:4 <b>populations</b> 18:20 <b>Port</b> 10:10</p>	<p><b>portfolio</b> 112:23 <b>portfolios</b> 213:6 <b>portion</b> 69:13 85:23 131:23 <b>pose</b> 132:22 <b>posing</b> 176:2 190:5 <b>position</b> 13:18 14:11, 13 20:19 26:15 32:12 33:11 114:10, 11 190:22 192:22 199:18 <b>positions</b> 17:10 <b>positive</b> 83:17 209:4 222:12 <b>positivity</b> 67:6 201:7 <b>possibility</b> 65:14 77:22 115:19 164:10 193:2 <b>possible</b> 88:21 89:18 162:15, 25 164:1 180:19, 20 192:14 197:25 <b>post</b> 5:20 15:14 <b>post-SARS</b> 14:3 57:13 96:16 <b>postulated</b> 113:10 115:12, 13 <b>potential</b> 65:24 <b>potentially</b> 193:15 209:12 <b>power</b> 35:7 46:23 47:1, 14, 17 85:1 194:4 207:13 228:2 <b>powers</b> 33:15 34:19, 24 35:1 45:23 46:3, 14 47:7 93:1, 2 109:23 193:18 210:13 <b>PPE</b> 109:2 143:23 148:25 149:23 150:8 151:2 154:4, 6 156:17 177:14 208:11 <b>practice</b> 5:6 6:24 81:24</p>	<p>95:6 153:16 <b>practiced</b> 134:11 <b>practices</b> 78:2 79:5, 8 81:15 96:6, 11, 19 102:4 103:2, 8 106:2, 22 108:23 109:3 <b>practitioner</b> 100:22 101:5 <b>practitioners</b> 97:20 98:11 103:19 107:19 <b>Pre</b> 174:7 <b>precautionary</b> 82:25 162:6, 10, 17 163:2, 13 164:9 174:15 175:23 176:5 181:17, 19 182:6 183:1 <b>Pre-cautionary</b> 174:9 <b>predicated</b> 38:1 <b>predicted</b> 212:1 <b>prefer</b> 25:1 <b>preferable</b> 110:25 <b>Premier</b> 216:19 217:1 218:20 219:23 225:2 <b>preparation</b> 29:9 <b>prepare</b> 29:24 48:19 63:18 80:12 123:3 128:16 <b>prepared</b> 10:20 61:20 62:25 91:15 121:24 122:5 <b>preparedness</b> 118:5, 25 119:6 120:14, 22, 24 121:6, 15, 17 122:13 123:16 125:19, 23 126:1 128:5 137:18 <b>preparing</b> 224:16 <b>presence</b> 59:15 <b>PRESENT</b> 4:9 39:9 63:19 99:25 207:22, 23 208:4</p>
--	--	---	--	---

<p><b>presentation</b> 92:7 114:19 130:14 156:8</p> <p><b>presentations</b> 12:9</p> <p><b>presented</b> 129:7 157:19</p> <p><b>PRESENTERS</b> 2:6</p> <p><b>presenting</b> 63:2</p> <p><b>press</b> 161:12 223:19, 22 231:6</p> <p><b>pressure</b> 111:24</p> <p><b>pre-symptomatic</b> 171:7 181:6</p> <p><b>pretense</b> 69:19 80:1</p> <p><b>pretty</b> 46:23 209:18 214:11</p> <p><b>prevalence</b> 217:14, 19 218:7 222:3, 7, 8 225:14 229:15</p> <p><b>prevent</b> 154:15</p> <p><b>preventing</b> 102:1</p> <p><b>prevention</b> 51:11, 16 78:2 80:24 81:15, 23 96:19 97:1, 15, 20, 24 98:10 99:4 100:22 101:4, 11 102:3 103:1 104:25 105:18 106:1 108:10 117:10 175:1</p> <p><b>Preventive</b> 10:6</p> <p><b>primary</b> 18:4 80:21 150:22 152:18</p> <p><b>Princess</b> 171:16</p> <p><b>principle</b> 82:25 162:7, 10, 17 174:16 176:6 181:17, 20 182:6 183:1</p> <p><b>principles</b> 164:9 225:25</p> <p><b>prior</b> 10:18 11:9</p> <p><b>priority</b> 91:13 129:25 153:21</p>	<p><b>private</b> 56:3, 11 73:25 85:1 105:23</p> <p><b>privilege</b> 28:1, 15</p> <p><b>privileged</b> 22:23</p> <p><b>privy</b> 24:17 57:7 208:1</p> <p><b>proactive</b> 106:5</p> <p><b>problem</b> 13:8 28:12 29:1 36:23 107:11 139:10, 12 143:8, 20 150:13 179:7 185:6 189:14, 18</p> <p><b>problematic</b> 29:4</p> <p><b>problems</b> 12:23 132:1 134:22</p> <p><b>procedure</b> 81:4</p> <p><b>proceed</b> 164:6</p> <p><b>proceeded</b> 184:21</p> <p><b>proceedings</b> 233:5</p> <p><b>process</b> 13:17, 25 15:9, 11 24:4, 22 26:6 27:3, 19, 20 29:6 39:23 47:4 50:22 87:17 92:24 105:6 128:23, 24 134:8 136:2 139:23, 25 140:24 141:7 148:16 175:24 211:22 217:5, 8 225:6</p> <p><b>processes</b> 39:6</p> <p><b>procure</b> 148:3</p> <p><b>procurement</b> 122:18 145:24 146:1 153:10 160:10</p> <p><b>produce</b> 154:4</p> <p><b>produced</b> 26:12 28:4 145:21</p> <p><b>producing</b> 55:3</p> <p><b>product</b> 188:15</p> <p><b>production</b> 158:15</p>	<p><b>products</b> 142:2, 6 145:12, 15 147:21</p> <p><b>professor</b> 19:18 97:6 101:18</p> <p><b>professors</b> 17:18</p> <p><b>program</b> 6:22 7:10 9:7, 24 17:24, 25 18:2 19:19 43:6 44:20 84:3, 6 91:4, 11 101:5 104:17</p> <p><b>programs</b> 19:14 38:4 45:19</p> <p><b>project</b> 131:10 133:1</p> <p><b>projected</b> 156:19</p> <p><b>projecting</b> 228:20</p> <p><b>projects</b> 9:15 50:15</p> <p><b>proliferate</b> 58:23</p> <p><b>prolong</b> 28:9</p> <p><b>Promotion</b> 32:5 33:13 34:17 48:11 49:21 95:4</p> <p><b>prompt</b> 86:24</p> <p><b>promptly</b> 89:18</p> <p><b>proof</b> 182:8 195:7</p> <p><b>proper</b> 81:22, 23 91:25 95:3, 11 141:21 153:17 225:23, 24</p> <p><b>properly</b> 142:23</p> <p><b>proposals</b> 223:13</p> <p><b>propose</b> 5:11</p> <p><b>pros</b> 21:15</p> <p><b>protect</b> 108:20</p> <p><b>Protection</b> 14:1 33:13 34:17 44:20 48:11 49:21 51:1 95:4 225:22</p> <p><b>protections</b> 226:4</p> <p><b>protective</b> 139:9, 14 143:8 144:6 154:23</p>	<p><b>protocols</b> 78:5 83:10 91:7</p> <p><b>proved</b> 175:22</p> <p><b>provide</b> 52:21 87:17 138:5 229:18</p> <p><b>provided</b> 54:24 80:11 118:20</p> <p><b>provider</b> 199:3</p> <p><b>provides</b> 33:14</p> <p><b>province</b> 17:12 19:13 25:9, 16 34:5 36:9 38:2, 17 43:10 45:6, 17 53:10, 16 54:22 115:15 118:7 126:17, 18 129:13 150:12, 19, 24 151:3, 10, 17 152:6 154:14 155:8 186:12 192:5 197:12 205:5 213:10 214:22 227:22</p> <p><b>provinces</b> 113:7 189:19</p> <p><b>province's</b> 151:20</p> <p><b>province-wide</b> 185:10, 12 197:10, 13</p> <p><b>provincial</b> 10:16 11:16 42:16 48:12, 14 51:17 96:17, 24 98:7 112:24 123:17 150:18 156:9 179:3, 12 212:20 216:16</p> <p><b>provincially</b> 216:13</p> <p><b>provision</b> 47:17</p> <p><b>PUBLIC</b> 2:7 8:18 9:12 10:5 11:4 17:10, 11, 18 18:13, 19, 21 19:1, 12, 21 20:1, 23 21:3, 4 22:5 23:1 25:2, 6, 18 31:21 32:9, 13 33:3 34:4, 14 36:6 37:5 38:14, 17, 18, 22 40:4</p>	<p>41:8, 13, 16, 20 44:17 45:21 46:6, 7 47:23, 25 48:2, 3, 20, 21 49:1, 18, 20, 22, 25 50:11, 14 51:25 52:16, 22 56:2, 10, 22 57:8, 25 58:15, 17, 19 74:1 76:22 77:19 78:21 79:10, 19 80:6 85:11 88:9 91:6, 8 93:21 94:3 95:24 96:12 97:24 98:4 102:15 106:25 107:18 109:13 112:14, 19, 21 114:11, 17, 19 115:5 116:17 117:4, 5, 14 119:24 120:23 125:20 126:3 127:6, 11 161:17 165:8 166:20 167:9 168:25 169:1, 16 171:2, 11 173:18 181:2, 10, 22 188:6 191:13 196:12 201:1 205:18 210:5, 8, 9 213:19 217:14 218:11, 24 220:12, 13, 19 221:1, 8, 9 223:3, 11, 16, 25 224:2, 8 225:2, 3 227:16 228:9, 16 229:11</p> <p><b>publicly</b> 225:20 229:18</p> <p><b>public's</b> 169:15</p> <p><b>published</b> 182:24</p> <p><b>pulled</b> 174:2</p> <p><b>purchase</b> 122:18 151:24 152:22</p> <p><b>purchased</b> 146:18 150:7,</p>
---	---	---	---	--

<p>10 152:2, 13 157:21</p> <p><b>Purchases</b> 156:24</p> <p><b>purchasing</b> 140:24 141:7 143:17 160:4</p> <p><b>purported</b> 209:5</p> <p><b>purpose</b> 196:6</p> <p><b>purposes</b> 70:22 97:7 146:7 161:10</p> <p><b>push</b> 24:21 135:3</p> <p><b>pushed</b> 226:14</p> <p><b>pushes</b> 99:6</p> <p><b>pushing</b> 24:7, 21 25:23 98:20 100:6, 24 226:14</p> <p><b>put</b> 8:5 14:2 15:10 35:1 37:3, 6 38:20, 24 39:9 47:4 48:22 53:21 54:7 58:24 78:3 91:13 97:2, 18 104:10, 14 108:25 110:21 113:13, 19 114:22 115:15 119:21 123:10, 12 130:18 136:6 140:12 141:1 142:21 143:4 148:17 149:15 153:11 156:7 169:7 170:2 182:20 188:6, 15 190:13 197:14 198:2 204:15 211:9, 10 214:24 218:12 219:2, 6, 11 221:20 223:7, 14 226:4 227:24</p> <p><b>putting</b> 22:20 85:1 98:23 114:20 197:9 213:5, 22 215:4 228:19</p> <p>&lt; Q &gt; <b>QA</b> 69:16 74:11</p>	<p><b>qualifications</b> 24:25</p> <p><b>quality</b> 37:6 53:4 54:15 55:18 64:5 65:22 69:5, 8, 10 80:24 104:16 108:9 137:4</p> <p><b>quarantine</b> 72:12</p> <p><b>quasi-officer</b> 23:16</p> <p><b>Queen's</b> 161:14</p> <p><b>question</b> 5:10 6:15 17:15 27:8, 23 28:13, 20 64:25 65:1 67:21 74:5 76:2 77:5, 14 80:14 90:22 106:20 110:6 132:12, 22 133:4, 7, 9 134:19 188:1 190:16 201:14</p> <p><b>questioning</b> 90:8 231:5</p> <p><b>questions</b> 5:8 6:4, 6 16:13 76:18 92:5 113:16 176:2 195:17 208:4</p> <p><b>quick</b> 89:12</p> <p><b>quicker</b> 74:12 76:12</p> <p><b>quickly</b> 48:15 58:22 59:11, 14, 17 63:20 65:19 66:18 80:23 88:20 100:18 153:9 161:22 163:9 168:3 173:11 185:11 186:17 212:23 216:3 221:24</p> <p><b>quite</b> 19:2 29:23 30:23 65:2 71:20 84:3 90:17 126:22 201:7 218:7 219:14</p> <p>&lt; R &gt;</p>	<p><b>raise</b> 73:22 87:20 89:13, 17 97:14 101:7 105:17, 25 142:11</p> <p><b>raised</b> 54:5 101:15 104:13 128:19 145:25 176:11, 25 209:8</p> <p><b>raising</b> 100:23 106:21</p> <p><b>ramp</b> 55:9 59:9, 16 68:14</p> <p><b>ramping</b> 68:18 69:9, 11</p> <p><b>ran</b> 109:15 151:2 152:8, 15, 20</p> <p><b>range</b> 46:9 222:23</p> <p><b>rapid</b> 58:23 80:16</p> <p><b>rapidity</b> 58:21</p> <p><b>rapidly</b> 178:2 213:1</p> <p><b>rarely</b> 37:1</p> <p><b>rates</b> 127:7, 9 143:23 223:12</p> <p><b>ratified</b> 192:22</p> <p><b>ratifies</b> 199:18</p> <p><b>ratify</b> 82:10 191:6</p> <p><b>ratifying</b> 198:2</p> <p><b>rationale</b> 114:25 115:7 136:6</p> <p><b>reaction</b> 67:15 99:19</p> <p><b>read</b> 58:7 83:5, 7 85:8 114:6 122:12 174:7 175:25 199:25 200:8 209:24 210:19</p> <p><b>readily</b> 43:14 213:20</p> <p><b>reading</b> 114:2 116:1</p> <p><b>ready</b> 5:4 39:8, 22 57:21, 23 61:15 62:6 91:11 100:11 118:7 124:21 127:19, 20 128:1, 8, 12, 15 129:8, 16</p>	<p>130:10, 15 133:10, 15, 23 136:8 138:17 148:15 154:24</p> <p><b>reagents</b> 68:20 74:9</p> <p><b>real</b> 17:12 35:12 81:19 107:11 135:9 140:21 154:12 236:1</p> <p><b>realities</b> 69:3</p> <p><b>reality</b> 107:8, 12</p> <p><b>realize</b> 164:11</p> <p><b>realized</b> 133:19 215:21</p> <p><b>really</b> 17:20 18:16 27:11 28:23 30:10 35:21 59:16 61:16 66:23 67:7 72:6 73:6 96:23 97:13 102:23 103:24 105:15 106:8 107:12 116:5 134:7, 13 141:19, 21 142:21 144:2, 25 167:6 173:24 178:12 195:24 216:4</p> <p><b>reason</b> 113:25 172:5 202:16 203:4 221:23</p> <p><b>reasonable</b> 54:20 109:6 223:9</p> <p><b>reasons</b> 98:18 176:4</p> <p><b>reassured</b> 53:5</p> <p><b>recall</b> 59:10 82:12 165:9</p> <p><b>receive</b> 50:2 87:8 89:5, 9, 21</p> <p><b>received</b> 26:9, 21 27:24 30:7 88:20</p> <p><b>receiving</b> 88:17 89:2</p> <p><b>RECESSED</b> 75:3 161:25</p> <p><b>recognize</b> 76:19 108:18 200:5 210:12</p>	<p><b>recollected</b> 132:14</p> <p><b>recommend</b> 221:14 225:13 229:21</p> <p><b>recommendation</b> 159:2 207:24 218:22 220:25 221:3, 6, 12</p> <p><b>recommendation s</b> 181:25 198:10 208:5 224:2</p> <p><b>recommended</b> 44:1 52:3 221:8, 9, 10, 17 229:16</p> <p><b>recommending</b> 105:20 180:11</p> <p><b>record</b> 19:20 68:25 126:2 138:19 150:4</p> <p><b>recorded</b> 233:9</p> <p><b>records</b> 145:20</p> <p><b>recruited</b> 9:19 14:12 48:16 219:18</p> <p><b>recruitment</b> 220:1</p> <p><b>red</b> 218:13 221:22 229:23</p> <p><b>redacted</b> 26:23</p> <p><b>reduce</b> 54:12 185:20 228:4, 23</p> <p><b>reference</b> 208:9</p> <p><b>referral</b> 134:4</p> <p><b>referred</b> 125:12 183:25</p> <p><b>referring</b> 135:16 174:15</p> <p><b>refers</b> 200:3 234:11, 15 235:8, 10 236:4, 15 237:2, 5</p> <p><b>reflect</b> 26:20</p> <p><b>reg</b> 36:7</p> <p><b>regard</b> 52:16 174:12</p> <p><b>regards</b> 36:6</p> <p><b>regional</b> 41:25 45:14 98:9 103:16 134:3</p> <p><b>regroup</b> 5:15</p> <p><b>regular</b> 8:22 50:22 55:13</p>
--	---	---	---	--

<p>91:23 104:20, 23 105:10 107:23, 25 <b>regulation</b> 42:13 45:20 <b>regulations</b> 95:15, 18 109:20 <b>reintroduce</b> 228:17 <b>re-introduced</b> 227:20 <b>reject</b> 129:9 <b>related</b> 112:15 182:7 188:22 205:5 215:16 <b>relates</b> 47:23 <b>relation</b> 90:11 <b>relationship</b> 30:16, 19, 23 31:2 39:3 49:4 65:25 76:22 90:10 91:19 92:9, 21 93:8 102:17 119:16 <b>relationships</b> 26:4 <b>relative</b> 8:13 181:5 183:13 <b>relatively</b> 19:9 51:14, 15 <b>releases</b> 33:7 <b>reliable</b> 67:23 171:10 <b>reliance</b> 79:21 <b>relocate</b> 11:25 <b>relocated</b> 13:18 <b>reluctant</b> 109:10 <b>rely</b> 200:22 <b>remainder</b> 83:25 <b>remarkable</b> 111:2 <b>remarks</b> 233:8 <b>remember</b> 10:18 17:17, 19 19:11 44:3 64:2 75:1 81:16 85:10 98:5 166:25 167:5 186:17 223:4 228:3 <b>remind</b> 26:16 29:19 30:9 <b>remote</b> 61:11 63:1 <b>remotely</b> 1:15</p>	<p><b>removing</b> 139:23 <b>renewal</b> 43:7 53:23 <b>renewed</b> 15:2 159:20 <b>rep</b> 178:6 <b>repeatedly</b> 79:7 <b>repeating</b> 69:14 <b>replace</b> 141:23 142:23 143:1 <b>replaced</b> 100:13 139:19 140:10 146:21 <b>replenish</b> 140:4, 6 141:3 142:11 <b>replenished</b> 142:16 179:5 <b>replenishment</b> 140:14 <b>report</b> 23:15 26:20 33:2 42:4, 24, 25 45:10 53:11 72:22 73:1 85:11 131:24 162:8 174:13 190:2 203:3, 4 211:8 <b>reportability</b> 45:2 <b>reported</b> 93:11 119:24 197:18 208:22 <b>Reporter</b> 12:14 133:5 185:13 202:23 233:4 <b>reporter's</b> 185:22 233:1 <b>reporting</b> 23:19 31:2 43:3 49:19 93:14, 15 119:16 120:2, 6, 8, 10 122:21, 22 <b>reports</b> 32:25 33:7 36:5 50:11 55:3 93:23 112:25 119:20 168:10 181:12 204:3 211:21 212:6 <b>representatives</b> 22:13 42:18 <b>represented</b></p>	<p>223:20, 22 <b>request</b> 111:4 <b>requests</b> 50:24 <b>require</b> 27:23 198:25 <b>required</b> 22:7 33:1, 4 35:21 52:7 123:9 146:24 150:12 <b>requirement</b> 191:7 <b>requirements</b> 45:20 <b>requires</b> 38:8 122:17 <b>requisitioned</b> 158:23 <b>residence</b> 104:18 <b>residency</b> 9:7, 18 17:24 18:2 19:2, 14 20:4 <b>resident</b> 9:24 <b>residents</b> 19:16, 25 87:12 89:12 91:12 196:24 197:20 201:5 225:18, 23 <b>Resilient</b> 57:21 62:7 124:21 127:20, 21 128:2, 8, 12, 16 129:8, 17 130:10, 15 133:10, 16, 23 136:8 138:17 148:15 <b>resolve</b> 12:22 149:13 <b>resonate</b> 108:17 <b>resource</b> 96:3 98:13 <b>resourced</b> 97:25 <b>resources</b> 22:22 36:2 43:13 45:4, 12, 15, 18 56:24 65:15 67:18 98:15 216:9 <b>respect</b> 47:25 50:7 63:6 90:14 129:14 <b>respective</b> 36:12 179:9</p>	<p><b>respects</b> 32:17 <b>respiratory</b> 78:4 <b>respond</b> 62:7 133:15, 16, 23 <b>responded</b> 129:19 <b>responding</b> 205:5 <b>response</b> 11:1, 4 12:4 111:4 120:23 175:14 205:6 211:4 213:13 <b>responsibilities</b> 21:5, 11 34:19 36:3, 9 37:9 45:19 46:5 110:16 111:5 133:12 <b>responsibility</b> 35:15 45:2 50:8, 10 51:6 96:13 107:14, 23 109:12 118:7, 25 119:4, 11 120:16 122:5, 13 123:4 137:18 <b>responsible</b> 15:7 38:14 42:19 46:9 95:1 105:9 118:21 119:5 120:14 121:5 123:11, 12 126:1 139:17 147:2 <b>rest</b> 12:3 20:24 71:3 <b>restriction</b> 194:4 197:14 <b>restructured</b> 32:10 <b>restructuring</b> 113:6 <b>result</b> 48:13 52:24 58:10 73:3 81:16, 17, 20 82:2 101:25 190:4 199:6 222:15 <b>results</b> 55:8 66:15, 19, 20 69:6, 7 75:12 76:11, 16 79:22</p>	<p>80:8, 10, 13, 23 81:8 86:24 87:2, 6, 14, 18, 22 88:3, 9, 18, 20 89:3, 12, 18, 22 186:4 202:4 236:1 <b>RESUMED</b> 75:4 133:11 162:1 <b>resumés</b> 20:18 <b>retired</b> 98:15 100:25 174:24 <b>retirees</b> 112:24 <b>retirement</b> 199:3, 12 <b>return</b> 188:23 220:24 <b>reveal</b> 28:15 <b>revealing</b> 27:25 <b>Revera</b> 202:17 203:2 <b>reverse</b> 223:8 <b>review</b> 10:21 29:8, 25 44:17, 20 85:12 105:16 130:10 131:1 157:9 182:19 <b>reviewed</b> 83:8 85:11 127:5 137:14 173:22 194:6 219:8 <b>reviewing</b> 29:15, 21 51:6 57:13 71:12 157:8 <b>reviews</b> 44:19 128:25 158:4 173:17 <b>revised</b> 60:5 223:15, 16 <b>revisions</b> 60:9 <b>Richard</b> 204:10 <b>ring</b> 15:10 <b>rising</b> 166:17 <b>risk</b> 28:7 37:6 64:7, 8 89:11 117:5 187:13, 16 190:5, 10 225:20 227:7 <b>risking</b> 225:22 <b>risks</b> 62:11 192:18 <b>R-naught</b> 187:5 <b>road</b> 163:2</p>
---	---	---	--	--

<p><b>robust</b> 145:16 158:9 184:22 <b>robustly</b> 224:10 <b>Rokosh</b> 3:10 <b>role</b> 15:25 16:1 17:1 32:22 35:9 37:15, 21 38:5, 7, 21 40:10 47:22, 23, 25 48:1 49:24 58:17, 18 92:12, 13 118:6, 11, 13 119:25 121:14, 16 181:5 183:13 220:9 223:23 227:15 <b>roles</b> 32:17 <b>roll</b> 91:11 <b>room</b> 83:20 105:23 109:2, 3 <b>Rose</b> 3:20 <b>rotate</b> 159:4 <b>rotating</b> 159:8, 19 <b>rotation</b> 42:14 <b>rotations</b> 20:1 <b>rotting</b> 146:18 <b>route</b> 76:20 <b>Royal</b> 19:10 <b>RPR</b> 233:3, 23 <b>ruled</b> 168:3 <b>run</b> 104:16 153:16 213:17 <b>running</b> 42:20 75:20 152:19 153:6 <b>runs</b> 212:9 <b>rural</b> 9:15 54:21 67:5</p> <p>&lt; S &gt; <b>safety</b> 87:12 159:8 <b>samples</b> 68:24 72:19, 21 235:21, 22 <b>sampling</b> 68:21 <b>Santedicola</b> 4:10 233:3, 23 <b>Sapsford</b> 120:2 <b>SARS</b> 10:18, 23 11:9, 12 12:2, 4 17:6 34:20 44:1, 18 46:20 48:7, 18 53:11</p>	<p>66:25 67:1, 4, 6, 13 72:23 97:10 98:2 99:17, 18 117:19 145:10 175:21, 23 178:17 186:3, 8 188:7 210:1 213:2 <b>sat</b> 11:15 70:2 <b>satellite</b> 65:18 <b>Saturday</b> 26:22 <b>save</b> 76:9 228:23 <b>saved</b> 76:13 <b>scare</b> 61:2 <b>scenes</b> 24:17 111:18 <b>scheduled</b> 161:1 <b>school</b> 6:21 7:7 17:18 19:12, 21 97:5 101:19 <b>schools</b> 169:2 <b>Science</b> 10:6 11:3 48:17 71:4 117:16 163:8, 15 176:12 180:18, 23 182:11, 13, 19 183:2, 6 <b>sciences</b> 6:20 9:11 <b>scientific</b> 48:5, 7 158:5 163:10 164:22 181:24 182:3, 7, 23 183:7, 8 223:24 <b>scientifically</b> 158:7 <b>scientist</b> 83:14 <b>scientists</b> 60:6 71:6 82:22 165:17 217:8 224:6 229:17 <b>scope</b> 25:13 80:7 194:8 <b>screen</b> 134:21 <b>screening</b> 172:19 225:24 <b>se</b> 35:18 59:5 91:21 133:18 226:24 <b>search</b> 21:24 <b>searching</b> 42:21 <b>seasonal</b> 59:9</p>	<p><b>second- youngest</b> 19:7 <b>Secretariat</b> 3:9, 11, 13, 15, 17, 19, 21, 23 <b>section</b> 18:14 45:23 46:1 47:18 207:8 <b>sections</b> 35:3 60:9 <b>sector</b> 114:13 126:15 149:24 150:1, 19 160:2 <b>sectors</b> 98:23 101:15 143:16 146:1, 3, 23 149:24 160:8 200:4 <b>seek</b> 45:15 94:14 162:20 163:6, 25 164:1 <b>seeking</b> 14:21 23:10 45:5 <b>segments</b> 112:21 <b>select</b> 34:24 <b>selected</b> 32:7 <b>selection</b> 23:12 <b>self</b> 34:24 <b>sending</b> 68:24 <b>Senior</b> 3:16, 18, 20, 22 21:6 25:2, 11 31:5 42:3 50:17 52:20 92:13 <b>seniority</b> 25:8 36:16 <b>sense</b> 24:23 31:16 36:20 52:12 56:12 70:15 103:6 108:15 109:11 148:1 153:4 154:12 155:12 166:16 192:7 198:9 204:4 225:21 <b>sensing</b> 89:14 <b>sensitive</b> 112:3 <b>sensitivity</b> 68:4 <b>sentiment</b> 115:1, 18 <b>separate</b> 32:2 37:21 82:6 86:4, 9, 12</p>	<p>105:23 114:12 118:24 <b>separated</b> 21:8 117:15 <b>separating</b> 86:3, 21 177:25 <b>September</b> 15:17 217:16 <b>sequencing</b> 55:19 67:12, 19 <b>series</b> 201:2 <b>serious</b> 139:10, 11 <b>seriously</b> 178:13 198:10 <b>service</b> 45:20 136:1 199:3 211:9 <b>Services</b> 3:2, 4 41:12 52:22 53:5, 20, 22 54:15 55:13 91:24 107:25 122:20 <b>set</b> 22:12 23:6 24:4, 13 33:14 105:5 117:13 118:1 139:25 174:1 216:6, 22 233:6 <b>sets</b> 205:8 <b>setting</b> 103:3 105:1 171:21 172:9 <b>settings</b> 170:14 172:1 190:4 216:8 <b>severe</b> 222:16 <b>Shanghai</b> 155:10 <b>share</b> 33:20 96:4 <b>sharing</b> 32:3 <b>sharpening</b> 52:13 <b>Shaw</b> 9:8 <b>Sheela</b> 12:12 13:13 <b>shelf</b> 159:16, 23 <b>Shelley</b> 125:18 217:12 221:1 <b>shift</b> 114:4 <b>Shingler</b> 57:18 62:6 124:18 126:13 127:23</p>	<p>128:7 129:19 131:8 132:6 134:22 136:14 211:18 <b>shiny</b> 116:12 <b>ship</b> 154:22 171:24 <b>shipment</b> 154:21 <b>shipped</b> 154:5, 6 <b>ships</b> 171:17 <b>shocking</b> 144:19 145:1 <b>Shoemaker</b> 4:7 <b>short</b> 27:17 61:18 63:2 74:18 <b>shortage</b> 111:8 139:9 143:7, 17 144:10 150:8 177:9, 10, 11, 13 <b>shorten</b> 161:7 <b>shortened</b> 161:4 <b>shorthand</b> 205:8 233:4, 12 <b>Shortly</b> 184:11 <b>shortness</b> 70:6 <b>show</b> 113:18, 25 115:22 131:13 161:18 200:14 217:13 224:20 <b>showed</b> 85:14, 19 210:1 <b>shown</b> 200:10 <b>Sick</b> 7:9 84:4 169:25 209:16, 19 212:2 <b>SickKids</b> 7:10 <b>side</b> 19:23 36:15 43:6 108:13 146:22 226:10 <b>signed</b> 139:3 <b>significant</b> 71:17 79:4 106:21 109:4 149:8 <b>signing</b> 212:2 <b>signs</b> 72:2 81:21 82:14 169:24 <b>similar</b> 115:21 <b>simply</b> 61:5 111:4</p>
---	--	--	--	--



<b>single-site</b> 187:21	68:1 84:14 112:10 113:20 115:12 130:10, 16 147:11 150:17 157:9 160:22, 23 176:17 180:8 192:25 197:6 203:25 218:2, 3, 6 231:21	<b>spending</b> 60:21 <b>spent</b> 29:21 <b>spoke</b> 89:7 112:11 169:10 <b>spread</b> 82:17, 21 84:8 85:19 86:1 164:11, 22 165:4, 13, 14, 22, 24 166:3, 23 167:2, 16 170:20 171:21, 23 172:11, 12, 14 181:18 183:5, 10 184:10, 24 186:6, 16 187:10 188:4 193:19 195:20 203:6 207:7 222:17 228:18 <b>spreading</b> 86:6 189:12 190:10 <b>spreads</b> 172:1, 4 <b>staff</b> 13:23 21:1 42:3 46:7 55:1 79:15 85:5, 7 91:15, 22 92:22, 23 97:17 100:14 102:5, 8, 11 104:24 105:21 106:13, 24 107:4 109:17 139:13 141:20 171:24 178:8 195:5, 7, 12, 15 196:13, 22, 24 197:15, 20 198:6, 25 199:6, 10 200:17 201:5 203:7 204:2 206:2, 9 208:16, 21 209:12 212:2 213:4 222:12 225:24 <b>staffing</b> 36:2 68:19 74:9 84:13 106:8 113:2 <b>stage</b> 58:3 135:7 221:21 223:5, 8 <b>staged</b> 223:4	<b>stages</b> 67:14 162:13 <b>staging</b> 226:24 230:2 <b>stakeholders</b> 188:9, 16 <b>stand</b> 74:17 131:4 227:15 <b>standards</b> 36:7 45:21 46:6 78:21 91:7 191:13 196:12 <b>standing</b> 91:11 <b>standpoint</b> 112:23 168:8 187:3 <b>start</b> 15:5 73:12 74:1 77:25 78:3 92:4 97:19 101:3 104:6 141:7 165:20 169:3, 6 211:23 212:13, 15 215:10 <b>started</b> 5:18 9:21 10:8 13:18, 25 14:12 17:24 19:12 29:6 67:10 70:5 76:2 128:9 130:24, 25 131:9, 10, 14 132:4 141:11, 15 145:5 166:4 167:6, 10 168:7, 9 170:2 173:10 184:15 195:16 211:20 215:21 230:16 <b>starting</b> 48:19 211:24 <b>startling</b> 144:19 <b>starts</b> 25:14 212:3 <b>state</b> 33:3 96:11 99:11 148:25 <b>statement</b> 23:1 189:9 229:18 <b>States</b> 144:16 187:15 <b>static</b> 158:20 <b>status</b> 138:12 <b>statute</b> 210:13	<b>stay</b> 12:1 15:16 169:25 170:1 <b>stay-at-home</b> 229:12 230:11 <b>stayed</b> 11:3 <b>staying</b> 92:14 <b>Steele</b> 204:9, 10 <b>steeped</b> 39:18 40:17 <b>Stenographer/Tra</b> <b>nscriptionist</b> 4:10 <b>stenographically</b> 233:9 <b>step</b> 14:6, 8, 10 37:11 <b>Step-Down</b> 124:20 131:14 132:5 138:17 <b>Stephanie</b> 2:16 <b>stepped</b> 16:11 31:18 <b>steps</b> 19:11 77:23 78:11, 14 80:20 136:4 137:3 182:12, 16 191:7 206:3 226:11 230:20 <b>stock</b> 147:5 151:18 179:3 <b>stocked</b> 20:13 <b>stockpile</b> 118:22, 23 119:1, 3, 4 120:12, 15 121:1 122:11, 12, 16 123:13 126:25 127:3 130:10 131:1 134:9 139:17, 18 140:4, 7, 9, 14, 18 141:3 142:11, 15 143:2 146:6, 21 147:3, 8, 18 150:6, 11, 18, 20, 22 151:6, 11, 12, 16, 20 152:10 153:2, 24 156:3, 5, 10 157:2, 8 158:13, 20, 21, 22 159:4, 7, 8, 12, 20 179:4, 11, 13, 16
------------------------------	--	---	--	--

<p><b>stockpiles</b> 152:12 158:6, 9</p> <p><b>stop</b> 8:16</p> <p>57:15 58:14</p> <p>161:9 162:3</p> <p>193:18, 21, 22</p> <p>222:17 227:25</p> <p>231:10 236:18</p> <p><b>stopgap</b> 151:2</p> <p><b>stopped</b> 52:2</p> <p>158:23</p> <p><b>stops</b> 122:4</p> <p><b>store</b> 193:8</p> <p>200:4</p> <p><b>stores</b> 193:5</p> <p><b>stories</b> 111:2</p> <p>178:8</p> <p><b>storing</b> 139:24</p> <p><b>story</b> 217:14</p> <p>218:11</p> <p><b>straight</b> 80:13</p> <p>121:12</p> <p><b>strains</b> 63:12</p> <p><b>Strategic</b> 49:12</p> <p><b>strategy</b> 168:18</p> <p>170:9</p> <p><b>street</b> 226:2</p> <p><b>strength</b> 101:7</p> <p><b>strengths</b> 43:10, 23 65:20</p> <p><b>stridently</b> 144:2</p> <p><b>striking</b> 208:13</p> <p><b>stringence</b> 226:8</p> <p><b>strong</b> 178:11, 12, 18 193:18</p> <p>194:12</p> <p><b>stronger</b> 101:4</p> <p>230:9, 11</p> <p><b>strongly</b> 56:19</p> <p>70:21</p> <p><b>structural</b> 16:18</p> <p>31:15 102:25</p> <p><b>structure</b> 16:19</p> <p>21:10 33:11</p> <p>34:11 43:7</p> <p>120:13 129:4</p> <p>133:20</p> <p><b>structured</b> 48:24</p> <p><b>structures</b> 40:16 41:21, 24</p> <p>42:6, 10 44:14</p> <p>45:13, 15 117:6, 9, 25 134:4</p>	<p><b>structuring</b> 134:2</p> <p><b>Stuart</b> 120:2</p> <p>211:14</p> <p><b>Student</b> 3:3</p> <p>17:17</p> <p><b>studies</b> 163:7</p> <p>182:11, 18</p> <p>209:18</p> <p><b>study</b> 18:9</p> <p>85:9 201:7, 8, 11 202:1, 2, 13</p> <p><b>studying</b> 18:9</p> <p><b>stuff</b> 29:16, 18</p> <p>43:8 65:23</p> <p>66:8 77:25</p> <p>91:25 98:19</p> <p>106:3 126:23</p> <p>152:1 159:22, 25 163:8 170:2</p> <p>174:25 186:15</p> <p>213:24</p> <p><b>subcommittee</b> 42:7</p> <p><b>subcommittees</b> 48:18 212:14</p> <p><b>sub-director</b> 51:11</p> <p><b>submission</b> 145:9</p> <p><b>submissions</b> 140:13</p> <p><b>submit</b> 36:4</p> <p>50:4, 14, 20</p> <p><b>submitting</b> 45:17</p> <p><b>subscribe</b> 162:6</p> <p><b>subsections</b> 137:13</p> <p><b>subsequent</b> 148:24 187:25</p> <p><b>subsequently</b> 187:24</p> <p><b>successful</b> 13:17</p> <p><b>succession</b> 25:23</p> <p><b>successor</b> 24:5</p> <p><b>sudden</b> 168:5</p> <p>187:8 197:18</p> <p><b>sufficient</b> 61:4</p> <p>75:20</p> <p><b>suggest</b> 12:19</p> <p>151:10 174:19</p> <p>227:8</p>	<p><b>suggested</b> 130:9 134:9</p> <p><b>suggesting</b> 80:3, 4 120:16</p> <p>130:24 132:3</p> <p>134:24 142:4, 6</p> <p><b>suggestion</b> 13:8 111:7</p> <p>185:16</p> <p><b>suggests</b> 171:5</p> <p><b>suits</b> 108:19</p> <p>180:20</p> <p><b>summer</b> 165:6</p> <p><b>Sunil</b> 2:18 7:25</p> <p>8:3, 6 27:4, 7, 21 28:14 130:4, 5, 22 132:17</p> <p>160:22, 23</p> <p><b>superior</b> 142:20</p> <p><b>supervisor</b> 20:6</p> <p><b>supplement</b> 206:14</p> <p><b>supplied</b> 30:3</p> <p>144:14</p> <p><b>supplies</b> 123:5</p> <p>147:22 152:7, 8</p> <p><b>supply</b> 43:19</p> <p>140:21 143:15</p> <p>144:1 145:11, 16 146:4, 7, 8, 24 147:1, 6, 24</p> <p>148:5 149:4</p> <p>151:25 152:24</p> <p>153:6, 23</p> <p>157:22 158:10, 15, 16 159:3, 16</p> <p>160:5 179:7, 12</p> <p><b>support</b> 206:6</p> <p><b>supported</b> 71:6</p> <p>114:16 158:7</p> <p><b>supposed</b> 98:6</p> <p>110:9 124:4</p> <p>125:5 149:3</p> <p>151:15, 21</p> <p>153:16 179:13</p> <p>215:3</p> <p><b>Surely</b> 85:2</p> <p><b>surge</b> 65:12, 17</p> <p>66:8, 17 85:7</p> <p><b>surgery</b> 228:12</p> <p><b>surgical</b> 208:12</p> <p><b>surprise</b> 99:15</p> <p><b>surprised</b> 99:10, 11, 23, 24</p> <p>198:12 213:3</p>	<p><b>surprising</b> 46:24 97:13</p> <p>144:12</p> <p><b>surveillance</b> 55:1 172:19</p> <p><b>suspicion</b> 77:22</p> <p><b>switch</b> 13:1</p> <p><b>switched</b> 122:22</p> <p><b>switching</b> 184:23</p> <p><b>symptomatic</b> 69:25 70:4</p> <p>83:23 85:21</p> <p>86:5 167:4</p> <p>171:6 181:17</p> <p>216:1</p> <p><b>symptoms</b> 67:6</p> <p>70:5, 11, 18</p> <p>72:3 81:21</p> <p>82:14 165:10, 11 169:24</p> <p>209:6 217:3</p> <p><b>synopsis</b> 138:11</p> <p><b>system</b> 16:24</p> <p>20:23 21:5</p> <p>25:6, 18 38:18</p> <p>44:18 49:20</p> <p>56:15, 17 62:5</p> <p>64:16, 21 67:18</p> <p>68:16 72:24</p> <p>73:12, 14 87:8</p> <p>96:20 97:16</p> <p>101:14 106:8</p> <p>108:8 110:5, 12, 20 118:3, 17</p> <p>127:24 128:2</p> <p>132:2 133:10, 15, 23 134:3, 4</p> <p>135:11, 13, 23</p> <p>136:10 148:18</p> <p>153:23 158:15</p> <p>159:17, 19</p> <p>166:20 173:18</p> <p>186:21 206:18</p> <p>211:25 212:2, 10, 16 213:17</p> <p>225:9</p> <p><b>systematic</b> 101:13 102:25</p> <p>105:16</p> <p><b>systems</b> 39:19, 24 54:17 65:22</p> <p>134:4 153:10</p> <p>160:10</p>	<p><b>system-wide</b> 136:3</p> <p>&lt; T &gt;</p> <p><b>tab</b> 130:2</p> <p>131:13, 24</p> <p>172:18 190:24</p> <p><b>table</b> 31:4 48:7, 17 50:18 91:1</p> <p>92:6, 12, 19</p> <p>98:21 99:5</p> <p>163:24 178:20, 21 181:24</p> <p>182:3 183:8</p> <p>207:19, 21</p> <p>208:2, 6 212:4</p> <p>214:8 215:7</p> <p>216:20 218:25</p> <p>219:1 220:20</p> <p>221:10 223:3, 17 224:10, 15</p> <p><b>tables</b> 71:8</p> <p>212:14 218:17</p> <p><b>takeover</b> 112:16</p> <p>114:5 115:2, 7</p> <p>116:16, 19</p> <p><b>takes</b> 86:18</p> <p><b>talk</b> 17:17</p> <p>30:16 35:22</p> <p>36:23 47:12</p> <p>52:18 57:20</p> <p>60:2 83:1 85:7</p> <p>118:4, 22</p> <p>120:12 137:6</p> <p>189:3, 7 203:20</p> <p><b>talked</b> 8:17</p> <p>75:10, 22 84:21</p> <p>85:14 185:3</p> <p>204:11 211:16</p> <p>214:5, 9</p> <p><b>talking</b> 12:24</p> <p>75:24 76:8, 9</p> <p>79:23, 24 81:3, 4 112:12</p> <p>118:22 120:21, 25 127:2, 3</p> <p>128:7 133:18</p> <p>146:11 155:14</p> <p>157:15 160:6</p> <p>167:5 169:18</p> <p>174:20 178:13</p> <p>180:3 186:2, 10</p> <p>189:22, 23</p> <p>194:23 202:7</p> <p>205:4 207:4, 12</p>
---	--	---	---	---

208:11, 12 217:19, 22 <b>tandem</b> 67:17 <b>targets</b> 52:5 <b>task</b> 14:20 26:18 97:14 <b>tasting</b> 215:6 236:25 <b>taxing</b> 161:4 <b>team</b> 11:2 12:4 21:6, 12 31:5 40:24 122:10 210:2 <b>teams</b> 106:14 <b>Technical</b> 71:11 185:16 <b>technological</b> 54:17 <b>technologies</b> 55:22 <b>technology</b> 8:8 13:9 89:9, 21, 25 <b>teleconferences</b> 188:12 <b>tend</b> 103:23 118:1 <b>tends</b> 42:6 <b>ten-minute</b> 161:5 <b>ten-year</b> 17:25 <b>term</b> 23:10 <b>terms</b> 62:6 90:5 148:25 <b>terrific</b> 15:21, 23 <b>tertiary</b> 65:21 <b>test</b> 63:25 64:25 66:15, 16 67:1, 3, 22 68:2, 3, 23 69:7, 24 70:20 71:16 72:4, 5, 6, 20 73:2, 19 75:12, 23 76:10 80:1 81:8, 16, 17, 20, 25 82:2 86:16, 24 87:1 88:18 89:18 124:16 169:20 184:5 195:17 217:3 <b>tested</b> 70:4 80:18 168:3 169:25 186:19 209:3, 4 217:2 <b>testified</b> 125:7	214:20 216:20 <b>testify</b> 214:8 <b>testimony</b> 114:7 <b>testing</b> 55:24 56:24, 25 58:22, 23, 25 59:5, 11, 15 64:2, 3, 5 65:3 66:19, 20 67:7, 15 68:12, 14, 17, 22, 23 69:2, 5, 13, 15, 20 70:8, 22 73:14 74:1, 11 78:9, 10, 12 79:1 80:17, 22, 25 81:13 86:21 87:1, 14 172:20 200:25 202:14 204:19 214:7, 8, 21, 23, 24 215:5, 7, 8, 10, 12, 15, 20, 24 216:5, 8, 19, 23 217:14, 19, 21 218:1 235:18 236:24 <b>tests</b> 56:21 68:1 72:17 77:25 <b>Thailand</b> 187:12 <b>theoretically</b> 81:10 <b>theory</b> 120:17 134:7 <b>therapists</b> 192:25 <b>therapy</b> 72:8 <b>theses</b> 175:13 <b>thesis</b> 172:15 <b>thing</b> 17:7 27:21 43:18 45:8, 10 68:22 93:5 99:5 111:18 114:8 116:25 117:4 130:5 136:16 144:17 145:4 153:1 160:23 201:19, 20 222:8 226:6 227:21 <b>things</b> 14:2 24:11 29:17 33:5 36:21 39:8 43:18 46:9 48:9	49:13 55:10, 16, 22 57:1 68:5 72:23 76:3 79:14 83:4 91:1, 2 96:8, 17 97:18 99:1, 6 101:14 104:12 105:2 106:6, 8 109:9, 10 118:17 123:9 134:17 136:6 137:14 138:16 144:13 148:7, 12, 17 152:15 153:13 159:1 160:10 163:9 165:24 169:3, 4, 8 170:11 171:16 173:21 175:11 188:7 193:5 203:18 211:5 226:17, 20, 23 228:23 230:12, 17, 18 <b>thinking</b> 172:7 <b>third</b> 143:19 167:7 168:6, 11 196:24 <b>thought</b> 6:8 7:11 54:5 67:13 75:11 95:6 97:11 110:20 121:7 135:6 144:21 145:15 155:24 160:13, 20 179:13 206:21 209:6, 7, 15 215:20 224:15 <b>thoughts</b> 167:20 <b>thousand</b> 100:3 <b>three-month</b> 19:1 <b>three-party</b> 22:1 <b>throat</b> 208:25 <b>throw</b> 73:11 182:13 <b>throwing</b> 195:4 <b>Thunder</b> 9:20 10:8, 10 11:14 14:18 19:18 <b>tidal</b> 143:10 <b>tier</b> 41:24 45:13 <b>tiered</b> 133:20 <b>tightening</b> 52:12	<b>time</b> 5:10 8:19, 23 9:3, 10 10:3, 15 11:15 13:23 16:10 17:19, 23 19:11 20:9 22:2, 23 23:5 24:11 28:24 29:15, 21 32:2 34:12 35:2, 9 36:18 38:2 39:24 40:14 41:16 45:1, 11 46:21 48:4, 21 49:2, 7 52:21 56:1 57:4 59:21, 22 60:11, 12, 21 61:15 65:10, 14 66:10 67:25 69:2, 12 70:12 71:4 73:2, 7, 18, 19, 24 74:3, 7 77:1, 3, 19 78:22 80:16 81:19 82:1, 20 83:7 84:9 86:18 89:13 93:4, 6 95:13, 17 97:17 98:9, 14, 19, 22 102:17, 18 103:21 104:1, 21 107:6 115:17 116:6 130:13 131:12 134:5 135:10 137:22 138:12 142:19, 21 144:7 149:6 152:23 160:1 163:11 164:23, 24 166:15 168:23 170:6, 11 171:15 172:13 173:8 175:8 178:7 179:1, 19 181:1 187:21 188:9, 21 189:18 190:13 192:10 193:9 194:4, 15 199:14 211:10, 23 213:20 218:12, 13 223:16 227:23 229:14 230:20	231:23 233:6, 8 234:23 236:1, 2 <b>time-delayed</b> 81:25 <b>timelines</b> 50:23 <b>timeliness</b> 55:7 <b>timely</b> 55:3 72:16 80:7, 11, 12 <b>times</b> 45:4 46:18, 19 80:10 95:16 98:25 99:1 100:2 102:21 106:13 108:10, 11 117:10 129:3 130:9 204:11 229:16 234:22 <b>title</b> 48:12 181:21 <b>today</b> 6:2 29:9 231:19 <b>told</b> 7:14 26:10 28:8 55:8 60:16 85:18 107:9 119:10, 19, 22, 23 120:9 125:6, 13 128:9 134:16 137:17 138:7, 14, 15 150:5 152:4 156:11 157:2 158:1, 22, 24 179:20 202:9 220:25 222:2 <b>tools</b> 20:5 46:10 <b>top</b> 91:13 111:5 170:23 222:20 <b>topic</b> 139:5 <b>topic-oriented</b> 6:4 <b>Toronto</b> 6:19, 22 7:1 9:7 19:13, 15 41:23 67:16 77:2 <b>total</b> 42:19 83:21 <b>totally</b> 20:23 49:6 163:16 183:2 198:15 <b>town</b> 8:24 <b>tracing</b> 186:22
--	---	---	---	---

<p><b>train</b> 19:24 102:24</p> <p><b>trained</b> 38:22 79:23 100:17</p> <p><b>training</b> 6:25 9:4 14:20, 21 17:9 20:3 25:10, 24 39:20 74:10 79:16 97:19 101:5 102:22 103:7 107:1, 2, 7, 14 108:3 110:11</p> <p><b>transcribed</b> 233:10</p> <p><b>transcript</b> 5:20 83:5 233:12</p> <p><b>transfer</b> 21:2</p> <p><b>transferred</b> 84:4</p> <p><b>transient</b> 215:16 216:17</p> <p><b>translate</b> 104:19</p> <p><b>transmission</b> 71:5 171:8 181:7 184:3 222:10</p> <p><b>travel</b> 70:6, 7, 16, 17 155:6, 16, 19 167:8, 11 168:1 169:2 170:7, 8 187:11, 12, 14, 15</p> <p><b>Treasury</b> 50:20 52:6</p> <p><b>treatment</b> 70:24 76:4</p> <p><b>triad</b> 70:5</p> <p><b>trigger</b> 47:5</p> <p><b>triggers</b> 95:3, 11</p> <p><b>tripling</b> 168:8</p> <p><b>true</b> 56:19 187:15 230:4 233:11</p> <p><b>truly</b> 216:4</p> <p><b>trying</b> 20:17 28:24 29:6, 24 34:25 55:23, 25 59:4 80:9, 13 90:18 105:25 126:14 144:6 160:6 161:16 169:14 172:6 189:2 190:16 193:12 196:5 198:17 202:25</p>	<p>203:20 204:12 209:14 215:1 219:16 224:14</p> <p><b>tuberculosis</b> 56:25</p> <p><b>turn</b> 27:19 28:3 163:9 185:19</p> <p><b>turn-around</b> 73:2, 7 77:1, 3 78:22 80:16</p> <p><b>turned</b> 199:16 202:1</p> <p><b>turnover</b> 100:19 102:4, 12 106:24 107:4 148:5</p> <p><b>turns</b> 183:4</p> <p><b>type</b> 18:11 148:9</p> <p><b>typed-up</b> 139:2</p> <p><b>types</b> 43:19 63:22</p> <p><b>typical</b> 49:5</p> <p><b>tyranny</b> 99:5 117:12</p> <p><b>&lt; U &gt;</b></p> <p><b>Uhm-hmm</b> 172:21</p> <p><b>unacceptable</b> 75:11</p> <p><b>unbelievable</b> 154:2</p> <p><b>uncertainty</b> 77:8 162:16 163:1</p> <p><b>undergrad</b> 7:7</p> <p><b>undergraduate</b> 6:19</p> <p><b>understand</b> 21:16 25:17 26:15 37:14, 19 40:14 51:20 72:17 77:11 80:7 81:5 90:18 101:24 116:7 125:10 126:17 131:5 146:15 148:20 151:4 164:8 169:18 170:16 173:24 177:12 186:9 198:16 210:11 215:1</p>	<p>219:17, 22 220:23 229:8</p> <p><b>understandable</b> 110:16</p> <p><b>understanding</b> 21:17 85:17 89:20 123:6 126:9 152:11, 21 160:16 177:14 178:5</p> <p><b>understands</b> 40:18</p> <p><b>understood</b> 82:17 129:11 132:6, 24 141:18 154:8 216:3</p> <p><b>undertake</b> 47:2, 7 191:10 220:7</p> <p><b>undertaken</b> 81:14 200:25</p> <p><b>unfortunately</b> 14:5 99:23 230:22</p> <p><b>uninfected</b> 86:12, 22</p> <p><b>Union</b> 128:4 195:5</p> <p><b>unions</b> 177:13</p> <p><b>unique</b> 41:23 56:23, 24 114:23</p> <p><b>uniqueness</b> 56:16</p> <p><b>unit</b> 36:22 37:4 41:13 91:15 168:16 185:6, 7</p> <p><b>United</b> 144:15</p> <p><b>Units</b> 41:8 79:11 95:24 96:12 184:16 186:23 202:7, 8, 13</p> <p><b>universities</b> 101:6</p> <p><b>University</b> 6:19, 21 9:7</p> <p><b>unknowingly</b> 199:7</p> <p><b>unknown</b> 67:21</p> <p><b>unmute</b> 12:21</p> <p><b>unredacted</b> 26:25</p> <p><b>unusual</b> 33:11 150:22</p>	<p><b>unwell</b> 82:6, 7, 12 85:16 86:3, 4, 14</p> <p><b>update</b> 124:9 137:11 138:10 157:8</p> <p><b>updated</b> 58:5 122:2 123:20 136:18, 20 137:22, 24 138:7, 15, 20, 24 188:19</p> <p><b>updating</b> 160:4</p> <p><b>upgrade</b> 137:8</p> <p><b>upgraded</b> 134:11</p> <p><b>upper</b> 41:24 45:13</p> <p><b>uptake</b> 143:23</p> <p><b>urgency</b> 118:2</p> <p><b>urgent</b> 50:24 98:16 99:2, 6 117:12</p> <p><b>urgently</b> 101:16</p> <p><b>USA</b> 180:21</p> <p><b>usage</b> 143:23</p> <p><b>usual</b> 225:8</p> <p><b>utilize</b> 160:3</p> <p><b>utilized</b> 175:2</p> <p><b>&lt; V &gt;</b></p> <p><b>vaccination</b> 16:5 91:4, 10 142:20</p> <p><b>vaccinations</b> 91:13 125:24</p> <p><b>vaccine</b> 147:21</p> <p><b>vaccines</b> 123:25 140:23</p> <p><b>Valentini</b> 2:20</p> <p><b>validity</b> 175:14 181:13</p> <p><b>valuable</b> 20:8 25:25 70:10 97:25 175:1</p> <p><b>value</b> 18:2 40:13 127:5 214:6 224:5</p> <p><b>valued</b> 11:21</p> <p><b>Vanessa</b> 55:17 214:19 216:21</p> <p><b>variants</b> 230:15</p> <p><b>variation</b> 44:23</p> <p><b>varied</b> 74:11</p> <p><b>variety</b> 43:20</p>	<p><b>various</b> 17:5 18:8 20:6 26:4 39:9 41:1 42:5 49:11 50:4 98:23 121:18 126:5 134:3 149:23 163:10 175:10, 13</p> <p><b>vast</b> 203:7</p> <p><b>ventilators</b> 148:9</p> <p><b>verbally</b> 198:3</p> <p><b>verified</b> 157:3</p> <p><b>verify</b> 145:21 156:14</p> <p><b>VERITEXT</b> 233:22</p> <p><b>version</b> 139:2</p> <p><b>versions</b> 43:9</p> <p><b>versus</b> 93:2</p> <p><b>vest</b> 103:6</p> <p><b>veteran</b> 11:1</p> <p><b>veterans</b> 98:15</p> <p><b>vetted</b> 21:19 23:3 173:22</p> <p><b>vetting</b> 22:20</p> <p><b>vexing</b> 29:5</p> <p><b>Videoconferenci ng</b> 1:14</p> <p><b>view</b> 17:8, 11 34:1 41:11 44:7 55:11 71:1, 2 117:1 140:3, 5, 10 183:7 186:5 210:23 224:25 225:3, 4</p> <p><b>vigilance</b> 226:7</p> <p><b>violence</b> 228:13</p> <p><b>virus</b> 64:1 154:25 169:13 193:19 195:13 199:7 222:16 230:14</p> <p><b>visit</b> 6:2</p> <p><b>visitors</b> 174:19 175:4 195:22 222:12 226:16</p> <p><b>vital</b> 142:17</p> <p><b>voices</b> 175:12</p> <p><b>volume</b> 55:24 56:23 69:19 146:14, 20, 22 151:24 152:13</p>
---	---	---	--	--

156:17 185:20 <b>volumes</b> 141:3 <b>VP</b> 125:23  < W > <b>Wagner</b> 2:19 <b>wait</b> 77:24 78:9, 25 81:20 186:4 217:18 <b>waited</b> 81:7 183:8 <b>waiting</b> 162:22 182:7, 10, 23 183:6, 7 194:20 <b>Walker</b> 190:2 <b>walls</b> 109:11 <b>Walwyn</b> 3:22 <b>waned</b> 140:18 <b>wanted</b> 6:23 22:18 39:12 46:22 49:3 52:11 54:13, 19 77:1 86:11 88:3, 19 90:9 96:23 98:12 116:7 131:3 139:15 140:6 178:19 215:11 217:1 219:1 227:19 229:20 <b>wanting</b> 76:3 <b>wants</b> 161:2 212:7 223:17 <b>warehouse</b> 159:15 <b>warning</b> 149:14 <b>wasting</b> 60:12 65:14 <b>watch</b> 64:15 <b>watched</b> 206:4 <b>wave</b> 12:2, 7 16:3, 14, 15 70:1, 14 143:10 164:18 203:3 221:25 227:4 230:3 <b>ways</b> 41:1 52:14 228:17 <b>weaknesses</b> 43:10, 23 <b>wearing</b> 109:2 <b>website</b> 5:21 <b>week</b> 15:15 26:10 143:19 167:7 168:6, 8,	11 174:24 184:21, 24 186:7, 11, 13 187:1 213:5 <b>weeks</b> 67:11, 20 73:3 74:10 92:4 115:23 143:14 147:25 151:7, 18, 19, 22 152:5, 6 153:5, 24 157:23 158:14 226:20 <b>weigh</b> 163:18 <b>weighing</b> 205:14 <b>wide</b> 25:19 46:9 73:11 215:10 216:13 222:24 <b>wider</b> 160:2 169:1 <b>widespread</b> 172:24 173:5 <b>Williams</b> 2:9 5:16, 22 6:13, 16 7:21 8:7, 11, 19 11:13 12:25 13:6, 10 16:2 17:14 20:16 21:21, 23 22:10 23:7, 25 24:6 28:11, 19 29:7, 10, 14 30:3, 8, 22 31:20, 25 32:18, 23 33:16, 19 34:2 35:6, 17 37:17, 20, 24 38:3, 11, 24 40:7, 12 41:15 44:9 45:25 46:15 47:15, 19 48:1 50:1, 9 51:8, 15, 22 52:4, 25 53:17 54:1, 4, 11 55:12 57:10 58:1, 20 59:25 60:4, 17 61:6, 24 62:2, 13 63:9, 24 65:4, 8, 11 66:22 70:1 71:2, 18, 23 72:1 73:24 74:4, 19, 23 76:1, 25 77:16 79:9, 25 80:15	81:12 82:9, 13, 19 83:6, 13 84:2, 11, 16, 20 85:4, 10, 25 86:8, 11, 16, 20, 25 87:7, 13, 24 88:2, 5, 8, 13, 19 89:4, 16, 23 90:4, 21 93:10, 20 94:7, 11, 21 95:2, 10 96:2, 14 99:14, 22 102:6 103:12 107:17 109:7 111:10 112:22 114:10 115:11 116:3, 21 117:3, 21 118:9, 14 119:2, 7, 15 120:20 121:3, 9, 13, 16 122:6, 10, 16 123:1, 7, 18 124:6, 8, 11, 17, 23 125:1, 8, 11, 15, 22 126:3, 11, 20 127:4, 22 128:14, 24 129:2, 7, 10, 16, 22 130:1 132:8, 10, 12, 22 133:8 135:4, 20 136:12, 15, 20 137:1, 10, 19, 23 138:2, 9, 21 139:1, 8, 20 140:5, 12 141:6, 11, 17 142:8, 14 143:5, 11 144:8, 11, 25 145:14, 23 146:9, 13, 20 147:4, 10, 14, 16 148:21 149:2, 12, 20, 25 150:9, 14, 21 151:5, 14, 23 152:11 154:8, 18 155:1, 5, 18, 22 157:6, 12, 18 158:3 159:10 160:13 161:11, 14, 21 162:9, 18 163:3, 22 164:13, 17, 21 165:1, 5, 14, 19, 23 166:3 167:22 168:24	169:14 171:13, 18, 22 172:2, 10, 21 173:4, 15 174:14, 20, 23 175:9 176:1, 8, 14, 20, 24 177:6, 11, 15, 19 178:4, 17 179:6, 17 180:5, 8, 13, 16, 24 181:11, 19 182:9 183:9, 15, 17, 20 184:1, 11 185:2, 23 186:7, 10 188:5 189:15, 17, 25 190:7, 12, 18, 21 191:2, 5 192:1, 7, 21 193:21, 25 194:5, 14, 25 195:3, 11, 14 196:1, 7, 10, 18 197:8 198:14, 21 199:17, 24 200:7, 13, 19, 24 201:17 202:5, 11 203:16, 22 204:1, 8, 10, 18, 24 205:10, 24 206:24 207:8, 11, 20 208:19 209:21 210:18, 22 211:1 213:16, 19 214:13, 16 215:9 216:15, 25 217:6, 10, 18, 22, 25 218:4, 9, 15, 19, 24 219:21 220:2, 14, 21 221:5, 11, 15, 17 222:1, 6, 19 223:7 224:4 225:4, 21 227:13, 18 228:8 229:6, 10, 20 231:2, 8, 12, 17 <b>willing</b> 111:8, 12 188:10 <b>wing</b> 182:14 <b>wish</b> 17:22 225:11 234:5, 7 <b>wished</b> 206:20 <b>witness</b> 27:23 160:24	<b>witnessing</b> 178:16 <b>WLG</b> 3:25 4:1, 2, 3, 4, 5, 6, 7 <b>woeful</b> 79:8 <b>woefully</b> 79:5 <b>wonder</b> 15:22 <b>wondered</b> 209:9 221:19 <b>wondering</b> 77:9 161:4 184:17 203:12 <b>won't</b> 110:24 158:4 189:10 224:19 <b>word</b> 82:12 <b>wording</b> 82:7 <b>work</b> 7:12 9:10, 14, 19 10:8 13:23 34:6 35:20 40:25 41:1 44:13 48:25 55:20 63:14 67:8, 22 68:10 69:4 71:3 73:16 92:11, 23 101:25 105:11, 12, 19 107:3 123:19 137:4 144:2 158:4 188:24 192:8, 9, 15, 16 193:4, 6, 8, 10, 13 196:21, 23 197:16, 24 198:1, 18, 25 199:2, 10 201:8 205:7 209:2, 7, 19 210:2 212:25 220:15 228:14 <b>worked</b> 8:20 9:1 40:15 55:15 97:22 98:2 103:13 162:10 174:25 215:14 219:14 <b>worker</b> 178:9 188:23 <b>workers</b> 139:13 189:20 198:9 215:16 216:17 <b>working</b> 7:13 11:21 20:5, 22 25:7 39:3, 23
---	--	---	--	--

<p>40:19, 20 58:3 61:8 67:16 77:1 92:21 93:3 97:12 100:1 104:3 137:24 161:17 162:11 189:8, 13 190:9 191:15 192:17 193:4, 19, 22 194:17 196:16 200:3, 4 201:16 204:2 205:19 206:2, 10, 12, 16 <b>workload</b> 214:1, 2 <b>workplace</b> 109:18 <b>works</b> 18:7 21:22 25:18 39:21 56:12 134:16 230:15 <b>world</b> 6:10 57:22, 23 60:15, 16 65:21 144:6 <b>worldwide</b> 145:2 <b>worried</b> 179:2 <b>worry</b> 62:15, 16, 17, 18 <b>worse</b> 197:14 <b>Wow</b> 97:8 <b>wrangling</b> 27:11 <b>wrenching</b> 177:24 <b>writ</b> 79:19 179:12 211:25 212:10 <b>write</b> 94:12, 13 188:17 207:13 <b>writes</b> 57:23 <b>writing</b> 184:4 <b>written</b> 10:19 124:4 <b>wrong</b> 125:14 126:2 <b>wrote</b> 10:1 176:2 209:25 <b>Wuhan</b> 145:3, 4 154:3, 14 155:7 180:20</p> <p>&lt; Y &gt; <b>Yaffe</b> 170:23 <b>Yeah</b> 8:4, 9 86:25 96:14</p>	<p>99:22 100:11 202:11 220:14 <b>year</b> 6:25 9:9, 10, 17 10:1 15:18 19:25 33:2 52:21 59:1 78:6 91:3, 8 100:2, 5, 9, 15 141:8 142:17 157:11 234:20 <b>yearlong</b> 101:16 <b>years</b> 8:21 14:24 17:9, 16 18:14, 24 23:4 25:2, 11 30:23 34:17, 18 39:22 40:16 47:4 52:1 56:8 128:13 129:1, 13 136:19, 22, 23 141:2 148:24 159:22 162:11 174:25 215:14 <b>yellow</b> 229:22 <b>York</b> 12:9 41:25 <b>youngest</b> 19:6</p> <p>&lt; Z &gt; <b>Zika</b> 64:1 <b>Zone</b> 7:8 221:19 <b>Zoom</b> 1:14 <b>Zoutman</b> 48:16</p>			
---	---	--	--	--