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of the

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Standing Committee on Public Accounts

Chairperson
Mr. Josh Guenter
Constituency of Borderland

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MANITOBA LEGISLATIVE ASSEMBLY
Forty-Third Legislature

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LEGISLATIVE ASSEMBLY OF MANITOBA

THE STANDING COMMITTEE ON PUBLIC ACCOUNTS

Wednesday, October 23, 2024

TIME – 1 p.m.

LOCATION – Winnipeg, Manitoba

CHAIRPERSON – Mr. Josh Guenter (Borderland)

VICE-CHAIRPERSON – MLA Jim Maloway (Elmwood)

ATTENDANCE – 10 QUORUM – 6

Members of the committee present:

Mr. Brar, MLAs Chen, Dela Cruz, Devgan, Mr. Guenter, MLAs Kennedy, Maloway, Sandhu

Substitutions:

MLA Bereza for Mrs. Stone
Mr. King for Mr. Nesbitt

APPEARING:

Tyson Shtykalo, Auditor General

WITNESSES:

Hon. Uzoma Asagwara, Minister of Health, Seniors and Long-Term Care

Scott Sinclair, Deputy Minister of Health, Seniors and Long-Term Care

MATTERS UNDER CONSIDERATION:

Auditor General's Report – Investigation of the Protection for Persons in Care Office (PPCO), dated July 2023

Auditor General's Report – Manitoba's Rollout of the COVID-19 Vaccines, dated April 2023

* * *

The Chairperson: Good afternoon. Will the Standing Committee on Public Accounts please come to order.

Before we begin our business today, I would like to inform the committee that a resignation letter from Mr. Khan as a member of this committee was received. Mr. Nesbitt is now the replacement Public Accounts Committee member for the remainder of this Legislature.

Committee Substitutions

The Chairperson: And I would like to also inform the committee that we have received two membership substitutions for this meeting only: Mr. King for Mr. Nesbitt and MLA Bereza for Mrs. Stone.

* * *

The Chairperson: Finally, I table the following document: responses from the Department of Finance to questions from the Standing Committee on Public Accounts meeting on June 20, '24.

This meeting has been called to consider the following reports: the Auditor General's Report– Investigation of the Protection for Persons in Care Office, dated July 2023, as well as the Auditor General's Report–Manitoba's Rollout of the COVID-19 Vaccines, dated April 2023.

Are there any suggestions from the committee as to how long we should sit this afternoon?

An Honourable Member: Three hours?

The Chairperson: I hear a–*[interjection]*

I'll just recognize members wishing to speak for the sake of Hansard, but, MLA Brar.

Mr. Diljeet Brar (Burrows): Three hours.

The Chairperson: There has been a recommendation for a suggestion that we sit for three hours.

Is that agreed? *[Agreed]*

All right. So then we will sit 'til, it should be 4:08. All right. Agreed and so ordered.

Does the Auditor General wish to make an opening statement?

In what order does the committee wish to consider the two reports before us?

MLA JD Devgan (McPhillips): Can I propose that we consider the PPCO before the vaccinations?

The Chairperson: All right, there's been a suggestion to consider the Investigation of the Protection for Persons in Care Office report, dated July 2023. Is that agreed? *[Agreed]*

Does the Auditor General wish to make an opening statement?

Mr. Tyson Shtykalo (Auditor General): First, I would like to introduce the staff members I have with me today that worked on this investigation.

I'm joined by the assistant auditor general, Jeffrey Gilbert, who is the executive for the investigations area of my office.

I'm also joined by Jacqueline Ngai, who is an audit principal on the investigation, and Ryan Riddell, also audit principal on the investigation.

* (13:10)

Mr. Chair, the Protection for Persons in Care Office or PPCO, plays a key role in protecting vulnerable Manitobans. It does this by receiving and investigating allegations of abuse and neglect in health-care facilities.

My office received several calls from Manitobans describing alarming incidents where loved ones in personal-care homes were physically or verbally harmed. These incidents were reported to PPCO, but the resulting investigations concluded there was no abuse.

Mr. Chair, my office investigated three allegations and confirmed serious systemic issues within PPCO. These issues jeopardized PPCO's ability to produce meaningful investigation results to help protect vulnerable Manitobans in care.

We found PPCO concluded incidents were unfounded for abuse where victims were punched, kicked or sexually assaulted. Unreasonable conclusions like these were reached because of the interpretation of the definition of abuse. At the time of our investigation, PPCO was already aware there were issues with the interpretation of the definition of abuse. This had previously been identified in three separate reports over the course of a decade, one report by the Ombudsman of Manitoba, another by a task force external to PPCO and another by the Department of Families. Despite these reports, PPCO did not take meaningful action to remedy the situation.

PPCO was also not conducting investigations in a timely manner. In 2022, PPCO had a backlog of files, with some allegations dating back to 2018 for which investigations had not yet started. As a result, some families and victims waited over three years for the PPCO investigations to start. These delays have a significant impact on families, victims and the accused and can result in a loss of evidence and impact PPCO's credibility.

We also found that PPCO was not publicly reporting statistics on investigations. Publicly reporting on an organization's work is a crucial tool that allows policymakers and the public to determine if an entity is fulfilling its mandate.

Lastly, we noted there were improvements needed to PPCO's investigation processes as there was no prioritization of allegations on a risk basis, no documentation of–or little documentation of key decisions and no quality assurance process.

My report includes 12 recommendations to PPCO to address our findings on the allegations and to improve their investigation processes.

I'm deeply concerned by these findings and recognize the painful experiences the victims and families went through. I want to acknowledge the efforts of the individuals who recognized there were issues and brought forward their concerns. I would also like to thank PPCO management and their staff for their co-operation and my staff for their dedication and hard work on this investigation.

I look forward to the discussion today on this report.

The Chairperson: Thank the Auditor General for his opening statement.

Does the deputy minister wish to make an opening statement, and would he also please introduce his staff joining him here today?

Mr. Scott Sinclair (Deputy Minister of Health, Seniors and Long-Term Care): I'll start with introducing staff.

First, I have Ron Oberlin, who's the executive director for licence compliance and has responsibility for the persons for protection and care office. And Jennifer Chiarotto, who is the executive director with population public health and has responsibility for vaccines in the department.

On July 26, 2023, the Office of the Auditor General publicly released its report on the Protection for Persons in Care Office. The OAG investigation was initially promoted–or prompted, sorry, by allegations, external complaints, that the OAG received regarding PPCO's administration of The Protection for Persons in Care Act, including delays in the investigation and intake process, with an investigation backlog of more than five years.

The OAG confirmed serious systemic issues existed and that they jeopardized the PPCO's ability to produce meaningful investigation results. The report included 12 recommendations to help protect vulnerable Manitobans in care. In response, the department accepted the OAG reports, recommendations and committed to improving the function of the office without corrective management letter being issued.

The PPCO fully addressed its backlog and introduced legislative administrative measures that will ensure full administration of The Protection for Persons in Care Act, improve resident and patient safety and restore public trust.

The Chairperson: Thank you to the deputy minister for his opening statement.

At this time, I will ask the committee if there is leave for all other witnesses in attendance to speak and answer questions on the record, if desired.

Is that agreed? *[Agreed]*

Before we proceed further, I'd like to inform all in attendance of the process that is undertaken with regard to outstanding questions. At the end of every meeting, the research clerk reviews the Hansard for any outstanding questions that the witness commits to provide an answer to and will draft a questions-pending-response document to send to the deputy minister. Upon receipt of the answers to those questions, the research clerk then forwards the responses to every Public Accounts Committee member and to every other member recorded as attending that meeting.

The floor is now open for questions.

MLA Devgan: So thank you for being here and being available to answer some of the questions.

Having read the OAG's report, clearly, there was a lot of serious abuse and allegations in there–was a difficult read, to be honest. But I am happy to see that the department has agreed to all of the OAG's recommendations.

However, the legislation was updated in May 2023 but was only adopted in January of 2024. Wondering if you can tell us why it took about six months for it to be adopted.

The Chairperson: Just a reminder to all members to direct your questions and answers through the Chair.

Mr. Sinclair: So thank you for the question.

It's a–the implementation of the definition–this legislation being referenced is the actual definition. The change of definition that was contemplated was fairly complicated and complex because it didn't just apply to the protection of persons in care act. It actually also applied to The Adults Living with an Intellectual Disability Act. And in many instances, individuals that could be covered by both statutes may be living in the same facility and may be actually living, in theory, in the same room.

So co-ordination of that definition between the offices that have an investigative responsibility under the acts that relate to that abuse had to be co-ordinated. The Department of Families is responsible for the adults living with intellectual disabilities act and the investigation offices for complaints under that act. And it took, you know, both departments a number of months to ensure that the definition would be, as contemplated in legislation and then ultimately enacted through regulatory provisions, was workable for both departments–both offices under both statutes, which required some extensive conversation with Legislative Counsel, as well as legal counsel, Civil Legal Services, to ensure it would work.

So the legislation was a step in bringing in the new definition. The substantive work was around the regulatory components of it and then the administrative implementation of how it would be implemented between the two departments that have those investigative functions under separate acts, again, reminding the committee that in many cases, the investigations could be in the same facility, on the same floor, potentially in the same room with separate individuals under different legislation. So co-ordinating that was a somewhat complicated regulatory piece that resulted in taking some time to implement.

MLA Mintu Sandhu (The Maples): I know–questions on page 20. This is regarding some victims who are waiting three and a half years for an investigation to start. And there were some reports where, like, some people were waiting for 10 years. This was October 2022.

So my question is: What is being done to increase the PPCO capacity and safety for the seniors?

DM can answer or the minister can answer.

***** (13:20)

Hon. Uzoma Asagwara (Minister of Health, Seniors and Long-Term Care): I'll just pose a question to the Chair, just for clarity of process. If I want to follow up and provide a supplementary

response to the deputy, do I go through the Chair after the question has been answered?

I ask that because I raised my hand to follow up on the previous and that was missed, so I just want to make sure I understand the process.

The Chairperson: All right, so the–I will recognize the witness that the member addressed the question to, but if, you know, as the minister, you'd like to respond as well, or vice-versa, you can do that as well, and I'll recognize you. So I just didn't happen to see your hand up. But go ahead.

MLA Asagwara: Thank you for the clarification.

So I'll–if it's okay, I'll start by responding to the previous, if that's–offer my remarks there?

The Chairperson: Sure, yes, I recognize the member–the Minister of Health.

MLA Asagwara: Thank you, Chair; I appreciate that clarity.

First, I would say that I want to thank the Auditor General and his team for their work on this really important issue. As the Auditor General stated, you know, there are aspects and concerns brought forward previously that had gone unaddressed, and I appreciate very much the amount of work that went into producing the report.

You know, as MLA for McPhillips has already indicated, very, very difficult report to read. Very tough to know how families and Manitobans were affected by investigations either not being done, being delayed or having outcomes that were insufficient and inadequate.

I also want to thank the department. I want to thank the PPCO staff and team, who have been working–who have worked very, very hard to address those concerns and make significant improvements.

To the MLA's question in terms of timeline, I do want to state that, you know, coming into this role as the minister, being on the other side of the curtain perhaps, was interesting to see what the process looked like and to see the work that was under way and the work being done. As deputy has already indicated, there were complexities to that work that, you know, it took me a little while to fully understand and appreciate as well.

But I do want to make clear that, right from the start, it was a priority for myself as the minister and for our government to make sure that this issue was addressed as quickly as possible. It was something that was still very much top of mind for Manitobans. I was hearing from seniors and families who wanted clarity on–as to why that aspect had not been proclaimed as of yet.

And so, you know, that is something that I reflect on in terms of, you know, coming into this role and it being very clear to us that there had to be a level of urgency in getting this work done and working across departments, as the deputy indicated, having to work with the Department of Families as well, in order to get that enacted.

And so the reason why I'm here today is to really honour the fact that this is a really–it was a difficult time for Manitobans. It was a difficult report that really deserves our full attention and commitment to making sure that we don't allow the missteps and the mistakes of the past that hurt families and seniors to be repeated. And so I appreciate the opportunity to be here today and to talk about the work that we've been doing on this particular file and the work that we'll continue to do.

And I appreciate that question. It's good to provide clarity in terms of how much this has been a priority for us to move in the right direction to address these recommendations.

Thank you.

MLA Sandhu: My question was, again–it was actually on page 20–there were–some people were waiting for three-plus years for the investigation to start. And then there were reports in October 2022 that there were–some people were waiting for 10 years.

And I just want to know what is being done to increase the capacity at PPCO and the safety for seniors.

Mr. Sinclair: Thank you for the question.

So the backlog, I think, was one of the more concerning elements of the report, recognizing that the population that we're dealing with is elderly. They are in personal-care homes. Many of them are end of life. So investigations that start when somebody is in a home, that take five or more years, may not have even started until that person has passed, which leaves a lot of angst and unfinished business for families.

So that was really–it came out in the report, and even the conversations that I had with family and–as we worked through the improvements in the office after the Auditor General's report.

So to ensure the backlog doesn't build up again and that we're able to respond in a timely manner, the office has added additional investigators to its staffing complement; a total of six additional staff have been hired since the Auditor's report has come out.

We've worked hard to improve its investigator skills by mandating specialized training, and this specialized training has been identified by experts in the field of investigations, particularly with this population. They've received or are expected to receive training on all new processes, procedures and timelines, as well as all changes with the PPCO software–and I'll speak a little bit more about new software–ongoing training on health system processes, policies, practices and health-related topics such as wound care, dementia and safe transfers so investigators can appropriately and properly assess abuse related to those processes.

Investigators have completed training in the areas of investigative report writing, to improve the quality and the accuracy of the reports; interviewing and investigation process; best practices including financial investigations and trauma training.

We've also incorporated new software, which improves the process by making available the ability to log and track the life cycle of a referral or investigation through the predefined stages, monitor each stage against timelines to ensure that investigators are staying on track to establish those timelines.

The Province has also made significant improvements to ensure the effective administration of The Protection for Persons in Care Act itself. Those improvements have included the public's understanding of what is meant by abuse or neglect and focus on the actions of abuser and not the impact it had on the victim; so making changes in those areas.

We've–rewrote the policy manual with input from the Department of Justice legal services and special counsel, Kim Gilson, addressed its investigation backlog and has established in-policy and investigation standard of 179 days. That standard was put in place in November of 2023 and to date, investigations undertaken since that date have all complied with that 179-day standard.

I will note, however, there are cases where, from the point of complaint to conclusion, that that 179 days may be exceeded, particularly in those areas where there is a concurrent or a preceding criminal investigation. We are unable to start a PPCO investigation while there is an active criminal investigation; whether it be city police in the jurisdictions that have municipal police officers or in jurisdictions with RCMP. We will be advised by the investigators that we cannot contact family, 'complaitants' or any others involved in the investigation as it may compromise the criminal case.

So once the criminal investigation is concluded, whether charges are being pursued or not, that's the point in time that the PPCO would start on the 179-day clock. So I just wanted to be clear on that because there will be instances where families will come back and say, well, it's–you know, the complaint was made two and a half years ago. Much of that time would be related to police investigation.

MLA Asagwara: I thank the MLA for Burrows for the question.

I think it's important–for Maples, sorry. I think it's important to note that, as I said, previously, this is a priority for this government, right. This is a priority for me as minister. It's something that, you know, we are able to–and I am able to set priorities and to engage with our teams and our department and identify how we prioritize issues.

And so I think that previously there was an approach taken that perhaps contributed to a lack of urgency around these issues. And, you know, for us and for me, the protection of seniors is a top priority. It is a top priority. It will remain a top priority.

And so again, I–credit to the department who have worked tirelessly to action these recommendations and to follow through but, you know, an important part of this is the conversations we've had within our team to ensure that we continue to do this work as we move forward; that we build on this. It's important that, you know, there isn't a mission accomplished box that we're going to check to say that the work is done and it stops.

* (13:30)

Now we want to make sure that seniors and families in this province know and understand that we're going to continue to build on this work. We're going to continue to communicate with families and across the system to make sure that they know that this is a priority, that we want to learn from issues that continue to arise. The system continues to evolve and change. We want to make sure that we're evolving and changing with it.

So, you know, setting the standard in terms of the 179 days and doing the work to understand how can

we set some targets that are achievable, that are realistic and that are pretty aggressive in their timeline and their nature to make sure that we're delivering for families was really important. But it's also important for us to maintain a level of flexibility so that should families and seniors bring concerns forward, that we can be responsive.

And so that's our commitment beyond addressing this really, really important and essentially transformative report. Because that's what it is; this report is resulting in transformative change in terms of the protection of seniors.

We're also committed to ensuring that we keep the door open and the lines of communication open so we can continue to improve. And no doubt we'll have to make changes as we move ahead and in the years to come in order to continue to meet the growing needs of seniors across the province.

MLA Jennifer Chen (Fort Richmond): My question is around the recommendation No. 2 in the report, page 19, section 1.1.4, the interpretation issues, which have been known and raised for many years.

The report states that despite the interpretation issue being raised three times by three separate bodies over the course of 10 years, the PPCO still failed to take meaningful action to remedy the situation.

So my question is what systems and practices has PPCO developed to ensure the interpretation of the updated definition is in line with the objective of protecting vulnerable Manitobans in care?

Mr. Sinclair: It's a very good question, because a lot of the challenges that the PPCO found in the findings of the Auditor were rooted in the definition. So now that we believe we have an appropriate definition of abuse, it's important to ensure that that is consistently applied and utilized in the determinations of the investigations.

So how do we ensure that that definition is consistently applied and appropriately applied in all instances of investigations?

We consult–or PPCO consults regularly with legal counsel. We have legal counsel available to us and available to investigators when they feel they may need that advice as they're going through an investigation. While investigators are well trained, well equipped, as I'm sure some of you are aware, navigating the ins and outs of law, particularly complex law, sometimes requires that legal perspective, so having access to legal counsel to ensure that the definitions being a–properly, consistently, appropriately applied is important.

We also have a very close working relationship with the Adult Abuse Registry folks, so while there's an investigation and a determination, we still work with them to ensure, because they are also involved in using this definition, again as I referred to in an earlier answer, potentially in the same facility, on the same floor within neighbouring rooms. So that consistency between the areas that are using that definition of abuse is very important.

And then, finally, the office has implemented a quality assurance process, so as investigators are finalizing their reports and working through their investigations, there is a process that's in place where their supervisors and management have an opportunity to review reports and ensure that there is a consistent application of that definition across the investigators, and the consistency is there, the application is there, and determinations are appropriate based on the definition as the way that it's intended to be in the legislation.

MLA Asagwara: The only thing I would add–the deputy gave a really wonderful, comprehensive response–is that there's a lot of value and importance here working across departments, and so recognizing that, you know, our teams, Families, the Department of Families and Department of Health, have to work together, right, in order to make sure that people are on the same page. And that is going to be ongoing work. There's still work that needs to be done, right.

So these definitions were updated and brought up to a standard that they needed to be historically. But there will be ongoing work across departments and across teams to continue to advance, to ensure that we can deliver on consistency for folks, right, and communicate no matter where people are posing the question, because perhaps the question may come through a different department. We want to make sure that folks are on the same page and moving in the same direction. But that's a really great question.

MLA Jelynn Dela Cruz (Radisson): I would like to take this opportunity also to extend my thanks to the OAG's office as well as the department for, you know, committing themselves day on day to ensure that folks who are in care are being, you know, done justice by those that are in these halls.

Of course, echoing other committee members, I found these issues incredibly unsettling, the issues that were uncovered by the OAG. As someone with

loved ones who are in care–community members and really close friends who are in care as well–I can't imagine being one of those folks who even, you know, within the shortest time frame faced 100–440 days waiting for an answer on–about something that happened to their loved ones, and the longest stretched into 1,200.

So it's really reassuring that there's this new standard coming into play. Though my question is a little bit about–well, a little bit more tangible for the department. What was the investigative backlog within the PPCO a year ago, and further, where does that leave us today?

MLA Asagwara: Thank you, MLA for Radisson, for that question.

So coming into this role, it's been just over a year now that I've been the Minister of Health, and I appreciate your question very much because it's been amazing, quite frankly, to see just how much work has gone into addressing the backlog.

***** (13:40)

The dedication, I can't say it enough, the dedication of the team, of the department staff and folks to honour families, because it's–you know, I think we sometimes maybe divorce ourselves from what the work is on paper, right.

But the folks doing this work, I believe, have been very much invested in making sure that justice, and you use that language, that families have justice and closure and have their voices meaningfully heard and can see the results of them being brave enough to raise their concerns and follow through on their concerns and their painful experiences.

And so, you know, a year ago, there were a remaining 34 cases–about 34 cases that were outstanding. At the time of the Auditor General's report, there were over 200 cases that were outstanding, dating back as far as five years. That is substantial, really.

And as deputy minister indicated, for any family, you know, who has a loved one in a long-term-care home or in a setting where they could be end of life, perhaps they have dementia, right, and their progression of disease over two years means the person you were having a conversation with two years ago was very different than the person you're having a conversation with two years from then.

And so the work that went into addressing a backlog that spanned years, hundreds of cases, to honour these families can't be overstated, the importance of that work. And so coming into this role and recognizing that there were about 34 cases outstanding was very concerning, still. Knowing the team was working as hard as they could and that they were able to clear that backlog in short order–essentially that backlog is entirely cleared–is significant.

And then, you know, then working to meet these new standards is a really important thing to note, but you know, as reported in the Auditor General's report, as reported in media previously–I think as far back as 2018, 2019–we've seen–we've for–we all in this Chamber have seen stories from families who were impacted by the backlog. And I think it's important for us to reflect on that, and I certainly reflect on that as minister, simply because we don't want for families to ever go through that again.

And so again, commend the work that's been done. Still much more work to do in order to mitigate that happening in future.

But to answer your question directly, about 34 cases were outstanding, and they've all been cleared since then.

The Chairperson: Just a general reminder to pose questions and answers through the Chair.

Mr. Brar: I want to say thank you to the AG office and–AG office for their recommendations and the department for follow-up and your hard work on addressing these issues.

It was not a pleasant experience reading through the report. A lot had been neglected.

When I look at redefining abuse and neglect, I'm happy that these terms have been redefined now, but I want to touch on the scope of the new definitions.

When we look at the ethnic diversity of our province and–range and diversity of their needs also expands.

So for example, seniors from ethnic groups, they would have different priorities for food. They would have different priorities for their information needs and their preference for TV channels and what they read, books and newspapers, and their spiritual needs and language preference and language barriers and their recreational activities and so on. It's totally different.

And there are very few or no culturally appropriate PCHs for many ethnic groups and minorities in Manitoba.

So my question is for both the AG and the department: Was there any consideration for these needs and possible neglect to address these needs during, before or after the investigation? Is there any plan to address specific issues faced by seniors from minority ethnic groups in Manitoba?

Mr. Shtykalo: Yes, maybe I'll just speak briefly to our audit and the scope of our audit.

The work that we did with respect to looking at the definition in the inclusion of other cultural specificities; that was sort of outside the scope. Being an investigation, we looked at specific allegations, and in the files we looked at, you know, I have to say, they covered a wide range of backgrounds and cultures, but that wasn't the focus of the reports. We don't have any recommendations specifically towards that.

Mr. Sinclair: Thank you for the question. Sorry to take time. We just wanted to make sure that we were able to fully answer that question because it is an important observation; it's an important element of the work that staff are doing.

I just want to start by answering the question by sort of contrasting the definition because I think it's important for the committee to understand how this would have been dealt with under the former definition versus how it could be dealt with under the current definition.

So I'll read the definition of abuse as it was under the old definition. So in the act, abuse means, subject to section 2, an act or omission that is mistreatment, whether physical, sexual, mental, emotional, financial or a combination of any of them; and, causes or as reasonably likely to cause death, serious physical or psychological harm or significant loss to a patient's property. So I think you can hear from that definition it's a fairly strict definition of it.

The new definition of abuse means, subject to section 2, the use of physical force resulting in pain, discomfort or injury, including slapping, hitting, beating, burning, rough handling, tying up or binding; or (b), and this is the piece I think is more relevant to your question: the intentional causing of emotional or psychological harm, including through threats, intimidation, humiliation, harassment, coercion or restriction from appropriate social contact.

***** (13:50)

So I think that definition gives a lot more latitude and direction for investigators to be able to determine that abuse is happening in an instance that you referring to where a resident of a personal-care home is denied access to or not appropriately supported to have access to culturally relevant or comforting materials or people or processes or approaches.

So the ability to find abuse in those circumstances with a increasingly diverse population with different needs is certainly something that the office would be much more likely to be able to support than they would have under the old definition.

I'll also add to that that of those six staff that we–I referred to earlier that have been hired, one of them is an educational outreach worker, and one of their–the ability for that outreach worker to reach into ethnic communities and various communities within the province to understand where we need to be mindful of these needs and the opportunities for those to be withheld in the definition from residents to ensure that we have a good understanding on an investigation how abuse may be suffered from a resident of a PCH as a result of that.

So we have a very specific individual that will be able to support investigators to learn and understand from communities what those–where those risks are and to be able to manage those through investigations.

MLA Asagwara: Such a great question. Such an important question. I want to thank my colleague for that.

The–as the deputy's explained, the new definition really does allow the opportunity for folks to bring broader concerns or more culturally specific concerns forward and have the opportunity for the PPCO to have the capacity and the mandate to address them, whereas previously that mandate was not in place.

The other thing that I would offer is that as a government, we have been very clear about our approach to health care, our approach to seniors, our approach to governance, that we value diversity–diversity is one of our province's greatest strengths–that we understand the importance of equity and advancing equity. We talk about anti-racism approaches in health care and in systems, and we recognize the existence of systemic discrimination and that, you know, we have a beautifully diverse province where we want everybody to thrive at every stage in life–certainly, in your older years–elder years.

And so, for us and for myself as the minister, I really do see this work that is being done and the new

definition and even this new timeline in terms of the target window to complete the work as being a great opportunity to support families and seniors who bring their concerns forward and seeing real changes advanced in a very aggressive timeline.

Whereas previously, you know, investigations took years and there was a big backlog, now we have this opportunity to say to folks when they bring their concerns forward, not only do we have the mandate to look at this concern in a fulsome and equitable manner, but we can give you a timeline here in terms of how we're going to address it and potentially make changes in the system and benefit from an education co-ordinator and relationships across communities and across services that can support us in advancing the needs of folks who have diverse backgrounds, be it culturally, spiritually, racially, in terms of, you know, 2SLGBTQ+ community needs as well.

And, you know, what we don't want and what I don't want, certainly, is for folks to become senior, enter this stage in life and then feel like they have to abandon parts of who they are in order to have community or have housing or receive quality care in residence, et cetera. We want for folks to age with dignity, wherever that is that they need to, and to do so as whole people.

And so, you know, it's a commitment of ours–it's a commitment of mine–to not only protect seniors but to also affirm seniors and the diversity of seniors that we have in this province, and that means affirming the diversity of identities that we have here in Manitoba.

And so, really wonderful question. It's something that I will actually take away from this and make sure that as a team, we're doing our due diligence in communicating that to seniors and families and organizations because it is something that we know is really important to folks.

And I'll share here that I've had conversations with diverse community members. Folks in my own community, Nigerian community, Black community, my own nne, you know, she told me years ago. And she's someone who has dementia, and she's, you know, in a home where she receives assistance and care, and she always made clear to me, if I get to a stage in my life where people don't recognize that I love curry and I can't eat it, that's a problem.

And so, you know, it–recognizing that people deserve to have their unique needs met as they age no matter where they are is a priority for us, and on a personal level I appreciate and understand it greatly, so thank you for that question and it's something that we can take away and also do some more work around to make sure we strengthen this area as we move forward.

MLA Devgan: A bit of a two-part question here: in the OAG's report, it–I guess they found that the PPCO had decided that, I think it was in 2016, that they would stop producing annual reports. I'm wondering if maybe the deputy minister and the minister could comment on whether there's a plan to provide periodic reporting or annual reporting.

And the second part of the question, related, is, procedural and systems improvements are fantastic. They're great, and it seems to be that the department is on board with this. But I'm curious to hear what the deputy minister and the minister have to say about the root causes of some of the issues that we saw in the report. Staffing shortages: How much of that is a component of what we're seeing here?

***** (14:00)

Mr. Sinclair: Yes, thank you, again, for that question.

So in terms of the first question on reporting and where are we at with that, so yes, the last published report on this was in 2015-16. We are undertaking and have undertaken significant efforts to get to a place where we can publish all those reports between now and then.

We do currently have two staff that are dedicated to working on this. A lot of their work is around validation of data that's in those. And just to put a context to the level of work, those years where a report hasn't been published includes 23,000 data points that have to be reviewed and validated–sorry, 13,000 data points that have to be reviewed and validated. So a significant amount of work going in on files on those pieces.

We will be in a position where we will start to publish. And we're going to start to publish with more recent and then going backwards in a planned manner. A reason for that is we are much more confident in the data that we have now, so we're going to have to do more validation as we go backwards in time, but we will be in a position to publish, before the end of the year, the '22-23 report for that.

Going forward, we will be reporting annually on the same metrics and the same measures that we've historically reported on, but we'll be looking at exploring options to produce reports in potentially more detail than we have historically. But the

commitment right now is annually the same level of detail that we have.

I'll just note that while '23-24 year has passed and we're not starting with that year, the reason we're not doing that is there was a change in the data system which also requires some additional data validation points. So that will be going up sort of out of the sequence of the '22-23 and then backwards. We'll publish that report when we've concluded the validation of the data coming out of the new system.

MLA Asagwara: So as the deputy said, and I'll provide a couple of stats here, I think that they were flip-flopped.

So there were about 13,000 files that needed to be gone through that had been essentially unaddressed from 2016 up until catching up, which is obviously extensive. It's a ton of work to do all that, and there are 23 data points that were assessed.

And to speak to your question on staffing and capacity, so there's two staff who are dedicated to doing that work, a ton of work there. As already noted earlier by the deputy, six additional investigators were brought on-board in order to clear the backlog and do that work.

But to your question and to your point, you know, the challenges around staffing in the health-care system certainly contribute to pressures that we see and outcomes that we don't want to see in the health-care system, quite frankly, and in long-term-care homes.

And so the challenges in years prior in terms of lack of staff, losing staff from the health-care system year over year, losing capacity in the health-care system directly contributes to pressures that we see on the front lines where folks are receiving care in long-term-care home sites across the province, et cetera.

Evidence data tells us that very clearly, that when front-line staff are in increasingly pressured situations, when they are short-staffed, when they are without the human resources and the capacity they need, you have increased opportunity for error, mistakes being made, you know, 'bether'–be it medication errors or other errors. You have conditions where perhaps you see increased behaviours from residents, patients, et cetera.

And so when you add staff, when you add capacity, which is what our government's priority has been–it's what my priority, our entire team's priority has been. When you add capacity and add people to the front lines, what you're ultimately doing is you're bringing down those pressures. You're reducing the pressures on the system. You're giving people the literal tools and resources they need to provide a better quality care more consistently. You have folks in situations where they're not having to wait as long for that person to get to their bedroom, their room and provide care. You see decreased levels of agitation in patients and residents.

And so the approach that we've taken in terms of prioritizing staffing is because we know that you need front-line folks and experts in the health-care system to deliver quality care, but it's also because we recognize that for any of this work, the work of the PPCO, to, again, honour the report from the Auditor General and these families who brought all these concerns forward, in order to honour all of that, in order for that to be successful and sustainable, you actually need people. You need people in long-term-care homes, you need people on the front lines, you need people on your teams who are doing investigations. You have dedicated health-care human resource and expertise who can help execute in these areas of need and priority.

And so when I mentioned earlier that, you know, we're taking a long-term approach to this, I was also talking about staffing. I talk about health-care human resource a lot, but certainly one of the objectives that we have that is required in order to make sure that the work of the PPCO and the changes that have been made are sustainable and can continue to improve is making sure that we have as many people as possible on the front lines of health care, working in personal-care homes and, quite frankly, on the–our teams in the department doing this work so that we can execute on the recommendations and on any concerns and issues as they arise moving forward.

The Chairperson: MLA Bereza.

MLA Jeff Bereza (Portage la Prairie): Thank you, Chair.

The Chairperson: The–sorry, MLA Bereza, can I–I will just recognize the deputy minister, who I think wanted to make a follow-up comment, and then I will give you the floor.

Mr. Sinclair: Thank you for that. Sorry, I'd only answered the first part of the question and then, sort of, minister and I are playing tag team on this and then they answered the second part.

So I would like to give a bit of an answer from an administrative perspective on the root causes, which I think is a, you know–the purpose of the–of an audit

is to understand and diagnose root causes and find solutions to those so that they don't happen again.

I'd say the answer to the root causes falls into two categories from my perspective as somebody who has–you know, took leadership of the department after the investigation was well under way, and I'd say those two root causes were definition and leadership.

So the definition of the–of abuse was highly problematic, and I think the Auditor found that–made that determination. It's not an excuse for how the office operated, but it certainly is an explanation of how many of the findings came to be.

In talking with the investigators in the office after the Auditor General's report came out, that was one of the things I think I sensed stressed them the most, is that they wanted to find instances of abuse, but simply could not because of the limitations of the definition that they had to work with. Even legal counsel, as we were looking through this, were very clear, so, like, your hands are tied by a definition that clearly is an inappropriate definition. So that resulted in a significant portion of the challenges that the Auditor identified.

The other is leadership, both at PPCO and at the department. And when I say that, I'm not referencing anybody that's here, because I think, as minister has said, you know, current leadership has done a fantastic job to really focus in on and hone in on how to improve the operations of the office. It's been, you know, a significant undertaking to assess every single process that they do to find efficiencies, improvements, better training, better response, better supports for staff. But previous leadership clearly was not as committed to that as they were.

And this is something the Auditor referenced in his opening remarks, that this goes back over a decade of this problem. It covers investigations by the Ombudsman, by internal audit, by the–other departments, so there's–these things have been identified over an extensive period of time, which can only really be explained by leadership or a failing in leadership.

***** (14:10)

That fail in leadership also was at department executive levels; I unfortunately will have to say that.

The commitment to finding solutions of these just simply weren't there. When the Auditor's report came in–and without getting too far into detail about how these reports are written and the exchange back and forth between the departments–the department does have an opportunity to provide a response to the Auditor's report, and we don't–I don't–we haven't always seen eye to eye on reports, and I will often take opportunities in response letters to take a different perspective on the findings of the Auditor.

But in this instance I felt it was very important to just accept the findings as they were. The letter, if you read it, will clearly indicate that we said, we agree. This is not acceptable. It needs to change. And from that point I think, you know, leadership is how the root causes will be addressed, and that we won't see this happen again.

MLA Bereza: To the Auditor General, thank you so much for the report and the investigation that has gone into this–as a son of a mother and father that are now deceased–and going through the personal-care home facilities. Thank you for doing this.

My question is, to both the Auditor General or the department, is: How will the department ensure that staff members of the health-care facilities are educated about the process and procedures of the PPCO?

And further to that is, there is both private and public facilities. Will there be any difference on how this is reported? Will the information be publicized so that people that are looking at personal-care homes for their loved ones may have the opportunity to see if the staff training has been going on?

And again, to address the ethnicity question as well too because of some of the people that are being involved in the workforce with health care now, will that be taken into consideration as well? And also with staff turnover, how do we handle the training as well too and regarding the public being aware of what's going on here?

Thank you, Chair.

MLA Asagwara: A clarifying question for the MLA just in terms of his reference to ethnicity of staff, I'm just–can you clarify what he means by that? What's the question there?

MLA Bereza: So again, through the report that I'm reading here, so, you know, in reading the report here, when it talks about staff people from the health-care facilities, I'm talking about aides; I'm talking about nurses. I'm talking about from top to bottom: How do we ensure that everybody is having the proper training so that we don't see any of this type of abuse happening again?

Thank you.

MLA Asagwara: So just–I just want to make sure that I'm perfectly clear. So the word ethnicity was used. Was that in reference to–and used in relation to staff? I just want to make sure, was it staff or was it residents? What–just, how are we factoring that into the response that we're going to provide?

MLA Bereza: Just so that we're looking at the staff that is providing care to the people within the facilities.

MLA Asagwara: Just wanting clarity. So was the–is the MLA asking whether or not we collect ethnicity data on the staff, and–is that his question? And if so, is–why is that pertinent to–just seeking clarification there.

MLA Bereza: That–no, not regarding the ethnicity of it. But what I'm concerned about is, how will the department ensure that the staff members of these facilities–so, whether they be a nurse, an aide, a dietary person or that, how will they–how will the–how will they be educated about the processes and procedures from the investigative report that we have here so that we don't see this happening again?

Again, what I'm saying there regarding ethnicity, depending–you know, there's different people, again, will they–will this be published questions for, you know, the training manuals or how they might be is will they be developed in different languages, again, to make it easier for the staff to be able to understand?

Mr. Sinclair: Yes, thank you for that question.

So hopefully throughout the answers I've given, I've tried to reinforce the importance of, you know, training, education, quality assurance. Because this is only going to be successful if we are properly supporting staff, not only in the PPCO office for investigations, but staff within the facilities.

So I'll start by answering the question to indicate that investigations that are undertaken by the PPCO come from a place of education. So there are two outcomes from an investigation. One is, you know, typically what families are looking for, which is a finding of abuse or neglect. And that's the–a bulk of the work that's done. It's an important component of the work, but it's not the only important work that's done.

The other thing that comes out in investigation, every investigation, are improvements to the–that are a part of the investigator's report. And those improvement orders go not just to the staff that were a subject of the investigation, they go to the facility and the facility management. So there may be pieces that the investigator finds that requires improvements in the way the facility is organized or the facility operates or gaps in their training or in their approaches and processes.

So just, you know, appreciate that the purpose of the investigation isn't just to find an instance of abuse or neglect, it's also to ensure that there's ongoing improvement to the education, the process, the quality of the care that's provided.

Beyond that, education is a significant part of the office's work function, daily work function. This, to date this year, we've offered in the–it's north of 70 education sessions, and that is across a number of categories. So whether it's individuals, whether it's to facility managers, education facilities, these education sessions are tailored to the audience that they're being delivered to, to ensure that they're well aware of the obligations, requirements and best practices.

And I'll also reference back again that we have hired a dedicated educator. So, historically, this has been the germane of investigators to deal with. Now we have an educator that supports them as well as focusing on a good chunk of their work too on the education side.

In terms of your question about public and private facilities and how we interact with those, in terms of that, the legislation does not differentiate in any way, shape or form between whether it's a publicly operated facility that is owned and managed and operated by a health authority or a not-for-profit home or a private-operated home. Investigators treat each home equally the same. The expectations are the same. The level of information that's shared across the three home types, operator types, is the same.

For the exact reason which you've identified is we want families to have the best information available to them to make the best choices they can for those family members that they're looking for a new home for with supports within those.

***** (14:20)

So there's no differentiation between those various categories of operators for PCHs in the province.

MLA Asagwara: Just to answer or to speak to the MLA's sort of question, and I think that the MLA, when I was asking for him to please clarify his choice of words around ethnicity in relation to staff, I suspect

he understood maybe why I was trying to get him to clarify.

The question is a bit concerning. The nature of the question is a bit concerning, quite frankly. Folks in our health-care system, we have a very–increasingly, thankfully, diverse health-care workforce in Manitoba. We know that the more representative your workforce is, it improves outcomes, opportunities for education. It really strengthens health-care teams. It, quite frankly, strengthens all teams.

You know, folks on the front lines of our health-care system are highly equipped, educated, well-trained folks who go through interviews and different processes to get to the point of being on our broader health-care team across our health-care system.

The experts in our health-care system who run teams, who are on the front lines, have access to educational opportunities. The deputy just articulated, over 70 delivered; many, many more opportunities to access training, more training if they choose. And many folks do just that to enhance their skills and enhance opportunities in the health-care system in terms of employment and practice, et cetera.

And so it does worry me, it concerns me, the nature of the question that was posed, in terms of the ethnicity of front-line health-care workers in relation to what does it mean in terms of how we're training folks. I think that that's a space we should probably not step into.

Our health-care workers, again the workforce is very diverse and we've got approaches in our health-care system–and I take this very seriously as minister because we want our workforce to be diverse. And so we want to make sure that our teams are welcoming, that we create environments, whether it be in long-term-care homes or anywhere, that are welcoming for folks and that celebrate the diversity of folks on the front lines.

And so–but we also trust our leaders and folks on the front lines that if they identify there are gaps in terms of someone's skills or concerns in how they are doing the work performance, that they can be supported in addressing those gaps and concerns.

And again, you know, the changes made to the definitions is a good example. Perhaps if you have folks who bring forward concerns that their experiences in their residence are not quite meeting their specific needs, maybe that does require some more training for the teams or for the site in terms of being able to meet someone's specific needs.

We have, like I said, increasingly diverse communities, and it's important that the training that we provide and that we offer reflects our evolving communities. And so certainly, as a government, as a minister, we endeavour to work with our department and our teams to deliver the kind of training and education that supports all Manitobans having a positive experience wherever they reside in our long-term-care homes.

And certainly, I think front-line staff who are just absolute rock stars on the front lines, who care deeply for the folks they provide care to every single day and build really meaningful relationships with families. I know that they often go above and beyond to enhance their own skills and their own expertise so they can provide the highest quality care to the residents and the people that they provide care to.

The Chairperson: MLA Bereza on a follow-up.

MLA Bereza: Again, my apologies if my question wasn't correctly–and maybe I didn't articulate it properly.

My question regarding ethnicity was to make sure, do we have proper material if a person is from a Ukrainian background, from a English background, from a whatever background that it might be, so that we are able to provide the best material that we can for those people that are coming in.

And thank goodness we do have a very diverse workforce out there. But are we making sure that we are providing that information for them, whether it be in a language that they are most comfortable in, in working as well with this. Again, that should have been the part of my question.

My apologies if I wasn't clear.

MLA Asagwara: So there are standards that, just as an example, that colleges maintain, right, in terms of folks being licensed or accredited to practise on the front lines of our health-care system, whether you are a physician, a health-care aide, nurse, there's a whole host of checks and balances in terms of making sure that people are equipped with the necessary skills in order–and are proficient in order to deliver care on the front lines and in long-term-care homes. Those are standards that are, again, set by different entities, whether it be regulatory colleges, certainly standards across the health-care system that are a part of sites being accredited; that's just one example.

And so certainly, you know, I take a lot of pride in the fact that our government values diversity and champions diversity and representation. We have a caucus that for the first time in our province's history looks like Manitoba, looks like the constituents of this province and citizens that we serve. We take very seriously the opportunity to welcome as many Manitobans as possible to personal-care homes, long-term-care homes to deliver care to Manitobans because we know that that results in folks having enhanced experiences in having their needs better met and understood.

And so, fundamentally, in terms of expectations for training and for accreditation and licensing and all that, we have very clear standards that must be met in order for folks to be able to practise in health care, be it allied health-care professionals, nurse, physicians, health-care aides, et cetera.

The Chairperson: Is that on a new question or is that a follow-up? MLA Bereza? *[interjection]* A follow-up, okay.

MLA Bereza, on a follow-up.

MLA Bereza: Thank you for the clarity on that.

MLA Nellie Kennedy (Assiniboia): I'd like to start off by thanking the Auditor General's office for this report, for the minister and deputy minister for being here today to answer questions.

Of course, I'm going to echo what my colleagues and other committee members have expressed about this report being very concerning. You know, it's really difficult to read, the abuse and neglect that's occurred as, you know, I think every person in this room has a senior that they love and care about, and it's really distressing to see that these things were occurring in personal-care homes and that the office for persons in care were, you know, really quite behind in the investigations. I think these are really quite serious allegations that were occurring, and I commend the office for being up to date and clearing the backlog. I think it's really important that we recognize that work.

I want to talk about the definitions changing. I think it's incredibly important. I myself worked with adults living with intellectual disabilities and the–worked under the adults living with intellectual disabilities act and took part in investigations. And I know that it is very difficult when the deputy minister was saying, you know, for investigators wanting to find cause and saying that something was abuse or neglect but being unable to because of the very narrow definition. Certainly I know that that is incredibly frustrating. It sends the message to people that they don't matter and the experience that they had was somehow–we're minimizing it, and it's not what we want to because these are very serious allegations.

So I appreciate that these definitions have been updated, that they're not so stringent and narrow and that they capture, you know, for people who are being punched or kicked, that these are real issues; they should not be happening and that they–this does constitute neglect and abuse, that family members can trust in the fact that we are going to have people, you know, who are in care being cared for in an appropriate way with dignity and respect.

***** (14:30)

So for me, I think what I would like to really talk about here is the Adult Abuse Registry Committee and the checks that happen, right, because it's important that if there is serious harm that comes to someone, that these names, you know, of the abusers or the people who are being neglectful are–there is a referral made to the Adult Abuse Registry Committee and that, you know, when someone is looking for another job within this field, whether it be with–working with any vulnerable people that their name does get flagged and that there is something, you know, that will capture the fact that this person should not be working within these fields within–for vulnerable people.

So for me, I guess what I wanted to see–maybe the question is, if we can–if the minister or deputy minister can elaborate on how training's been updated and what kind of training's been provided to investigators. If the director receives the same training, I think, is very important, because they are the person who is in charge of reviewing all the investigations.

And then I'm wondering, like, if the Adult Abuse Registry Committee, if they have access to the investigative files and if they can conduct audit–random audits of the findings. I think that's really a very important sort of question to ask.

Mr. Sinclair: Thank you for that.

So I'll start with the question around the training for the director of the office, and a simple answer to that is yes, all staff of the office are expected to have the same degree of training, level of training and obligations for training around that.

In terms of the questions around AARC: AARC, I'll just–is a office that resides in another department,

so there's not–I can't speak to that as much. It's not within the Department of Health, Seniors and Long-Term Care. And the Auditor's investigation had a small element of AARC in there. So there were some references in the Auditor's report around the relationship between AARC and access to information, which I think is the question that you're asking.

In terms of what information AARC has available to it, AARC has available to it in terms of its deliberations around whether to register somebody on the Adult Abuse Registry or not, they have access to the information that the PPCO provides to AARC as a part of its referral to them.

So all of the investigative materials that PPCO has available to it as a part of its investigation doesn't necessarily go to AARC, nor does AARC have unfettered access to that. AARC may choose to gather additional information as a part of their process, but they really are two separate processes, two separate bodies.

In terms of random audits, the answer, no, is they are not an oversight body of PPCO, so they aren't–there's no ability for them to audit or randomly audit the activities of PPCO.

Again, their mandate is narrowly with respect to should somebody be placed on the Adult Abuse Registry check or not. And there are two entities that can refer to that: one is PPCO; the other is the office that investigates individuals that are under the adults living with disabilities in the community act.

Also want to clarify that not every investigation that's undertaken by the PPCO necessarily results in a referral to AARC. Even when there is a finding of abuse or neglect, it may or may not result in a referral to AARC. So there isn't a one-to-one relationship between the Adult Abuse Registry check and that office and PPCO in terms of the work that it does.

MLA Asagwara: I do want to reassure our colleague that the work is being done in collaboration, recognizing that they are separate, right. AARC resides in the Department of Families and not with Health, Seniors and Long-Term Care.

That being said, in order for the PPCO and our department to understand the best ways to do the work, we do have to understand how that functions and the realities there. And I do think that there's a lot of really great work that's been done at the PPCO that will actually really benefit that–the work of AARC in terms of learnings and applications and the training, et cetera.

So I do want to state for the record that there's a lot that I think will benefit that process and that work. They're not–they are separate; however, there's a relationship there, obviously. And so it is important for us to work in collaboration to move this in the right direction.

The Chairperson: MLA Kennedy, on a follow-up.

MLA Kennedy: So I genuinely appreciate the responses.

I guess my question is, of course, not every finding of abuse or neglect goes to AARC or is referred to AARC. And so I guess my question is: How–what is the actual criteria or how is that decision made? And how is that communicated to family members or people who are wondering about, you know, the outcome of the investigation and what that looks like?

Mr. Sinclair: So thanks for the follow-up question.

So I think communication is, I think, at the root of the question you're asking–is how do families know and how do we make sure that these decisions are being made? So I'll start with answering that question.

So fundamental to the processes that PPCO has since adopted is the concept and the commitment to communication at all stages. So there is regular and continuous communication with the family or the individuals that have brought forward the concern of abuse or neglect, and that communication includes the stage at where the determination of abuse or neglect is found and whether that's referred to AARC. Families will be made aware of that.

* (14:40)

Once a referral is made to AARC, that then moves to a different process and communication then would shift over to the Adult Abuse Registry check office for ongoing communication.

In terms of the question around how is a decision made to refer, could–based on the comment that I made that not all findings of abuse or neglect result in a referral to the Adult Abuse Registry check. About 80 per cent of the investigations that are undertaken by the PPCO are around allegations of abuse between patients; patient-to-patient abuse. So it isn't always patient to staff. I know that's the focus, that was certainly the primary focus of the Auditor's report. It's certainly the primary focus of the conversation. It's certainly the single largest concern that we have, is around the safe care that staff provide to patients. But

a large number of the investigations are patient to patient.

So when there is a finding of abuse on a patient-to-patient basis, the termination, whether something or someone is referred to the Adult Abuse Registry, is whether that individual has the capacity for future employment or not. If that individual does not have the capacity for future employment within the health-care system or a related occupation, the decision to refer them to the Adult Abuse Registry would be–you know, it's not necessary in that instance.

For the remaining 20 per cent, or the balance of that, of investigations that are staff to patient or staff to resident, there are instances where a finding of abuse or neglect is found but they are not referred to the Adult Abuse Registry. And the reasons for those would be it's unintentional, accidental or there's not pattern around that.

So there needs to be some sense of intent or a pattern. So if it's a significant instance of abuse, clearly that would go forward but if it's a pattern of smaller ones, that may go forward to Adult Abuse Registry as well. If it's a single event, the individual–it was determined that it was because of an inappropriate training; so there may be a health-care worker that has to administer an intramuscular drug or injection of some sort, they do it in a manner that results in significant pain or bruising, it may not have been–it may have–that would fit the definition, but the intent of it was they need retraining on how to do that to ensure that the needle is inserted in a manner that doesn't cause that unnecessary amount of pain or longstanding bruising around that.

Those are instances that would not be referred to the Adult Abuse Registry and instead, it would be a course of action of training, education support for the staff and for the staff supervisors to ensure that that–there is–pattern doesn't occur and that we can avoid those instances in the future.

MLA Chen: Yes, my question was actually attached in one of the previous answers by the deputy minister, which was about education sessions. However, in the report, in page 33–from page 33 to 34, section 2.3, it–the report finds that there was a significant reduction in the PPCO education sessions to facilities; particularly, on page 34, there's the chart showing that the educational sessions have significantly declined over the last five years, from a high of 57 sessions provided in 2015 to 2016 down to only 6 in 2020 to 2021. And this represents an 89 per cent reduction in educational sessions delivered.

I feel–by reading this section I feel it is–education sessions is really important, as it states in the report, some of the quotes from the front-line staff that some staff have no idea PPCO exists and they don't know what they are supposed to report and the importance, by reducing educational sessions, it's difficult for the PPCO to fulfil its purpose of working towards the prevention and detection of abuse and neglect in health-care facilities.

So my question is, the number of when–is the number of education sessions written in any policy manual of the PPCO, and what practices has the PPCO been implemented to provide education sessions, and what's the PPCO's plan or commitment moving forward with regards to deliver education sessions?

MLA Asagwara: Really great question, and certainly the MLA is correct. The member is correct that training markedly dropped over the years previous, and that is very, very concerning. We saw capacity reduce, we saw training opportunities, learning opportunities markedly reduced, essentially down to almost nothing.

And so it is a priority for us, certainly, to make sure that we are equipping people with the tools they need in order to deliver the highest quality services to seniors and their families. It's something that we're evaluating over time, as well, and so we've made some significant strides in this area; the exact–I'm going to see here–okay. And so previously, about '23, '24, somewhere around 70, so just under 70 training sessions were delivered, which is the–higher than any previous number of training sessions delivered previously.

We're already on track to surpass that, so we're, you know, midway point through the year, six months into the year, we have 44 sessions that have been delivered, with many, many more on the way. So I would ambitiously state that perhaps our target is around 100. Don't quote me on that, but you will because it's–I'm putting it on the record.

But, you know, the point is that we want to ensure we're delivering as much training as possible. The department is doing–PPCO is doing a great job providing global training, to really bring everybody up to a standard of understanding, education, skill set, et cetera, so that folks are on the same page; they're equipped to deliver this service equitably, the resources equitably.

But the other opportunity that we have and that the PPCO and the team and the department are

focused on is evaluating the impacts of those trainings and those sessions. So are there ongoing gaps, where are they really seeing it benefit folks, where are there opportunities to enhance training, where can we do better, where do we need to focus.

The opportunity to evaluate this process as we increase and ramp up training so that they can be–there can be a more targeted training approach. We can meet specific needs in a really meaningful and enhanced way. It is about delivering a certain volume of training and making sure we're reaching as many people as possible. You know, thousands of folks as–thousands of folks on the front lines in long-term care, personal-care homes.

But it is about the quality, and what is the outcome that we're looking for and delivering the training to folks. And so, you know, this is an area of ongoing priority in order to better protect seniors, serve seniors and their families and make sure their needs are met comprehensively.

* (14:50)

We want to make sure that we have a good appreciation of the kind of training and the targeted type of training we should be providing. And so that work will continue, but we're delivering more training and more sessions than probably ever but certainly since 2016.

MLA Dela Cruz: It's no question that trust was broken by the previous administration and, you know, the Auditor General's investigation of the PPCO illustrates exactly how; one case of exactly how that trust was broken.

On page 26, reading this for the first time about a year ago, I remember how shocked I was seeing that the PPCO had stopped producing annual reports in 2016, and the decision was made, the directive was made, year on year, by leadership at that time, not to report to the public. And the reason that–the reason why the Auditor General was necessitated to–or this investigation was necessitated by the public was because these reports weren't being done annually.

And so I find it incredibly concerning as, you know, a new legislator, that something has had to be hollowed out to the extent that it has, that public intervention was required. The Auditor General had to undergo a complete investigation.

Meanwhile, there were still, you know, the hundreds, the several hundred cases of a backlog to deal with at the same time that this investigation was happening. I'm very, very thankful that the departmental team has effectively cleared that backlog, but to prevent this from happening in the future, I also understand the importance of recommendation 6, and I trust that the new administration takes recommendation 6 seriously.

And so I ask the department: You know, knowing just how transformative this report can be, what are the steps that they are taking to increase transparency, outline a timeline for the public on reporting and, you know, really restore that trust that was broken by the previous administration?

The Chairperson: Well, before I recognize the minister, I'll just say, it is one of the features of this committee that we are non-partisan, and so references to previous government or current government fall outside of that boundary.

MLA Asagwara: Thank you, Chair; received that feedback. I certainly appreciate my colleague's question and what's at the heart of that.

It's–it is difficult–it's a difficult report to read. I've read it several times and, you know, it is important–and I think what I really value about this report is it humanizes the experiences that families had. It really paints a picture that you can't turn away from, and it really sears onto your brain and onto your spirit and onto your heart just how devastating previous inaction was for families.

And so I can appreciate where that question comes from and the, you know, the frustration perhaps that's attached to that, that's connected to families. I'm sure that member and, you know, I know I have, I'm sure many folks in this Chamber have heard directly from families who are impacted by the feelings and approach previously.

And I've said this before. I don't bring up the past because I delight in rehashing painful narratives. It is because it is so important for us to understand where things went wrong in order for us to not repeat those mistakes and for us to get things right.

That's not to say that there aren't going to be missteps moving forward or that we aren't going to have to pivot and adjust and be nimble and continue to learn and evolve. We're going to have to do all of that.

That being said, there are some pretty concrete concerns outlined here in the report that have been articulated by Manitobans before this report came out that we cannot minimize and that informed the way

that we're doing the work in the 'reford', including around reporting, which is what the question was about.

Reporting allows for us to communicate to the public and to families and to seniors what is happening, what we're hearing, what we're learning. It holds us accountable. It allows for transparency.

And at this stage a lot of the work that the PPCO has been doing, and certainly we are doing as a department and as government, is repairing trust. It's restoring trust. It is reassuring folks that this is a top priority, that we're going to do this work on behalf of seniors and Manitobans. And we're going to–we recognize that trust was broken, and we recognize that it takes a tremendous amount of work to restore and repair that trust.

And the way that you do that is by taking real, concrete steps. It's by accepting, as the deputy did, accepting the recommendations in full and saying we're not only accepting this, we're going to address it. We're going to fulfill these recommendations and go further than that, which is what our commitment is, and that is the work that we are doing.

We are going–we're going to continue to do work to go beyond the really important recommendations that were made. We are going to continue to learn and to listen so that we don't repeat the errors of the past and we mitigate harms to seniors and their families in this province.

And so reporting, you know, having had no public reporting since 2016 and the department, PPCO, working very hard to get through 13,000 files, 23 data points, to understand what was going on year over year over year. And now we're at the stage where we're going to be able to report on that.

It's–you know, the first step is actually closing that gap. It's shining light on what was going on for all those years where there wasn't reporting and there wasn't transparency. That is a big part of the way that we restore and repair trust with Manitobans.

And so that is how we will begin with '22-23 and then working back from there and shining a light on all of those years where families and seniors did not have answers to their questions or a line of sight into what was going on to protect their loved ones.

And then moving forward, as the deputy has stated, we intend to report in a manner that was done prior to 2016 when it concluded, when it was stopped. But we actually are looking at ways that we can make that more fulsome.

And so in the Auditor General report, it talks about looking at other jurisdictions and maybe aligning with them. We do want to make sure we take a Manitoba-specific approach and meet the needs of our citizens in this province and that we take feedback we hear from them and perhaps take an approach that is a bit more comprehensive than it was previously. But we're still working out some of those details.

But certainly I think that the really important place to start is finally giving folks a look and the information that they did not have access to for all of those years. And setting a really good, strong foundation in terms of repairing those relationships and reassuring people that we have practices now in place that even surpass what was going on pre-2016.

I think that it's important to acknowledge that there are improvements that we are making and that we intend to make long term that not only address the more recent years, but we want to make sure we do better than what was happening before as the standard. And we hope that, in doing so, Manitobans and seniors can feel confident that, you know, their government is indeed doing what's necessary to protect them and to make sure that their needs are adequately met.

Mr. Brar: Again, reflecting on the revised definitions, I guess the change in definitions would result in more and more incidents qualifying as abuse and neglect.

So what's the plan to address the demands created by this change, and what impact these revised definitions would have on staffing and infrastructure requirements for the PPCO?

***** (15:00)

Mr. Sinclair: So, thank you for the question.

So the definition of itself doesn't really impact the number of claims or concerns that are brought forward. So those were, you know, claims will come forward. We've seen a slight increase around that; that's probably more related to more beds in the system, more people being in personal-care homes, so, you know, more opportunities for people to feel that a family member may have been abused or neglected.

Where the definition impacts is, and I think your question was getting at, is to the number of findings of abuse and neglect would increase because

there's a broader definition or definition that allows investigators to determine abuse or neglect on a greater rate.

And I think the–fair question about impact. So what happens when we have more people, more staff that have been found to have abused or neglected a resident of a care home or a facility? And I think where we want to focus–or I want to focus my answer on–is that is, again, drawing the member's attention to that the vast majority of investigations are related to resident-to-resident abuse, so a small number, not an insignificant number, but a much smaller number is staff and that the focus of the investigations, again, isn't just about finding abuse or neglect; it's actually understanding why the abuse or neglect happened and identifying opportunities for training, process improvement, better supervisory or managerial oversight, improving processes within those facilities. And those don't necessarily result in an impact on staffing.

The instance of actual impact on staff or having somebody come out of the workforce what–is what is necessitated when a determination's made: look, this person has made–had an instance of abuse or neglect so egregious that they can't be employed in the facility. That will be a determination of the employer, ultimately, whether employment is terminated or not and then whether that individual's referred to the Adult Abuse Registry check. And if they're registered on the Adult Abuse Registry, then they're unable to find employment within the system.

So I think that's–we want to focus on where an individual needs to be removed from the system because of the incident; we'll deal with that. Primarily, we want to focus on the education and support for the staff, the facilities and the management to ensure that abuse and neglect doesn't happen again.

MLA Asagwara: Just following up. We've added additional capacity in terms of staffing to not only clear the backlog, but as I think folks have heard today, to advance this work in a good way moving forward to make sure that we continue to have increased capacity to address investigations in a timely manner, to better co-ordinate communicating with families, you know, communicating with families and loved ones throughout the process at all stages. I think over time we will see engagement with families perhaps continue to slightly increase, maybe more so, but ultimately, I–what we will see and what we should see and hope to see is that folks are going to bring these concerns forward because they know that they're actually being addressed, right.

For years there were people–and I heard this from folks: Why bother? I'm not–you know what I mean? I'm not calling; I know the waits are super long or we didn't hear back. And reputationally, changing the reputation, doing the work, again, to repair and rebuild trust will motivate and encourage families to bring those concerns forward, to talk about what their issues are because they will have heard, they will be aware, that there are targeted timelines; there are accountability measures in place that will allow for them to not be left in limbo for years after bringing an allegation forward.

And so to deputy's point, there may be steps taken to provide better education training to address a concern in a way that allows for staff to remain on the front lines and continue to provide good care and if it's appropriate.

But there are also going to be a lot of opportunities for, you know, as we move forward and we're delivering more training sessions and the definition has evolved to a place where folks can bring forward a host of concerns that may result in, maybe not necessarily specifically just that person getting trained, but, you know, system-wide changes and approaches. There's–I think what–it'll prompt a level of engagement from seniors and families and communities because folks will become aware of the opportunity to contribute to making personal-care homes, long-term-care homes safer, healthier, more equitable, all the things that everybody wants but previously, folks just didn't know how they could contribute to that. And this really allows folks the opportunity to not only bring concerns forward, but see meaningful change take place in a much more timely manner.

Mr. Trevor King (Lakeside): I want to thank the Auditor General for what I think is a pretty detailed report, and there are some key recommendations going forward. And the department, I want to thank them for taking the initiative to work on some of these recommendations.

We had a lot of talk about the definition here. And one of the key recommendations from the Auditor was changing that definition as we all know, for, you know, a better definition, interpretation of abuse and neglect.

Now it's my understanding back in 2021 a high threshold for the definition of abuse was set in the creation of the protection for persons in care. Just a kind of a two-part question here, I guess, is: Can the department or the AG tell us why that definition was used? And I appreciate the deputy minister reading

out the new definition and the old definition there earlier. If they could tell us why that definition was used or was it merely a determination by legislative drafters at that time.

And the second part to my question would be: The new definition of abuse includes the word intentional, and this is one of the potential questions from the Auditor here. So how will the investigators prove intent? And do you think including this helps meet the objectives of protecting vulnerable Manitobans in care?

Mr. Sinclair: So I'll start with answering the first part of the question, which is why that definition, why that was in legislation to start with.

So that definition was embedded in legislation as it followed Supreme Court decision on what the definition of abuse and neglect was. So at the time of drafting that legislation, the drafters' counsel felt that this is the definition the Supreme Court uses; it should be good for us.

***** (15:10)

And the benefit of time passed and realized that it was not a sufficient definition to cover a number of cases, many of which the Auditor looked at specifically, that would clearly from a–you know, any person reading the account of the act would say this clearly constitutes abuse or neglect. Whether the definition says that or not, a decision–a determination was made to change that definition.

So the original definition was just strictly based on a Supreme Court case that gave that forward as a definition.

In terms of the language in the new definition which does intentionally use the word intentional, the reason for that is, as I've discussed before, there are instances where abuse or neglect may happen, but it is not intentional; it may be accidental, for whatever reason. Investigators are receiving now enhanced training to be able to identify the difference between accidental versus intentional harm, and some of the things that they'll look for in terms of what would cause it to be intentional and not accidental would be, you know, recklessness of the behaviour.

So an example is a health-care aide is moving a patient to deal with bedsore, they accidentally roll them too far, they fall out of the bed. That was not an intentional act. We would then look at, okay, is this–is there a pattern of this? Is this the first time it's happened? Is it the fifth time that it's happened? If it's happened multiple times, it may be considered intentional because they are not following proper practice or procedure in order to do that in a safe manner.

Investigators can look at the training. If there's a conscious decision that we can–you can demonstrate–well you were trained to do it a certain way, but you made a conscious decision to not do it that way. You're cutting corners or you're rushing. Again, that would be–lead to a determination of an intentional versus a non-intentional.

So very specific training, and we're looking for patterns, deviations from a practice or process that they've been trained in, in terms of how they do their work, to see if there is an intentional intent to harm.

MLA Jim Maloway (Elmwood): I want to say this has, to me, been a very productive meeting. I'm not used to this.

But I can tell you that, you know, since MLAs' offices get a lot of complaints about this stuff, and it's very difficult for us to sort it all out and–because, as the deputy pointed out, a lot of the abuse is between the residents themselves. And we find this very difficult to deal with for many, many years now. And this legislation was brought in in 2001, clearly not sufficient probably even then.

And what's happened is–I'd like to know when the AG did the report and when the department did the follow-up work that's required, where do we sit–well, when we're done with all of this, where are we going to sit across Canada, right, vis-à-vis other provinces. And we do this with all–even our rules in the PAC committee for God sakes, right.

So where are we going to sit when we're finished with this, and how are we performing over the years vis-à-vis other provinces?

You know, the report references Alberta in some way. So I'd like to get a handle on that.

And second of all, where is this going to all end up from a legal point of view?

You know, because when we pass legislation, it's either going to–it could minimize legal action, or it could expand legal option, you know. We've certainly done that on auto insurance over the years, where we'd pass a law, and there is no room for legal action anymore, right–you know.

So I'd like to know what your observations are on this whole thing, and I didn't see this in the report. If it is in there, it's hidden really well.

Mr. Shtykalo: I'll just speak to–for our report and what we looked at.

As far as any type of where Manitoba sits across Canada, we didn't do a broad jurisdictional scan of, you know, practices or definitions or anything. The only thing that–and we mention it in the report–is we did look to other jurisdictions and their public reporting to kind of use that as a benchmark for what we were seeing in Manitoba. But that was sort of the extent of our looking to other jurisdictions and making any kind of comparison.

Mr. Sinclair: I think I will just expand on what the Auditor was referring to is, you know, we've spent a lot of time focusing on improving the system in Manitoba, clearing the backlog, staffing up, doing better at training, doing better at training the system to be able to ensure that abuse and neglect isn't happening.

You know, the good public administrator in me is already starting to think, okay, now how do we start to look at best practices across other jurisdictions once we've got that work under way–under hand.

I think the Auditor's recommendation to, you know, publish our statistics against other jurisdictions is a very good starting point to see how we measure up, get some key indicators so as we begin to build out the robustness of our reporting, we can begin to include some metrics in jurisdictions that are similar to us. We tend to look at Saskatchewan; Nova Scotia is a jurisdiction of a similar size. And how do they perform in these spaces?

So I think that's something that we would absolutely be turning to now that we've got the system and the office in a place where it's clearly performing at a level where we need it to be and want it to be and the public expects it to be on that front.

In terms of your question about minimizing or expanding legal action against this, I think it's a fair thing to be concerned about, is as we move in this space, do we expose ourself to more or less legal action? I think the way the legislation is written is, we are an investigative body around this.

So I think that our exposure would be–those decisions that we make in terms of finding an instance of abuse or neglect, and then a decision is made to send those decisions to the Adult Abuse Registry. I think that's really where our exposure is.

I would say that our exposure of doing it in a negligent way, so a reference to the Adult Abuse Registry, which will potentially take away somebody's livelihood if it's done in a negligent or less-than-professional way could–that could be where we get exposed to some legal exposure.

Under the old definition, unfortunately, there wasn't that many findings of abuse and neglect and even fewer cases that were referred to the Adult Abuse Registry, so that would minimize our exposure. This, with a definition that provides a bit more flexibility to find those and determinations to do that, there's–it certainly would increase the potential for it. But I think we're, you know, confident in the training that the staff have, that they are going to make very evidence-informed determinations around the acts of the individual and the determination as to whether they're referred to Adult Abuse Registry.

And then, ultimately, the burden of whether somebody is put on the Adult Abuse Registry belongs to another agency, and that's truly where the damage happens. Because the fact that somebody was referred to the Adult Abuse Registry isn't a public–matter of public record. It's–you know, we will share with the families that we've referred, but there is no record, unlike, you know a court of–where you're, you know, publicly known that you're charged and there's some ongoing potential damage to character, reputation as a result of that.

So I think the potential of that is narrow, but it's not zero. And the way that we protect ourselves against that is, again, the continued focus on training, quality, improvement and ensuring that the office is functioning at the highest possible standard that it can.

MLA Asagwara: Just following up on deputy's remarks.

The timing of this work and the timing of us being in government, quite frankly, has lined up in a way that–I mentioned opportunity previously, and I was very serious about that. This is a very important opportunity that we have as a government to take these issues seriously, to set mandates and direction in terms of how we protect seniors, how we equip folks in the system with the tools they need in order to provide the highest quality care and to be accountable and to evolve and learn and grow as we move forward.

You know, I'm fortunate, as a minister, to work with a team that, intrinsically, that's how folks operate anyhow. It's not like I have to go to these folks and push them or force them to want to take that approach. Thank you.

But certainly being highly motivated as a government and having, you know, leadership in the department and in the system, across the system, who are also highly motivated to implement not only immediate changes but sustainable changes and to work with our partners in order to move this in the right direction long term.

And so the PPCO, although this work is within the PPCO and, you know, there's outreach that's done, there's an outreach co-ordinator position now. And there's all of this work that's being done that's public facing and building and repairing those relationships.

* (15:20)

There are other entities across the health-care system that directly contribute to how our personal-care homes, long-term-care homes, are able to deliver care and ensure that residents are protected and safe. And so those are partnerships that we're actively forming in order to make sure that we are aligned throughout the system.

You know, I think about organizations–registrars like the CPSM is a good example, the College of Physicians and Surgeons of Manitoba, and the work that they're doing that is specific to addressing anti-Indigenous racism, the work that they're doing around accountability, the work that they're doing–you know, to the deputy's earlier point around sometimes folks perhaps don't need to be referred to the Adult Abuse Registry check, but maybe what they need is training and more education and more information and support. And CPSM and other folks are doing that kind of work throughout the system, which really aligns with what our priorities and mandates are, and I think, overall, is going to help in this particular area of health care in a really special and important way.

And so it's also incumbent on us to look beyond–to not be so insulated, to look beyond what is happening in this particular area, to look and see what other partners and stakeholders are doing and to learn from them as well and to work together. And that's an approach that we take really seriously and we're finding a lot of benefit in. And so that's going to be a part of the path forward in how we make sure that we don't repeat those missteps of the past and how we strengthen this area and set a good foundation moving forward.

Mr. Shtykalo: I just–I thought I'd quickly just speak to the part of the previous question on where to next, from the perspective of my office.

So today we heard a lot of work that's being done by the department and PPCO, and I just want to take this opportunity to let the committee know that, like most of the audits in my office, the process is to do a follow-up at a certain point. With respect to the PPCO, we're currently planning to do a follow-up next year, probably with a date–looking at sort of an as at date in September of 2025. At that point, we will be tabling our follow-up on the status of action taken on our recommendations in the report.

The Chairperson: Hearing no further comments or questions, I will now put the question on the report.

Auditor General's Report–Investigation of the Protection for Persons in Care Office, dated July 2023–pass.

All right, we'll now move on to consideration of the Auditor General's Report–Manitoba's Rollout of the COVID-19 Vaccines, dated April 2023.

Does the Auditor General wish to make an opening statement?

The Auditor General has the floor.

Mr. Shtykalo: I'd just like to take a minute to introduce another member of my staff. Dallas Muir is an audit principal that was the engagement leader on the Manitoba's Rollout of the COVID-19 Vaccines audit.

Mr. Chair, in Canada, acquiring and distributing COVID-19 vaccines was co-ordinated between federal, provincial and territorial governments. In this audit, we set out to determine whether Manitoba effectively managed the vaccine rollout in the province.

In Manitoba, we found the Province did effectively manage the COVID-19 vaccine rollout. Vaccines were appropriately administered, and the vaccine inventory was appropriately managed.

While the vaccine rollout was effective, efforts would've been assisted having better tools and practices in place. For example, system limitations sometimes necessitated the use of paper-based methods to collect consent and immunization data. This resulted in hundreds of thousands of paper forms being generated, which had to be manually inputted into electronic systems. A more robust electronic system would reduce some of the risks involved in using paper-based methods. These risks include incomplete and inaccurate data being recorded.

In addition, the pandemic exposed gaps in emergency preparedness. These gaps include a lack of clear roles and responsibilities between and within

Manitoba Health, Shared Health and the regional health authorities, and other groups and organizations involved in the vaccine rollout.

Now that we are post-pandemic, it is imperative that lessons-learned exercises be done to identify gaps in emergency preparedness that was exposed by COVID-19 vaccine rollout. Applying the learnings and best practices will help prepare for the next public health emergency that requires a whole-of-government response.

At the same time, the vaccine rollout demonstrated the success of a whole-of-government approach. The learning activities can also be used to implement a whole-of-government approach in normal operations where needed.

Finally, Mr. Chair, this audit underlined the extraordinary efforts of public servants and service delivery providers during the vaccine rollout. The success Manitoba achieved are directly linked to those efforts.

In conclusion, I'd like to thank the many provincial government officials and staff and the many other stakeholders we met with during our audit for their co-operation and assistance. And I'd like to thank my staff for their work on the audit.

I look forward to our discussion on this report.

The Chairperson: I thank the Auditor General for his opening statement.

Does the deputy minister have an opening statement? All right, Deputy Minister, the floor is yours.

Mr. Sinclair: I should have done what the Auditor did and swapped out staff. I had one of my staff here sit for the last few hours, so I apologize to them for that.

I'd like to re-introduce Jennifer Chiarotto, who is the executive director for population and public health, who has the responsibility for the Province's vaccine programs.

I'll just–I'm–I've–opening remarks: I'm going to start with, off-script a little bit, just for the committee's awareness and I'll indulge your time.

So I've been working for the Province for 25 years. I spent two and a half years dealing with the pandemic in, basically, the entirety of the Province's response to that, which included vaccine rollout. So for the committee's sake, I spent 10 per cent of my career dealing with COVID and the COVID response. So this is a topic I am more than happy to have a conversation about and will probably take much more time than you've allotted to this committee; so interested and excited to answer any of your questions you have around this topic.

But more specifically, you know, April 2023, the Office of the Auditor General released its report on Manitoba's rollout of the COVID-19 vaccines. The COVID-19 pandemic that began in 2020 had significant and profound impacts on society and the lives of Manitobans and in response, Manitoba saw the largest scale vaccine campaign in recent history. I'd say probably in history, period.

Vaccines were the way out of the pandemic, as you all appreciate and remember, at the point in time where we were social distancing and capacities with going into various stores or sporting events and our kids' schools being disrupted. Vaccines were our way out and continue to be our way out of managing the pandemic.

I'll also just remind the committee: the Auditor General made a comment that now that we are post-pandemic, technically we are actually not yet post-pandemic; the chief medical officer of health of both provincial and federal levels have not declared an end to the pandemic. While we have moved beyond the significant impacts, we are–still have elements of COVID around that leave us in a pandemic state.

That does not mean that we shouldn't take the time that we have, after COVID has had its most significant impacts, to look at how we can continue to improve and do things better.

The Auditor General found that Manitoba appropriately administered the COVID vaccines to Manitobans, that it appropriately managed the COVID-19 vaccine inventory and that there's an opportunity for Manitoba to apply learnings from COVID-19 to its normal operations. And appreciated the Auditor General's comments around the whole-of-government response to COVID, which was fundamental to how we were able to mount a response to COVID-19.

The report included three recommendations to apply learnings into normal operations and prepare for future pandemics. In response, the Manitoba government accepted the OAG report's recommendations and committed to incorporating the lessons learned from COVID-19 vaccine rollout into future pandemic plans.

A key aspect of pandemic planning is ensuring flexibility and adaptability. This is both a lesson learned and a best practice that we have taken to heart. For example, some elements of pandemic planning can be standardized, including the use of rapid response mechanisms, such as task forces and incident command or incident management systems to support responses in an efficient decision-making process.

However, other approaches will simply depend on having the right infrastructure, flexible plans and foundational elements in place so they can be rapidly tailored and adapted to fit needs of populations most impacted at the time of the pandemic.

* (15:30)

And while I do appreciate the findings and the recommendations of the Auditor General about being better prepared for the next pandemic, this will be one of the areas where the Auditor and I maybe have slightly different perspectives on the feasibility or the reasonableness of that.

COVID-19 caught the world off guard. There is no way to have a tabletop exercise to prepare for what COVID-19 brought to us. We can certainly be more mindful of what COVID-19 did to us, but the ability to actually, you know, predict, adequately plan and put processes in place to quickly, nimbly and efficiently respond to a pandemic of that scale of complexity and just generally scientifically unknown what was going on is very challenging.

I mean, I can share stories about the procurement process that we took, where I experienced receiving calls 2 o'clock in the morning of pandemic supplies that we had ordered from China that were being intercepted by the US military on docks in China. We were competing against each other in a global race to get whatever materials we could to fight the pandemic.

There was no–that had never even entered my mind as a senior public servant about what this meant and having the US military take stuff that we have bought from a foreign country.

So the ability to certainly better plan and prepare, yes. The ability to understand what COVID-19 was and really begin to simulate responses is an area that I think you just have to respond to in the moment and shift. Because the global environment was dictating how we responded. We didn't have much control over that.

So thank you.

The Chairperson: I thank the deputy minister for his opening statement.

The floor is now open for questions.

MLA Devgan: Sorry, my mic's not on yet. There you go.

Picking up on what the deputy minister had said, this–COVID caught the whole world by a–by surprise. And so I don't think, at least not in my memory, there's ever been a situation at this scale, where we would have had any muscle memory to tap into.

So I think, just as a caveat to any of the questions that are–come forward or my question forthcoming, is that I think there's a fair bit of understanding amongst Manitobans and Canadians that there were a lot of things that perhaps we can take lessons learned from, that we would not have known.

There's a lot of things that went right. And to cobble together a response, particularly on the logistics side, under such a short amount of time is nothing short of incredible.

So firstly, to the department and everyone involved, thank you for the work that you all put in. I know you put in a significant amount of time there, and I'm sure there's a lot of lessons that you'll take out of that.

I–the OAG's report–OAG or–the Attorney General's (Mr. Wiebe) report looks more into the rollout, so the logistics of the vaccine rollout. And I think that's important.

In my mind, though, it–involved in the rollout of the vaccines is also your communications. And that isn't covered in the report, and I can appreciate why.

But I would love to hear from the deputy minister his perspectives on what lessons have been learned, what we could have done better in terms of the communications rollout on the vaccines and uptake from citizens, communicating the availability, the eligibility of vaccines and how that factored in. I–yes, I'd be interested to get the deputy minister's perspective on that.

Mr. Sinclair: Thanks, appreciate that question.

So start with muscle memory, sorry, this is a subject that's very close to my heart. I hope my muscle memory doesn't have to be accessed for another one of these, I'll just say that. But so I–hopefully, I can leave behind some lessons learned for–should this

hopefully never happen again, but if it does, some lessons learned from that, so.

But even the idea–like this–yes, COVID-19 happened. We had SARS before that. We had avian flu before that. Lessons learned from that didn't translate. The muscle memory wasn't there. The people weren't even there.

Even when you look at our COVID response, I think, between myself and Dr. Roussin were the last two people standing in government that had a role within the Province of Manitoba dealing with COVID. So that muscle memory could go fairly quickly, so documenting and making sure you've got resilient structures will be very important.

Communications: I would hope to think we did a good job on the communication side because this is all we did for two years, and if we couldn't get communications right when this was the only thing that we were doing for an extended period of time, I'm not sure we'd ever be in an environment where we got it right.

We had Dr. Reimer, Joss Reimer, who's an outstanding medical officer of health, that was dedicated to vaccines, was my medical and scientific partner through this whole thing, who was out in the media constantly.

We had Dr. Marcia Anderson, who, again, a great voice for Indigenous First Nations communities in equity and the impacts of disequity of the disease on First Nations and how the data that she produced enabled us to make very difficult decisions, some of them not terribly popular with the public where certain priority access or, you know, I mean, everybody used to hopefully remember where we–every day we would announce the next layer of who's eligible, and First Nations quite rightly were being provided differential access because of the differential harms that were being suffered as–in terms of adverse outcomes from the disease.

So we were regularly communicating with the public. We were communicating hard decisions, but those decisions were evidence driven. And the other thing I'd say in terms of communications, in the time that I've been in government, it was, without a doubt in my mind, the first time when evidence was really guiding the decision making. This was a scientifically led, evidence-based, decision-making process around how vaccines were allocated, to whom vaccines were allocated, to the age groups.

You know, we were using very sophisticated data models to determine how disease was being transmitted in communities and understanding which postal codes were more vulnerable to disease transmission and therefore where should we be prioritizing access to vaccinations.

And we tried to communicate that because not everybody was agreeable with those. We had various constituency groups that were arguing that they needed priority access, whether it was first responders because they were coming across people with COVID-19 or educators who wanted to get back into the classroom. And they all had, you know, reasonable arguments as to why they should be next. But we very much stuck to the scientific evidence to say, where is harm, where is adverse outcomes happening, and there's where we needed to be focusing our vaccinations.

In terms of how successful we were, we were, I think, at the–by the time we went through our second dose of COVID vaccine in the first–in the early days, we were north of 80 per cent coverage on vaccines, so–like a vaccination rate we've never seen before. And going into respiratory virus season this year, I would be thrilled if we had 25 per cent uptake of COVID vaccines, let alone 80 per cent. So, you know, Manitobans did what we asked them to do. They rolled up their sleeves, they got two shots, and we were able to get enough herd immunity from that to be able to come back to some semblance of normalcy in through the fall, early winter of 2021, even though the campaign has continued to go beyond that.

The other thing that was successful and something I'm extremely proud of, was Manitoba held, for a period of time, the North American record for the most number of vaccinations administered in a single location, in a single day. We put through 24 or 25 thousand people at the RBC Convention Centre in a single day, and we were bested a few months later by Texas. I think it was the Astrodome or something, held a–or Houston stadium held an event where they beat us by only 5,000 people–if you can imagine, the state of Texas and the population size it is and the infrastructure it had–did beat us.

But we held the record for the single number–greatest number of vaccinations in a single day as well as the record for the most continuous days of vaccinations over 20,000. So we had a really excellent model for the distribution of and access to vaccines, for sure.

The Chairperson: MLA Devgan, on a follow-up.

MLA Devgan: Yes, just to follow up on that, specifically to the rollout of the vaccines and communicating

the different communities. You mentioned Dr. Anderson who did some phenomenal work in reaching out to the Indigenous communities during that time, and, of course, there's an acute need within certain populations.

* (15:40)

One thing–I guess more of a feedback than a question is–so during the–I'm having flashbacks now–I was at the Sikh Society of Manitoba, which is the largest organization gurdwara in the province. And the challenge we had at that time was translating public health information, including vaccination guidelines, into Punjabi for the community. That is something that we found was absent from the department at that time. So that fell really on the shoulders of organizations. And I'll repeat what you said, you know, God willing, we don't have to go through this ever again, and this is just a comment and a lesson learned.

But for future, what I would suggest is that we be mindful of the different ethnocultural communities within Manitoba as well. There's a lot of language barriers. And what that ends up leading to–and I'm sure you recall and, you know, had seen–a lot of misinformation about vaccinations, the amount you needed, what the vaccines were and so on and so forth.

So–and again, I know this isn't covered in the Auditor General's report, but it is important feedback just in terms of the logistics of vaccination. It makes that job all the more easier if you could communicate clearly in multiple languages and through, I guess, effective conduits to different communities.

So that would just be a feedback that I would have.

Mr. Sinclair: Yes. Thanks for that entirely fair comment and entirely correct. And I can use some data and evidence to back up that reality.

We certainly recognize that communicating to non-English, French or First Nations communities in some of their languages beyond that, we certainly struggled to communicate in those languages given the volume at the time. Not an excuse; again, just sort of the explanation of the reality around that.

But we did see differential uptakes in those communities. So yes, I referred 80 per cent or so of Manitobans received two doses of vaccine. Those rates were actually higher in First Nations communities because of the efforts of Dr. Anderson and others to do that. What that means is we had much lower vaccination rates in non-white, non-First Nations communities. So the ethnic communities referring to, much lower.

We did recognize that in terms of when we were moving towards prioritization of various communities and looking at what the population was of immigrants or new Canadians in there and trying to find ways–particularly Southeast Asian, Indian populations that weren't having the same vaccination–and finding ways to do that, but not necessarily in information in their own language or in culturally recognizable ways.

So yes, certainly, a good suggestion and something–a lesson learned that we can take away to do a much better job of engaging with communities in a language and ways that they're more comfortable with.

Mr. Brar: I just want to say thank you to the Auditor General's office and the department for your role on this report and especially the Health Department for your work during COVID to protect all of us.

I want to start with some shout-outs to especially our doctors and nurses and our front-line health-care workers and paramedics and grocery clerks, transit workers, taxi professionals, truckers, retailers, small businesses, international students, delivery drivers, social workers who delivered free food out of their own pockets and also the donors who contributed to save people and help them during COVID and people on precarious jobs as well. And many of these were impacted disproportionately, especially the seniors.

So my question here is, do we have data to reflect on what categories of our workforce or our society were disproportionately impacted, and what lessons did we learn from the information and what steps are being taken to address these impacts?

Mr. Sinclair: It's a very good question and certainly something that, I think from the start of the vaccine campaign, was given consideration in terms of who was, what populations and what people, were being disproportionately impacted by COVID-19. And how could we ensure that those inequities were being addressed?

One of the first things that we did when vaccines started arriving in Canada was a call to the federal government to–with a plea to say that they–like Canada–I'll back up a little–like Canada does every time, everything's just generally done on population, right. That's the easiest way they do it. We're going to give everybody vaccines proportionate to its population. And we recognized very early on in the disease

that our First Nations–or the First Nations, Métis and Inuit population living in Manitoba were having disproportionate outcomes and adverse outcomes from the disease.

So we called Canada and made an impassioned, again, evidence-based plea to say, you know, we think we need to get more than just a per capita access to this.

So they were in agreement and gave us more vaccines in the early days than we otherwise would have been allocated. And those first doses were transported to First Nations communities by First-Nations-led team to ensure that those communities had access to vaccine first.

Even that was a very–it was a logistical challenge. You know, there was–the first vaccines had to be held at sub -60° or -70°. We had to have freezers transported and located to rural and remote communities. We had to ensure that there was a continuity of power wherever the vaccines were being located.

Transporting vaccine on gravel roads or difficult roads was concerning. Because of the way that the vaccine companies presented the stability of the vaccine, it may as well have been nitroglycerine. It all had to be held in individual packages and, you know, couldn't be jostled around and all these sorts of things.

So rolling it out was quite challenging but was rooted in recognizing that we needed to provide vaccine to those communities that were most vulnerable. So right from day one, it was a part of how we made our decisions and supported the rollout.

In terms of the disproportionate impacts, I don't think we saw disproportionate impact at an occupational level. Certainly there was higher risk amongst health-care occupations to exposure, but the outcomes weren't necessarily any worse because you were a nurse or a doctor or a physiotherapist. But we certainly–initially, we made sure that those professions had access to vaccines so they could work a–you know, safely and effectively within environments where COVID was highly, highly transmissible.

And was primarily directed towards ensuring health-care workers were available to work and weren't getting sick. So we wanted to make sure health-care workers were healthy as they could, so they can continue coming to work and provide the important care that they were.

Where we saw disproportionate impacts were–was around ethnicity, race and ethnicity, and age. Those were really where we were finding those impacts. So Indigenous communities, First Nations, Métis and Inuit communities, immigrant, new Canadian, BIPOC communities, children under the age of six months, the elderly and patients that are–or populations that are immunocompromised, so those that are undergoing cancer treatments or organ transplants or other things like that, where their immune–they're on immunosuppression drugs or immunosuppressing drugs or have a lower immunity because of their health condition.

What we're doing, continuing to do that in terms of those recognitions is, again, partnering with communities–and take the member's comment about doing those outreaches in other languages, and we can start to look at how we can do that much better. But outreach to community groups to ensure that there's awareness; partnering on community-led vaccine clinics.

We ensure, every respiratory virus season, that PCHs, because of the vulnerability of elderly population, have they–you know, early access to vaccines.

***** (15:50)

First Nations and Métis and Inuit governments have access to vaccines early on; specialty clinics that are providing specialty care, again, to cancer patients or others; as well as ensuring that vaccine is widely available in communities where we know higher risk is present. And then we roll out to the general population, pharmacists, doctors offices, going forward and that. So we do take into account where we know vulnerability is highest to make sure that those populations have priority access to vaccines in the community.

The Chairperson: MLA Brar, on a follow-up.

Mr. Brar: One would think that somebody working maybe as a grocery store clerk as compared to an IT professional who's working within their office virtually would be more exposed to the virus. This is anecdotal; I don't have data to prove that, but this is general perception in the community. So I don't know how deeply this data has been analyzed.

The Vice-Chairperson in the Chair

But one would think that if the data shows that we had different ethnicities impacted disproportionately, that could be related to specific ethnicities being in

particular workforce groups, for example, transit or health care or other departments.

So I don't know how much deeply the data has been analyzed or there's a plan to analyze, or are research organizations or academic organizations sending their, you know, master's students to study on public health issues and impact of COVID. Just a flag or just a suggestion to go that route and find out what the real picture is.

Thank you.

MLA Chen: My question is also around data collected during COVID. However, I want to start by thanking the Auditor General's report and the department's–all the work that the department has been done during COVID. There's no doubt that a lot of effort and work has been put by the department during COVID.

I can speak on that based on my personal experience. I–during COVID, I, myself, worked with the FIT team, focused immunization teams, and alongside other ethno-cultural communities to promote COVID vaccine in different languages and set up a number of pop-up clinics at community gathering places such as at a gurdwara.

And as a visual minority person, I like to see data on our ethnicity; however, I didn't find in this report. I looked at Health Canada's website. They–there is COVID vaccine coverage by ethnicity, data from, I think, self-report survey. And I found it's–there's some interesting data, which is nationwide, showing that people having received at least one dose of COVID vaccine was lower among people who self identify as Black or Arab, and both groups are below 85 per cent. Higher among South Asian and Chinese; both groups are above 95 per cent.

So I'm wondering if there's any data from Manitoba in terms of COVID vaccine coverage by ethnicity. And the–I feel it's important to know the data so that we can determine if there's any inequities in vaccine–vaccination coverage and also in order to make informed and evidence-based decisions regarding future emergency preparedness. So that is my question.

Thank you.

The Chairperson in the Chair

Mr. Sinclair: So thank you for the question, and then I also, you know, thank you for your work on our FIT teams. They were, I think, one of the more innovative ways that we approached the vaccine, were those real focused immunization teams. So thank you for being part of that and sharing that.

In terms of the data around race and ethnicity in terms of coverage and uptake, we don't have really good data on race and ethnicity in the health system. So for us to be able to report out with any confidence as to, you know, various races and coverage of vaccine races is challenging.

We had, in the moment during COVID-19–again, the work that Dr. Anderson did, very good data on Black–or BIPOC, so Black, Indigenous, people of colour. She had much better data at the time and has continued that through work that she's doing with race and ethnicity and 'indaygenous' identifiers within hospitals.

So as that data is–begins to become more robust, we will be able to use that to identify vaccination coverage by race and ethnicity. But as of right now, we don't have very good–unless we were to start to do what the federal government did, which is really a survey-based piece of work, research work, around vaccine coverage.

We can certainly look at, from an epidemiology perspective, in terms of where various communities or populations are within health authorities and understand what vaccine coverage is. But it, you know, it becomes a bit of an assumption or a stretch to say, okay, well, these communities necessarily are represented by these, you know, races or ethnic or cultural communities, and therefore these are the coverage rates. So we're shying away from that until we have better data in terms of that.

But one hundred per cent agree, the more data at a race and ethnicity level will certainly help us make better decisions going forward. And again, I'll make reference to the groundbreaking work that Dr. Marcia Anderson has been doing in the space, which will enable Manitoba to be able to do that. Unlike other provinces that aren't collecting race, ethnicity and Indigenous identifiers at a hospital level to be able to understand, you know, what our population looks like in that space.

So not today, but certainly going forward we will have that capability and capacity to do that.

The Chairperson: MLA Chen, on a follow-up.

MLA Chen: Just note–clarify this–the data that I just cited from Health Canada, it is from the Canadian Community Health Survey.

And just wondering if–I don't know if they break down to provinces or if it's possible to collaborate with Health Canada when they collect data. If they break down to provinces, then we can have those data for Manitoba.

And just want to put on record as a comment to the department that I would like to suggest the department to collect ethnicity data on vaccines–not just about COVID vaccination, but vaccine coverage. It would certainly be helpful.

Thank you.

Mr. Sinclair: So we can–we will certainly follow up to see if Canada has that at a provincial level. And if they do, we'll have access to it.

But again, I'll reinforce that that was survey level. So they've surveyed people and found that the responses are that.

What I was referring to is, again, is the medical record information data that we have available to be able to produce that at a population level, which is, you know, far more robust and valid information.

Manitoba is–again, to the credit of Dr. Anderson, Manitoba is in a space where we're able to–we will be able to have that data for race and ethnicity for hospital presentations that we can then look at what the vaccination records are for those individuals. So we will certainly be able to produce this in short order in terms around vaccine coverage at that level.

***** (16:00)

And we do want to work and continue to build out our ability to report data out but also have data available to us in terms of decision making that helps us understand the disproportionate impacts of various communities, populations, people, in terms of disease progression and outcome.

So again, we can see what Canada's got. We can certainly get access to that if we have it, but we're looking to build that capability and capacity to do that ourselves so that we can really have a good understanding of the population of Manitoba and what we need to do best for Manitobans to serve them.

The Chairperson: All right, before I recognize the next member to ask questions, just a reminder the committee did agree to rise at 4:08. So we will need a minute just to put the question to be able to do that. But we'll see. Just keep that in mind.

So we'll go to MLA King.

Mr. King: Just–I'll try and make my question brief here.

But thanks again, the Auditor General, and–for such a great report and the department for stepping up throughout the pandemic and showing a successful–what I think, and I think the Auditor General's pointed out too is a successful rollout.

But the Auditor General has said that the government should apply some of the good practices implemented in the vaccine rollout to normal practices of government. Can the department tell us, looking back, what were some of those practices and decisions that made the vaccine rollout such a success story and how some of those practices have been carried over to government's normal practices, and can you tell us a bit about what else you think can be taken from the rollout that has not yet been applied government wide?

Mr. Sinclair: Thanks for that question.

So the–what enabled this to be successful was really what the Auditor General referred to in his opening remarks, was the whole-of-government response to this. It wasn't just the Department of Health that was dealing with COVID. In fact, a decision was made by government that the Department of Health was going to do–look after the health system and the rest of government was going to deal with the COVID response. And we brought together teams that cut across every single department.

People put down their day jobs and, you know, deputies and assistant deputy ministers volunteered their staff to come together on teams. It was multidisciplinary. It brought people from different experiences, different communities, different educational backgrounds, different work backgrounds, to really unpack the problem and find solutions to that. And I think that was what really underpinned the ability for Manitoba to be successful. It wasn't just clinicians, health-care clinicians, that were making these decisions; it was multidisciplinary.

I'll use the example of the RBC–the convention centre vaccines where we had an engineer that was leading that team, standing that up, who looked at vaccination implementation from a manufacturing perspective. Health-care professionals are not going to look at how you do health care from a manufacturing perspective, but the engineer absolutely did. And he recognized essentially what we were doing, the way we started off vaccines, was best practice at the time, clinically, where when you put a syringe in somebody

that contains something, the person that injects it needs to be the person that draws. And there's a reason for that–is you want to make sure you know what's going into that person because you're ultimately accountable for what's being injected.

But within the vaccine clinics, we had two things: we had Moderna and we had Pfizer vax; we didn't have anything else in there. So the risk of somebody getting something that wasn't supposed to go into them was extremely low.

And the only reason we were separating Moderna from Pfizer is because there was some belief that one vaccine would cancel out the other or wouldn't work as well if you didn't have the original one in you.

So the engineer recognized very quickly–says, look, we're actually–we can break this down into a manufacturing process. And we can have pharmacists separate from the nurses and other health-care professionals that are doing the injection that can do the draws, very safely.

You know, you didn't–every nurse before was moving around on their chair. And even the way that we did that, the hockey hub model, as it was referred to, was an engineering design about having somebody roll around on a chair and a cart that would move around, which was all done from an engineering design perspective of how you maximize throughput.

So again, looking at anecdotal sort of evidence around how we brought multidisciplinary background and folks to solve a problem that otherwise would've been solved, without a doubt in my mind, in a very different way, had it been done strictly by health-care professionals.

And all the respect in the world to health-care professionals, both at the time and continuing, there was resistance to change on this front. We've never done it that way; it's not safe to do it that way. And we challenged those health-care professionals to say, why? Like why is it unsafe? Why is it a problem? We need to do better. We can't possibly get the coverage that we need, that Dr. Roussin is challenging us to get to in order to open things up, if we don't look at doing thins differently. So again, multidisciplinary, whole-of-government focus on that was a big part of it.

I've spoken to this before, and MLA Chen has further challenged us on it, quite rightly, but data and evidence was a big part of what we did. Decisions were being made scientifically with the best available data and the best available evidence. Yes, the data changed; yes, the evidence changed; and as a result, decisions changed. And I think people found that frustrating, which was, well, one day you're telling us this, and the next day you're telling us that. Well, yes, because the evidence and the data's evolved and it's changed.

An example of that, we were starting to go down a road of, you know, buying very expensive ventilation because we thought that the disease was airborne. Well, it wasn't, so we had to shift. We're not doing retrofits of mechanical systems in personal-care homes and schools at exorbitant amounts of money, because that's not how the disease is transmitting. But people get frustrated: well, you're changing rules. But again, it was evidence and data driven. So that was another part of it.

And then just the focus of everybody pitching in. You know, I've never seen a government response where everybody was singularly minded on solving a problem. And it showed that when, you know, when we put our mind–when government puts its mind to something and commits the resources, we can do amazing things, and we can accomplish amazing things.

The challenge coming out that? Not a lot of that is sticking. We're going back to the way we used to do business, right? Everybody goes back to their regular work. You know, we still talk whole-of-government at the deputies' table, it's something the clerk talks a lot about. But we all have our obligations and our mandates and our responsibilities and we don't always think, again, about our partner departments in the whole of government.

Not everybody is focused on one thing, which is not a bad thing. It's good that we're focused on other things. But even the use of data and evidence is starting to erode a little bit, not because government and leaders aren't committed, but just–

The Chairperson: Sorry. So I will–I'll just interject here because we are at 4:08 right now.

Is there leave of the committee to extend by perhaps five, 10 minutes just to wrap up the last couple of questions and pass the report–or put the question of the report? *[Agreed]*

Okay, so we will sit to, I said five, 10 minutes, which is a little ambiguous–10 minutes, 4:18? Is that agreed? *[Agreed]*

We will sit 'til 4:18 just to wrap things up. Thank you.

Deputy Minister, carry on.

Mr. Sinclair: I was essentially done, so that was good.

Thank you.

The Chairperson: All right, thank you.

We'll move on to–that was MLA King–we'll move on to MLA Maloway.

MLA Maloway: Well, you know, I think it's great that we're congratulating ourselves for the rollout, because I think it was well done. I thought that holding those 10,000 shots for the seniors was very well done too because I don't think anybody else in Canada recognized that. And I know some seniors that did really think that was good.

But there would be nothing to congratulate us about if it weren't for the federal government having the good sense to basically sign up and buy every vaccine that was potentially going to be available.

And remember, at the time, there was maybe 20 companies that were given unlimited money by United States government to develop these vaccines. And in fact, they appointed a military general–forget his name now–but to be in charge of this. That's how serious they were.

* (16:10)

And all of the companies that were the favourites in the beginning, they were failures. The two that won out were Pfizer and Moderna, who were basically, and still are, developing cancer vaccines. They weren't doing any type of vaccines of this type, but they put this together just overnight. There are going to be movies made about this guy, the BioNTech fellow who got together with Pfizer.

But anyway, they developed this under military supervision in–one plant was in Belgium; another one was in Michigan. And there was a lot of guns there. And they shipped this–as you said, they shipped the vaccine to the convention centres, because it had to be -70° and they couldn't shake it around. At least that's what they said.

So for the people that didn't mind it being shaken around, they developed Moderna. And Moderna was given to my son who was in the military, anybody in the rural areas, military, they were given Moderna, because you didn't have to store it at -70°.

But if it weren't for all these things to happen in the order they did, as quick as they did, we wouldn't have had the rollout, because there wouldn't have been anything to roll out. And we moved science ahead by leaps and bounds in that short, you know, one-year period, getting these–this new vaccine, right? This M–what is it called–mRNA I think it is? And it's a–it's the new standard, just like that.

So a lot of good things happened here. I know we–people tend to be negative and so on, and I do wonder why it is that, you know, the first wave went through Canada and we didn't have anybody sick here in Manitoba. And then the second wave came and we had half the people in Maples dying, in the seniors' home. What was going on then? Were we asleep at the switch?

Well, we had lots of time to prepare. So there's lots of different, like, things that we can learn here for the next go-round. But the reality is that you have to, as you said, you have to think on your feet and next time will be similar but different.

And you can't use–people talked about all the plans we had from 1918. Well, guess what; they wouldn't have been–there were some similarities for sure, but guess–some of the mistakes they made in 1918 they made the same mistakes this time around.

Anyway, I know we have to get this report passed, so.

MLA Devgan: Just really quickly here, and my colleague alluded a little bit to the acquisition of vaccines, and I'm curious to get, through the Chair, your thoughts on the acquisition of vaccines for Manitoba, and I recall there were some issues with NACI somewhere along the line where, I guess eligibility and criteria–there was contradiction, frankly, between NACI and different jurisdictions.

So I'd be curious to hear how–what you think of how that unfolded and if there's a lesson learned there, just in terms of the vaccines specifically.

Mr. Sinclair: So I'll answer a little bit, but also maybe ask you just to clarify a little bit, because we're–staff and I are just conversing and we weren't really sure I'm aware of the disagreement or the separation from NACI.

So Manitoba followed the NACI guys. So NACI is the National Advisory Committee on Immunization, scientific body that comes together to give recommen-

dations on vaccinations. It wasn't just COVID-19; it existed prior to that and continues to exist. Recently just gave recommendations related to RSV vaccine.

So we followed–Manitoba followed NACI guidelines very, very closely. In fact, every morning when we knew a NACI recommendation, we'd all gather together, just like around the, you know, to get the report coming out from NACI. It was quite something to behold. But generally we followed it to the T.

The one thing we did do, there was–and there was flexibility that NACI gave in that to make determinations that might be unique to its population. And Manitoba did take advantage of that in terms of Indigenous populations and lowering the age rate by 10 years for age band that the recommendation came out at.

So generally, we–Manitoba was following that. And I have to confess, I wasn't really following what other provinces were doing. We were pretty busy and engaged in our own jurisdiction and what we needed to do.

The one thing I can comment is, and I do remember frustrations that NACI wasn't moving fast enough in terms of rolling out and producing those age bands. That was heat-of-the-moment frustrations.

I mean, I certainly appreciate, outside of that pressure, the time that they would need to take to make these scientific decisions. This is a scientific body. And I will say, the decisions they were making in that moment are–were way different than the timelines they were taking before and even after to make those decisions.

But certainly, that was the one thing that would stick at me with NACI, is just the time it would take. Where we'd be waiting, like, when's the next age drop going to drop? And I don't know, maybe I'm editorializing too much here, but how–really, how hard is it to knock 10 years off every four or five days?

And those were less clinical decisions. They were more supply decisions, really. Like how much do we have relative to is the outcome going to be any different if you're getting it at 45 or 44? Like it wasn't–you know, the age wasn't that important. It was more about supply.

But nonetheless, that was left to NACI, and we would have liked to have seen those decisions roll out quicker.

But if you wanted to clarify maybe the difference, I can maybe answer your question a little bit more directly.

MLA Devgan: Sure, thank you. I shouldn't have maybe said disagreement, but that is exactly what I was referring to, is the timelines on that.

And I know there was a little bit of perhaps frustration amongst experts and the rollout on that, but your answer was actually clarifying in terms of maybe this being a supply issue.

So thank you for that.

The Chairperson: Okay, hearing no further questions or comments, I will now put the question on the report.

Shall the governor's–audit–sorry.

Auditor General's Report–Manitoba's Rollout of the COVID-19 Vaccines, dated April 2023–pass.

The hour being 4:17, what is the will of the committee?

Some Honourable Members: Rise.

The Chairperson: Committee rise.

COMMITTEE ROSE AT: *4:17 p.m.*

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