Office of the Auditor General of Ontario
Bureau de la vérificatrice générale de l'Ontario

Outbreak Planning and Decision-Making

2020 Special Report

Why We Did This Audit

- As of August 31, 2020, Ontario had the third-highest number of cases and second-highest number of deaths per 100,000 people in Canada.
- While responding to COVID-19 involves federal, provincial and municipal collaboration, the Ministry of Health (Ministry) is ultimately designated as the lead for responding to COVID-19.

Why It Matters

- Ontario has been particularly challenged given its decentralized public health system as well as its lagging responses to long-standing issues identified in our past audit reports.
- Ontario needs to more effectively apply learned lessons in this fast-moving pandemic in order to better respond to future waves of COVID-19 and future pandemics.

What We Found

- On February 28, 2020, the Ministry established a Health Command Table to provide advice to Cabinet and the Premier regarding Ontario's COVID-19 response. The Health Command Table had grown larger and more complex over time, from 21 members with no sub-table to 83 participants (32 members and 51 attendees) by August 2020. In total, more than 500 people are involved in the Health Command Table and sub-tables.
- Public health experts did not play a leading role in the Health Command Table and the provincial response. For example, while the Chief Medical Officer of Health was identified as a co-chair of the Health Command Table on March 6, the terms of reference were not updated to reflect this and he did not chair any of the meetings. As well, while Public Health Ontario was specifically created after SARS to provide scientific and technical expertise during health emergencies, it played a diminished role as its expertise was not always sought by the Health Command Table.
- The purpose of setting up the Health Command Table was to allow the Ministry to make evidence-based recommendations to support the province's decision-making related to COVID-19. However, decisions were not always made based on expert advice. For example, Ontario expanded testing to individuals with no symptoms and no known exposure to COVID-19 even though evidence showed that asymptomatic testing has limited value. The percentage of asymptomatic individuals who tested positive for COVID-19 was immaterial (between 0% and 0.2%).
- The Chief Medical Officer of Health did not utilize his full powers to issue directives, such as wearing masks, despite almost all local Medical Officers of Health indicating this power should have been used. For example:
  - A provincial directive on wearing masks in public was needed earlier to ensure consistency across Ontario. It was not until October 3 that a provincial emergency order (as opposed to a directive from the Chief Medical Officer of Health) came into effect mandating the use of face coverings in all public indoor settings across the province.
  - Instead of issuing a directive related to foreign workers on farms, the Chief Medical Officer of Health only sent a memo strongly recommending local Medical Officers of Health issue their own order. Only 13 of the 34 public health units issued such an order.
- The SARS Commission's final report identified the precautionary principle as the most important lesson of SARS. The principle states "where there is reasonable evidence of an impending threat to public harm, reasonable efforts to reduce risk need not await scientific proof." However, the Ministry did not fully utilize this guiding principle to take timely action to limit the impact of COVID-19 on Ontarians. For example:
  - While COVID-19 was reported as having spread from China to countries including Japan, South Korea, and the United States, on January 22 the Ministry Emergency Operation Centre (reporting to the Chief Medical Officer of Health) identified the risk of COVID-19 to Ontarians as low. In fact, by the end of January 2020, more cases were confirmed in about 20 countries, including Canada, where the first case was confirmed in Ontario on January 27.
  - The Chief Public Health Officer of Canada recommended Canadians avoid all cruise ship travel due to COVID-19 on March 9 and the World Health Organization declared COVID-19 a global pandemic on March 11. However, on March 12, the province advised families to go away during March break, which contradicted the advice given by other provinces and the federal government.

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- An Associate Medical Officer of Health at one of the public health units emailed the Chief Medical Officer of Health on March 18 indicating requiring long-term-care home workers to wear masks as an urgent priority. However, this requirement was not implemented province-wide until three weeks later on April 8. At that time, 69 long-term-care homes had outbreaks involving 857 cases and 88 deaths.

Conclusions

- The Ministry of Health does not have effective systems and procedures to identify, learn and respond to the COVID-19 pandemic on an organized and timely basis. The Chief Medical Officer of Health did not take a sufficient leadership role in the response to COVID-19.
- The Ministry did not identify, assess and implement lessons learned for continuous improvement, particularly key lessons learned from Severe Acute Respiratory Syndrome (SARS).
- The Ministry did not measure and report on a timely basis the results and effectiveness of pandemic preparedness and management activities.

Read the report at www.auditor.on.ca