Board of Health Meeting # 06-26

Public Health Sudbury & Districts

Thursday, September 17, 2026

1:30 p.m.

Boardroom

1300 Paris Street

Public Health
Santé publique
SUDBURY & DISTRICTS

AGENDA – SIXTH MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, LEVEL 3
THURSDAY, SEPTEMBER 17, 2026 – 1:30 P.M.

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

4. DELEGATION/PRESENTATION

i) Early experiences, lifelong Health: building resilience across the lifespan

- Katerina Debruyn, Health Promoter, Health Promotion and Vaccine Preventable Diseases
- Tania Freimanis, Public Health Nurse, Health Promotion and Vaccine Preventable Diseases

5. CONSENT AGENDA

i) Minutes of Previous Board of Health Meeting

a. Fifth Meeting – June 18, 2026

ii) Business Arising From Minutes

iii) Report of Standing Committees

iv) Report of the Medical Officer of Health / Chief Executive Officer

a. MOH/CEO Report, September 2026

v) Correspondence

a. Provincial Funding for Local Public Health Agencies

- Letter from the Association of Local Public Health Agencies (alPHa) Chair to the Minister of Health dated August 20, 2026

b. Improving Highway Safety in Northern Ontario

- Letter from Thunder Bay District Health Unit Board of Health Chair to the Prime Minister and the Premier of Ontario, dated July 20, 2026

c. Response to the Verdict and Recommendations of the 2021 Blastomycosis Inquest

- Letter and appendix from Public Health Sudbury & Districts Board of Health chair to the Office of the Chief Coroner dated July 15, 2026

d. Global Conflict, Health Equity, and Community Preparedness
- Resolution from Windsor-Essex County Health Unit Board of Health Chair dated May 14, 2026

e. Addressing Household Food Insecurity in Ontario
- Letter from Thunder Bay District Health Unit Board of Health Chair to the Minister of Finance and National Revenue dated June 19, 2026

f. Bill 121 An Act to enact the Save a Life Act (Naloxone Kit Registration and Public Access), 2026
- Letter and motion from Robin Lennox, Member of Provincial Parliament for Hamilton Centre to Public Health Sudbury & District Board of Health members dated July 23, 2026

g. alPHa – 2026 Ontario Municipal Elections Resources
- Email from alPHa dated September 8, 2026

h. Rat Activity in Minnow Lake
- Letter from Dr. Hirji to City of Greater Sudbury City Council dated September 4, 2026

vi) Items of Information

None.

APPROVAL OF CONSENT AGENDA

MOTION:

THAT the Board of Health approve the consent agenda as distributed.

6. NEW BUSINESS

i) Boil Water Advisory After Action Review
- Briefing Note from the Medical Officer of Health and Chief Executive Officer dated September 10, 2026
- After Action Review Report

ii) Board of Health Skills & Competencies Matrix
- Briefing Note from the Medical Officer of Health and Chief Executive Officer dated September 10, 2026
- Public Health Sudbury & Districts Skills and Competencies Matrix

SKILLS & COMPETENCIES MATRIX – BOARD OF HEALTH FOR PUBLIC HEALTH SUDBURY & DISTRICTS

MOTION:

WHEREAS the Capacity Review Committee of 2006 recommended that Ontario move towards Skills-Based Boards of Health;

AND WHEREAS the provincial government has not implemented that recommendation;

AND WHEREAS Skills Matrices are a best practice in other sectors to support the appointment of Skills-Based Boards;

AND WHEREAS the Board of Health directed the Medical Officer of Health & CEO in Motion #39-25 to "recommend a comprehensive skills-matrix to guide municipalities and the Public Appointments Secretariat in future Board of Health appointments";

BE IT RSOLVED THAT the Board of Health approve the Skills and Competencies Matrix;

THAT the Board of Health endorse the Skills and Competencies Matrix to be used to support Board recruitment, training, self-evaluation, and committee assignments;

THAT the Medical Officer of Health and CEO be directed to communicate the Skills and Competencies Matrix to municipalities and to the Ontario Public Appointments Secretariat, encouraging they use it for selection of Board members in upcoming vacancies;

THAT the Medical Officer of Health and CEO be directed to incorporate the Skills and Competencies Matrix into future Board of Health Self-Evaluations surveys;

THAT the Board of Health endorse a committee selection process where the Executive Committee would assess the skills and competencies of Board members, and share their assessment with the Board of Health to guide committee appointments.

iii) Board of Health Manual – 2026 Revisions

- Briefing Note from the Medical Officer of Health and Chief Executive Officer dated September 10, 2026, and appendices

BOARD OF HEALTH MANUAL

MOTION:

THAT the Board of Health approve the Manual as presented on this date;

THAT the Board of Health adopt the amendments to the following bylaws:

- **By-Law 04-88 concerning proceedings of the Board of Health**
- **By-law 01-93 concerning signing authorities and financial matters**

AND THAT the Board of Health adopt new titles ("subject") for each By-Law as outlined in the Briefing Note.

iv) Public Health Sudbury & Districts' 2025 Annual Financial Report

– 2025 Financial Report (English and French)

7. ADDENDUM

ADDENDUM

MOTION:

THAT this Board of Health deals with the items on the Addendum.

8. ANNOUNCEMENTS

i) September 17, 2026, Board of Health meeting survey

ii) Board of Health attendance – October 15 and November 12, 2026, Board meetings

iii) Annual Board of Health self-evaluation survey for 2026

iv) Mandatory annual emergency preparedness training for Board of Health members

v) Recognition of 70 years: Public Health Sudbury & Districts

9. ADJOURNMENT

ADJOURNMENT

MOTION:

THAT we do now adjourn. Time: ____

MINUTES – FIFTH MEETING
BOARD OF HEALTH
PUBLIC HEALTH SUDBURY & DISTRICTS
BOARDROOM, LEVEL 3
THURSDAY, JUNE 18, 2026 – 1:30 P.M.

BOARD MEMBERS PRESENT

Robert Barclay	Amy Mazey	Mark Signoretti
Michel Brabant	Ken Noland	Natalie Tessier
Natalie Labbée	Michel Parent	

BOARD MEMBERS REGRET

Renée Carrier	Angela Recollet
Abdullah Masood	Tom Trainor

STAFF MEMBERS PRESENT

Kathy Dokis	M. Mustafa Hirji	Renée St Onge
Stacey Gilbeau	Stacey Laforest	
Renée Higgins	Rachel Quesnel, Recorder	

M. SIGNORETTI PRESIDING

1. CALL TO ORDER AND TERRITORIAL ACKNOWLEDGMENT

The meeting was called to order at 1:32 p.m.

2. ROLL CALL

3. REVIEW OF AGENDA/DECLARATIONS OF CONFLICTS OF INTEREST

The agenda package was pre-circulated. Consensus was provided to consider the motion under 6.i) *Affirming and Advancing French Language Services at Public Health Sudbury & Districts* immediately following today's delegation.

4. DELEGATION/PRESENTATION

i) More than Words: Bringing French-language Public Health Services to life

- Renée St Onge, Director, Knowledge and Strategic Services

- Natalie Philippe, Public Health Nurse, Health Promotion and Vaccine Preventable Disease

The Board received a presentation on French Language Services at Public Health Sudbury & Districts by R. St Onge and N. Philippe, Co-Chairs of the Public Health Sudbury & Districts Francophone Advisory Committee. They presented an overview to the Board of Health on the importance, implementation, and impact of French Language Services at Public Health Sudbury and Districts. The presentation highlighted the active offer of French Language Services, the agency's legal and governance responsibilities, and the connection between language access, health equity, client understanding, trust, and service quality.

The presentation used two family scenarios to illustrate the importance of providing public health services in French from the first point of contact through to service delivery. The Board heard that French-speaking residents are located across the agency's service area and that just over 21% of residents in Sudbury and districts identify French as their first official language spoken, as compared to 3.4% in Ontario overall.

Reflecting the Board's longstanding support and leadership in advancing French Language Services through its governance and policy direction, French Language Services are supported through bilingual service delivery with particular importance to the active offer in French, translated materials, interpretation services, workforce development, designated bilingual positions, the Francophone Advisory Committee, and community partnerships.

In response to questions, staff noted that interpretation services are relatively new and that utilization data will be tracked as the service is further implemented and promoted for use across over 250 languages. Staff also described participation in a French Language Services community of practice with other health units serving designated Francophone areas. Discussion also addressed client feedback, the importance of community partnerships and opportunities for continued quality improvement related to French Language Services.

The presenters were thanked and the following motion was entertained.

33-26 AFFIRMING AND ADVANCING FRENCH LANGUAGE SERVICES AT PUBLIC HEALTH SUDBURY & DISTRICTS

MOVED BY BRABANT – TESSIER: WHEREAS Public Health Sudbury & Districts serves a region with a significant Francophone population, with approximately 21% of residents identifying French as their first official language spoken;

AND WHEREAS both long-standing Francophone community members and French-speaking newcomers rely on accessible, culturally appropriate public health services to support health, safety, and integration;

AND WHEREAS the Board of Health has established a longstanding policy commitment to providing equitable, accessible, and culturally competent French-language public health services for Francophone populations;

AND WHEREAS Public Health Sudbury & Districts lives this commitment through the active offer of service, bilingual service delivery, translation of public facing materials, staff training, community partnerships, and cross-agency engagement through the Francophone Advisory Committee; these efforts collectively support equitable health outcomes and help mitigate risks related to client safety and service quality and accessibility and;

THEREFORE BE IT RESOLVED THAT the Board of Health for Public Health Sudbury & Districts

- **Affirms its commitment to equitable high-quality, culturally- and linguistically-appropriate French-language public health services for populations across Sudbury and districts in all programs and service delivery points;**
- **Supports the continued advancement of French Language Services, including the active offer of service, workforce capacity development, community partnerships, and integration of Francophone perspectives in program planning and delivery;**
- **Recognizes French Language Services as integral to health equity, accessibility, and the organization's mission to promote and protect the health of all communities served.**

CARRIED

5. CONSENT AGENDA

i) Minutes of Previous Meeting

a. First Meeting – May 21, 2026

ii) Business Arising from Minutes

iii) Report of Standing Committees

a. Board of Health Finance Standing Committee – Unapproved Minutes dated June 10, 2026

iv) Report of the Medical Officer of Health/Chief Executive Officer

a. MOH/CEO Report, June 2026

v) Correspondence

a. Membership, Board of Health for Public Health Sudbury & Districts

– Letter of Resignation by Board of Health member, Ryan Anderson, dated May 27, 2026

b. Healthy Smiles Ontario Fee Schedule and Access to Dental Care for Children and Youth

- Letter from the Board of Health for Algoma Public Health to the Minister of Health, dated May 21, 2026

c. Waterpipe Smoking Restrictions

- Resolution from Windsor-Essex County Health Unit Board of Health dated May 14, 2026

d. Enhancing Municipal Readiness for Ontario's Bring-Your-Own-Beverage (BYOB) Legislation through Public Health Engagement

- Resolution from Windsor-Essex County Health Unit Board of Health dated May 14, 2026

vi) Items of Information

None.

Dr. Hirji and Robert Barclay provided an overview of the 2026 alPHa Annual General Meeting and Conference, including key insights from the presentation, *Projected Patterns of Illness in Ontario*.

34-26 APPROVAL OF CONSENT AGENDA

MOVED BY NOLAND – TESSIER: THAT the Board of Health approve the consent agenda as distributed.

CARRIED

6. NEW BUSINESS

i) French Language Services at Public Health Sudbury & Districts

Motion dealt with following 4.i)

ii) 2025 Audited Financial Statements

- Public Health Sudbury & Districts Audited Financial Statements for 2025
- Questions and Responses at Finance Standing Committee – 2025 Annual Financial Statements

The Board Finance Standing Committee Chair, M. Signoretti shared that the Finance Standing Committee met on June 10, 2026, and reviewed the 2025 draft audited financial statements. KPMG Audit Partners joined the Finance meeting to review the audit processes and present the audit findings report. Based on the auditor's report, the financial statements present fairly, in all material respects, the financial position of Public Health Sudbury & Districts as of December 31, 2025. The auditors did not identify any material misstatements, illegal acts or fraud and no internal control issues. As such, the auditors propose to issue an unqualified report on the financial statements subject to the Board's approval today of the draft statements. The financial statements for 2025 are presented with the Board Finance Standing Committee's recommendation for approval of the 2025 audited financial statements.

Highlights from the Finance Committee discussions were summarized and it was noted that the variances observed on the financial statements are attributable primarily to the investments in technology and capital projects in 2025. The Board Finance Standing Committee had a Q&A summary prepared and included in the agenda package.

Dr. Hirji and the Corporate Services Finance team were thanked for their thorough, accurate, and careful stewardship of the organization's finances that has led to the auditor's making an unqualified assessment around the accuracy of the financial statements.

35-26 ADOPTION OF THE 2025 AUDITED FINANCIAL STATEMENTS

MOVED BY MAZEY – BARCLAY: WHEREAS the Board of Health Finance Standing Committee recommends that the Board of Health for the Sudbury and District Health Unit adopt the 2025 audited financial statements, as reviewed by the Finance Standing Committee at its meeting of June 10, 2026;

THEREFORE BE IT RESOLVED THAT the 2025 audited financial statements be approved as distributed.

CARRIED

7. ADDENDUM

None.

8. IN CAMERA

36-26 IN CAMERA

MOVED BY LABBÉE – BARCLAY: THAT this Board of Health goes in camera to deal with personal matters about an identifiable individual, including…local board employees, and to deal with labour relations…. Time: 2:24 pm

CARRIED

9. RISE AND REPORT

37-26 RISE AND REPORT

MOVED BY BRABANT– LABBÉE: THAT this Board of Health rises and reports. Time: 2:54 p.m.

CARRIED

M. Parent reported that two in-camera matters were discussed to deal with two in-camera matters relating to a personal matter about an identifiable individual, including…local board employees, and labour relations. The following three motions emanated:

38-26 APPROVAL OF BOARD OF HEALTH INCAMERA MEETING NOTES

MOVED BY TESSIER – NOLAND: THAT this Board of Health approve the meeting notes of the May 21, 2026, Board in-camera meeting and that these remain confidential and restricted from public disclosure in accordance with exemptions provided in the Municipal Freedom of Information and Protection of Privacy Act.

CARRIED

39-26 CUPE MEMORANDUM OF SETTLEMENT RATIFICATON

MOVED BY LABEE – BARCLAY: THAT the Board of Health ratify the Memorandum of Settlement between Public Health Sudbury & Districts and the Canadian Union of Public Employees, dated June 10, 2026.

CARRIED

40-26 ELECTRONIC MEDICAL RECORDS (EMR)

MOVED BY BRABANT – PARENT: THAT the Board of Health approve extending the EMR Project timeline and associated resources to April 2027 to enable full onboarding of all remaining programs, as well as adoption and integration into routine practice, supported by a draw from the Working Capital Reserve of $198,769 in 2027;

AND THAT the Board of Health approve an additional draw from the Working Capital Reserve of $91,872 in 2026 to support overtime and additional staffing associated with the EMR Project.

CARRIED

10. ANNOUNCEMENTS

- June 18, 2026, Board of Health meeting evaluation

Board members were invited to complete the evaluation for today's Board meeting.

- Next Board of Health Meeting

The next Bord of Health meeting will be held on Thursday, September 17, 2026, at 1:30 p.m.

11. ADJOURNMENT

41-26 ADJOURNMENT

MOVED BY TESSIER – NOLAND: THAT we do now adjourn. Time: 2:58 p.m.

CARRIED

_____ _____

(Chair) (Secretary)

Medical Officer of Health/Chief Executive Officer Board of Health Report, September 2026

Words for thought

C.D.C. Director Challenges Pennsylvania's Report of Two Measles Deaths

The new director of the Centers for Disease Control and Prevention ordered agency officials to challenge two measles deaths reported by Pennsylvania, shunning the agency's normal procedure of accepting data shared by states and amplifying comments made by her boss, Health Secretary Robert F. Kennedy Jr.

The incident draws the C.D.C. into a highly political disagreement about whether the deaths were a result of measles or merely coincided with the infection, echoing similar disputes over causes of death during the coronavirus pandemic.

It also pits the agency against a state health department, an extraordinary move for the C.D.C. …

"This week's measles outbreaks update will not include the two measles-associated deaths reported by the Pennsylvania Department of Health on Aug. 25," the C.D.C. posted on its website, after Mr. Kennedy, in a social media post, accused the state's Democratic governor of "manipulating" the truth.

One of the two deaths involved a newborn with a ruptured spleen. Details of the second case have not been disclosed, but both people were unvaccinated and both tested positive for the measles virus, according to the Pennsylvania Health Department.

Source: https://www.nytimes.com/2026/08/31/health/measles-deaths-pennsylvania-schwartz-kennedy-shapiro.html?searchResultPosition=1

Date: August 31, 2026

In Public Health, data on diseases—how many, in whom, where—are the foundation of how we approach issues. Unfortunately, that data is now being increasingly politicized in the United States.

Currently the U.S. is facing a significant measles outbreak which started around the same time as the one in Canada last year. The measles outbreak in Canada was stabilized within weeks and then had a long tail of decline to get back to zero infections. The U.S. over a year and a half in, is seeing more rapid increases now, with the federal public health agency communicating skepticism to the vaccine against it.

Misinformation is one of the critical risks identified in the Public Health Sudbury & Districts Risk Management Plan. When formally respected sources of information like the C.D.C. begin to question established science and bedrock data, we can expect misinformation to grow. Worse, as the measles outbreak continues in the U.S. the potential spillover into Canada will put all of our health at risk.

General Report

1. Board of Health

Board of Health annual self-evaluation survey – 2026

As part of the Board of Health's commitment to good governance and continuous quality improvement, in compliance with provincial requirements, and in accordance with Board of Health Manual policy C-I-12 and C-I-14, the Board of Health annual self-evaluation of its governance practices and outcomes is now available.

Board of Health members are asked to complete the *2026 Board of Health Annual Self-Evaluation Survey* in BoardEffect (under the Board of Health workroom – Collaborate – Surveys) **by Friday, October 16, 2025**. Results of the annual Board of Health member self-evaluation of performance evaluation will be presented at the November Board meeting.

Annual mandatory training for Board of Health members

Emergency preparedness

The *Ontario Public Health Standards* require that boards of health effectively prepare for emergencies to ensure 24/7 timely, integrated, safe, and effective response to and recovery from emergencies with public health impacts in accordance with ministry policy and guidelines. Given the municipal election and the potential for changes in Board membership, Public Health Sudbury & Districts is deferring the annual emergency preparedness training for Board of Health members from fall 2026 to early 2027.

2. Meeting with NOSM University Leadership

In follow-up to the Board's recent letter to NOSM University regarding the opportunities in their strategic plan to support the strengthening of public health across Northern Ontario, I joined Board Chair Mark Signoretti on August 10 in meeting with the NOSM University President, Provost, and other senior leaders to discuss more about the opportunity. NOSM University advised that they will invite us to be part of the working group that begins this fall to plan for the strategic plan's proposed new operating model.

3. Advocacy to the Federal Government on Board Priorities

On August 12, I was pleased to meet with **M.P. Viviane Lapointe**. We discussed a range of issues concerning the health of our community, including the substance use crisis, as well as the Board's recent motion Strengthening Critical Infrastructure Resilience in Public Health: Seeking Federal Partnership on Airborne Biological and Cyber Risk (Motion #18-26)**.**

On August 25, the office of Viviane Lapointe was able to arrange a meeting with federal Parliamentary Secretary of Emergency Management and Community Resilience, Anthony Housefather. We discussed the aforementioned motion, as well as the Board's motion on Improved Indoor Air Quality in Public Settings (Motion #17-23). The Parliamentary Secretary graciously offered to highlight these issues when the opportunities arise.

4. Espanola Visit

On August 13, Associate Medical Officer of Health Dr. Emily Groot, Director of Corporate Services Renée Higgins, and I had the pleasure of visiting Espanola to connect with our staff in person there and discuss the current challenges in the community. Dr. Groot and I also had the opportunity to meet with Martin Lees, the new CEO of Espanola Regional Hospital and Health Centre, along with members of their senior leadership team. We had the opportunity to discuss current health care challenges in Espanola, including the substance use crisis, and potential opportunities for collaboration. We are continuing exploration of some potential new collaborations.

5. Financial Report

As of July 31, 2026, cost-shared programs are reporting a deficit of $109,805. The reported deficit is attributable to planned reserve-funded expenditures approved by the Board to support strategic initiatives and investments. Reserve spending of $1,280,643 exceeds the reported deficit, resulting in an adjusted operating surplus of $1,170,838 when these one-time costs are excluded. This indicates that underlying program operations are underspending at this point in the year, primarily driven by significant challenges with recruitment and retention. Financial performance will continue to be monitored closely, with any emerging pressures or opportunities reported to the Board as they arise.

6. Electronic Medical Record (EMR) Onboarding Continues

The onboarding of teams to the EMR system continues. With the support of the additional fund allocated by the Board of Health in June, the work is now progressing on timeline with no issues. Our vaccine preventable disease team began use of the electronic medical record system on September 8, in time for the busy school and fall vaccination seasons to begin.

7. IT Roadmap & AI Strategy

Work continues apace in implementing year one of the three-year IT Roadmap. Significant milestones have now been achieved with transition to a new digital phone system that integrates with our broader information systems, as well as transitioning to an upgraded internal networking and file management system. Significantly, both these changes allow more of our data to be mobilized by linking to other datasets and integrating into our AI tools.

Our AI strategy is continuing with a comprehensive update planned for the October Board meeting. A recent achievement is discussed later in this report, the Online Vaccine Ordering Portal.

8. Indigenous Data Sovereignty Project

The Agency launched its Indigenous Data sovereignty Project over the summer, a collaborative initiative with Indigenous Communities led by an Indigenous vendor, identified through a Request for Proposal earlier this year. Our goal is to identify how to collect, use, store, and share health data on Indigenous peoples in a good way that respects their rights and sovereignty. Currently, there are no guidelines on this for public health practice, or practice in most disciplines. We expect the tools and processes we develop will be useful for local public health agencies across Ontario and beyond.

9. Chapleau Daycare Screening

Public Health Sudbury & Districts expanded dental screening in Chapleau daycares to reach 28 children who are not served through the Community Oral Health Initiative, addressing a gap in preventive oral health care. In collaboration with the Chapleau Daycare Coordinator and Northeastern Public Health, an opportunity was identified to provide screening to children who might otherwise have missed this care. Fluoride varnish, a cost-effective intervention that helps prevent early childhood caries and supports long term oral health, will also be offered to these children in the fall. By reducing barriers to preventive services and responding to an identified community need, the initiative advances health equity. This collaboration also strengthens local partnerships and may support future expansion of oral health programming.

10. Expanded Eligibility for Immunization Services

Public Health Sudbury & Districts recently expanded eligibility for immunization services to improve access for individuals experiencing barriers to vaccination. Services are now available to children and youth aged 2 months to 17 years who do not have a primary care provider, cannot obtain timely immunization services, or face barriers to receiving vaccines from community providers. The change responds to community feedback about access challenges, as well as the realization of additional capacity from achieving operational efficiencies through

recent investments in technology. By making immunization services more accessible, supports equitable access to care, higher vaccination coverage, and stronger protection for individuals and communities against vaccine preventable diseases.

11. Nourishing Students Through Strong Public Health Partnership

The Northern Fruit and Vegetable Program supports healthy eating by increasing acceptance, enjoyment, and consumption of fruit and vegetables. Delivered in partnership with the Ontario Fruit and Vegetable Growers' Association, the Ministry of Health, local school boards, and schools, the program provided approximately 27,300 students with one serving of fruit and one serving of vegetables each week during the 2025-2026 school year. In early 2026, the program expanded to publicly funded secondary schools and youth alternative schools, reaching 107 of 109 eligible schools. It advances strategic priorities by promoting equitable access to healthy food, including in First Nations communities, strengthening cross-sector partnerships, and supporting evidence-informed public health practice. Positive end-of-year feedback from coordinators will inform program enhancements for 2026–2027.

12. Manitoulin Partners for Water Safety

The Manitoulin Partners for Water Safety brings together municipalities, health services, paramedic and police services, provincial partners, and Public Health to help prevent drownings and near-drownings across Manitoulin Island. In May 2026, the Partners launched a coordinated awareness campaign that included media messaging, communications to parents of Rainbow District School Board students, and outreach to municipalities regarding lifejacket and personal flotation device (PFD) use, waterfront signage, and by-laws. This year's theme, *"Be Water Safe! Be Water Smart! Let your lifejacket keep you afloat!"*, promoted safe behaviours on and around the Island's waterways, with Anishinaabemowin translations incorporated into campaign materials. The Partners also continued to advocate for provincial legislation requiring life jacket or PFD use while pleasure boats are underway. This work marked the final year of the Partners' three-year initiative to strengthen water safety education, promote injury prevention, and reduce preventable water-related injuries and deaths. Resources developed through the initiative will remain available to support future water safety promotion efforts.

13. New Online Vaccine Ordering Portal

Public Health Sudbury & Districts is launching a new online vaccine order form for providers ordering publicly funded vaccines. The web-based form will allow providers to submit orders, upload vaccine refrigerator temperature logs, and receive real-time updates on the status of their orders. The form will support routine, school-based, high-risk, and respiratory vaccine orders. Replacing the current email and fax-based process, the new vaccine order form is intended to improve the provider experience and reduce order processing times.

14. 2025 Financial Report

The 2025 Public Health Sudbury & Districts Financial Report is included in the Board of Health package. The report outlines Public Health's various revenue sources and operating expenses. In a challenging fiscal environment, Public Health focused public funds where they could best support community health. This included vaccination, the control of infectious diseases, and engaging with our diverse communities. Additionally, to build sustainability in a sub-inflationary funding environment, the agency made initial investments towards technology-driven efficiencies and a strengthened workforce. Through collaboration and public health action, the agency helped address local priorities, responded to emerging health challenges, and strengthened communities across the service area. This work is highlighted in the 2025 Year-in-Review: Lasting Ripples of Impact. The financial report is also being posted online and shared with the community (NB: the link will only become live following the Board of Health meeting).

Activity Metrics for Public Health

Monthly and annually reported Activity Metrics for Public Health provide an overview of activities and showcase the breadth of the agency's work. The metrics highlight essential and routine efforts of Public Health that positively contribute to community well-being. Public Health's accountability monitoring and annual performance and financial reports provide additional information.

Respectfully submitted,

M. Mustafa Hirji, MD, MPH, FRCPC
Medical Officer of Health and Chief Executive Officer

Public Health Sudbury & Districts

STATEMENT OF REVENUE & EXPENDITURES

For The 7 Periods Ending July 31, 2026

Cost Shared Programs

	Adjusted BOH Approved Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over)/under	Balance Available
Revenue:					
MOH - General Program	18,910,969	11,031,398	11,031,481	(83)	7,879,488
MOH - Unorganized Territory	1,092,500	637,292	637,300	(8)	455,200
Municipal Levies	11,800,921	6,883,871	6,883,656	214	4,917,265
Interest Earned	225,000	131,250	129,581	1,669	95,419
Total Revenues:	$32,029,390	$18,683,811	$18,682,018	$1,793	$13,347,372
Expenditures:					
Corporate Services:					
Corporate Services	5,711,223	3,490,527	4,851,011	(1,360,484)	860,213
Office Admin.	104,350	60,871	23,873	36,998	80,477
Espanola	131,896	79,714	73,499	6,215	58,397
Manitoulin	136,962	82,734	70,493	12,240	66,469
Chapleau	139,335	84,054	74,723	9,331	64,613
Sudbury East	17,880	10,430	12,045	(1,615)	5,835
Intake	385,472	237,213	227,256	9,957	158,216
Facilities Management	792,033	462,019	390,362	71,657	401,671
Electronic Medical Records	149,907	92,250	521,049	(428,799)	(371,142)
Total Corporate Services:	$7,569,059	$4,599,812	$6,244,310	$(1,644,498)	$1,324,748
Health Protection:					
Environmental Health - General	1,341,750	817,928	744,667	73,262	597,083
Enviromental	2,915,324	1,806,358	1,646,347	160,011	1,268,977
Vector Borne Disease (VBD)	43,708	28,338	4,087	24,251	39,622
CID	1,819,049	1,119,124	1,004,399	114,725	814,650
Districts - Clinical	1,000	583	2,413	(1,830)	(1,413)
Risk Reduction	53,756	30,566	11,285	19,281	42,471
Sexual Health	1,700,104	1,039,152	1,037,363	1,790	662,741
SFO- Local Capacity Building: Prevention and Protect	274,327	164,769	144,245	20,524	130,082
Total Health Protection:	$8,149,017	$5,006,819	$4,594,806	$412,013	$3,554,212
Health Promotion and Vaccine Preventable Diseases:					
Health Promotion and VPD- General	2,575,752	1,562,637	1,472,633	90,004	1,103,119
Comprehensive Health Promotion	3,950,589	2,428,071	1,945,944	482,128	2,004,645
Infant Feeding Clinic	645,413	396,110	336,265	59,845	309,148
Oral Health	540,421	330,974	276,911	54,064	263,511
Healthy Smiles Ontario - HSO	620,744	381,058	392,321	(11,263)	228,423
SFO- Tobacco Control Area Network	280,705	162,217	96,533	65,684	184,172
MOH - Harm Reduction Program Enhancement	191,822	117,860	92,319	25,542	99,504
VPD	2,725,683	1,662,416	1,384,280	278,136	1,341,404
MOH - Influenza	0	231	0	231	0
MOH - Meningittis	0	432	(93)	526	94
MOH - HPV	0	917	(417)	1,333	417
MOH - Northern Fruit & Vegetable Program	176,100	122,292	102,675	19,617	73,425
Total Health Promotion:	$11,707,231	$7,165,215	$6,099,370	$1,065,846	$5,607,861
Knowledge and Strategic Services:					
Knowledge and Strategic Services	3,457,368	2,124,587	2,094,977	29,610	1,362,391
Workplace Capacity Development	44,457	5,023	23,771	(18,748)	20,686
Health Equity Office	11,720	6,862	7,481	(619)	4,239
MOH - Special Nursing Initiative	557,232	342,912	331,594	11,318	225,638
Indigenous Public Health	407,705	246,098	210,120	35,978	197,585
MOH Local Model for Indigenous Public Health	125,601	77,293	76,204	1,089	49,397
Total Knowledge and Strategic Services:	$4,604,083	$2,802,774	$2,744,147	$58,627	$1,859,936
Total Expenditures:	$32,029,390	$19,574,621	$19,682,633	$(108,012)	$12,346,758
Net Surplus/(Deficit)	$(0)	$(890,810)	$(1,000,615)	$(109,805)	

Public Health Sudbury & Districts

Cost Shared Programs
STATEMENT OF REVENUE & EXPENDITURES
Summary By Expenditure Category
For The 7 Periods Ending July 31, 2026

	Adjusted BOH Approved Budget	Budget YTD	Current Expenditures YTD	Variance YTD (over) /under	Budget Available
Revenues & Expenditure Recoveries:					
MOH Funding	32,029,390	18,683,811	18,686,682	(2,871)	13,342,708
Other Revenue/Transfers	493,475	287,860	518,643	(230,783)	(25,168)
Total Revenues & Expenditur	32,522,865	18,971,671	19,205,324	(233,653)	13,317,540
Expenditures:					
Salaries	19,814,870	12,168,635	12,684,366	(515,731)	7,130,504
Benefits	7,675,018	4,722,842	4,083,270	639,572	3,591,749
Travel	228,818	126,010	122,353	3,657	106,465
Program Expenses	588,207	345,401	304,078	41,323	284,129
Office Supplies	74,700	42,541	32,368	10,173	42,332
Postage & Courier Services	90,100	52,558	31,567	20,992	58,533
Photocopy Expenses	4,909	2,720	1,476	1,244	3,433
Telephone Expenses	61,530	35,893	47,234	(11,342)	14,296
Building Maintenance	562,416	328,076	292,847	35,229	269,569
Utilities	190,447	111,094	117,222	(6,128)	73,225
Rent	329,521	192,221	184,860	7,361	144,662
Insurance	125,000	122,917	99,901	23,015	25,099
Employee Assistance Program (	50,000	37,500	19,031	18,469	30,969
Memberships	51,900	43,742	40,628	3,113	11,272
Staff Development	158,203	56,714	70,278	(13,564)	87,925
Books & Subscriptions	11,395	7,027	4,952	2,075	6,443
Media & Advertising	55,714	37,925	13,284	24,641	42,431
Professional Fees	697,194	406,696	404,526	2,170	292,667
Translation	75,325	43,106	38,325	4,781	37,000
Furniture & Equipment	16,684	9,996	1,036	8,960	15,648
Information Technology	1,660,914	968,866	1,612,337	(643,471)	48,577
Total Expenditures	32,522,865	19,862,481	20,205,939	(343,458)	12,316,926
Net Surplus (Deficit)	(0)	(890,810)	(1,000,615)	(109,805)	

The reported deficit reflects planned use of reserves for one-time strategic investments approved by the Board. Excluding these items, our core operations are tracking in line with the approved budget.

Total Deficit at July 31, 2026	**(109,805)**
Approved Reserve Spending included Above	1,280,643
Adjusted Cost-Shared Surplus/(Deficit)	**1,170,838**

After accounting for Reseves costs, there is a surplus in the cost shared budget at July 31, 2026 of $1,170,838

Sudbury & District Health Unit o/a Public Health Sudbury & Districts
SUMMARY OF REVENUE & EXPENDITURES
For the Period Ended July 31, 2026

Program	FTE	Annual Budget	Current YTD	Balance Available	% YTD	Program Year End	Expected % YTD
100% Funded Programs							
LHIN - Falls Prevention Project & LHIN Screen	736	100,000	21,755	78,245	21.8%	*Mar 31/2027*	33.3%
Healthy Babies Healthy Children	778	1,760,463	432,597	1,327,866	24.6%	*Mar 31/2027*	33.3%
IPAC Congregate CCM	780	932,250	292,003	640,247	31.3%	*Mar 31/2027*	33.3%
Ontario Senior Dental Care Program	786	1,315,000	529,232	785,768	40.2%	*Dec 31*	58.3%
Anonymous Testing	788	66,893	20,582	46,311	30.8%	*Mar 31/2027*	33.3%
Total		4,326,956	1,296,169	3,030,787			

alPHa
Association of Local PUBLIC HEALTH Agencies

alPHa's members are the public health units in Ontario.

alPHa Sections:

Boards of Health Section

Council of Ontario Medical Officers of Health (COMOH)

Affiliate Organizations:

Association of Ontario Public Health Business Administrators

Association of Public Health Epidemiologists in Ontario

Association of Supervisors of Public Health Inspectors of Ontario

Health Promotion Ontario

Ontario Association of Public Health Dentistry

Ontario Association of Public Health Nursing Leaders

Ontario Dietitians in Public Health

PO Box 73510, RPO Wychwood
Toronto, ON M6C 4A7
E-mail: info@alphaweb.org

Hon. Sylvia Jones
Minister of Health
College Park, 5th Flr,
777 Bay St
Toronto, Ontario M7A 2J3

August 20, 2026

Dear Minister Jones,

Re: Provincial Funding for Local Public Health Agencies

On behalf of the Association of Local Public Health Agencies (alPHa), including its Boards of Health Section, the Council of Ontario Medical Officers of Health Section, and our Affiliate Organizations, I am writing to acknowledge and thank you for announcing an extension of the 1% annual increase in provincial base funding for local public health units for another year.

We appreciate the Province's continued commitment to local public health and the greater certainty this provides as boards of health plan and allocate resources for the coming year.

At the same time, alPHa remains concerned that a 1% annual increase is not sufficient to maintain the current scope of provincially mandated public health programs and services. According to the Bank of Canada, inflation has averaged nearly 3.5 per cent over the past five years, and corresponding annual public health base funding increases have been well under this rate. This has contributed to ongoing pressure on local public health capacity.

Inflationary pressures have a measurable impact on local public health agencies' capacity to deliver the programs and services for which they are legally responsible under Ontario's Health Protection and Promotion Act (HPPA) and the Ontario Public Health Standards. In addition to these, they must absorb substantial costs related to collective bargaining, operating costs, technology upgrades, innovation strategies related to program and service delivery, facilities, and expenditures related to growing and changing populations.

As cost pressures outpace investments year after year, our members are experiencing increasing difficulty in maintaining capacity, service reliability, and readiness. Local public health agencies are committed to prudent financial management, pursuing efficiencies and innovation, sharing approaches, and collaborating with municipal and health-system partners. However, these measures on their own cannot fully address the growing gap between available funding for our mandate and the cost of fulfilling it.

A healthy economy is not possible without healthy people. Public health is a foundational component of Ontario's health-care system and is a critical driver of economic strength. By preventing illness, protecting communities, and promoting long-term health, public health contributes to higher productivity, reduced health-care costs, and economic prosperity. For these reasons, public health needs sufficient, predictable, and sustained funding to ensure its long-term stability.

Public health units will continue to make every effort to deliver essential services and protect the health of their communities with the resources available to them, and alPHa looks forward to continuing its constructive relationship with the Province and to working together to support strong, effective and sustainable public health services across Ontario.

We would be pleased to discuss this with you further, and welcome your staff to contact Loretta Ryan, Chief Executive Officer, alPHa, at loretta@alphaweb.org or 416-595-0006 x 222 to follow up.

Sincerely,

Carmen McGregor
alPHa Chair

Copy: Dr. Kieran Moore, Chief Medical Officer of Health, Ontario
Elizabeth Walker, Executive Lead, Office of Chief Medical Officer of Health

The Association of Local Public Health Agencies (alPHa) is a not-for-profit organization that provides leadership to the boards of health and public health units in Ontario. alPHa advises and lends expertise to members on the governance, administration, and management of health units. The Association also collaborates with governments and other health organizations, advocating for a strong, effective and efficient public health system in the province. Through policy analysis, discussion, collaboration, and advocacy, alPHa's members and staff act to promote public health policies that form a strong foundation for the improvement of health promotion and protection, disease prevention and surveillance services in all of Ontario's communities.

Thunder Bay District
Health Unit

MAIN OFFICE
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Thunder Bay, ON P7B 6E7
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GERALDTON
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Tel: (807) 854-0454
Fax: (807) 854-1871

MANITOUWADGE
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MARATHON
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Marathon High School building,
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Fax: (807) 229-3356

RED ROCK
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Superior Greenstone District School Board Learning Centre
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TERRACE BAY
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19 Hudson Drive, Suite 100
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Fax: (807) 825-7774

TBDHU.COM

July 20, 2026

The Right Honourable Mark Carney, Prime Minister of Canada
80 Wellington Street Ottawa, ON K1A 0A2
Sent via email: PM@pm.gc.ca

The Honourable Doug Ford, Premier of Ontario
Legislative Building Queen's Park
Toronto, ON M7A 1A1
Sent via email: Premier@ontario.ca

Re: Improving Highway Safety in Northern Ontario

Dear Prime Minister Carney and Premier Ford,

On June 17, 2026, at a regular meeting of the Board of Health (the Board) for the Thunder Bay District Health Unit (TBDHU), the Board considered a letter from Northeastern Public Health (NEPH), which calls upon Federal and Provincial governments to improve highway safety in Northern Ontario with investments in infrastructure, considerations for equity, and proactive safety measures. The Board also received an update on Ontario's commitment to improve safety measures along the Highway 11/17 corridor, including increased enforcement, infrastructure improvements, and better support for commercial traffic.

The Trans-Canada Highway is a critical lifeline for residents of Northern Ontario, providing essential access to health care, education, employment, and other vital services. However, communities in the Thunder Bay District face significant threats to safety due to inadequate highway infrastructure and challenging road conditions. These risks are compounded by the region's long distances between communities, severe weather, heavy commercial traffic, and wildlife hazards.

Within the TBDHU region, land transport incidents (LTIs) are a cause of concern as they account for the third highest category (6.9%) of all emergency department visits for unintentional injuries. There are typically 1.5 times more LTIs in the TBDHU region compared to provincial rates.

With respect to provincial highways, Ontario Road Safety Annual Report data from 2015-2022 show that provincial highways consistently produced the largest share of roadway deaths in Thunder Bay District. While municipal roads generated many lower severity collisions, highway crashes were far more likely to result in fatal outcomes. This pattern reflects the unique transportation realities of Northwestern Ontario, where residents depend on long stretches of high-speed highways for work, health care, education, and essential services.

Several municipalities and unorganized areas experienced notable increases in collision activity over the 2015-2022 time period. Areas such as Greenstone and Oliver Paipoonge showed growth in reported collisions, reflecting increasing transportation pressures along major highway corridors.

Given the impact of land transport incidents in our catchment area, the TBDHU Board of Health endorses the letter and recommendations put forward by NEPH, and urges swift action on measures to improve safety along the Highway 11/17 corridor in Northern Ontario, a critical segment of the Trans-Canada Highway.

Sincerely,

James McPherson
Chair, Board of Health
Thunder Bay District Health Unit

cc:

The Honourable Steven MacKinnon, Minister of Transport
The Honourable Prabmeet Sarkaria, Minister of Transportation
Marcus Powlowski, MP – Thunder Bay – Rainy River
Patty Hajdu, MP – Thunder Bay- Superior North
Kevin Holland, MPP – Thunder Bay – Atikokan
Lise Vaugeois, MPP – Thunder Bay – Superior North
Northern Ontario Boards of Health
TBDHU District Municipalities

Northeastern
PUBLIC HEALTH
SANTÉ PUBLIQUE
du Nord-Est

January 14, 2026

The Right Honourable Mark Carney, Prime Minister of Canada
80 Wellington Street Ottawa, ON K1A 0A2
Sent via email: PM@pm.gc.ca

The Honourable Doug Ford, Premier of Ontario
Legislative Building Queen's Park
Toronto, ON M7A 1A1
Sent via email: Premier@ontario.ca

Dear Prime Minister Carney and Premier Ford

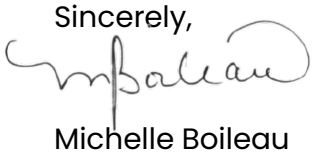
Re: Highway Safety in Northern Ontario

Highway safety in Northern Ontario has been a long-standing concern for Northern communities with tremendous tragic losses of beloved community members, impacts on local economies with frequent inability to access to work, education and necessary social and health care services. In addition, the Board of Health for the Northeastern Health Unit has seen the negative impacts and delays in emergency response systems during public health emergencies across the region. Please find enclosed a resolution along with a Briefing report outlining issues, impacts to public health, evidence and key recommended interventions for the improved development of Northern highways.

The Board of Health respectfully requests careful and urgent consideration of options to address highway safety and accessibility. While ensuring the same standards are available at minimum for residents of Northern Ontario would be preferred with four lane highways that are consistently cleared, FONOM's letter *A Nation-Building Case for a 2+1 Highway for enhanced east-west Canadian trade* issued by the Federation of Northern Ontario Municipalities (FONOM), shared important options for consideration. The Northern population already experiences poorer health outcomes on most indicators compared to the rest of the province, and prioritizing highway safety and accessibility across Northern Ontario is critical to protecting and preserving the health of our communities.

On behalf of the Board of Health, thank you for the attention that you will give to this report.

Sincerely,



Michelle Boileau
Chair, Board of Health
Northeastern Public Health

Copies to:
Right Honourable Mark Carney, Prime Minister of Canada
The Honourable, Steven Mackinnon, Minister of Transportation
Honourable Doug Ford, Premier of Ontario
Honourable Prabmeet Sarkaria, Minister of Transportation
Honourable Jill Dunlop, Minister of Emergency Preparedness and Response
Honourable Sylvia Jones, Minister of Health
Honourable Paul Calandra, Minister of Education
Honourable Michael S. Kerzner, Solicitor General
Honourable George Pirie, Minister Northern Economic Development and Growth, Member of Provincial Parliament – Timmins
Guy Bourgoin, Member of Provincial Parliament – Mushkegowuk – James Bay
John Vanthof, Member of Provincial Parliament – Timiskaming - Cochrane
Bill Rosenberg Member of Provincial Parliament – Algoma – Manitoulin
Dr. Kieran Moore, Chief Medical Officer of Health (CMOH)
NEPH member municipalities
Commissioner Thomas Carrique, Ontario Provincial Police
Ontario Boards of Health
Association of Local Public Health Agencies (alPHa)
Board of Health for the Northeastern Health Unit

Encl: Northeastern Public Health Resolution BOH – 2025-R-51 Improving Highway Safety and Equity in Northern Ontario Early
Northeastern Public Health Briefing Note – Northern Highways
Federation of Northern Ontario Municipalities A Nation Building Case for a 2+ 1 Highway for Enhanced east-west Canadian Trade

October 23, 2025

SUBJECT: Improving Highway Safety and Equity in Northern Ontario

At the October 23rd meeting, the Board of Health for the Northeastern Health Unit, supported this motion to highlight the need to address Northern highway safety.

The following motion was read:
MOVED BY: Andrew Marks
SECONDED BY: Jeff Laferriere

Board of Health Resolution #BOH-2025-R-51

WHEREAS Highway safety is a critical public health issue in Northern Ontario, where long distances between communities, severe weather, heavy commercial transport traffic, and wildlife hazards increase risks for residents, service providers, and emergency responders. Spanning more than 11,000 kilometres, Highways 11, 17, 101, and 144 serve as lifelines, connecting Northeastern communities to the rest of the province (2). These routes are vital links in the Trans-Canada Highway system, providing essential access to health care, education, employment, and basic services (1,2); and,

WHEREAS From 2018 to 2022, emergency department visits for motor vehicle collisions in the Northeastern Public Health (NEPH) region were consistently 1.6 to 2.0 times higher than the Ontario average, highlighting both the region's elevated collision risk and its heavy reliance on these critical corridors (8); and,

WHEREAS The Northern region records the highest rate of large-truck collisions in Ontario - 94% higher than the next highest region and over three times higher than the lowest – as well as the highest fatality rate from motor vehicle collisions, 27.8% above the next highest region and 15.5 times higher than the lowest (7,8).; and, serious and fatal collisions along with prolonged road closures, hinder access to goods and essential services, delay emergency response and jeopardize the well-being and safety of Northern Ontaria

WHEREAS Northern communities, including Indigenous and First Nation communities and Francophone populations (32.8% Francophone, 17.5% Indigenous), face significant barriers to health care that are intensified by highway closures, isolating residents from emergency care and essential services. These inequities are further exacerbated for First Nations and Indigenous peoples, rooted in historical trauma and reflected in ongoing disparities in access to care, essential services, and overall health outcomes (3,4,5). Unsafe and unreliable highways deepen these inequities, threaten community well-being, and widen gaps in overall health and quality of life; and,

WHEREAS Limited access to primary care and medical specialists further compounds the challenge. In 2022–2023, more than 170,000 Northern Health Travel Grants were issued to assist 66,000 residents with travel and accommodation for medical needs, demonstrating the region's dependence on long-distance highway travel for essential health care (6); and,

WHEREAS Each year, Northern Ontario roads experience increasing numbers of drivers and collisions, traveling on highways that are substandard, outdated, and unsafe (1). Every day, more than 8,400 trucks transport over $200 million in goods across these same routes, which have limited passing lanes, inadequate shoulders, and numerous high-collision zones (10). Current highway designs lack sufficient median separation, safe passing lanes, and refuge zones, increasing the risk of head-on collisions and dangerous overtaking, especially under winter conditions; and,

WHEREAS Investing in safer Northern Ontario highways is a matter of health equity(10). Residents of Northern Ontario and First Nation communities deserve the same level of safety, accessibility and opportunity as those in southern regions, and the continued loss of life on unsafe roads is unacceptable (9, 10).

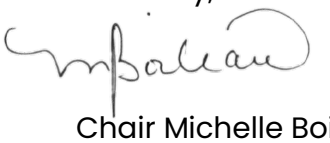
WHEREAS FONOM and Northern municipalities propose the 2+1 upgrade on Highways 11 and 17, including *North Bay to Cochrane* and *Renfrew to Sudbury* in Phase 1, and *Cochrane to Nipigon*, *Thunder Bay to Kenora*, and *Sault Ste. Marie to Sudbury* in Phase 2 recognizing this alternating passing lane design with a crash-rated median barrier is proven, safe and cost-effective fit for Northern Ontario, and reducing fatal crashes by up to 76% (10);

NOW THEREFORE BE IT RESOLVED THAT The Board of Health for the Northeastern Health Unit calls upon the Government of Ontario and Canada to prioritize highway safety and equity across Northern Ontario by:

1. Committing to the full, phased implementation of the 2+1 highway model along Highways 11, 144 and 17 as a priority investment in safety and health equity
2. Collaborating with northern Municipalities, First Nation communities and urban First Nation, inuit and Metis partners to ensure infrastructure planning incorporates health, safety and equity considerations.
3. Designating high-collision and high-risk zones for safety upgrades, with priority for sections that affect emergency response, health-care access, and the delivery of essential goods and services.

CARRIED AS PRESENTED

Sincerely,



Chair Michelle Boileau,
Board of Health for the Northeastern Health Unit

Copies to: Right Honourable Mark Carney, Prime Minister of Canada
The Honourable, Steven Mackinnon, Minister of Transportation
Honourable Doug Ford, Premier of Ontario
Honourable Prabmeet Sarkaria, Minister of Transportation
Honourable Jill Dunlop, Minister of Emergency Preparedness and Response
Honourable Sylvia Jones, Minister of Health
Honourable Paul Calandra, Minister of Education
Honourable Michael S. Kerzner, Solicitor General
Honourable George Pirie, Minister Northern Economic Development and Growth, Member of Provincial Parliament – Timmins
Guy Bourgoin, Member of Provincial Parliament – Mushkegowuk – James Bay
John Vanthof, Member of Provincial Parliament – Timiskaming - Cochrane
Bill Rosenberg Member of Provincial Parliament – Algoma – Manitoulin
Dr. Kieran Moore, Chief Medical Officer of Health (CMOH)
NEPH member municipalities
Commissioner Thomas Carrique, Ontario Provincial Police
Ontario Boards of Health
Association of Local Public Health Agencies (alPHa)
Board of Health for the Northeastern Health Unit

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Briefing Note:
Northern Highways

Issue

Northern Ontario highways pose serious risks. Dangerous single lane designs, narrow winding roads, unpaved shoulders, harsh winters, and limited emergency access (i.e. poor cellular service, intermittent patrols, few exits and rest stops). Northern highways carry heavy-load commercial vehicles and residents who rely on them for specialized and life-saving medical care, amenities, employment and education (1, 2). Alongside serious and fatal collisions, prolonged road closures and delays hinder timely access to goods and essential services, slow emergency response time with concern for timely life saving measures and overall well-being of Northern Ontarians.

Background

Road safety is not just a concern – it is a critical public health issue. Every year, Northern Ontario roads see more drivers, and more collisions (1). Northern Ontario highways span over 11, 000 km, with highways 11, 17, 101 and 144 serving as lifelines connecting Northeast communities to the rest of the province (2). These highways are crucial links in the Trans-Canada highway and essential routes for residents who need access to healthcare, education and basic services.

The Impact on Public Health:

During the COVID-19 pandemic and a blastomycosis outbreak in a remote First Nation community, Northern Ontario's single-road access to remote communities failed. A three-day highway closure delayed critical healthcare and access to supplies. Throughout the pandemic, vaccine shipments were constantly at risk from road conditions, and healthcare workers faced dangerous commutes to reach isolated communities.

- The Northeastern region is shared with 11 First Nations, many without road access (3, 4).
- **Rural and Vulnerable Populations:** Higher rates of residents who identify as Francophone (32.8% vs. 3.3% Ontario), Indigenous (17.8 % vs. 2.9% Ontario) (4). The Northeastern Public Health (NEPH) area has a larger rural population (32.9%) compared to the province (13.3%) (17, 18).
- **Poorer Overall Health:** Elevated rates of chronic disease and preventable deaths (associated factors such as smoking and substance use, increased cost of living, and lack of affordable nutritious foods) (5).

- **Lack of Healthcare Services:** 2.5 million in Ontario do not have a family doctor (16). In 2022-2023, about 170,000 Northern Health Travel Grants were issued for 66,000 residents' travel and accommodation needs (6).
- **Increase Use:** In just one year, the number of licensed drivers increased by 170, 877 individuals with a staggering total of 10, 877, 259 driving on Ontario roads in 2021 (1).

Current Status

The Ministry of Transportation has made some initial investments in Northern Ontario's highways, but it is not enough. These efforts are a start, but fall short to the actions needed:

- Expanding parts of Highways 11/17 and 69 (2).
- Piloting a 2+1 passing lane model on highway 11 (7).
- Improvements to and addition of rest areas (2, 8).
- Enhancements the Cochrane by-pass, 11 to 652 (2).

Winter highway clearing is inadequate. The MTO strives for 90% bare pavement, but in Northern Ontario, this translates to subpar standards that fall short of those in other areas of the province. In Northern Ontario, minor highways (servicing 401-800 vehicles per day) only require the center lanes to be cleared within 24 hours after a storm. For local highways (service an average 400 vehicles per day), the standard permits for snow-packed driving surfaces within 24 hours post-storm.

Minor improvements have been announced, yet none address the need for adequate clearing times to meet bare pavement standards, leaving safety compromised:

- 14 new Road Weather Information System (RWIS) stations for winter crews.
- Enhanced use of anti-icing liquids for highway snow clearing.
- Upgrades to the Ontario 511 app (limited cellular service restricts access to this app) (8).

Key Considerations

Human behaviour inevitably increases the risk of highway injuries and deaths with distracted driving, high speeds, substance impairment, and fatigue as major factors (9). In 2022, the Northern region led in motor vehicle collisions due to each of these causal factors: alcohol/drugs, distraction, seatbelt non-use, speed. The Northern region was higher by 2.5 to 4.6 times compared to other regions (10).

The Evidence

- **Injury Rates:** From 2018 to 2022, Northeastern ED visits due to motor vehicle collisions consistently exceeded the Ontario rate – 1.6 to 2.0 times higher than the Ontario average (2018-2022) (11).
- **Truck Collision:** The Northern region reported the highest rate of large trucks collisions in Ontario - 94% higher than the next highest region and 3.1 times higher than the lowest region (11).

- **Cost of Transport-Related Injuries:** In 2019, transport-related injuries in Ontario cost over $1.3. billion annually, with motor vehicle collisions accounting for the highest cost, even before pedestrian and cycling collisions (12).
- **Fatalities:** Between 2018 and 2022 the Northern region recorded the highest fatalities from motor vehicle collisions - 27.8% above the next highest region and 15.5 times higher than the lowest (10, 11).
- **Impact on Emergency Response:** Poor highway conditions and closures have repeatedly prevented paramedics from reaching their regional bases, jeopardizing emergency response:

"Ensuring our highways are properly maintained, especially in Northern Ontario, is critical for the safety of all road users. Improved highway cleaning and maintenance can significantly reduce the risk of motor vehicle collisions, which have devastating consequences for families and communities. Additionally, highway closures not only cost lives but also hinder our ability to respond to emergencies and assign paramedics where they are needed most. Keeping our highways clear is essential for saving lives and ensuring that emergency services can reach those in need without delay." *Marc Renaud, Chief (A) of Cochrane District Paramedic Service*

- **Essential Services Perspective:** Luc Mignault, a local business owner and tow truck operator, highlighted how lengthy highway closures severely impact safe, timely travel across Northern Ontario. Northern Ontario highways require commercial drivers to navigate unique challenges, including rapidly changing weather and remote, single-lane routes. To address these specific risks, additional training and education for drivers of heavy-load vehicles are essential, equipping them to respond safely to Northern Ontario's demanding conditions.
- Public Concern: A 2021 national survey found that road safety to be a top 5 priority of Canadians, yet fewer than half feel safe on our roads (39% vs 46%) (13).

Options

Vision Zero has cut road mortality by 68% in Sweden from 2000 to 2019 and by 50% in Edmonton between 2015 and 2021. A zero-tolerance approach to road injuries demands a system-wide commitment from policy makers, law enforcement, road users and roadway designers (14).

Key interventions are recommended for the improved development of Northern highways:

1. **Target High-Risk Areas:** Assess collision prone sites in the Northeast, especially where vulnerable road-users are at risk (15).
2. **Overhaul Winter Maintenance Standards:** Prioritize timely, effective winter clearing, especially in rural and remote areas and align Northern Ontario's bare pavement standards with the rest of the province. **Equitable standards across Ontario are essential to ensuring safe, accessible roads for all residents, no matter where they live.**
3. **Expand Emergency and Law Enforcement Presence:** Enhanced presence of emergency respondents and law enforcement, for effective intervention.
4. **Strengthen Road Safety Education:** Implement targeted education for both commercial and residential road-users, addressing specific risks on Northern Highways.
5. **Revise Emergency Response Plans:** Update plans for motor vehicle collisions where closures are expected to exceed 8-12 hours, ensuring readiness for extended incidents.

6. **Expand Cellular Coverage:** Commit to improving cellular infrastructure to ensure travelers can access emergency services and real-time updates.
7. **Implement 2+1 Road Designs:** Expand the piloting of 2+1 highway model with alternating passing lanes on major Northern routes to reduce head-on collisions and allow safer passing in high-traffic areas.
8. **Increase Lighting and Signage:** Install better lighting and clear, reflective signage on high-risk stretches to improve visibility, especially in winter conditions.
9. **Install Safety Measures:** Install safety features (i.e., barriers, rumble strips), to prevent vehicles from veering off-road and to reduce the severity of collisions.
10. **Expand and Enhance Rest Stops and Road Shoulders:** Increase the number of safe and accessible rest stops to reduce driver fatigue and support commercial and long-distance drivers. Improve road shoulders to provide essential space for emergency stops and safer travel. Appropriately maintained rest stops.

Conclusion

The built environment has direct impact on preventable road injuries and deaths. Moving to a Vision Zero framework requires action from policy makers and influencers to enact meaningful change. With increasing numbers of vulnerable road users in the Northeast, urgent improvements in infrastructure, highway maintenance, emergency response, and management of highway closures and delays are essential. **Northern Ontario's road safety crisis demands immediate, decisive action.**

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FONOM

Federation of Northern Ontario Municipalities

July 15, 2025

The Right Honourable Mark Carney Prime Minister of Canada

80 Wellington Street Ottawa, ON K1A 0A2

SENT BY EMAIL: PM@pm.gc.ca

The Honourable Doug Ford Premier of Ontario

Legislative Building, Queen's Park

Toronto, ON M7A 1A1

SENT BY EMAIL: Premier@ontario.ca

Dear Prime Minister Carney and Premier Ford,

Subject: *A Nation-Building Case for a 2+1 Highway for enhanced east-west Canadian trade*

in Alignment with Prime Minister Carney's Five Criteria

Purpose

This briefing presents a compelling case for federal investment in upgrading Northern Ontario's Highway 11 and Highway 17, utilizing **the proven 2+1 highway model.** Supported by evidence in infrastructure policy, safety, economic performance, and national security, the proposal aligns directly with the **five nation-building criteria** set out by Prime Minister Carney under the ***Building Canada Act*.**

We propose a two-phase approach:

- **Phase 1**
  - Construct 2+1 on **Highway 11 segments from North Bay to Cochrane**
  - Construct 2+1 on **Highway 17 from Renfrew to Sudbury**

- **Phase 2**
  - Extend the 2+1 **configuration from Cochrane to Nipigon on Highway 11**
  - Construct the 2+1 **configuration from Thunder Bay to Kenora on Highway 11 and 17**
  - Construct 2+1 on **Highway 17 from Sault Ste. Marie to Sudbury**

This initiative is far more than a regional infrastructure upgrade—it is a nation-building investment. It will strengthen Canada's internal connectivity, improve transportation resilience, and contribute to long-term economic growth, safety, and sovereignty.

Background

With the **Building Canada Act** in place, the Government of Canada is proceeding with consultations with provinces, territories and Indigenous rights-holders to determine the initial list of national interest projects. This proposal presents a project deemed of national interest.

The **Building Canada Act** focuses on creating a unified Canadian economy that promotes enhanced trade between the east and west within Canada. It also focuses on the development of major nation-building projects that will likely involve the transportation of large industrial materials for building. With a vast land area and diverse geography, an efficient transportation network is crucial for connectivity and facilitating the movement of materials.

While air and rail form part of Canada's transportation network, **highways and trucking are the backbone of Canada's transportation system**, connecting major cities, towns and rural communities. Trucking companies and drivers rely on governments to ensure a well- connected transportation network, including highways, major routes, border crossings, and ports, for efficient and safe operations. In turn, knowing the most efficient and safe highways and routes helps truckers save time, fuel, and operational costs.

The Trans-Canada Highway itself—of which Highways 17 and 11 are a vital part—is the **longest continuous national highway in the world**, connecting all ten provinces and three territories. During the Great Depression, the federal government funded the highway's early development as a job-creation initiative and a strategic investment in national cohesion. Over $19 million was allocated to the provinces to construct a continuous road, enabling Canadians to travel across the Dominion without entering the United States. **That same nation-building spirit is now needed once again in Northern Ontario.**

Proposal

Except for Newfoundland, Prince Edward Island, and Ontario, most of the routes used by truckers crossing Canada are four-lane highways. In Ontario, truckers heading east from Manitoba or west from Quebec can choose to cross the province via Highway 17, the Trans-Canada Highway, or Highway 11, and what is now known as the **Northern Trans- Canada Route.** Truckers travelling from Toronto to western Canada can choose to take either 1) Highway 69 to Highway 17, then join the **Northern Route** of Highway 11 via West Nipissing and King's Highway 64, or 2) Highway 11 to North Bay, then the **Northern Route**. Almost all sections of Highways 17 and 11 between the Manitoba border and Renfrew in eastern Ontario are two lanes, except for ongoing highway

twinning projects near Nipigon and west of Thunder Bay, as well as a small, complete section east of Sault Ste. Marie. A small section of twinning has also been completed at Arnprior.

With Ontario being Canada's busiest province for truck traffic, these vital highways, which are linked to much of the country's economic activity, need to be considered for continued expansion beyond their existing two-lane profile. From their early days, they have formed part of Canada's **critical national corridor,** from playing a foundational role in connecting Canada's frontier communities to enable economic development and assert national sovereignty across the North. Unfortunately, road safety and infrastructure conditions in northern Ontario are deteriorating, according to the Ontario Trucking Association. Their primary concern is the danger of passing other vehicles. In turn, the Truckers for Safer Highways association recently stated: "People and truckers are dying on these highways!" That is why the Federation of Northern Municipalities, an organization representing 110 cities, towns and municipalities, has been a consistent and vocal advocate for the adoption of the 2+1 highway model in Northern Ontario. This cost-effective, safety-enhancing design has proven successful in many countries, including Sweden, Finland, and Australia. A 2+1 highway expands on a 2-lane road by implementing continuously alternating passing lanes and separates opposing directions of traffic with a crash-rated median barrier, resulting in safety outcomes that are equal to fully twinned highways.

The Government of Ontario is responding and has announced two pivotal initiatives that mark a turning point for Highway 11, offering a clear opportunity for federal collaboration. First, a **pilot project** is scheduled to commence in 2026 on a 2+1 highway segment between **North Bay and Temagami**. Second, the province committed to extending the 2+1 configuration further north, from **Temiskaming Shores to Cochrane**. These two segments lay the groundwork for a scalable, long-term corridor strategy—a shared infrastructure vision well-suited to a federal-provincial nation-building partnership that would see a phased approach to northern Ontario's highway development.

Data from Statistics Canada (see Appendix A) highlights that a five-year average from 2013 to 2017, over 925,000 truck shipments were made between Western Canada and the Toronto/Montreal region via two-lane highways in Northern Ontario. By comparison, 960,005 between Toronto and Montréal, 206,574 between Toronto and Hamilton and 96,607 between Toronto and Windsor — routes served by four-lane highways. Put simply, there is as much transport traffic on Highway 17 and 11 as on the Highway 401 corridor—but it is forced to spread over narrower, less safe roads.

Priority should be given to Highway 11, as it offers a **preferred westward route** for commercial carriers. Compared to Highway 17, it is less hilly reducing fuel consumption and is not subject to frequent closures caused by Lake Superior's weather systems. In short, Highway 11 is more reliable and increasingly indispensable to national logistics and supply chains. Highway 11 will also be critical to the rapidly expanding mining and agriculture sectors in the north that depend on a safe and efficient transportation corridor.

Ministry of Transportation **Annual Average Daily Traffic (AADT)** volumes from 2021 confirm this importance:

- **Near Temiskaming Shores**: 7,800
- **Near Englehart**: 6,100
- **Between Kirkland Lake and Cochrane**: 3,200 to 5,500

These figures **meet or exceed international thresholds** for 2+1 highway justification. In fact, Ontario's Ministry of Transportation and Swedish transport authorities both find 2+1 highways are effective and safe at volumes of up to **18,000–20,000 AADT**, which is well above the current corridor levels of 3,200–7,800. This places Highway 11 within the model's ideal "sweet spot"—not only today, but for decades to come.

Moreover, these traffic counts were gathered during the COVID-19 pandemic, when private vehicle use was depressed. Actual normalized volumes are likely even higher.

Despite this high usage and strategic importance, Highway 11 faces challenges stemming from decades of underinvestment. These include:

- **Substandard Road Geometry**
- **Insufficient passing opportunities**
- **Above-average collision and fatality rates**
- **Regular closures due to weather and accidents**

These weaknesses not only endanger lives but also **disrupt freight movement**, **delay goods**, and **increase costs** for industries that depend on timely delivery. The **2+1 model, featuring a crash-rated median barrier and alternating passing lanes every few kilometres, significantly improves safety and traffic flow at a substantially reduced cost compared to** traditional four-lane twinning. This makes it the ideal design for long rural corridors with steady but moderate traffic, such as Highway 11.

Alignment with Prime Minister Carney's Five Nation-Building Criteria

1. **Strengthen Canada's Autonomy, Resilience, and Security**

- **Strategic Defence Logistics**: Highways 17 and 11 support access to key military and NORAD infrastructure, including CFB North Bay. It also offers critical redundancy should either highway become compromised.
- **Nuclear Waste Transport**: The Nuclear Waste Management Organization has identified these highways for the secure transport of used nuclear reactor rods to a planned long-term storage site in Northwestern Ontario. Enhanced road safety is essential.
- **Emergency and Climate Resilience**: These roads play a vital role in wildfire evacuations and emergency response functions that will only grow more urgent with climate change.
- **Critical Minerals Access**: As Canada builds out its critical minerals sector, Highways 17 and 11 are essential for transporting the tools, supplies, and workforce needed to unlock Northern resource potential.

2. **Deliver Economic Benefits and Support Growth**

- **Economic Resilience and Supply Chain Reliability**: Highways 17 and 11 are a lifeline for national industries such as mining, forestry, agriculture, and manufacturing. Collisions and closures in this corridor disrupt supply chains, delay shipments, and raise costs—undermining productivity and competitiveness. A safer, more reliable route will protect against these losses and help sustain Canada's industrial and export performance, particularly as interprovincial trade barriers ease and east-west commercial traffic increases.
- **Workforce Access and Regional Efficiency:** Improved traffic flow enhances access for workers, goods, and services, strengthening regional economies and making it easier for businesses to attract and retain talent.
- **Job Creation and Indigenous Participation:** Construction and long-term maintenance will create employment opportunities, with strong potential for Indigenous training, contracting, and equity partnerships.
- **Tourism and Local Business Vitality:** As the primary transportation artery for dozens of rural communities, Highways 17 and 11 support tourism, retail, and service sectors. Safer, faster routes help keep these towns economically viable and socially connected.
- **High Return on Investment:** According to the Northern Policy Institute, the proposed 2+1 pilot for Highway 11 delivers a benefit-cost ratio of **1.0 at 20 years**, rising to **3.6 at 60 years**—clear evidence of enduring value.

3. **High Likelihood of Successful Execution**

- **Shovel-Ready Projects**: Ontario's North Bay–Temagami pilot is fully designed and poised to go to tender
- **Provincial Commitment Already Secured**: The province has also announced plans to extend the 2+1 model northward between Temiskaming Shores and Cochrane.
- **Proven Design Model**: The 2+1 design has achieved fatality reductions of up to 76% in countries like Sweden, Finland, and Australia. It offers a practical model for safe, efficient travel across long rural corridors. Ontario's projects benefit from this international evidence.
- **Faster Cheaper Delivery**: By leveraging existing roadbeds, 2+1 roads require less land acquisition and construction time, avoid delays from environmental permitting, and can be implemented in phases. Ontario's own pilot designs incorporate global best practices from around the world.
- **Expandable by Design**: 2+1 highways can be converted to 2+2 highways in the future when traffic volumes warrant it, making 2+1 roads a flexible and cost- efficient steppingstone, ideal for future-proofing national transportation infrastructure.

4. **Advance the Interests of Indigenous Peoples**

- **Early and Ongoing Engagement:** Highways 17 and 11 intersect the traditional territories of several Indigenous Nations. Their early and ongoing involvement ensures meaningful participation and long-term benefits.
- **Pathways to Economic Reconciliation**: Indigenous-led training, employment, and equity stakes can be prioritized into project delivery, creating generational value. With designs that are modular, the Proposal also supports phased contracting models.
- **Improved Safety for Remote Access**: Both Highways are a lifeline for many Indigenous communities, enabling access to healthcare, food, education, and evacuation routes. Safer highways are a matter of equity.

5. **Contribute to Clean Growth and Climate Objectives**

- **Lower Emissions from Freight**: Improved traffic flow reduces idling, braking, and congestion, directly cutting greenhouse gas emissions. Infrastructure for electric vehicle (EV) charging can be integrated into the design.
- **Sustainable Construction Practices**: Ontario's design process is already integrating lower-emission materials and recycled aggregates to help Canada reach its climate goals.
- **Reduced Environmental Footprint**: Compared to full twinning, 2+1 highways use less land, preserve wildlife corridors, and prevent overbuilding—balancing transportation needs with environmental stewardship.

Conclusion

Transforming the Trans-Canada's Highway 17 and its Highway 11 Northern Route into 2+1 corridors is not simply a matter of regional equity—it is a strategic investment in Canada's future. It safeguards our autonomy, strengthens our supply chains, advances reconciliation, and supports economic growth—while reinforcing the vital national bond between northern and southern Canada. FONOM believes this project reflects the values and vision of a confident, resilient country—one that invites its northern regions to be equal partners in prosperity. **We now call on the provincial and federal government to build a Trans-Canada Highway worthy of our national ambitions—modern, safe, autonomous, and truly coast-to-coast.**

Sincerely,

Danny Whalen President Federation of Northern Ontario Municipalities

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Appendix A

Number of Truck Shipments by Routes Note 1						**# of lanes in Ontario**
	2013	**2014**	**2015**	**2016**	**2017**	
Truck shipments to and from major destinations in western Canada to Toronto and Montreal	1,019,899	927,405	986,136	924,682	767,998 **NOTE: 5 year average 2013 to 2017= 925,224**	2 lanes northern Ontario / 4 lanes southern and eastern segments
Truck shipments to and from Toronto and Montreal	867,321	894,068	1,237,732	916,433	884,474 **Note: 5 year average = 960,005**	4+ lanes
Truck shipments to and from Toronto and Windsor	67,119	100,507	97,640	80,267	142,502 **Note: 5 year average= 97,607**	4+ lanes
Truck shipments to and from Toronto and Hamilton	181,567	191,839	186,954	332,986	139,044 **Note: 5 year average= 206,514**	4+ lanes

Note 1: Statistics Canada. Table 23-10-0142-01 Origin and destination of transported commodities, Canadian Freight Analysis Framework (see Appendix A). Shipments represent the aggregate number of shipments transported.

Public Health
Santé publique
SUDBURY & DISTRICTS

July 15, 2026

Via Electronic Mail

The Office of the Chief Coroner
Inquest Unit

To Whom it May Concern:

Re: Response to the Verdict and Recommendations of the 2021 Blastomycosis Inquest

Public Health Sudbury & Districts acknowledges, with deep sorrow and respect, the lives lost during the 2021 blastomycosis outbreak in Constance Lake First Nation. We extend our heartfelt condolences to the families of Luke Moore, Lorraine Shaganash, Lizzie Sutherland, Mark Ferris, and Douglas Taylor, their fellow community members, and all those impacted. We recognize the profound and lasting impact of this loss and honour their lives by committing ourselves to reflection, accountability, and sustained action.

We are grateful to the families, community members, and the Jury whose voices and advocacy brought forward the findings and recommendations of this inquest. Their leadership has underscored the need for stronger, coordinated, and culturally respectful public health systems.

Public Health Sudbury & Districts acknowledges that we have a responsibility to contribute to this change. We recognize that public health systems, including our organization, must do better to ensure responses are timely, equitable, and culturally safe. This requires learning from this tragedy, acknowledging where systems did not work as they should have, and taking meaningful action moving forward.

On January 15, 2026, our Board met and discussed the findings of the inquest, and we reviewed the recommendations that we have a role in implementing: recommendations 1, 4, 24, 27, 28, 31, 33, 34, and 35. Staff presented on actions and plans to move those recommendations forward. As a Board, we endorsed the directions our staff outlined. The discussions from that meeting form the basis of our attached response to your request of January 23, 2026. To supplement our earlier discussion, we have added commentary on recommendations 48 and 52, pursuant to your specific request.

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As you will see from our response, Public Health Sudbury & Districts has begun taking concrete actions. This includes affirming Joyce's Principle, advancing culturally safe and anti-racist public health practice, implementing actions aligned with the Truth and Reconciliation Commission Calls to Action, strengthening relationships and coordination with First Nation communities and partners, and advancing Indigenous data sovereignty through community-informed approaches guided by OCAP® principles.

At the same time, we acknowledge that more is required. The actions we have already taken are important, but they do not lessen our responsibility to continue this work with urgency and transparency. Rebuilding trust requires sustained effort and close collaboration with First Nation communities whose voices, priorities, and leadership are essential.

Public Health Sudbury & Districts will continue learning, reflecting, reporting on progress, and working with First Nation communities to ensure public health approaches are responsive, respectful, and grounded in Indigenous voices and priorities.

Above all, we honour those who lost their lives by committing to do better, together.

Sincerely,

Original signed by

Mark Signoretti
Chair Board of Health
Public Health Sudbury & Districts

cc: Dr. Kieran Moore, Chief Medical Officer of Health, Ministry of Health
Dr. Kate Bingham, Associate Chief Medical Officer of Health, Ministry of Health
Dr. Fiona Kouyoumdjian, Associate Chief Medical Officer of Health, Ministry of Health
Leonor Tavares, Manager, Indigenous and Intergovernmental Unit, Office of the Chief Medical Officer of Health, Ministry of Health
Dr. M.M. Hirji, Medical Officer of Health and CEO, Public Health Sudbury & Districts
Dr. Emily Groot, Associate Medical Officer of Health, Public Health Sudbury & Districts
Kathy Dokis, Director of Indigenous Public Health, Public Health Sudbury & Districts

Public Health
Santé publique
SUDBURY & DISTRICTS

Responses to Jury Recommendations

BLASTOMYCOSIS Inquest Q2025-31

BOARD OF HEALTH:
Public Health Sudbury & Districts

RECOMMENDATION #: 27 – 28, 33, 48, 52

Rec. #	Organization's Response
1	Public Health Sudbury & Districts affirms Joyce's Principle as foundational to our organizational values and Public Health Sudbury & Districts practice. Joyce's Principle recognizes the right of Indigenous peoples to equitable access to health and social services, free from racism and discrimination, and to receive those services without delay or denial due to jurisdictional disputes, while upholding the right to self-determination. Through our Indigenous Engagement Strategy, Public Health Sudbury & Districts is actively working to create culturally safe, inclusive, and equitable systems by • Advancing our Positive Space Initiative to foster inclusive and respectful environments for people of all backgrounds, including Indigenous peoples. • Committing to applying the lessons learned from our Unlearning & Undoing White Supremacy and Racism project across policies, practices, and workplace culture with the goal of reorienting our organization. • Implementing ongoing mandatory cultural safety and anti-racism training for staff. • Supporting Indigenous representation at all levels of the organization; we have instituted Indigenous representation among staff positions, management, senior leadership, and governance (Board of Health). • Respecting and integrating Indigenous ways of knowing and engaging Elders, Knowledge Holders, and community voices in program design and decision-making.

	This work is ongoing and relational, recognizing that reconciliation requires sustained action and accountability.
4	Public Health Sudbury & Districts is actively advancing TRC Calls to Action 22 and 23 through its Indigenous Engagement Strategy and workforce practices: Call to Action 22 – Indigenous Healing Practices • Public Health Sudbury & Districts recognizes the value of Indigenous healing practices and works in partnership with Indigenous communities to support culturally grounded approaches to health and wellness. The Indigenous Public Health team is collaborating with our client-facing programs to incorporate culturally safe and grounded practices into the delivery of clinical services by end of 2027. Call to Action 23 – Indigenous Health Workforce & Cultural Safety • Increasing Indigenous representation: Public Health Sudbury & Districts supports Indigenous recruitment by promoting employment opportunities through Indigenous job boards and networks. The organization also recognizes the contributions of Indigenous staff and governance, including the Indigenous Public Health team and dedicated Indigenous representation on the Board of Health. • Public Health Sudbury & Districts requires ongoing, mandatory learning for staff, facilitates voluntary initiatives for additional learning and skill-building around decolonization such as the Unlearning Club, and regularly offers anti-racism education and Indigenous-led training opportunities.

24	Public Health Sudbury & Districts works with First Nation communities to support a range of public health programs aligned with the Ontario Public Health Standards. Services are provided upon request and through partnership with individual First Nation communities. The specific services offered are determined by each community based on their priorities and needs. This list is not exhaustive of all services that may be available or provided.
	
	• Chronic Disease Prevention and Well-Being Program Standard
	  ◦ Oral Health Programs
	  ◦ Healthy Eating
	  ◦ Mental Health Promotion
	  ◦ Healthy Sexuality

	• Healthy Growth and Development Program Standard
	  ◦ Healthy Growth and Development
	  ◦ Parenting
	  ◦ Infant feeding
	  ◦ Healthy Pregnancies
	• Immunization Program Standard
	  ◦ Community Based Immunization Outreach
	  ◦ COVID-19 Vaccine Program
	• Safe Water Campaigns
	• School Health Program Standard
	  ◦ Healthy Smiles Ontario Program
	  ◦ Oral Health Assessment and Surveillance of grade school children
	• Substance Use and Injury Prevention Program Standard
	  ◦ Harm Reduction
	  ◦ Needle Syringe Program
	• Foundational Standards
	  ◦ Epidemiology and surveillance
	  ◦ Community and partner engagement
	  ◦ Program evaluation and knowledge exchange
	Public Health Sudbury & Districts would support Ontario Ministry of Health efforts to formally inventory and share this information with Indigenous partners and government agencies to improve transparency, coordination, and equitable access.

27	Public Health Sudbury & Districts is actively seeking collaboration with ISC to strengthen relationships and coordinated responses, including • Joint work on Diseases of Public Health Significance • Collaboration in responding to the opioid and substance-related harms, including harm reduction supports in First Nations • Ongoing engagement to improve readiness for public health emergencies in First Nation communities, with an active commitment to offering meaningful collaboration informed by lessons learned through our shared work during the Covid-19 pandemic.

	This relationship-based approach aligns with Public Health Sudbury & Districts' Indigenous Engagement Strategy and emphasizes trust, communication, and shared responsibility. This approach also aligns with our provincially defined mandate for "multi-sectoral collaboration" to reduce health inequities and improve health outcomes, as outlined in the Ontario Public Health Standards (OPHS). Public Health Sudbury & Districts is also committed to being an active and mindful participant in any broader public health sector coordination in Ontario.
28	Public Health Sudbury & Districts is actively engaged in discussions with Indigenous Services Canada, and First Nation partners to clarify and formalize roles and responsibilities for case and contact management for diseases of public health significance. This work is ongoing and is being approached collaboratively to ensure clarity and respect for jurisdiction but also not allowing rigid jurisdictional fidelity to limit our support for effective response. Public Health Sudbury & Districts would also be pleased to support and participate in any broader Ontario public health sector coordination to align efforts as discussions on those evolve. We are pleased to have volunteered to participate in provincial working groups to help develop such coordination.
31	Public Health Sudbury & Districts currently has an Indigenous member on its Board of Health and continues to prioritize Indigenous voices in governance. The organization has • Communicated with First Nation and urban Indigenous partners regarding opportunities for board representation; • Invited communities to nominate or recommend off-reserve band members; • Worked to identify and reduce barriers to participation, consistent with principles of equity and inclusion, and, • Advocated to the Ontario government and through the provincial association of local public health agencies for Indigenous representation across all boards of health in the province.

33	Public Health Sudbury & Districts is advancing secure and respectful data sharing through • Existing Band Council Resolution (BCR) with a First Nation for case and contact management; • Memoranda of Understanding for harm reduction signed with twenty-three First Nations and organizations. We are now engaged with 13 First Nations communities as well as urban Indigenous partners, and an Indigenous consulting organization to develop an Indigenous Data Sovereignty Strategy in 2026/2027 that will inform respectful and community driven data practices for Public Health Sudbury & Districts and the Indigenous communities and people we serve. This strategy will support the routine collection of Indigenous identity data health-related data from Indigenous community members in ways that respects Indigenous sovereignty and governance and are considered safe for Indigenous populations. We intend for this Indigenous Data Sovereignty strategy to be generalizable to use by our peers, so that it can be a resource for the entire province, and perhaps the country, on Indigenous data sovereignty. In addition to collection of Indigenous identity data, Public Health Sudbury & Districts is finishing a sociodemographic data collection project to integrate the routine collection of race, ethnicity, and other demographic data into all of our client interactions. Collection of this data will be the standard for our agency moving forward. We acknowledge that Ontario Regulation 559 sets out the requirements for data collection for infectious diseases under the Health Protection and Promotion Act. Our agency is committed to working with the province on any amendment of this regulation to incorporate a requirement to collect Indigenous identity and broader sociodemographic data such as race and ethnicity.
34	Public Health Sudbury & Districts is committed to Indigenous data sovereignty and is currently • Developing an Indigenous Data Sovereignty Strategy, including engaging Indigenous communities to guide how identity data is collected, used, stored, and shared by ensuring this work is done in a good way; • Including Indigenous identity collection, alongside other sociodemographic data collection, into the new electronic medical records (EMR) and surveillance data systems as per the Indigenous Data Sovereignty Strategy, ensuring key staff have completed OCAP® training, with plans to expand

	training for staff involved in, research, health promotion, data collection and use.
35	Public Health Sudbury & Districts supports Indigenous-led data governance and recognizes that First Nations must lead the development of information-sharing frameworks that affect their communities. While broader legislative and trilateral processes fall outside Public Health Sudbury & Districts' direct authority, the organization is: • Working collaboratively with First Nations communities and ISC; • Advancing its Indigenous Data Sovereignty Strategy in alignment with OCAP® principles, CARE principles and community collaboration; and, • Supporting consistent, informed, and respectful approaches to Indigenous health data governance.
48	Public Health Sudbury & Districts sends advisory alerts to the health care community in our service area on the diagnosis and treatment of diseases of concern, particularly infectious disease during period of higher incidence, or when they become seasonally more common. We also organize continuing medical education events for diseases of particular importance or risk to our community. A continuing medical education event on blastomycosis is in planning for spring 2027. Consideration will also be given to developing advisory alerts on blastomycosis. Public Health Sudbury & Districts will also leverage any provincial public health sector coordinated processes and knowledge products that are developed to disseminate information on blastomycosis to local health care providers.
52	Implementation of this recommendation falls to the provincial government. Public Health Sudbury & Districts would be pleased to receive any data and analysis from the provincial government around blastomycosis risk and incorporate those analysis into our local prevention planning.

Contact Information and Recommendation Referrals

Responses to Jury Recommendations

BLASTOMYCOSIS Inquest Q2025-31

BOARDS OF HEALTH

Public Health Sudbury & Districts

Part I: Contact Information

Email address	**Telephone number**
groote@phsd.ca	705.522.9200, ex. 417 l Fax 705.677.9606 Toll-free / sans frais 1.866.522.9200
Name	**Position Title**
Emily Groot, MD, MPH, FRCPC	Associate Medical Officer of Health

Part II: Referral

We believe the following recommendations may be best addressed by these organizations:

Recommendation Number	**Organization Name & Address**	**Contact Name & Title**
52	Ministry of Health, Office of the Chief Medical Officer of Health kieran.moore1@ontario.ca	Kieran Moore Chief Medical Officer of Health for Ontario

Forward to occ.inquests.registraroffice@ontario.ca

Windsor-Essex County Health Unit Board of Health

RECOMMENDATION/RESOLUTION REPORT – Global Conflict, Health Equity, and Community Preparedness

2026-05-14

ISSUE

Global armed conflict can affect population health, health equity, and health systems in Canada and Windsor-Essex. Recent military conflict in the Middle East has resulted in civilian harm, disrupted global energy markets and environmental damage. These impacts can be felt locally through higher living costs, food insecurity, increased stress, and added pressure on health and social services.

BACKGROUND

Global conflicts increasingly cause health impacts that extend far beyond national borders. The current conflict in the Middle East has disrupted global energy supplies, leading to higher fuel prices and unstable supply chains. In Canada, rising fuel costs disproportionately affect low-income households, single parents, rural and remote communities, and people living with chronic illnesses who rely on transportation to access care. Increased fuel and fertilizer costs are also drivers of higher food prices, exacerbating food insecurity at a time when approximately one quarter of people in Windsor-Essex and nationally already live in food-insecure households (including 2.5 million children in Canada), and food banks are operating beyond capacity. Food insecurity is a well-established determinant of poor physical and mental health. Rising costs of living deepen poverty-related stress, worsen chronic disease outcomes, and increase demand for health and social services.

The mental health impacts of armed conflict are profound and well-documented. Children directly exposed to violence experience high rates of post-traumatic stress disorder, depression, and long-term developmental impacts. Adults experience chronic anxiety, depression, and increased substance use. Importantly, these effects are not limited to those living in conflict zones. Diaspora communities in Canada are experiencing complex and prolonged grief, fear, and uncertainty as they monitor events impacting loved ones abroad. Similar patterns were observed following the war in Ukraine, resulting in increased demand for trauma-informed mental health services within Canadian health systems.

Armed conflict also undermines global public health security. Damage to health infrastructure, disruption of disease surveillance, and constrained access to medicines increase the risk of infectious disease outbreaks, including disruptions to tuberculosis and HIV care documented in prior conflicts. Iran’s role as a host country to millions of refugees, coupled with regional instability, raises the likelihood of further displacement and humanitarian need.

Environmental health risks are also escalating. Bombardment of oil refineries and industrial sites releases toxic pollutants that increase long-term risks of cancer and respiratory disease and contribute to global

environmental degradation and climate change. Conflict near sensitive nuclear facilities can create a low-probability but high-impact risk of radiological contamination.

Taken together, these developments underscore that Canada's health is inseparable from global stability. Preparedness for the health consequences of global conflict is a matter of local health protection, health promotion, and health equity.

PROPOSED MOTION

WHEREAS armed conflict and global instability are recognized drivers of adverse population health outcomes, including food insecurity, mental illness, infectious disease risk, and environmental harm; and

WHEREAS rising fuel and food costs disproportionately harm low-income households, children, older adults, people with chronic illness, and rural and remote communities, deepening existing health inequities; and

WHEREAS war-related trauma affects people both in conflict zones and in diaspora communities in Canada, increasing the need for trauma-informed mental health and community-based supports; and

WHEREAS disruptions to global health infrastructure and surveillance during conflict increase the risk of infectious disease outbreaks with downstream impacts on Canadian health systems; and

WHEREAS resilient food systems, social protections, and accessible health care are essential components of public health preparedness and community resilience;

NOW THEREFORE BE IT RESOLVED THAT the Windsor-Essex County Board of Health:

1. Affirm by passing this resolution that global conflict and global inequity are critical public health issues with direct implications for the health and well-being of Windsor-Essex residents;
2. Calls on all levels of government to strengthen policies and investments that protect population health in the face of global instability, including:
    - Investments in food security and income supports
    - Measures to mitigate the health impacts of rising fuel and transportation costs, including advocating for more active transportation
    - Expansion of trauma-informed mental health services, with particular attention to children, youth, and diaspora communities
    - School-based mental health and well-being support programs
    - Health care access models proven effective in humanitarian and refugee-receiving contexts
3. Urge the Government of Canada to ensure preparedness for increased humanitarian migration by supporting continuity of care, culturally and linguistically appropriate mental health services, and rapid access to primary and preventive care; and
4. Encourage federal leadership in advancing peace, global equity, and protection of civilian populations as essential strategies for safeguarding health at home

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TBDHU.COM

June 19, 2026

The Honourable Francois-Philippe Champagne, Minister of Finance and National Revenue
Delivered via email: francois-philippe.champagne@parl.gc.ca

National Finance Committee
Delivered via email: nffn@sen.parl.gc.ca

Dear Minister of Finance and National Finance Committee,

Re: Addressing Household Food Insecurity in Ontario

On January 21, 2026, at a regular meeting of the Board of Health for the Thunder Bay District Health Unit, the Board recognized Household Food Insecurity as an income-driven problem that requires income-based solutions.

This letter is to urge your support of Bill S-206, an Act to develop a national framework for a guaranteed livable basic income, currently being considered by the National Finance Committee of the Senate, and soon proceeding to second reading in the House of Commons. The Thunder Bay District Health Unit aligns with the Ontario Dietitians in Public Health (ODPH) in its support for the concept of a Guaranteed Livable Basic Income as an effective policy lever for reducing the pervasive problem of household food insecurity in Canada.

We support and endorse the attached letter by the ODPH, who strongly support the concept of a Guaranteed Livable Basic Income as an effective policy lever for reducing the pervasive problem of household food insecurity in Canada.

In 2024, the rate of household food insecurity in Canada reached an all-time high since its measurement in Canada began nearly two decades ago. The percentage of households in Canada's ten provinces experiencing household food insecurity increased significantly to 25.5% in 2024 from 15.9% in 2021. This represents 9.9 million people, including 1 in 3 children. These estimates do not include people living on First Nations or the territories where rates of household food insecurity are typically higher.

Households struggling to put food on the table also struggle to afford other basic needs. Household food insecurity, originally perceived as a "food problem," is now understood to be a potent marker of material deprivation, rooted in inadequate and unstable incomes that have not kept pace with the costs of living.

Research on federal and provincial income policies, including public pensions for seniors, social assistance, child benefits, and minimum wage, has documented reductions in food insecurity when these interventions improve the incomes of low-income households. Research on the impact of Canada's public pension system for seniors provides the strongest parallel to a Guaranteed Livable Basic Income.

…/2

Reaching the age of eligibility for collecting public pensions has been shown to reduce the risk of food insecurity for low-income, unattached seniors by almost 50%.

The only interventions proven to reduce household food insecurity are those that improve the incomes of vulnerable households. Thank you for reviewing this information. We appreciate your attention to this significant matter.

Sincerely,

James McPherson
Chair, Board of Health
Thunder Bay District Health Unit

Cc:
Marcus Powlowski, MP – Thunder Bay – Rainy River
Patty Hajdu, MP – Thunder Bay- Superior North
Association of Local Public Health Agencies (alPHa)
Association of Municipalities of Ontario (AMO)
Federation of Canadian Municipalities (FCM)
Ontario Public Health Association (OPHA)
Ontario Dietitians in Public Health (ODPH)
Ontario Boards of Health
Health Unit Member Municipalities

National Finance Committee:
Senator Claude Carignan, Chair, National Finance Committee Claude.Carignan@sen.parl.gc.ca
Senator Éric Forest, Deputy Chair, National Finance Committee Eric.Forest@sen.parl.gc.ca
The Honourable Senator Clément Gignac, National Finance Committee Member Clement.Gignac@sen.parl.gc.ca
The Honourable Senator Andrew Cardozo, National Finance Committee Member Andrew.Cardozo@sen.parl.gc.ca
The Honourable Senator Pierre J. Dalphond, National Finance Committee Member PierreJ.Dalphond@sen.parl.gc.ca
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The Honourable Senator Joan Kingston, National Finance Committee Member Joan.Kingston@sen.parl.gc.ca
The Honourable Senator Jane MacAdam, National Finance Committee Member Jane.MacAdam@sen.parl.gc.ca
The Honourable Senator Elizabeth Marshall, National Finance Committee Member Elizabeth.Marshall@sen.parl.gc.ca
The Honourable Senator Krista Ross, National Finance Committee Member Krista.Ross@sen.parl.gc.ca
Sara Gajic, Clerk, National Finance Committee Sara.Gajic@sen.parl.gc.ca

Ontario Dietitians in Public Health
Diététistes en santé publique de l'Ontario

www.odph.ca
info@odph.ca

January 7, 2026

The Honourable Claude Carignan, Senator, and Chair, National Finance Committee
Claude.Carignan@sen.parl.gc.ca

The Honourable Éric Forest, Senator, and Deputy Chair, National Finance Committee
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The Honourable Clément Gignac, Senator, and National Finance Committee Member
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The Honourable Martine Hébert, Senator, and National Finance Committee Member
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The Honourable Elizabeth Marshall, Senator, and National Finance Committee Member
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The Honourable Krista Ross, Senator, and National Finance Committee Member
Krista.Ross@sen.parl.gc.ca

Sara Gajic, Clerk, National Finance Committee Sara.Gajic@sen.parl.gc.ca

National Finance Committee NFFN@SEN.PARL.GC.CA

Dear Chair, Deputy Chair, Members, and Clerk of the National Finance Committee of the Senate of Canada:

Ontario Dietitians in Public Health (ODPH), the professional association of Registered Dietitians working in Ontario's public health system, is writing to urge your support of Bill S-206, an Act to develop a national framework for a guaranteed livable basic income, currently being considered by the National Finance Committee of the Senate. Since 2015, ODPH has strongly supported the concept of a basic income guarantee as an effective policy lever for reducing the pervasive problem of household food insecurity in Canada.[1]

Food Insecurity Policy Research (PROOF) defines household food insecurity (HFI) as "the inadequate or insecure access to food due to financial constraints," and further states it is a serious public health problem, a marker of pervasive material deprivation, and a matter of public policy.[2] The experience of HFI can range from concerns or problems of food access (marginal HFI), to the inability to afford a balanced diet and/or missing meals (moderate HFI), to extreme cases of not eating for days (severe HFI).

In 2024, HFI in Canada reached its highest level since national monitoring began nearly 20 years ago. One in four Canadians (25.5%) living in the ten provinces experienced HFI, representing approximately 9.9 million people, including 2.5 million children – 75% of these children lived in households facing moderate or severe HFI.[3] These estimates do not include First Nations communities or the territories, where rates are typically even higher, particularly in Nunavut. Provincial rates varied significantly, ranging from 19.8% in Quebec to 30.9% in Alberta, highlighting the need for a coordinated national response.[3]

HFI is fundamentally an income issue, not just a "food problem." In 2023, 70% of households with social assistance as their main source of income in Canada reported experiencing HFI.[3] However, employment is not necessarily protective – 58.6% of households experiencing HFI report employment as their main income source, with this group showing the largest increase in HFI from 2021 to 2022.[3] A recent survey by Food Banks Canada found that low wages and insufficient hours were among the top reasons people turned to food banks.[4] Research also highlights a growing trend of precarious jobs with unstable hours, and a lack of essential benefits, creating significant challenges for today's workforce.[5] HFI is a critical indicator of a household's financial situation, as households unable to afford food also struggle to meet other basic needs. Incomes have not kept pace with the cost of living - since 2021, the Consumer Price Index has increased by 26% for shelter, 25% for food and 20% for transportation.[4]

Extensive Canadian evidence demonstrates HFI is tightly linked to adverse physical and mental health outcomes above and beyond the influence of other social determinants of health. Research linking HFI data from population health surveys with administrative health records, has provided strong evidence that people experiencing HFI are more likely to be hospitalized for a wide range of conditions, stay in hospital longer, and die prematurely (before the age of 83) from all causes except cancer.[6] A particularly strong relationship exists between HFI and poor mental health. The risk of experiencing depression, anxiety disorders, mood disorders, or suicidal thoughts increases with the severity of HFI for both adults and youth.[6] The health consequences of HFI are extremely costly to Canada's publicly funded healthcare system.[7] Policies designed with the aim of reducing HFI have the potential to offset considerable public expenditures on healthcare for federal, provincial and territorial governments. These savings must be considered in the proposed national framework for a guaranteed livable basic income.

For more than three decades, food banks have been the primary response to HFI in Canada. Despite massive investments in a secondary food system for people who cannot afford to obtain food in the most socially dignified manner (i.e., buying from food retailers), food banks are struggling more than ever to meet demands. In March 2025, there were more than 2 million visits to food banks across Canada, representing a 5% increase compared to March 2024, and a 99.4% increase compared to March 2019.[4] While food banks can provide temporary food relief, they do not address the root cause of HFI – inadequate and unstable income.[1] In fact, only about one-quarter of households experiencing HFI use food banks, and for those who do, the problem persists.[8]

Over the past 12 months, several Ontario municipalities declared food insecurity emergencies, including Mississauga, November 2024; Toronto, December 2024; Kingston, January 2025; Brantford, February 2025; Brockville, June 2025 and Orillia, August 2025. These declarations clearly demonstrate HFI has reached crisis levels across Ontario, resulting in an unsustainable demand on the charitable food system, and requiring municipal governments and community organizations to call on Federal and Provincial governments to step in with long-term policy solutions.

The only interventions proven to reduce household food insecurity are those that improve the incomes of vulnerable households.[9] Research on federal and provincial income policies, including public pensions for seniors, social assistance, child benefits, and minimum wage, has documented reductions in food insecurity when these interventions improve the incomes of low-income households.[8] Research on the impact of Canada's public pension system for seniors provides the strongest parallel to a basic income guarantee. Reaching the age of eligibility for collecting public pensions has been shown to reduce the risk of food insecurity for low-income, unattached adults by almost 50%.[10]

Establishing an income floor for working-aged Canadians and their families (similar to the support seniors receive through public pension programs) would reduce vulnerability among households that rely on employment incomes but are still unable to make ends meet, while also ensuring adequate income for those not in the workforce to cover basic needs. According to a recent report by the Parliamentary Budget Officer, a national guaranteed basic income would significantly reduce poverty in Canada by 2025 – by 34% for households defined as nuclear families and by 40% for those defined as economic families, based on the Market Basket Measure.[11]

Given the magnitude of HFI and its profound health impacts and economic costs, Canada urgently needs income-based policy solutions that directly address this issue. The 2025 Report of the National Advisory Council on Poverty has included consideration of a targeted basic income to ensure everyone reaches at least Canada's Official Poverty Line through wages and/or government benefits.[12] Supporting Bill S-206 is a critical step toward this vision, laying the foundation for a basic income framework that can reduce poverty and improve health outcomes in Canada. ODPH respectfully urges the National Finance Committee to support Bill S-206 and help build a stronger, healthier, and more equitable Canada. Thank you for your consideration.

Sincerely,

Luisa Magalhaes, MHSc, RD
Chair, ODPH

Karina Kwong, MPH, RD
Co-Chair, Food Insecurity Workgroup

cc. The Honourable Kim Pate, Senator

Loretta Ryan, Executive Director, Association of Local Public Health Agencies (Ontario)

References

[1] Ontario Dietitians in Public Health (ODPH). Available (in English and French) at: https://odph.ca/section/food-insecurity/

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Robin
LENNOX
Member of Provincial Parliament for Hamilton Centre

July 23, 2026

RE: Bill 121, Save a Life Act (Naloxone Kit Registration and Public Access), 2026

Dear Members of Sudbury Board of Health,

What if naloxone kits were co-located with AEDs and in other critical public spaces across Ontario?

MPP Dr. Robin Lennox, Hamilton Centre and her colleagues MPP France Gélinas, MPP Lisa Gretzky, and MPP Lise Vaugeois have recently introduced Bill 121: *Save a Life Act, 2026*, and are requesting the support of your Board of Health as we confront the toxic drug crisis in Ontario.

The Save a Life Act would ensure that naloxone is available in public spaces where opioid poisonings may occur. Currently, Ontarians' lives are saved by automated external defibrillators (AEDs) which are housed in community centres and other public spaces. This legislation will ensure that naloxone is equally accessible and available to save lives.

Expanding access to naloxone in public spaces has the potential to save lives by enabling rapid intervention during opioid poisonings, even before emergency responders arrive. Paramedic responses to opioid poisonings are rising in Ontario. Across Ontario, EMS calls for opioid toxicity rose from 604 (Q1 2025) to 739 (Q2 2025) to 1,024 (Q3 2025).

Ontario's health-care system continues to face considerable pressures, particularly within emergency medical services, emergency departments, and critical care units. Community-based interventions to respond to opioid poisonings could reduce the demand on already strained acute care resources.

Considering these public health benefits, we respectfully request that your Board of Health pass a motion endorsing Bill 121, Save a Life Act, and forward a copy of the motion to the Premier of Ontario and the Minister of Health in support of this important initiative.

Sincerely,

Robin Lennox, MD, CCFP
MPP Hamilton Centre

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Private Member's Bill	Projet de loi de député
MOTION FOR FIRST READING	MOTION DE PREMIÈRE LECTURE
MPP R. Lennox	Député(e) R. Lennox
I move that leave be given to introduce a Bill entitled	**Je propose** qu'il soit permis de déposer un projet de loi intitulé
"An Act to enact the Save a Life Act (Naloxone Kit Registration and Public Access), 2026"	«Loi édictant la Loi de 2026 visant à sauver des vies (accès public aux trousses de naloxone et leur enregistrement)»
and that it now be read the first time.	et que ce texte soit maintenant lu une première fois.

…….
Bill no. — N° du projet de loi

…….
First Reading Date — Date de la première lecture

…….
Clerk's Signature — Signature du greffier

Co-sponsors:	Coparrains :
MPP R. Lennox	Député(e) R. Lennox
MPP F. Gélinas	Député(e) F. Gélinas
MPP L. Gretzky	Député(e) L. Gretzky
MPP L. Vaugeois	Député(e) L. Vaugeois

Save a Life Act (Naloxone Kit Registration and Public Access), 2026

EXPLANATORY NOTE

The *Save a Life Act (Naloxone Kit Registration and Public Access), 2026* is enacted. The Act imposes certain requirements respecting the installation, maintenance, testing and availability of naloxone kits at designated premises. Designated premises include any premises at which a defibrillator is installed and any publicly accessible premises that are designated by the regulations.

The Act also requires naloxone kits at designated premises to be registered with the registrar within specified time periods, and requires prescribed persons to be notified of the registrations. Regulations may be made under the Act setting out details relating to the requirements under the Act.

Bill **2026**

An Act to enact the Save a Life Act (Naloxone Kit Registration and Public Access), 2026

CONTENTS

Preamble

Each year, more than 2,000 Ontarians die from opioid poisoning. Data indicates that for every opioid toxicity death, roughly 15 non-fatal overdoses may occur that require intervention with tools such as naloxone. Naloxone can safely be administered by bystanders to reverse opioid toxicities as they are occurring. Many opioid toxicity events are occurring in public places. Ensuring that naloxone kits are available to members of the public may prevent tragedies from occurring.

Therefore, His Majesty, by and with the advice and consent of the Legislative Assembly of the Province of Ontario, enacts as follows:

Definitions

1. In this Act,

"Minister" means the member of the Executive Council to whom responsibility for the administration of this Act is assigned or transferred under the *Executive Council Act*; ("ministre")

"naloxone kit" has the same meaning as in section 25.2 of the *Occupational Health and Safety Act*; ("trousse de naloxone")

"regulations" means the regulations made under this Act; ("règlements")

"prescribed" means prescribed by the regulations. ("prescrit")

Designation of registrar

2. The Minister may designate a registrar for the purpose of this Act.

Designated premises

3. (1) The following are designated premises for the purpose of this Act:

1. Subject to any prescribed exceptions, any premises at which a person is required by law to ensure that a defibrillator is installed.

2. Subject to any prescribed exceptions, any premises at which a person elects to install a defibrillator.

3. Any other publicly accessible premises that are designated by the regulations.

Installation, etc., of naloxone kits

(2) Every person who owns or operates designated premises shall,

(a) ensure that naloxone kits are installed at the premises in accordance with the regulations;

(b) ensure that any naloxone kit installed at the premises is available for use in locations that facilitate easy access to the naloxone kit, as described in the regulations;

(c) ensure that the location of a naloxone kit at the premises is appropriately indicated with signs in accordance with the regulations;

(d) ensure that any naloxone kit installed at the premises is maintained and tested in accordance with the manufacturer's guidelines and with any other guidelines as may be prescribed; and

(e) ensure that training is undertaken by prescribed persons for the use of a naloxone kit, according to the prescribed training and education guidelines.

Registration of naloxone kit

4. (1) Every person who owns or operates designated premises at which a naloxone kit is installed shall register the naloxone kit with the registrar,

(a) within 30 days after it is installed; or

(b) if, on the day this subsection comes into force, the naloxone kit has already been installed, no later than 30 days after that day.

Naloxone kit moved or removed

(2) Subject to the regulations, if a naloxone kit registered with the registrar is moved to a different location at the designated premises, or is removed from the premises for any reason, the owner or operator of the premises must notify the registrar in accordance with the regulations.

Notification re naloxone kit

5. The registrar must, in accordance with the regulations, notify the prescribed persons about,

(a) the registration of a naloxone kit under section 4; or

(b) the subsequent moving of the naloxone kit to a different location within the premises or its removal from the premises.

Inspectors

6. (1) The Minister may appoint inspectors for the purposes of this Act.

Inspection

(2) An inspector may, without warrant and without notice, enter any premises that is not a dwelling at any reasonable time and conduct inspections for the purpose of determining compliance with the requirements under this Act.

Identification

(3) An inspector conducting an inspection shall produce, on request, evidence of his or her appointment.

Powers of inspector

(4) An inspector conducting an inspection may,

(a) examine and make copies of a document or other thing that is relevant to the inspection;

(b) search for or demand the production for inspection of a document, in a readable format, or other thing, that is relevant to the inspection;

(c) remove a document or other thing that is relevant to the inspection for the purpose of making a copy, and return the document or other thing as promptly as reasonably possible; and

(d) question a person on matters relevant to the inspection.

Copy admissible in evidence

(5) A copy of a document or other thing that purports to be certified by an inspector as being a true copy of the original is admissible in evidence to the same extent as the original and has the same evidentiary value as the document or other thing itself without proof of the signature or official character of the person appearing to have certified the copy.

Obstruction

(6) No person shall obstruct, hinder or interfere with or attempt to obstruct, hinder or interfere with an inspector conducting an inspection or refuse to answer questions on matters relevant to the inspection.

False information, etc.

(7) No person shall provide an inspector with information that the person knows to be false or misleading, or conceal or destroy anything that is relevant to an inspection.

Offence

7. (1) A person is guilty of an offence if the person,

(a) contravenes a provision of this Act;

(b) obstructs, hinders or interferes with or attempts to obstruct, hinder or interfere with an inspector conducting an inspection contrary to subsection 6 (6); or

(c) provides false or misleading information to an inspector or conceals or destroys anything that is relevant to an inspection contrary to subsection 6 (7).

Penalty, individual

(2) An individual who is convicted of an offence under subsection (1) is liable to the prescribed fine.

Penalty, corporation

(3) A corporation that is convicted of an offence under subsection (1) is liable to the prescribed fine.

Same, officers and directors

(4) An officer or director of a corporation who authorizes or permits the corporation to commit an offence under subsection (1) is guilty of an offence and on conviction is liable to the prescribed fine.

Crown bound

8. This Act binds the Crown.

Regulations

9. The Lieutenant Governor in Council may make regulations,

(a) designating publicly accessible premises for the purposes of section 3;

(b) governing the registration of naloxone kits;

(c) prescribing and governing any matter that this Act describes as being prescribed, done in accordance with the regulations or provided for in the regulations;

(d) governing the powers and duties of inspectors appointed for the purposes of this Act, the obligations of other persons in respect of inspections conducted by an inspector and the admissibility in court of evidence procured by the inspector;

(e) respecting any matter necessary or advisable to effectively carry out the purposes of this Act.

Commencement

10. This Act comes into force six months after the day it receives Royal Assent.

Short title

11. The short title of this Act is the *Save a Life Act (Naloxone Kit Registration and Public Access), 2026*.

Loi de 2026 visant à sauver des vies (accès public aux trousses de naloxone et leur enregistrement)

NOTE EXPLICATIVE

La *Loi de 2026 visant à sauver des vies (accès public aux trousses de naloxone et leur enregistrement)* est édictée. La Loi prévoit certaines obligations en matière d'installation, d'entretien, de mise à l'essai et de mise à disposition des trousses de naloxone dans les lieux désignés. Les lieux désignés comprennent les lieux où un défibrillateur est installé ainsi que les lieux accessibles au public qui sont désignés par règlement.

La Loi exige également que les trousses de naloxone installées dans des lieux désignés soient enregistrées auprès du registrateur dans des délais précisés et que les personnes prescrites soient avisées des enregistrements. Les détails des exigences prévues par la Loi peuvent être précisés par règlement.

Loi édictant la Loi de 2026 visant à sauver des vies (accès public aux trousses de naloxone et leur enregistrement)

SOMMAIRE

Préambule

Chaque année, plus de 2 000 Ontariens et Ontariennes meurent d'une intoxication aux opioïdes. Les statistiques montrent que pour chaque décès par intoxication liée aux opioïdes, environ 15 surdoses non mortelles peuvent survenir, lesquelles nécessitent le recours à certains instruments comme la naloxone. La naloxone peut être administrée de façon sécuritaire par des passants afin de renverser les effets d'une surdose d'opioïdes en cours – un grand nombre desquelles se produisent dans des lieux publics. En mettant des trousses de naloxone à la disposition du public, de nombreuses tragédies pourraient être évitées.

Pour ces motifs, Sa Majesté, sur l'avis et avec le consentement de l'Assemblée législative de la province de l'Ontario, édicte :

Définitions

1. Les définitions qui suivent s'appliquent à la présente loi.

«ministre» Le membre du Conseil exécutif à qui la responsabilité de l'application de la présente loi est assignée ou transférée en vertu de la *Loi sur le Conseil exécutif*. («Minister»)

«prescrit» Prescrit par les règlements. («prescribed»)

«règlements» Les règlements pris en vertu de la présente loi. («regulations»)

«trousse de naloxone» S'entend au sens de l'article 25.2 de la *Loi sur la santé et la sécurité au travail*. («naloxone kit»)

Désignation de registrateurs

2. Le ministre peut désigner un registrateur pour l'application de la présente loi.

Lieux désignés

3. (1) Les lieux suivants sont désignés pour l'application de la présente loi :

1. Sous réserve des exceptions prescrites, tout lieu où une personne est tenue par la loi de veiller à ce qu'un défibrillateur soit installé.

2. Sous réserve des exceptions prescrites, tout lieu où une personne choisit d'installer un défibrillateur.

3. Les autres lieux accessibles au public qui sont désignés par règlement.

Installation, accès et entretien des trousses de naloxone

(2) Le propriétaire ou l'exploitant d'un lieu désigné s'assure que :

a) des trousses de naloxone sont installées dans le lieu conformément aux règlements;

b) les trousses de naloxone installées dans le lieu sont situées à des endroits facilement accessibles conformément aux règlements;

c) les endroits où se trouvent les trousses de naloxone sont indiqués de façon adéquate à l'aide de panneaux conformément aux règlements;

d) les trousses de naloxone installées dans le lieu sont entretenues et mises à l'essai conformément aux lignes directrices du fabricant et aux autres lignes directrices prescrites, le cas échéant;

e) les personnes prescrites suivent une formation sur l'utilisation d'une trousse de naloxone conformément aux lignes directrices prescrites en matière de formation et d'instruction.

Enregistrement

4. (1) Le propriétaire ou l'exploitant d'un lieu désigné où une trousse de naloxone est installée enregistre la trousse de naloxone auprès du registrateur :

a) dans les 30 jours suivant l'installation de la trousse de naloxone;

b) si la trousse de naloxone est déjà installée le jour de l'entrée en vigueur du présent paragraphe, au plus tard 30 jours après ce jour.

Déplacement ou enlèvement

(2) Sous réserve des règlements, si une trousse de naloxone enregistrée auprès du registrateur est déplacée dans le lieu désigné où elle est située ou est enlevée du lieu pour une raison quelconque, le propriétaire ou l'exploitant du lieu doit en aviser le registrateur conformément aux règlements.

Avis

5. Le registrateur doit aviser les personnes prescrites, conformément aux règlements, de ce qui suit :

a) l'enregistrement d'une trousse de naloxone en application de l'article 4;

b) le déplacement subséquent de la trousse de naloxone dans le lieu où elle est située ou son enlèvement du lieu.

Inspecteurs

6. (1) Le ministre peut nommer des inspecteurs pour l'application de la présente loi.

Inspection

(2) L'inspecteur peut, sans mandat ni préavis, pénétrer à toute heure raisonnable dans tout lieu qui n'est pas un logement et y effectuer des inspections afin de déterminer si les exigences prévues par la présente loi sont respectées.

Identification

(3) L'inspecteur qui effectue une inspection produit, sur demande, une preuve de sa nomination.

Pouvoirs de l'inspecteur

(4) L'inspecteur qui effectue une inspection peut :

a) examiner des documents ou toute autre chose se rapportant à l'inspection et en tirer des copies;

b) chercher des documents, sur support lisible, ou toute autre chose se rapportant à l'inspection, ou en demander formellement la production;

c) enlever des documents ou toute autre chose se rapportant à l'inspection pour en tirer des copies et les remettre aussi promptement que raisonnablement possible;

d) interroger des personnes sur toute question se rapportant à l'inspection.

Copies admissibles en preuve

(5) Les copies de documents ou de toute autre chose qui se présentent comme étant certifiées conformes aux originaux par l'inspecteur sont admissibles en preuve au même titre que les originaux et ont la même valeur probante que ceux-ci, sans qu'il soit nécessaire de prouver l'authenticité de la signature ou la qualité officielle de la personne qui semble les avoir certifiées.

Entrave

(6) Nul ne doit gêner ni entraver le travail de l'inspecteur qui effectue une inspection, ou tenter de le faire, ni refuser de répondre à des questions se rapportant à l'inspection.

Faux renseignements

(7) Nul ne doit fournir à l'inspecteur des renseignements qu'il sait faux ou trompeurs ni dissimuler ou détruire quoi que ce soit se rapportant à l'inspection.

Infraction

7. (1) Est coupable d'une infraction quiconque, selon le cas :

a) contrevient à une disposition de la présente loi;

b) gêne ou entrave le travail de l'inspecteur qui effectue une inspection, ou tente de le faire, contrairement au paragraphe 6 (6);

c) fournit à l'inspecteur des renseignements qu'il sait faux ou trompeurs ou dissimule ou détruit quoi que ce soit se rapportant à l'inspection, contrairement au paragraphe 6 (7).

Peine : particulier

(2) Le particulier qui est déclaré coupable d'une infraction prévue au paragraphe (1) est passible de l'amende prescrite.

Peine : personne morale

(3) La personne morale qui est déclarée coupable d'une infraction prévue au paragraphe (1) est passible de l'amende prescrite.

Idem : dirigeants et administrateurs

(4) Le dirigeant ou l'administrateur d'une personne morale qui autorise ou permet la commission par la personne morale d'une infraction prévue au paragraphe (1) est coupable d'une infraction et passible, sur déclaration de culpabilité, de l'amende prescrite.

Obligation de la Couronne

8. La présente loi lie la Couronne.

Règlements

9. Le lieutenant-gouverneur en conseil peut, par règlement :

a) désigner des lieux accessibles au public pour l'application de l'article 3;

b) régir l'enregistrement des trousses de naloxone;

c) prescrire et régir tout ce que la présente loi mentionne comme étant prescrit, fait conformément aux règlements ou prévu par règlement;

d) régir les pouvoirs et fonctions des inspecteurs nommés pour l'application de la présente loi, les obligations d'autres personnes par rapport aux inspections effectuées par les inspecteurs et l'admissibilité devant un tribunal des preuves obtenues par les inspecteurs;

e) traiter de tout ce qui est nécessaire ou souhaitable pour réaliser efficacement l'objet de la présente loi.

Entrée en vigueur

10. La présente loi entre en vigueur six mois après le jour où elle reçoit la sanction royale.

Titre abrégé

11. Le titre abrégé de la présente loi est *Loi de 2026 visant à sauver des vies (accès public aux trousses de naloxone et leur enregistrement)*.

From: allhealthunits <allhealthunits-bounces@lists.alphaweb.org> **On Behalf Of** alPHa communications
Sent: September 8, 2026 12:54 PM
To: 'allhealthunits@lists.alphaweb.org' <allhealthunits@lists.alphaweb.org>
Cc: Board <board@lists.alphaweb.org>
Subject: [allhealthunits] alPHa - 2026 Ontario Municipal Elections Resources

PLEASE ROUTE TO:

All Board of Health Members
All Members of Regional Health & Social Service Committees
All Senior Public Health Managers

Dear alPHa Members,

With the return to school, and the 2026 municipal election campaign in full swing, alPHa would like to highlight a number of resources that may be useful to members during the election period. Whether you are engaging with municipal candidates, participating in local conversations about public health, or looking for accessible resources to share, the following are available for your use:

Public Health Matters

Aimed at decision-makers, the ***Public Health Matters*** infographic series is a particularly useful resource during the municipal election campaign. The series provides concise and accessible information that helps to explain the role of local public health and its contribution to healthy communities and a strong Ontario. Together, the five infographics provide a broad picture of local public health, from explaining its role and demonstrating its impact, to making the case for investment and highlighting its contribution to healthy communities and a strong economy. The infographics can be shared individually, or as a collection, and are useful when communicating with municipal candidates and others during the campaign. The infographics, and associated videos, are available in English and French.

Public Health Matters Infographic	**Focus**
#1 A Public Health Primer	Explains what local public health is and the role it plays in protecting and promoting health.
#2 Fall Vaccine Success	Demonstrates the impact of prevention and immunization in protecting communities.

Public Health Matters Infographic	Focus
#3 A Business Case for Local Public Health	Makes the case for investment in local public health.
#4 Keeping Ontarians Healthy and Safe	Highlights how local public health protects and promotes the health and safety of communities.
#5 A Strong Economy Supported by Healthy Communities	Illustrates the connection between healthy communities and a strong economy.

Resolutions and Correspondence

The **alPHa Resolutions** and **Correspondence** provide a valuable source of information about the priorities, issues, and positions that have shaped alPHa's work on behalf of Ontario's local public health agencies. For Members preparing for conversations with municipal candidates, these resources offer a wealth of background information on issues that matter to local public health and the communities we serve. These can help provide context on current public health priorities, identify relevant past work, and provide additional information when questions arise during the campaign. The collection includes the **alPHa submission to the 2026 Ontario Budget consultation**, along with correspondence and Resolutions addressing a wide range of public health priorities. The Resolutions can also be searched by year and/or topic, making it easy to find information on specific issues. Members are encouraged to explore these resources as a source of background,
context, and supporting information throughout the municipal election period.

***Information Break* Newsletter**

Information Break is alPHa's members' portal and an important source of information on issues, developments and activities affecting local public health in Ontario. The **newsletter archive** provides access to previous issues of *Information Break*, offering a useful record of alPHa updates, public health developments, government announcements, resources and other information shared with members over time. During the municipal election period, the archive can be a valuable starting
point for members looking for additional background or context on issues that may arise in conversations with candidates, municipal leaders and community partners. It is also a convenient way to revisit information and resources that may have been shared previously but are particularly relevant to current discussions. Members are encouraged to use the archive when preparing for conversations and looking for additional information to share throughout the campaign.

Use These Resources During the Municipal Election Period!

The municipal election campaign provides an important opportunity to help candidates and communities better understand the role, value and breadth of local public health and the contribution it makes to healthy, safe and vibrant communities across Ontario. We encourage members to make use of these resources throughout the campaign and to share these with municipal candidates, community partners and others who may benefit from a better understanding of local public health. Thank you for your continued work to strengthen local public health across Ontario!

Take Care,

Loretta

Loretta Ryan, CAE, RPP
Chief Executive Officer
Association of Local Public Health Agencies (alPHa)
PO Box 73510, RPO Wychwood
Toronto, ON M6C 4A7
Tel: 416-595-0006 x 222
loretta@alphaweb.org
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Public Health
Santé publique
SUDBURY & DISTRICTS

September 4, 2026

City Council
City of Greater Sudbury
200 Brady Street, Box 5000, Station A
Sudbury, ON P3A 5P3

Dear Members of Council:

RE: Rat Activity in Minnow Lake

Public Health Sudbury & Districts, like many of you, has been hearing the frustration and concern experienced by Minnow Lake residents and businesses affected by increased rat activity.

We are pleased to see Mayor Paul Lefebvre's request to bring together the City of Greater Sudbury, Public Health Sudbury & Districts, community organizations, businesses, property owners, waste management providers, and other partners to identify feasible approaches for reducing rat activity. We look forward to participating in this collaboration.

It is our sense that some of the frustration experienced by the community on this issue is the result of confusion and incorrect information. At times for the community, the lack of clarity has probably felt like obstacles to action taking place. In the interest of clarifying science-based information so that everyone can be on the same page, we are sharing what follows.

It is extremely rare for rats in Ontario to carry diseases that can affect humans. Although rats can contaminate food and surfaces through urine, droppings, or other waste, the risk of illness to the general public is extremely low when rats are outside. Therefore, rats are fortunately not a health hazard, though they are a pest, a nuisance, and do damage to property. As with waste from other urban animals, appropriate precautions should be taken when cleaning affected areas or handling contaminated materials.

Because rats are not a health hazard, managing rats on residential property does not fall directly within Public Health's legislated mandate, nor does Public Health have authority to take action. We are, therefore, limited to non-interventional activities such as education. To this end, Public Health inspectors, in collaboration with City of Greater Sudbury staff, will continue to respond to public inquiries, and to provide educational information and guidance.

Sudbury
1300 rue Paris Street
Sudbury ON P3E 3A3
t: 705.522.9200
f: 705.522.5182

Elm Place
10 rue Elm Street
Unit / Bureau 130
Sudbury ON P3C 5N3
t: 705.522.9200
f: 705.677.9611

Sudbury East / Sudbury-Est
1 rue King Street
Box / Boîte 58
St.-Charles ON P0M 2W0
t: 705.222.9201
f: 705.867.0474

Espanola
800 rue Centre Street
Unit / Bureau 100 C
Espanola ON P5E 1J3
t: 705.222.9202
f: 705.869.5583

Île Manitoulin Island
6163 Highway / Route 542
Box / Boîte 87
Mindemoya ON P0P 1S0
t: 705.370.9200
f: 705.377.5580

Chapleau
34 rue Birch Street
Box / Boîte 485
Chapleau ON P0M 1K0
t: 705.860.9200
f: 705.864.0820

toll-free / sans frais
1.866.522.9200

phsd.ca

@PublicHealthSD
@SantePubliqueSD

When the public contacts us, a key message of ours is that the most effective way to address rat infestations is to ensure properties are free of waste and clutter that can be food for rats or can form shelters for rat nests. We encourage the community to focus on eliminating all waste and clutter, thereby removing the potential food and shelter that allows rats to thrive. As well, we understand that property standards bylaws have been effectively used in other municipalities to compel the clearing of waste and clutter from properties where the owners are not doing so. We believe that use of the City of Greater Sudbury's bylaw, whether in its current form or with amendments, could be a very helpful tool to address the rat infestation in Minnow Lake.

We recognize that reducing rat activity requires coordinated action, and Public Health remains committed to collaborating with the City on this issue, whether through Mayor Lefebvre's proposed coalition, or through our current and ongoing direct partnership.

Best regards,

Original Signed By

M. Mustafa Hirji, MD, MPH, FRCPC
Medical Officer of Health and Chief Executive Officer

APPROVAL OF CONSENT AGENDA

MOTION: THAT the Board of Health approve the consent agenda as distributed.

Public Health
Santé publique
SUDBURY & DISTRICTS

Briefing Note

To: Board of Health for Public Heatlh Sudbury & Districts

From: Dr. Oscar Javier Pico Espinosa, Resident Physician &
Dr. Emily Groot, Associate Medical Officer of Health

Date: 2026/09/10

Re: After Action Review of the May 2026 Boil Water Advisory affecting the City of Greater Sudbury

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☒ For Information ☐ For Discussion ☐ For a Decision

Issue: Public Health Sudbury & Districts (PHSD) completed an After Action Review (AAR) of the May 6 to 8, 2026, Boil Water Advisory (BWA) that affected approximately 90,000 residents in the City of Greater Sudbury (CGS). The review identified strengths in the public health response, as well as opportunities to strengthen preparedness, coordination, communications, and operational capacity for future large-scale drinking water emergencies, and other health emergencies.

Recommended Action: That the Board of Health receive the After Action Review for information.

Alternative Actions: The Board of Health may request additional information or progress updates regarding implementation of recommendations arising from the AAR.

Background: On May 6, 2026, total Coliforms and *E. coli* were identified in routine water samples from CGS drinking water systems. Based on the available evidence and a precautionary approach to protecting public health of a very large number of people, a Boil Water Advisory was issued affecting approximately 90,000 residents.

Public Health worked closely with CGS, health care partners, long-term care homes, school boards, childcare settings, food premises operators, and the public throughout the advisory. The advisory was rescinded on May 8, 2026, after follow-up testing and risk assessment established that the water was safe to drink.

Given the uniqueness of the incident and the large-scale and disruptive nature of it, an AAR was conducted to summarize the response, identify lessons learned, and strengthen preparedness for future large-scale water-related incidents. The review included an internal facilitated debrief session, review of response documentation, Public Health staff feedback, an interview with a City of Greater Sudbury representative, and comparison with Health Canada guidance.

2024–2028 Strategic Priorities:

1. Equal opportunities for health
2. Impactful relationships
3. Excellence in public health practice
4. Healthy and resilient workforce

The review found several strengths, including:

- Strong leadership and engagement from Public Health and municipal partners.
- Rapid mobilization of experienced staff.
- Effective outreach to priority partners and organizations.
- Strong collaboration with operational City staff and community partners.
- Adaptability of information technology and communications teams during periods of high public demand and website disruptions.

The review also identified opportunities for improvement, including:

- Limited prior experience responding to BWAs affecting large urban populations.
- Lack of large-scale BWA-specific emergency preparedness exercises, to complement existing small-scale BWA exercises.
- Uncertainty regarding governance, roles, responsibilities, and decision-making structures, in the context of collaborating with CGS managers.
- Challenges managing high volumes of public inquiries.
- Delays and inconsistencies in some public communications generating confusion, particularly regarding the geographic areas affected by the advisory.
- Internal communication gaps and website disruptions.

The report provides recommendations organized into five themes:

1. Preparedness exercises.
2. Leadership, governance, and internal communications.
3. Technical capacity, documentation, tracking, and monitoring.
4. Strengthening partnerships with the City of Greater Sudbury and other stakeholders.
5. Public communications and information management.

Implementation of these recommendations will strengthen organizational readiness for future large-scale public health emergencies.

Financial Implications: Most recommendations can be addressed within existing operational planning and emergency preparedness activities. Some recommendations may require future investments in communication systems, technological enhancements, staff training, emergency exercises, and operational tools. Any significant resource requirements will be incorporated in future budget planning.

Impacts on Strategic Priorities or Medium-Term Operational Priorities: The recommendations support three of the four Board of Health Strategic Priorities:

1. Equal opportunities for health by improving the ability to communicate risks and protect communities during drinking water incidents.
2. Impactful relationships through strengthened collaboration with municipal and community partners.
3. Excellence in public health practice through enhanced preparedness, emergency response capacity, and continuous quality improvement.

Impacts on Risk Management Plan: Implementation of the AAR recommendations will reduce organizational risks related to emergency preparedness, communications, operational continuity, partner coordination, and public confidence during future emergencies. The recommendations support ongoing risk mitigation and organizational resilience.

Impacts on Fulfillment of the Ontario Public Health Standards: The review and associated improvement activities support PHSD's obligations under the Ontario Public Health Standards related to emergency preparedness, response, environmental health, health protection, effective public health practice, and continuous quality improvement.

Author:

Dr. Oscar Javier Pico Espinosa
Resident Physician
Public Health and Preventive Medicine, NOSM University

Boil Water Advisory Response in the City of Greater Sudbury, May 6 to 8, 2026

After Action Report

Public Health Sudbury & Districts
August 2026

Contact for More Information

Public Health Sudbury & Districts
1300 Paris Street
Sudbury, ON P3E 3A3
Telephone: 705.522.9200, ext. 350
Email: resourcecentre@phsd.ca

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Table of Contents

Executive Summary

A Boil Water Advisory (BWA) affecting approximately 90,000 residents was issued in the City of Greater Sudbury (CGS) on May 6, 2026, following the detection of total Coliforms and *E. coli* in routine drinking water samples. Public Health Sudbury & Districts (Public Health) conducted an After Action Review (AAR) to identify strengths, challenges, and opportunities for improvement in the response to this large-scale public health event. The review included a facilitated debrief session, review of response documentation, an interview with a CGS representative, additional staff feedback, and comparison with Health Canada guidance.

The response demonstrated several strengths. Engaged leadership, experienced staff, established relationships with municipal and community partners, and prior emergency preparedness experience supported a rapid and coordinated response. Operational teams mobilized quickly, communication channels were established, and proactive outreach was conducted with hospitals, long-term care homes, school boards, childcare settings, and food premises. The ability of information technology staff to adapt to website disruptions and increased public demand was also viewed positively.

The review identified opportunities to strengthen preparedness, coordination, operational capacity, and communications. Challenges included limited experience with BWAs affecting large populations, the absence of large-scale BWA-specific exercises, uncertainty regarding roles, responsibilities, and decision-making structures, and insufficient planning for surges in public inquiries. Communication challenges included delays in some messaging, inconsistent guidance for specific audiences, uncertainty regarding communication responsibilities and channels, internal staff communication gaps, website disruptions, and public confusion regarding the geographic areas affected by the advisory.

Recommendations focus on conducting emergency preparedness and simulation exercises; enhancing coordination with CGS; establishing clear governance and communication structures; strengthening technical systems, mapping, tracking, and operational tools; improving high-volume call management and surge capacity planning; maintaining and updating communication materials; and improving public information delivery and messaging consistency, particularly in the context of working with partners.

Background

Boil water advisories (BWAs) are an important tool in protecting human health(1). BWAs are issued when drinking water could contain microbes that could make humans sick. Bringing water to a roiling boil for at least one minute kills potentially harmful bacteria, viruses, and parasites.

BWAs for drinking water systems serving communities of more than 5000 people are uncommon. In 2023, 89% of BWAs were issued in communities of 500 people or fewer(2). In 2023, 2% of water advisories were due to detection of *E. coli* and 11% were due to other microbiological parameters, including detection of total coliforms(2). The remainder of water advisories resulted from non-microbiological parameters or water system operational issues that could result in water contamination, such as loss of water pressure.

Emergency BWAs are issued when *E. coli* is detected in drinking water. The detection of *E. coli* is a definitive indication of human or other animal faecal contamination of drinking water, and indicates the possible presence of pathogenic microorganisms(1). While most strains of *E. coli* are not harmful, some strains can cause severe disease. At minimum, the presence of any strain of *E. coli* in drinking water signals that there is a problem and the water may not be safe to drink.

Precautionary BWAs are issued in a variety of situations, including persistent presence of total coliforms in the distribution system, despite remedial measures(1). "Coliforms" are a group of bacteria that can be found in soil, on plants, and in animals. *E. coli* is a type of coliform. Most coliform bacteria are not harmful, but like a positive test for *E. coli*, detection of other colifirms also signals there may be a problem with water treatment or distribution.

If a BWA is issued due to the detection of *E. coli* or persistent coliforms, at least two consecutive sets of negative bacteriological samples, collected at least 24 hours apart, are necessary to rescind a BWA(1).

The Falconbridge Drinking Water System (DWS: 240000020) is a secure ground water system comprised of three drilled wells (Wells 5, 6 and 7). The raw water is treated using chlorine gas for disinfection. The distribution system includes the Falconbridge Fluoridation Facility with continuous on-line analyzers for fluoride and chlorine residuals, the Falconbridge Elevated Storage Tank, and the Mott Street Booster Station. The service population is approximately 675.

The Sudbury–David Street Drinking Water System (DWS: 220003537) is a surface water system with water coming from Ramsey Lake, treated with sodium hypochlorite and ultraviolet disinfection units. The David Street Water Treatment Plant serves the south-west area of the CGS and the Wahnapitae Water Treatment Plant serves the northeast area of the city. The two distribution systems are connected. There are 8 booster stations in the system, including the Copper Park station. There is one storage facility connected to the distribution system, the Ellis Reservoir, which is fed by both the Wahnapitae Water Treatment Plant and the David Street Water Treatment Plant. Combined, the two WTPs serve an estimated population of 91,000.

Abnormal results from different sites across the City of Greater Sudbury (CGS) from routine microbiological sampling and testing by CGS operators were received on May 6, 2026 (Table 1). The laboratory findings and initial investigation findings were difficult to reconcile: one one hand, several water samples from different sites were positive for *E. coli* and total coliforms. On the other hand, there were no known treatment failures, no loss of water pressure, no flooding, and chlorine levels remained appropriate. There was no evidence of faulty collection or testing processes. While the source of the *E. coli* and total coliforms was not identified at the time the BWA was issued, nor was it identified after further investigation, Public Health issued a BWA because the safety of the drinking water, and the health of 91,000 people, could no longer be assured without further follow-up testing.

Timeline of key events

May 4	Routine water sampling by the City of Greater Sudbury
May 6 13:43-14:08	Public Health receives notice of bacteria detected in drinking water test results from the May 4 samples (see Table 1)
May 6 16:16	14 sites resampled
May 6 18:19	Boil Water Advisory Issued
May 7 16:17	Second set of samples taken from 14 sites
May 7 17:38	Test results from May 6 samples received. No evidence of bacteria detected.
May 8 18:22	Test results from May 7 samples received. No evidence of bacteria detected.
May 8 18:36	Boil Water Advisory Rescinded

Table 1. Sample collection and communication of results by location.

Date of sample collection	Time of sample collection	Source	Total coliform result	*E. coli* result	Free chlorine residual	Notification to CGS, Public Health and SAC, respectively
Falconbridge Well Supply (Nickel Rim Well #6)						
May 4, 2026	10:40 am	Ground water system, Treated water sample	Overgrown with target	Overgrown with target	1.76 mg/L	May 6, 2026 1:30 pm 1:43 pm 1:45 pm

David St. Drinking Water System, SD1 Copper Park Booster						
May 4, 2026	1:20 pm	Surface water system, Distribution water sample	Overgrown with target	Overgrown with target	0.87 mg/L	May 6, 2026 1:56 pm 2:08 pm 2:48 pm
David St. Drinking Water System, SD12 New South End Library						
May 4, 2026	10:30 am	Surface water system, Distribution water sample	24	Negative	0.89 mg/L	May 6, 2026 1:56 pm 2:08 pm 2:48 pm
David St. Drinking Water System, SD16 Kelly Lake WWTP						
May 4, 2026	1:50 pm	Surface water system, Distribution water sample	15	Negative	0.82 mg/L	May 6, 2026 1:56 pm 2:08 pm 2:48 pm

Key: CGS=City of Greater Sudbury; Public Health=Public Health Sudbury & Districts; SAC=Ontario Ministry of the Environment, Conservation and Parks Spills Action Centre; Overgrown with target=

Objectives

The goal of this report was to gather information to improve preparedness and future response through constructive learning. Specific objectives are

- To review actions undertaken during the BWA, identifying successes and challenges.
- To assess Public Health's capacity to prepare for and respond to abnormal water testing affecting large jurisdictions.
- To identify opportunities to improve in the future, and to institutionalize any lessons emerging from the management of this BWA.

Methods

We conducted an After Action Review (AAR). An AAR is a review of actions taken to respond to a public health incident. It is a quality improvement tool to documenting best practices

demonstrated and challenges encountered during the response to the event or the implementation of the project (3).

Internal reports and documentation from the BWA were reviewed and discussed with the managers of the Environmental Health team if clarifications were needed.

A 1-hour debrief-style meeting was held on June 18, 2026. A structured facilitation instrument was developed in advance of the meeting covering leadership and planning, partner coordination delivery and operations, and communication and information management (Appendix A). A parallel list of questions was circulated among those involved in the response and the debrief in advance to facilitate reflection prior to the discussion. The questions were designed to review what was in place before the response, what actually happened during the response, what went well, what went less well, why events occurred as they did, and how to improve. A separate interview was conducted with a representative from CGS. The interview guide was adapted based off the structured facilitation instrument developed prior to the debrief-style meeting. Additional feedback was sought from staff involved in the response during the BWA.

The lead author (OJPE) was not affiliated with Public Health Sudbury & Districts at the time of the BWA.

Health Canada's Guidance for Issuing and Rescinding Boil Water Advisories in Canadian Drinking Water Supplies was reviewed and actions were contrasted with the actions taken during this advisory.

No ethics approval was required as this report is part of a quality improvement project.

Findings

Findings were organized into four themes: leadership and planning, partner coordination, delivery and operations, and communications and information management. For each theme, recommendations were categorized as short and long-term actions.

Leadership and Planning

Successes

The team benefited from significant expertise among management and operators. Long-standing relationships with leaders and operators, as well as strong contextual knowledge, facilitated the response.

The Environmental Health team felt prepared to manage the situation based on experience and previous emergency preparedness exercises conducted for other types of incidents.

The Medical Officer of Health communicated with the Board of Health, City leadership, and other key partners (e.g. Health Sciences North) throughout the advisory, while the Associate Medical Officer of Health focused on operational and public communications activities.

Supplemental fact sheets for certain services (e.g., day cares) required updating during the advisory. This lack of standardization created the potential for inconsistent or unclear messaging. However, the team proactively issued email updates to school boards early in the response, and allocated sufficient time to respond to questions and addressed concerns by partners regarding issues like handwashing.

Media release templates were updated during the response to better reflect the large number of people affected.

Challenges

Because large-scale urban BWAs are relatively rare in Canada, Public Health staff had limited experience with BWAs affecting a large population. Previous experience was primarily with smaller-scale advisories and no emergency preparedness exercises specific to a BWA affecting a large municipality had been conducted before this incident by Public Health or CGS. Events of this scale were seen as unlikely and neither Public Health nor CGS had protocols specific to a large-scale urban BWA.

In part because Public Health did not have protocols specific to a widespread urban BWA, there was a lack of clarity regarding responsibility for internal staff communications and what information staff were authorized to share outside of the organization.

Recommendations

Short term

Update fact sheets and both internal and external communication templates, and create a regular cycle for their review. External templates should include specific information for services like child care settings, and for specific processes such as dishwashing, including sanitation.

Long term

Collaborate with the CGS and other municipalities on joint emergency preparedness exercises, including exercises focused on BWAs affecting large populations.

Establish clear leadership and accountability for internal staff communications during emergencies, and ensure internal messaging is aligned before external communications are released.

Partner coordination

Successes

Following discussions, Public Health and CGS leadership successfully agreed on information dissemination methods, including the use of City alerts.CGS personnel responsible for operations were very experienced and highly engaged throughout the response.

Challenges

Contact persons and decision-making responsibilities were not always clear, resulting in redundant communication. For example, receiving information from Public Health through upper level managers was perceived as inefficient by some external partners; this was solved by establishing direct communication between managers directly in charge of the response.

Recommendations

Short term

Clarify Public Health and partner roles, contact persons, responsibilities, and task distribution regarding BWA communication and dissemination activities.

Long term

Strengthen relationships between Public Health and external partners at the senior management and executive level through shared training opportunities and emergency exercises.

Operations delivery

Successes

An engaged workforce enabled the rapid assembly of a response team. Lead managers called a meeting on the morning on May 7th with staff rapidly deployed to the field by 10:30AM.

The manager on call proactively established a communication channel with staff, facilitating strong teamwork, responsiveness and knowing who was leading the response. In addition, a new internal emergency notification tool was used to communicate with staff before coming in to the office

The established mass email communication process to inspected premises (e.g. food premises, personal service settings) who would be impacted by the boil water advisory were successful at reaching those premises in a timely manner.

Team huddles ensured that program assistants, office assistants, and intake staff had clearly defined roles and responsibilities, which contributed positively to the response.

IT responded quickly to website-related challenges by implementing user verification and a virtual waiting room system to manage increased web traffic.

Challenges

The initial BWA response took up most of the available on-call capacity, resulting in limited time and staff for operational planning for the following day. This limited the in-field response to only high- and moderate-risk food premises. Some food premises operators were reluctant to follow Public Health direction after hearing mixed messaging in the media that potential risks to health were low. Capacity was insufficient to arrange visits to other public facilities utilizing water for cleaning and disinfecting (e.g., high-risk personal service settings).

Website servers were affected by a cyberattack and by outages due to high public traffic, which was interpreted by security systems as a threat.

There were numerous calls from residents who were uncertain whether the advisory applied to their area. Using different terminology to describe the local geography may have caused confusion among residents. In response, Public Health developed a map of the affected areas, but there were internal delays in approving its release. Due to the cyberattack, the map was shared via social media instead of via Public Health's website.

Some Public Health Inspectors (PHIs) perceived the response as disorganized at times, particularly due to the absence of a plan to manage the anticipated volume of calls (Appendix B). The response team was not equipped to respond through a shared email account, resulting in staff using personal email accounts. In addition, the duty line could only be staffed by one person at a time, causing some delays at the beginning of the response. However, the team quickly addressed this issue by creating a Microsoft Teams group to re-distribute calls.

Recommendations

Short term

Enable Teams Phone functionality to support inquiry management and allow multiple staff to access shared phone lines and general inboxes.

Establish mechanisms to provide staff with timely updates on the situation and changes in responsibilities.

Determine which communications tools and templates are needed to facilitate a response and establish coordination mechanisms to execute such tools and templates when needed. For example, update and validate maps in advance to support communication activities.

Update Hedgehog features, including the functionality that links a water source to each premise within the inspection inventory.

Long term

Assess whether partial activation of the Incident Management System (IMS) would be appropriate for similar situations.

Conduct internal mock exercises with annual refreshers around internal communication, coordination, and incoming call surges, including administrative staff and office assisstants in these exercises.

Plan for high volumes of inquiries from the public during future large-scale BWAs, and other large scale incidents, and incorporate this consideration into contracts with telecommunications and web service providers.

Communication and Information Management

Successes

A communications team lead was assigned, providing consistency and ensuring information was shared within the response structure. The broader communications team wrote, reviewed, and translated messages, as well as coordinated with their CGS counterparts. The Associate Medical Officer of Health and a Manager served as spokespersons, and were readily available to respond to media inquiries. Frequent communication with the public was viewed positively.

Public Health maintained close communication with Health Sciences North (HSN), long-term care homes, school boards and food premises, providing regular updates and proactive outreach.

When the Public Health website experienced outages, information continued to be actively shared through alternative platforms such as Facebook and Instagram

Challenges

Because there was no obvious explanation for why *E. coli* and total coliforms were detected in the municipal water system, there was internal and external disagreement regarding how to communicate the uncertainty regarding risk to the public. As a result, there were delays in decision making regarding the release of some communications. The BWA also highlighted internal organization tensions between attempting to manage public interpretation of information and providing timely, transparent updates. As a result, the 24-hour update message was delayed because it had to be developed in real time, unlike the baseline and final communications, which were pre-drafted.

Separately, food premises identified that they required clearer guidance on how to operate during the advisory. Additional customized messaging had to be developed for high-risk food premises due to the complexity of the information, and Public Health's website did not contain information on how services should operate during a BWA.

Public Health did not have a specific internal communication protocol resulting in similar confusion internally. Internal staff did not receive direct notifications, posting internal signage over sinks and water fountains was delayed, and there was uncertainty regarding whether some services (e.g., sexual health clinic operations) could continue during the advisory.

Recommendations

Short term

Develop a protocol outlining how various Public Health services should operate during a BWA.

Develop or adopt existing provincial resources such as a Frequently Asked Questions (FAQ) document addressing what *E. coli* and coliform bacteria are and what risks they pose to the public.

Long term

Develop a proactive internal communications plan, including guidance on information sharing, public health staff frequently asked questions, and update existing fact sheets for both internal use and public distribution.

Collaborate with CGS to ensure coordinated and consistent messaging and clarification of roles and responsibilities.

Establish a proactive media engagement strategy, including social media, to reduce repetitive inquiries and improve information dissemination.

Develop protocols for alternative communication channels in the event of Public Health website outages.

Discussion

The abnormal microbiological results received on May 6, 2026 triggered a response involving Public Health and CGS. The positive *E. coli* and coliform results were unusual because they originated from multiple locations across two separate drinking water systems despite adequate free chlorine residuals and no other indicators of widespread contamination. To further evaluate the validity of the initial findings, a second set of samples was submitted through the Public Health Ontario Laboratory (PHOL) for independent testing. Although not routine practice, independent testing was undertaken to support decision-making and provide additional

assurance. Epidemiologic surveillance following the BWA taking place in CGS showed no deaths or cases of waterborne illnesses attributable to the incident.

Public Health rapidly established communication channels and response structures to manage the advisory, in collaboration with CGS. Leadership from both organizations remained engaged throughout the event, with regular communication between public health officials, city leadership, and operational staff. Although not without challenges, meetings were held to coordinate activities, assign responsibilities, and support decision-making. Established relationships between public health and municipal staff facilitated collaboration, while direct communication between operational managers helped address initial challenges related to information flow and role clarity. Outreach was also conducted with key stakeholders, including Health Sciences North, long-term care homes, school boards, childcare settings, and food premises operators, to provide guidance and address operational concerns.

Further investigation did not identify a definitive cause for the detection of bacteria in the water samples. Despite uncertainty regarding the cause, the event was an exercise of preparedness and response capacity during a large-scale BWA. The lessons identified emphasize the importance of clear communication, coordinated leadership, and adaptable response structures when managing uncommon but high-consequence drinking water incidents.

Literature shows that public compliance with BWAs is variable (between 68 and 98%) (3), which aligns with anecdotes of non-adherence among residents during the current BWA (we did not survey residents regarding adherence with the BWA recommendations). Noteworthy BWA affecting millions of residents include one affecting Sydney, Australia in 1998 and one affecting Boston, MA in 2010 (4,5). The former generated fear and anger across the community (4). A survey following the Boston BWA showed that younger individuals and racialized individuals were less likely to comply with BWA recommendations (5). The survey also revealed significant variations in how individuals first learned about the BWA: television news, family or friend, radio, internet, phone calls, newspaper, public officials and social media. Individuals who learned of the BWA on the first day (approximately 90%) were more likely to comply with recommendations, highlighting the importance of prompt communication.

Communication with the public and affected organizations was a major component of this BWA. Media releases were developed, updated, and translated as new information became available, while public messaging was disseminated through multiple channels. Public Health staff responded to a high volume of public inquiries and complaints. Environmental Health staff conducted site visits to priority food premises and provided direct guidance to operators regarding safe practices during the advisory. Public health leadership and designated spokespersons also responded to numerous media requests throughout the event. As the situation evolved, regular updates were provided to stakeholders and the public, culminating in the

communication and implementation of the rescission of the BWA once the necessary bacteriological evidence and operational assessments supported lifting the order.

The precautionary approach adopted during this incident should be considered within the broader Canadian drinking water context shaped by the Walkerton tragedy (6). In May 2000, Walkerton's drinking water system became contaminated with *E. coli* 0157:H7 and *Campylobacter jejuni*. This resulted in more than 2,300 illnesses, seven deaths, and multiple hospitalizations. It was concluded that the outbreak could have been prevented: lack of monitoring, underfunding and improper practices contributed to the system failures. In particular, when bacteria was detected in the water, there was the presumption that these lab results were likely a false positive, and so no action was taken. This information and other details were concealed from the local public health agency (Bruce-Grey-Owen Sound Health Unit). As a result, a BWA was issued only after reports of widespread illness in schools and hospitals emerged. Subsequent public inquiry findings identified failures in water system operations, monitoring, reporting, and communication, leading to substantial regulatory reforms and the adoption of a multi-barrier approach to drinking water protection (6,7). The event heightened public awareness of water safety and reinforced expectations for rapid, precautionary action when contamination is suspected, an approach applied during the Greater Sudbury BWA examined in this report.

The response demonstrated strong alignment with Health Canada's guidance for issuing and rescinding BWAs (1), particularly regarding verification of unacceptable microbiological quality samples through additional sampling, inter-agency consultation, ongoing risk assessment, and communication with affected partners. Other areas of strong alignment included the rapid assessment of the situation and following actions according to published decision trees, and communications containing the recommended elements of BWA notices and specific guidance.

Limitations of this report include a possible recall bias and the use of purposive sampling. The debrief meeting took place approximately six weeks after the incident, which is within the 3 months recommended by the WHO (8,9). Although a purposive sample was used, it captured the different sectors involved: communications, operations, front-line staff, managers, Medical Officer of Health and Associate Medical Officer of Health. Additionally, efforts were made to include the opinion of those who could not participate in the debrief; namely, administrative staff and a person from CGS. That diversity of participants is one of the strengths of this report, which enabled examination of the incident from several complementary viewpoints.

Next steps

AAR results will be shared with senior management and the Board of Health. The recommendations identified in this AAR address challenges and build on existing strengths, including preparedness exercises; leadership, internal coordination and staff communication;

technical capacity, documentation, tracking and monitoring; strengthening partnerships; and communications to the public. Overall, this AAR demonstrated the dedication and adaptability of Public Heath staff and partners in protecting community health, while identifying opportunities that will further strengthen preparedness for future drinking water emergencies.

Acknowledgements

Thanks to the staff and managers at Public Health and CGS involved in the response during the BWA, to those contributing to the debrief and to those contributing to the report, and to Dr. Oscar Javier Pico Espinosa, Resident Physician, Public Health and Preventive Medicine at NOSM University, for serving as lead author of this report.

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Appendix A: Debrief questions guide

Below are the questions that will be posed during **the debrief session taking place June 18th at 9:30 a.m**. We encourage you to review and reflect on these in advance of the session.

Planning

What planning activities were undertaken in advance of this boil water advisory that contributed to this response's success?

- Prompt: Were any emergency plans or protocols reviewed and used to guide the response? *May include internal tools such as the Emergency Readiness Checklist*
    - *Prompt: Were the plans, protocols, or templates used in the response helpful and easy to find?*
    - *Prompt: Were any parts of the response built in real time because planning tools were missing or unclear?*
- How well did existing plans, protocols, or templates support a boil water advisory in a large municipality?
    - *Prompt: What had to be adjusted because of the size of the municipality, the number of people affected, or the public's familiarity with boil water advisories?*

Operations: Delivery & Implementation

Consider the resources invested to support the delivery and implementation of the boil water advisory response efforts. Resources include:

Human resources: sufficient staff are available to meet the demands and responsibilities of the response.

Knowledge and training: staff are adequately and appropriately trained to meet the demands and responsibilities of the response.

Logistics of program/service delivery: there was adequate and appropriate support staff to assist in the response.

Partnerships and collaborations: new and established partners facilitated the implementation of Public Health's response.

- **What resources contributed to a successful boil water advisory response?**
    - *Prompt: What existing processes or resources helped the response go more smoothly?*

  - Prompt: What helped staff respond quickly and effectively?
- **What resources (or lack of) made Public Health's boil water advisory challenging?**
  - *Prompt: Were there any staffing, training, or logistical gaps?*
  - *Prompt: What created the most pressure during the response?*

Communications

Consider both internal and external communications that Public Health created and that were provided during this boil water advisory.

- **How did working with external partners support the boil water advisory response, and where were there challenges?**
  - *Prompt: Were there any gaps in coordination with partners?*
  - *Prompt: Were expectations between Public Health and partners clear?*
  - *Prompt: What would help partner coordination work better next time?*
- **What communications or communication strategies (internal and external) supported the success of Public Health's response?**
  - *Prompt: What helped make these communication strategies successful?*
  - *Prompt: Were messages clear about who was affected, what actions were needed, and when the advisory would end?*
- **What communications or communication strategies were not effective or should be modified for future boil water advisories?**
  - *Prompt: What changes would make these communications more effective next time?*
  - *Prompt: What questions or misunderstandings came up most often?*
- **How did we ensure that equity-denied or underserved populations were supported?**
  - *Prompt: Were partners or community groups representing equity-denied populations included in the response?*
  - *Prompt: Were there any groups that may not have received, understood, or been able to act on the information?*

Tracking and monitoring

Tracking and monitoring can refer to the communication or operations aspect of the response.

- **What aspects of tracking and monitoring were successful during this boil water advisory? *Consider operational and communication tracking/monitoring.***
    - *Prompt: What helped make these tracking and monitoring activities successful?*
    - *Prompt: How were the needs and strengths of equity-denied or underserved groups considered?*
- **What were some of the monitoring challenges encountered during this boil water advisory?**
    - *Prompt: What made these monitoring activities challenging?*
    - *Prompt: Were there any information gaps that made monitoring harder?*

Recommendations for improvements

- Considering everything we've talked about today, what recommendations do you have to improve how Public Health issues drinking water advisories, especially large-scale advisories in the City of Greater Sudbury, where scale and public unfamiliarity may have created unique challenges?
    - *Prompt: What is one part of the response that should always be included in future boil water advisory responses?*
    - *Prompt: What worked well in the transition from active response to lifting the advisory?*
    - *Prompt: Are there any materials (templates, maps, etc.) that can be prepared in advance that would help staff and partners feel more ready next time?*

Appendix B: Analytics

Web Analytics

- Initial NR and updated version (May 6 to 7 traffic): 75 039 (views), 45 652 (users).
- Second NR (May 7 to 8): 8 392 (views), 6 030 (users).
- Third NR [samples] (May 7 to 8): 4 475 (views), 3 233 (users).
- 4th NR [lift] (May 8 to 9): coincides with Cyber attack. Loss of analytics.
- 5th NR [PHO results]: Cyber attack analytics blackout

Social Reach

Facebook: [totals] – Full NR details includes in each post along with NR ULR to phsd.ca

- NR (BWA issued) and update: 378 360 reach, 1 252 395 views, 404 885 viewers
- NR (BWA remains in effect, first set of results): 107 576 reach, 235 772 views, 107 721 viewers
- NR (BWA, update, remains in effect): 91 075 reach, 218 612 views, 91992 viewers
- Map post: 55 788 reach, 138 954 views, 56 392 viewers
- NR (BWA lift): 130 634 reach, 320 795 views, 129 211 viewers
- NR (PHO results): 20 241 reach, 37 347 views, 20 849 viewers

Phone calls

Extension 464 (*see note below)

- May 7: 109 calls
- May 8: 83 calls
- May 11: 59 calls
- Total: 251

Hunt Pilot 398

- May 7: 44 calls
- May 8: 33 calls

- May 11: 31 calls
- Total: 108

Calls to Front Desk reception:

- These calls reflect the increase from the baseline of 200-250 calls normally received in a day:
    - May 6: 345 calls
    - May 7: 1,324 calls
    - May 8: 258 calls

Calls to PHI on-call (provided to us by Northern Communications)

The timeframe for these stats are from 4:30 pm to 8:30 am as they are after-hours calls:

- May 6th-7th 5 calls
- May 7th-8th 1 call
- May 8th-9th 1 call
- May 9th-10th 2 calls
- May 10th-11th 0 calls
- May 11th-12th 0 calls

*464 duty inspector line was not previously a Hunt Group but is now. This allows for multiple people to answer the duty line at the same time by toggling on and off the button for that call cue. This will save time for the office assistantss transferring calls and trying to figure out which public health inspector is free.

Public Health
Santé publique
SUDBURY & DISTRICTS

Briefing Note

To: Board of Health for Public Health Sudbury & Districts

From: M. Mustafa Hirji, Medical Officer of Health & CEO

Date: 2026/09/10

Re: Board of Health Skills & Competencies Matrix 2026

☐ For Information ☐ For Discussion ☒ For a Decision

Issue:

A Board of Health Skills and Competencies Matrix is proposed as a live governance tool to support skills-based recruitment, orientation, training, self-evaluation, and committee assignments.

Recommended Actions:

1. That the Board of Health approve the proposed Board of Health Skills and Competencies Matrix as a live governance tool.
2. That the Skills and Competencies Matrix be shared with municipalities and the Public Appointments Secretariat with the request that it inform appointments to the Board of Health.
3. That the Skills and Competencies Matrix be reflected in a question on the Board of Health Self-Evaluation.
4. That the Skills and Competencies Matrix be used to assess gaps in skills and competencies of appointed Boards, and that inform training and development plans for the Board.
5. That the Skills and Competencies Matrix be used to inform the board of Health's committee assignments.

Alternative Actions:

N/A

Background:

In 2025, the Board of Health considered governance lessons arising from communications shared with Ontario boards of health regarding correspondence between the Chief Medical Officer of Health and the Chair of the Grey Bruce Health Unit Board of Health. The discussion highlighted risks to Board governance, including governance training, financial oversight, and safeguards to ensure that municipal political considerations do not influence Board deliberations.

At the September 2025 meeting, the Board of Health adopted a motion recommending the development of a comprehensive skills matrix to support future appointments by municipalities and the Public Appointments Secretariat. This direction also built on the Board's recent recommendation that

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2024–2028 Strategic Priorities:

1. Equal opportunities for health
2. Impactful relationships
3. Excellence in public health practice
4. Healthy and resilient workforce

municipalities appoint an Indigenous person to the Board of Health. Skills-based governance has been recommended for Ontario's local public health system since the 2008 Capacity Review Committee, and skills matrices are used in other sectors to support the selection and operation of skills-based boards. Several local public health agencies in Ontario have adopted skills matrices, including Algoma Public Health, Southwest Public Health, and Grey Bruce Public Health, as of summer 2026.

Strong governance requires an appropriate balance of competencies, experience, and perspectives across the Board. A skills-based approach shifts the focus from having diversity based primarily on geography (the municipal council appointing members) toward the intentional selection of members who bring the skills, knowledge, and perspectives needed to govern public health effectively.

A balanced Board composition supports strategic oversight, fiduciary duty, continuity through membership changes, and effective governance of the public health unit. Given renewed provincial attention to Board of Health governance and the long-standing recommendation for skills-based governance in Ontario's local public health system, this is an important opportunity for PHSD to act on a long-outstanding recommendation and demonstrate provincial leadership. The matrix is intended to inform and guide appointment-related discussions, while recognizing that final appointment decisions remain with municipalities and the Public Appointments Secretariat.

The proposed matrix was developed through a review of provincial legislation, organizational standards, published governance competencies, other boards of health and board of directors' matrix templates, recent peer-reviewed modified Delphi studies, and expert opinion.

Skills matrices for many other boards that were reviewed documented a comprehensive set of skills of use to the board—often 15-20. For Public Health Sudbury & Districts, a more strategic approach has been taken: a shorter list of skills that aligns with where the Board most needs to focus to support organizational success. The resulting matrix is a strategic set of 10 competences and one additional factor. This shorter list not only seeks to focus the Boad strategically but is also pragmatic in that with a total of only 13 board members, a lengthy list of skills would be unwieldy for appointing bodies to capture all.

The proposed matrix organizes priority competencies into two categories:

Core competencies expected of each Board member:

- Governance, strategic and systems thinking, and fiduciary duty
- Ethics, integrity, and conflict of interest
- Collaboration, communication, and Board readiness
- Public health literacy and population health thinking
- Health equity, Indigenous relations, and community responsiveness

Collective expertise to be represented across the Board:

- Financial oversight and audit
- Risk oversight
- Organizational transformation

- Government relations, advocacy, and public policy
- Workforce and executive oversight

Diversity of perspective is also identified as an essential consideration across the Board's overall composition. This includes, but is not limited to, gender diversity, cultural and racial diversity, Francophone representation, Indigenous representation, and lived or professional experience that reflects the communities served by PHSD. The Board's resolution to seek Indigenous representation on the Board of Health is incorporated into this approach.

The Skills and Competencies Matrix is proposed to be used in the following ways:

- **Recruitment:** The matrix would provide municipalities and the Public Appointments Secretariat with a clear description of the skills, competencies, and perspectives needed on the Board. It would help identify priority gaps before each appointment cycle and support more intentional recruitment of members whose experience strengthens the Board's overall governance capacity, including representation that reflects the communities PHSD serves.

- **Orientation & Training:** The matrix would help clarify expectations for new and returning Board members and align orientation content with the competencies required for effective governance. It could also be used to identify individual or collective learning needs across the Board and inform annual training priorities.

- **Committee Assignments:** The matrix would support more deliberate matching of Board members to committees based on their skills, experience, and development interests. This would help ensure that committees have the collective expertise needed to fulfill their mandates, while also creating opportunities for members to build knowledge in areas that support succession planning and stronger overall Board performance. It is proposed that that the Board of Health Executive Committee would assess skills at the first meeting of the year and share that assessment with the full Board to inform committee assignments.

- **Self-Evaluation:** The matrix would provide a structured dimension for Board self-assessment by helping members reflect on the Board's collective competency profile. Over time, this would support continuous learning, identify emerging gaps, and provide useful information for future recruitment, orientation, training, and Board development planning.

Together, these applications would help identify priority gaps before appointment cycles, clarify expectations for new and returning members, align training priorities with governance needs, support more deliberate committee assignments, and provide a structured dimension for ongoing Board self-assessment and development.

Financial Implications:
No direct financial implications are anticipated. Implementation would occur through existing recruitment, orientation, self-evaluation, and committee assignment processes. Any future training needs would be considered through existing planning and budget processes.

Impacts on Strategic Priorities or Medium-Term Operational Priorities:
The matrix supports the 2024–2028 Strategic Plan and medium-term operational priorities by aligning desired Board competencies with what is needed to advance those plans and priorities. This includes sustaining services in a challenging fiscal environment, advocating to government, supporting the organization through ongoing change, and participating in Indigenous engagement.

Impacts on Risk Management Plan:
The matrix supports risk management by helping the Board identify gaps in collective expertise before they affect governance, oversight, or decision-making. It also supports continuity planning as Board membership changes over time.

Impacts on Fulfillment of the Ontario Public Health Standards:
The matrix supports fulfillment of the Ontario Public Health Standards by strengthening Board capacity for governance, accountability, population health thinking, health equity, Indigenous engagement, and evidence-informed decision-making.

Contact:
Dr. Chidubem Okechukwu, PGY5 NOSM University PHPM Resident
Dr. M. Mustafa Hirji, Medical Officer of Health and CEO

Public Health
Santé publique
SUDBURY & DISTRICTS

Board of Health Member Skills & Competencies Matrix
Adopted September 2026

Skill / Expertise	Description	Expectation
CORE COMPETENCIES		
Governance, strategic and systems thinking & fiduciary duty (Priority 1)	Upholds the Board's legislated role in strategic oversight, policy direction, and fiduciary duty under the Health Protection and Promotion Act; uses systems thinking to support strategic planning and priority-setting aligned with the Board's strategic plan, risk management plan, and medium-term operational priorities.	All members at appointment
Ethics, integrity & conflict of interest (Priority 1)	Acts with integrity, protects confidential and privileged information, and identifies and manages conflicts of interest in decision-making.	All members at appointment
Collaboration, communication & board preparation (Priority 1)	Communicates clearly, listens actively, works constructively with differing perspectives, and reliably prepares for and participates in meetings and orientation.	All members at appointment
Public health literacy & population health thinking (Priority 2)	Uses core public health concepts, including prevention, health promotion, health protection, and determinants of health, as well as evidence-informed decision-making to consider how Board decisions affect population health outcomes.	All members, potentially through training
Health equity, Indigenous relations & community responsiveness (Priority 2)	Applies an equity, cultural safety, and reconciliation lens to Board decisions, considering how social, economic, cultural, linguistic, Indigenous, geographic, rural/northern, and Francophone community factors affect access to services and population health outcomes.	All members, potentially through training
COLLECTIVE EXPERTISE		
Financial oversight & audit (Priority 1)	Interprets budgets, audited financial statements, and long-range fiscal plans, and makes sound resource-allocation decisions.	Two or more members
Risk oversight (Priority 1)	Brings specialized expertise in risk management, including enterprise sustainability, reputational management, and responding to a dynamic external context, as well as cyberthreat preparedness, emergency preparedness, and business continuity.	Two or more members
Organizational Transformation (Priority 1)	Provides expertise in workforce modernization, digital transformation, innovating service delivery, and managing reputation through change.	Two or more members
Government relations, advocacy, & public policy (Priority 1)	Builds cross-sector and intergovernmental relationships, navigates political systems, anticipates policy and political trends, advocates for public health and healthy public policy, and supports public/media communication to advance popular and political standing.	Two or more members
Workforce & executive oversight (Priority 2)	Provides expertise in workforce strategy, labour relations, organizational culture, change leadership, and executive oversight, including Medical Officer of Health/CEO recruitment, performance evaluation, and succession planning.	One or more members
DIVERSITY OF PERSPECTIVE		
Dimensions of Diversity (Priority 1)	In addition to the geographic diversity inherent in municipal appointments, Board membership should include diversity of gender, race, and francophone identity as a primary consideration, with at least one Indigenous member across its overall composition. While a small Board cannot include all dimensions of diversity, representations across age, sexual orientation, and disability are also desirable.	Across overall Board composition

Notes

- Skills and expertise included reflect the competencies **most significant in the next several years** to fulfilling the Board's governance responsibilities, managing current and anticipated critical risks, and advancing the agency's strategic and operational priorities.
- **Core Competencies** are fundamental to the effective function of the Board and should be present in all members.
- **Collective Expertise** reflects areas where the Board benefits from having one or more members with relevant knowledge, experience, or professional expertise. These competencies do not need to be held by every Board member but should be represented across the Board's overall composition.
- **Priority rankings** reflect the extent to which competencies are expected at the time of appointment and the level of representation required across the Board.
- **Priority 1** competencies should generally be present upon appointment (core skills) or represented through multiple Board members (collective expertise), while **Priority 2** competencies may be strengthened through orientation and training (core skills), or be present in only one member (collective expertise).

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SKILLS & COMPETENCIES MATRIX – BOARD OF HEALTH FOR PUBLIC HEALTH SUDBURY & DISTRICTS

MOTION:

WHEREAS the Capacity Review Committee of 2006 recommended that Ontario move towards Skills-Based Boards of Health;

AND WHEREAS the provincial government has not implemented that recommendation;

AND WHEREAS Skills Matrices are a best practice in other sectors to support the appointment of Skills-Based Boards;

AND WHEREAS the Board of Health directed the Medical Officer of Health & CEO in Motion #39-25 to "recommend a comprehensive skills-matrix to guide municipalities and the Public Appointments Secretariat in future Board of Health appointments";

BE IT RSOLVED THAT the Board of Health approve the Skills and Competencies Matrix;

THAT the Board of Health endorse the Skills and Competencies Matrix to be used to support Board recruitment, training, self-evaluation, and committee assignments;

THAT the Medical Officer of Health and CEO be directed to communicate the Skills and Competencies Matrix to municipalities and to the Ontario Public Appointments Secretariat, encouraging they use it for selection of Board members in upcoming vacancies;

THAT the Medical Officer of Health and CEO be directed to incorporate the Skills and Competencies Matrix into future Board of Health Self-Evaluations surveys;

THAT the Board of Health endorse a committee selection process where the Executive Committee would assess the skills and competencies of Board members, and share their assessment with the Board of Health to guide committee appointments.

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Briefing Note

To: Board of Health for Public Health Sudbury & Districts

From: M. Mustafa Hirji, Medical Officer of Health and Chief Executive Officer

Date: September 10, 2026

Re: Board of Health Manual Review – 2026

☐ For Information ☐ For Discussion ☒ For a Decision

Issue:
As per Board Policy A-III-10, the Board of Health Manual has been reviewed in its entirety and revisions are recommended for Board of Health approval. In particular, this year's review sought to streamline and slightly reduce the size of the Manual in preparation for Board of Health membership turnover after municipal elections.

Recommended Action:

THAT the Board of Health approve the Manual as presented on this date.
THAT the Board of Health adopt the amendments to the following bylaws:

- By-Law 04-88 concerning proceedings of the Board of Health
- By-law 01-93 concerning signing authorities and financial matters

AND THAT the Board of Health adopt new titles ("subject") for each By-Law as outlined in this Briefing Note.

Background:

- To support the review of the Board of Health Manual, each policy, procedure, information sheet, and by-law was assigned to a member of Senior Management Executive Committee for review. Proposed amendments were summarized and reviewed by the MOH/CEO for recommendation to the Board of Health for approval.
- At its May 21, 2026, meeting, the Board of Health Executive Committee sought clarification as to whether Board members absent at a meeting could move or second the approval of the meeting notes for that meeting.
    - Based on a review with the assistance of Microsoft CoPilot, it was found that
        - The **Health Protection and Promotion Act** does not prescribe who can move or second motions.
        - The **Municipal Act** requires a procedure by-law governing meeting proceedings but does not require that only attendees of the previous meeting can move, second, or vote on approval of minutes.
        - **Bourinot's Rules of Order** provide that any member may move a motion that is in order and generally requires a seconder; they do not restrict movers or seconders to members who attended the meeting being approved.
    - By-law 04-88 expressly permits any Board member, including the Chair, to move or second a motion. The by-law contains no requirement that a member must have been

present at the meeting to which the minutes relate in order to move, second, or vote on their approval.

Board review:

- Proposed revisions from the Board of Health Manual are displayed via tracked changes.
    - Revisions considered substantive are *appended* to this briefing note.
    - Revisions considered housekeeping/minor in nature listed below and are not included in the agenda package to streamline the volume of material for Board member review. Any Board member can request to the Board Secretary to review the housekeeping and minor edits, if interested.
- During the 2026 manual review, **housekeeping and minor** revisions were identified for the following:
    - B-I-13 Services to the Francophone Population includes minor revision to change the *Ontario Public Health Standards* reference to 2027 rather than 2021 (imminent update to the OPHS)
    - C-I-13 Membership includes minor updates to language and legislative citations
    - C-I-16 Conflict of Interest Policy and Procedure includes inclusive pronouns
    - C-II-11 Board Finance Standing Committee Terms of Reference includes minor language updates and updated meeting timeframes to reflect current practice
    - D-I-15 Health Unit Catchment Areas revised to remove reference to the number of local public health agencies, given changes to the number due to mergers
    - D-II-10 Funding Sources: Updates to clarify language
    - F-I-10 Community Liaison: removes references to former OPHS guidelines
    - G-I-10 By-law 01-88: Updated Subject title to specify *Management of Property* and removed lead in sentence
    - G-I-20 By-law 02-88: Updated Subject title to specify *Appointment and Duties of Auditor* and removed lead in sentence
    - G-I-50: Updated Subject Title to specify *Private Sewage Systems*, short title clarified as Private Sewage Systems and additional language included relating to the electronic submission of plans
    - G-I-60 By-Law 02-02: Updated Subject title to specify *Building Code Act Appointments*
    - G-I-70 By-Law 12-05: Updated Subject title to specify *Financial Reserves*
    - H-I-10 Professional Practice Support and Workforce Capacity Building Policy: Minor wording revisions proposed to reflect contemporary public health workforce development and professional practice concepts, including continuous learning, reflective practice, and alignment with the PHAC Core Competencies for Public Health in Canada (Version 2.0).
    - I-I-10 Remuneration and Expenses Policy and Procedure: minor updates

[0] 2024-2028 Strategic Priorities:

1. Equitable opportunities for health
2. Impactful relationships
3. Excellence in public health practice
4. Healthy and resilient workforce

- Proposed **substantive** revisions include the following:
  - A-I-10: Merge A-II-10 and A-III-10 Policies and Procedure into one Policy (A-I-10)
  - B-I-10: Merge with B-I-11 Strategic Plan and B-I-12 Strategic Priorities into one Policy (B-I-10). B-I-10 Policy Manual header (Category, Section and Subject) updated accordingly. The current strategic plan is now included as Appendix A in the Manual
  - C-I-11: Merge J-I-10 Ontario Public Health Standards and components moved to C-III-10
    - NOTE: It is recommended this be amended to the soon-to-be-approved new OPHS, with a delayed date of effect of January 1, 2027, ensuring incoming Board gets an up-to-date manual
  - C-I-12 Board of Health Roles and Responsibilities: Language clarification regarding accountability
  - C-III-10: Merge C-I-10 and C-II-11 into C-III-10 Governance Philosophy, Management Philosophy & Organizational Structure Information Sheet. Subject header renamed from Board of Health Mandate to Legislative Foundation. The current Public Health Sudbury & Districts' organizational chart is included as Appendix B
  - C-III-11: clarifying language, including re: Associate Medical Officer of Health having similar skills and qualifications to the Medical Officer of Health to be able to cover that role
  - C-IV-10 Ethical Practice of Public Health includes revisions to reflect contemporary public health practices and alignment with current terminology in the PHAC Core Competencies for Public Health in Canada
  - D-I-10: Merge D-I-11, D-I-12, D-I-14 and D-I-16 into D-I-10 Information Sheet. Updated Section and Subject names in the Information Sheet header and language revised
  - E-I-11 Preparation of Agenda Procedure: Updates to incorporate E-I-12 and official record keeping. Procedure Subject is renamed to Preparation & Distribution of the Agenda
  - E-I-13 Minutes/Motions Policy: Updates to incorporate E-I-14 Policy
  - E-I-13 Minutes/Motions Procedure: Updates to reflect format change for retention
  - E-I-15 Preparation of a Closed Meeting Agenda Procedure: Merge with F-III-19 and additional revisions to provide clarification
  - F-III-10 Freedom of Information Policy: Updates to delegation rules to include the Associate Medical Officer of Health
  - G-I-30 By-Law 04-88 revisions and updates to reference signing authorities in bylaw 01-93, edited to be use inclusive gender language; and added provisions for an Acting Chair when Chair and Vice-Chair are both unavailable or during periods where there is no Chair (e.g. between the end of one Board term and the first meeting of the next term). Updated Subject title to specify *Board of Health Proceedings*

[0] 2024-2028 Strategic Priorities:
1. Equitable opportunities for health
2. Impactful relationships
3. Excellence in public health practice
4. Healthy and resilient workforce

  - G-I-40 By-Law 01-93: Proposed major revision to create distinct authorities around financial approvals, procurement and document execution, and to modernize rules around banking. Updated Subject title to specify *Signing Authority, Financial Administration, and Procurement*
  - I-IV-10 Hiring of MOH, AMOH and Professional Staff: Change Policy to Information Sheet, with proposed addition for Associate Medical Officer of Health
  - I-VI-10 Performance Appraisal of MOH/CEO Procedure to improve clarity and align with current practice
- *Changed Status*
  - A-I-10 Purpose, Distribution/Access, Maintenance, Review Cycle Information Sheet to Policy
  - B-I-10 Strategic Plan Information Sheet to Policy
  - I-III-10 Orientation of Board Members: Procedure to Information Sheet
  - I-IV-10 Hiring of MOH and Professional Staff: Change Policy to Information Sheet
- Repealed
  - A-II-10 Distribution: information merged into A-I-10 Policy
  - A-III-10 Review cycle: information merged into A-I-10Policy
  - B-I-11 Strategic Plan: information merged into B-I-10 Strategic Planning Policy
  - B-I-12 Strategic Priorities: information merged into B-I-10 Strategic Planning Policy
  - C-I-10 Organizational Structure: information merged into C-III-10 Governance Philosophy, Management Philosophy, & Organizational Structure Information Sheet
  - D-I-11 Public Health Ontario: information merged into D-I-10 Information Sheet
  - D-I-12 Association of Local Public Health Agencies: information merged into D-I-10 Information Sheet
  - D-I-14 Ontario Public Health Association: information merged into D-I-10 Information Sheet
  - D-I-16 Ontario Health: Information merged into D-I-10 Information Sheet
  - E-I-10 Board Proceedings Policy
  - E-I-12 Distribution of Agenda Procedure
  - E-I-14 Posting and Circulation of Board Minutes Policy
  - F-II-20 Annual Report
  - F-III-10 Freedom of Information Procedure: merged into E-I-15 Procedure
  - I-II-10 Public Member Appointments to Board of Health Information sheet
  - I-III-10 Orientation of Board Members Policy

[0] 2024-2028 Strategic Priorities:
1. Equitable opportunities for health
2. Impactful relationships
3. Excellence in public health practice
4. Healthy and resilient workforce

- I-V-10 Board of Health Mobile Device Use Policy, Procedure and Form: Repealed as Board members now use their own devices and laptops, reducing equipment costs and administrative requirements associated with device management and support
- J-I-10 Ontario Public Health Standards Protocols and Relevant Legislation

Next Steps:

- Approved revisions will be updated on the Public Health Sudbury & Districts website.
- The Board of Health Manual is accessible through the BoardEffect application in the Board of Health workroom – Library – Handbooks.
    - Following Board approval, the updated manual will be posted on BoardEffect.
- The Board of Health Manual will be updated in SharePoint Online for staff to access.
- Per A-III-10 the Board of Health Manual will be reviewed in its entirety in 2028. Any more pressing revisions will be brought forward separately from the revision cycle for Board approval.

Financial Implications:
None

Impacts on Strategic Priorities or Medium-Term Operational Priorities:
No direct impacts, however, this work aligns with the *Excellence in Public Health Practice* Strategic Priority.

Impacts on Risk Management Plan:
This work does not impact currently identified risks in the Risk Management Plan 2026-2028.

Impacts on Fulfillment of the Ontario Public Health Standards:
This work aligns with fulfilling the Good Governance and Management Practices Domain of the Ontario Public Health Standards.

Author:
Rachel Quesnel, Executive Assistant and Secretary to the Board of Heath

[0] 2024-2028 Strategic Priorities:
1. Equitable opportunities for health
2. Impactful relationships
3. Excellence in public health practice
4. Healthy and resilient workforce

Board of Health Manual
Public Health Sudbury & Districts

~~Information Sheet~~Policy

Category
~~Introduction~~Governance

Section
Board of Health Manual Framework~~Purpose of Manual~~~~Board of Health Manual Administration and Maintenance~~

Subject
Purpose, Distribution/Access, Maintenance, Review Cycle

Number
A-I-10

Approved By
Board of Health

Original Date
September 4, 1991

Revised Date
~~June 21, 2018~~September 17, 2026

Review Date
~~September 19, 2024~~September 17, 2026

Information
The purpose of the Board of Health Manual is to ~~outline~~ document the governance practices of the Board of Health. The Manual contains the by-laws, ~~information,~~ policies, ~~and~~ procedures and other information that describe the key governance context, roles, responsibilities, and functions of the Board of Health.

The Board of Health will maintain written bylaws, policies and procedures describing its activities. These shall be consistent with the vision, mission, and values of the Public Health Sudbury & Districts; applicable legislation and regulations, directives and policies of relevant ministries, including the Ministry of Health and the Board of Health's own bylaws.

Policies will generally also be coherent with the general policies established by the constituent municipalities whenever reasonable.

The legal name is “Board of Health for the Sudbury and District Health Unit”. For the purpose of this manual, the operating names, “Board of Health” or “Public Health Sudbury & Districts” are used.

This manual ~~is intended to~~shall function~~s~~ in conjunction with the ~~General Administrative Manual which outlines the management and~~ operational policies and practices of Public Health Sudbury & Districts~~. Public Health Sudbury & Districts will also maintain divisional and program policies in relation to its programs, services and operations. Such policies should be consistent with the Board of Health vision, mission, values, strategic plan, policies and goals~~, created under the authority of the Medical Officer of Health/Chief Executive Officer and delegates. .

Maintenance

~~The~~One print copy of the Board of Health manual will be ~~distributed~~maintained ~~in print copy as follows:~~

- ~~Boardroom~~

~~Board Secretary~~for emergency use.

The Board of Health manual will be made available electronically for all staff, to Board members, and to the public~~access~~.

~~The Board of Health manual will be available electronically to Board members and to the public.~~

Review Cycle

Board of Health by-laws, policies, and procedures shall be reviewed at least every two years and revised as necessary.

The Medical Officer of Health/Chief Executive Officer and staff are responsible for developing and presenting policy options to the Board of Health for consideration. The Board of Health is responsible for establishing policy direction. The Medical Officer of Health/Chief Executive Officer and staff are responsible for implementing Board-approved policies and associated procedures.

Board of Health Manual
Public Health Sudbury & Districts

Policy ~~and Information~~

Category
Strategic Direction~~Plan/Vision/Mission/Priorities/Plan~~

Section
~~Health Unit~~Strategic Direction

Subject
Strategic Plan ~~Vision/Mission~~

Number
B-I-10

Approved By
Board of Health

Original Date
January 26, 1986

Revised Date
~~January 18, 2024~~September 17, 2026

Review Date
September 1~~7~~9, 2026~~4~~

Every three to five years, ~~Information~~Purpose of Strategic Plan

Public Health Sudbury & Districts shall ~~have~~ develop a strategic plan that expresses the mission, vision, values, goals, and ~~objectives~~priorities of the Board of Health for the period of the plan.

The strategic plan will

~~E~~establish strategic priorities that reflect how the vision and mission of the organization can most effectively be advanced given current capacity, internal context, community needs and perspectives, and the external environment. In particular, the strategic plan will make conscious choices about where effort and investment will be focused, recognizing that prioritizing some opportunities necessarily means not pursuing others.

- ~~addressing local contexts and integrate local community priorities.~~
- ~~Consider organizational capacity.~~

- ~~Include input from staff, clients, and community partners.~~
- ~~Reflect the local, provincial and federal context, and examine key influencing forces.~~
- ~~Establish policy direction regarding a performance management and quality improvement system.~~
- ~~Address equity issues in the delivery and outcomes of programs and services.~~

The Board of Health will ensure that ~~administration~~the Medical Officer of Health & Chief Executive Officer

- ~~Provides an operational plan to implement the strategic plan~~
- ~~Implements~~Proposes a monitoring ~~plan~~framework for the strategic plan
- Reports periodically to the Board on the progress of the strategic plan
- ~~Provides~~Aligns budgets and operational plans ~~an operational plan to implement~~ to implementing the strategic plan

~~The strategic plan will cover a three to five year timeframe, is reviewed at least every other year, and is reported upon regularly to the Board of Health through staff reports during the current timeframe.~~

~~The Strategic Plan will set direction for the organization and will be operationalized by the Medical Officer of Health and Chief Executive Officer.~~

~~Vision Statement~~

~~O: 04-02~~
~~R: 52-12~~

~~Healthier communities for all.~~

~~Accomplishing this vision is based on our ability to build on the following values:~~

- ~~Humility~~
- ~~Trust~~
- ~~Respect~~

~~Mission Statement~~

~~O: 06-99~~
~~R: 65-23~~

~~Working with local communities to promote and protect health and to prevent disease for everyone.~~

~~Strategic Priorities~~

~~The following are the strategic priorities for the 2024-2028 strategic planning cycle:~~

1. ~~Equal opportunities for health~~
2. ~~Impactful relationships~~

3. Excellence in public health practice

4. Healthy and resilient workforce

Board of Health Manual
Public Health Sudbury & Districts

Information Sheet

Category
Board of Health Structure & Function

Section
Board of Health

Subject
~~Board of Health Mandate~~Legislative Foundation

Number
C-I-11

Approved By
Board of Health

Original Date
January 16, 2003

Revised Date
September 1~~7~~5, 2026~~2~~

Review Date
September 1~~7~~9, 2026~~4~~

Information

Health Protection & Promotion Act

The Health Protection and Promotion Act (HPPA) ~~was proclaimed in July 1984. The HPPA is an important piece of legislation for a board of health, as it~~ prescribes the existence, structures, governance, and functions of boards of health, as well as the activities of medical officers and certain public health functions of the Minister. The Act and its regulations provide the legislative framework for the "organization and delivery of public health programs and services, the prevention of the spread of disease and the promotion and protection of the health of the people of Ontario". R.S.O. 1990, c.H.7, s.2

There are many different Regulations under the HPPA, including those that govern food safety, swimming pool health and safety, rabies control, school health, board of health composition and control of communicable diseases.

The Health Protection and Promotion Act establishes boards of health and invests in them the duty to provide or ensure the provision of health programs and services to the people who reside within the health unit. The required programs and services include~~:~~

- Community Sanitation
- Control of Infectious Diseases and Reportable Diseases
- Health Promotion, Health Protection and Disease and Injury Prevention
- Family Health
- Collection and Analysis of Epidemiological Data

Ontario Public Health Standards

Pursuant to Section 7 of the Health Protection and Promotion Act, t~~T~~he Ontario Public Health Standards~~: Requirements for Programs, Services, and Accountability (2021)~~ and the related Protocols and Guidelines are issued by the Minister of Health, and expand on the above statutory list by mandating additional programs that must be offered, and prescribing or advising on the details of how they are delivered. ~~are published as the guidelines for the provision of mandatory health programs and services by the Minister of Health, pursuant to Section 7 of the Health Protection and Promotion Act.~~

The Ontario Public Health Standards ~~(2021)~~ define responsibilities of boards of health as they pertain to foundational and program standards; but also accountability and organizational requirements; and transparency and reporting.

~~In carrying out its mandate, the Board of Health provides a policy framework within which the MOH/CEO defines the health needs of the community and design programs and services to meet these needs. The Board approves all programs and services.~~

The following standards are currently published:

- Foundational Standards
  - Population Health Assessment and Surveillance
  - ~~Health Equity~~
  - Effective Public Health Practice
    - Health Equity
    - Planning and System Coordination
    - Quality, Evaluation, and Knowledge Exchange
    -
  - ~~Emergency Management~~

- Program Standards
  - Comprehensive Health Promotion
  - Emergency Management
  - ~~Chronic Disease Prevention and Well-Being~~
  - Food Safety
  - Health Hazard Management
  - Immunization
  - ~~Healthy Environments~~

- ~~Healthy Growth and Development~~
- ~~Immunization~~
- Infectious and Communicable Diseases Prevention and Control
- Safe Water
- ~~School Health, Oral Health, and Vision~~
- Substance Use ~~and Injury~~ Prevention

Note: The Ministry of Children, Community and Social Services is responsible for the administration of Healthy Babies Healthy Children~~.~~

Boards of health may deliver additional programs and services in response to local needs identified within their communities, as acknowledged in Section 9 of the *HPPA*. Additional programs must be approved by the municipalities in the health unit.

The Protocols[i] that accompany the OPHS are program and topic specific documents which provide direction on how boards of health must operationalize specific requirement(s) identified within the OPHS and guidelines.

Boards of health have duties and responsibilities under other applicable Ontario laws, including but not limited to, *the Building Code Act, the Child Care and Early Years Act, the Employment Standards Act, the Immunization of School Pupils Act, the Occupational Health and Safety Act, the Personal Health Information Protection Act, Healthy Menu Choices Act, 2015, the Smoke-Free Ontario Act 2017, the Skin Cancer Prevention Act, and the Safe Drinking Water Act.*

~~The Board adopts a philosophy and management process that allows it to carry out its mandate in an efficient, effective and economical manner and complement this with a sound organizational structure, which reflects the responsibilities of the component parts.~~

~~The primary foci of the Board of Health are planning and policy development, fiscal arrangements and labour relations and accountability and reporting to the Ministry. The Board is not involved in day-to-day management decisions, such as approving vacations, staff training, travel expenses, etc. These day-to-day management decisions are the responsibility of the Medical Officer of Health/Chief Executive Officer and the Board develops policies to guide the Medical Officer of Health/Chief Executive Officer and other senior staff in such decisions.~~

[ii] Ministry of Health website:

i. https://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/protocolsguidelines.aspx#protocols (retrieved August 17, 2022)

Board of Health Manual
Public Health Sudbury & Districts

Information Sheet

Category
Board of Health Structure & Function

Section
Board of Health

Subject
Board of Health Roles and Responsibilities

Number
C-I-12

Approved By
Board of Health

Original Date
January 25, 2001

Revised Date
September 179, 20264

Review Date
September 179, 20264

Information

Summary
The Board of Health is convened in accordance with the Health Protection and Promotion Act (HPPA), RSO 1990, and Regulations thereunder. The Board of Health is composed of membersProvincial appointmentsed to the Board are made under section 49 under the of the HPPAHealth Protection and Promotion Act, RSO 1990 and Regulations. Municipal members are appointments are madeed by Municipal Councils as outlined in Regulation 559.

The Board of Health is the legal authority entity for Public Health Sudbury and Districts. The Board of Health is accountable to the community for ensuring that health needs are addressed by appropriate programs and that the organization is effectively governed.

Role

The Board of Health shall superintend, provide, or ensure the provision of health programs and services as per Part II (Health Programs and Services), Part III (Community Health Protection) and Part IV (Communicable Disease) of the Health Protection and Promotion Act, RSO 1990, and per the ~~2021~~ Ontario Public Health Standards~~: Requirements for Programs, Services, and Accountability~~. The Board of Health may also provide any other health programs and services that it ~~feels~~ determines are necessary or desirable and that are approved by the municipalities in the area.

The Board of Health operates through a formal structure that supports governance through a set of expectations regarding membership, size, terms of office, reporting relationships, and other structural features defined in the Health Protection and Promotion Act, RSO 1990, and regulations. Subject to the requirements of the Health Protection and Promotion Act, RSO 1990, the Board approves the overall structure of the organization.

Responsibilities

The Board of Health is responsible for ensuring the assessment, planning, delivery, management, and evaluation of public health programs and services.

~~Foundational and Program Standards outlined in the 2021~~The Ontario Public Health Standards articulate goals, outcomes, and requirements that all boards shall provide to promote and protect the health of the population and reduce health inequities. Protocols and guidelines provide additional direction and guidance on how to operationalize each requirement.

Members of the Board of Health ensure procedures are in place to uphold the implementation of the ~~Foundational and Program Standards outlined in the 2021~~ Ontario Public Health Standards. They remain informed about the delivery of OPHS programs and services as well as ~~research and~~ evaluations.

Accountability

In consideration of the public funds it spends, ~~Boards~~ boards of health must be accountable for the work they do, how they do it, and the results achieved. ~~Organizational requirements~~Accountability ~~specify~~agreements with the Ministry of Health ~~those areas that~~ require reporting ~~or monitoring and are used to demonstrate accountability~~ to the Ministry ~~of Health~~. The Board of Health must ~~thus~~ demonstrate accountability as it relates to four domains:

- delivery of programs and services;
- fiduciary requirements;
- good governance and management practices; and
- public health practice.

The Board of Health ensures implementation of organizational requirements to show compliance across the four domains as well as requirements that are common to all domains:

- The Board of Health ensures the delivery of programs and services and is accountable for achieving program outcomes in accordance with ministry expectations. For example, the Board of Health shall ensure the development and implementation of a strategic plan that establishes strategic priorities over 3 to 5 years (through the setting of local vision, priorities, and strategies directions).
- Board of health members are responsible for ensuring the efficient use of public resources and ensuring that funding is used in accordance with accepted accounting principles, legislative requirements, and government policy expectations. For example, the board of health shall ensure that expenditure forecasts are as accurate as possible.
- The Board of Health executes good governance practices to ensure effective functioning of the board and management of the ~~public health unit~~organization. For example, the Board of Health shall develop and implement policies or by-laws regarding functioning of the governing body (sub-committees, frequency of meetings, etc.) and shall provide direction to the administration and remain informed about the activities of the organization such as stakeholder and partnership building, workforce issues, financial management, and risk management.
- Board of health members ensure a high standard and quality of practice in the functioning of the organization including delivery of public health programs and services. For example, the Board of Health shall employ qualified public health professionals, support a culture of excellence in professional practices, and ensure a culture of quality and continuous organizational self-improvement.

~~Members of the Board of Health shall also demonstrate accountability through the submission of planning and reporting documents to the Ministry of Health including the Annual Service Plan and Budget Submission and associated quarterly and annual performance and financial reports.~~ The Board of Health ~~will also ensure~~is also accountab~~il~~ity to municipalities as funders and partners, as well as ~~stakeholders, including~~ the broader community. ~~by ensuring the development of, and a~~Annual reporting ~~for, an organizational accountability monitoring plan~~will be undertake to share what the organization is accomplishing for the community, and how public funds were stewareded..

Transparency and Reporting

~~A commitment to t~~Transparency is key to demonstrate responsible use of public funds and to disclose information that allows the public to make informed decisions about their health. The Board of Health shall ensure public access to key organizational documents, demonstrate contribution towards program and populations health

outcomes, and report on performance to demonstrate the impact of public health on creating healthier communities for all.

Board of Health Manual
Public Health Sudbury & Districts

Information Sheet

Category
Board of Health Structure & Function

Section
Management

Subject
Governance Philosophy, Management Philosophy, & Organizational Structure

Number
C-III-10

Approved By
Board of Health

Original Date
January 16, 2003

Revised Date
September 179, 20264

Review Date
September 179, 20264

Information

Governance Philosophy

The Board adopts a governance philosophy where it engages in strategic and high-impact decisions, and oversight of the Medical Officer of Health/Chief Executive Officer and executive staff. The Medical Officer of Health/Chief Executive Officer and executive staff are charged with the day-to-day operations of the organization.

The primary areas of focus of the Board of Health are strategic planning, stewardship of public resources, risk management, organizational accountability, political positioning and engagement, oversight of executive leadership, and reporting to the Ministry. The Board is not involved in day-to-day management decisions, such as approving individual expenses, determining activities of individual programs, travel expenses, etc. These day-to-day management decisions are the responsibility of the Medical Officer of Health/Chief Executive Officer and the executive leadership team. The Board may develop bylaws and policies to set parameters for operational decisions; but it defers day-to-day management to the Medical Officer of Health and executive staff, and exercises oversight rather than direct involvement in those decisions.

Management Philosophy

The Board of Health should be committed to the effectiveness of its organization, its human resources and a good management process.

Its programs should be based on sound epidemiological principles and an effective program evaluation system needs to be developed to ensure cost efficiency, effectiveness and benefits.

In terms of human resources, this philosophy implies that the Board is committed to using the talents, initiative and creativity of each employee and is dedicated to fair treatment, growth and development of each individual.

The management process that reflects this philosophy should focus on

- achieving results efficiently (primary target of every program, service and policy);
- requiring accountability on every level of management; and
- the systematic delegation of responsibility and authority to the lowest appropriate level in the organization.

Organizational Structure

The philosophy and objectives of good management requires that the ~~health unit~~ organization have a ~~sound~~n organizational structure that reflects the responsibilities at each level of the organization with the strengths and perspectives of that level.

The Board of Health is the governing body, the policymaker of the ~~health unit~~organization. It monitors all operations within the ~~unit~~ agency and is accountable to the community and to the Ministry of Health.

The Medical Officer of Health and Chief Executive Officer reports directly to the Board of Health and provides policy guidance on issues relating to public health concerns and to public health programs and services. The Medical Officer of Health is responsible under section 67 of the *Health Protection and Promotion Act* for management of the public health operations, programs and services and is accountable to the Board of Health.

The senior management/executive leadership team provides senior level leadership for the operational nucleus of the ~~unit~~agency. It ~~is created to provide a forum for~~leads formal planning ~~processes~~, which relate budgeting to programs and provides a mechanism for monitoring of staff, programs, and organizational performance. It also functions to implement decisions and execute operations in a coordinated fashion.

The membership of the senior management team consists of the Medical Officer of Health/Chief Executive Officer as Chair, the Associate Medical Officers of Health and the Directors.

The Medical Officer of Health/Chief Executive Officer sets the organizational structure within the Board-approved budgets, assigning directors to lead divisions, and establishing a reporting hierarchy. Notwithstanding this authority, one director must

always be the Director of Corporate Services who will have responsibilities over administering the organization's financial reporting, human resources administration, and legal advice, all subject to the direction of the Medical Officer of Health/Chief Executive Officer.

The current Public Health Sudbury & Districts organizational chart is included as Appendix B.

~~Through this forum, senior staff contributes to overall management co-ordination of health unit programs, policy development and implementation.~~

Bringing senior staff together into a goal-oriented team creates an efficient network of communication among its members and provides a milieu conducive to effective planning and management.

The management team is accountable to and acts in a directly supportive role to the Medical Officer of Health/Chief Executive Officer.

Board of Health Manual
Public Health Sudbury & Districts

Information Sheet

Category
Board of Health Structure & Function

Section
Management

Subject
Chief Executive Officer of the Board

Number
C-III-11

Approved By
Board of Health

Original Date
January 16, 2003

Revised Date
September 179, 20264

Review Date
September 179, 20264

Information
Pursuant to section 67 of the *Health Protection & Promotion Act*, tThe Medical Officer of Health is the Chief Executive Officer of the Board and all information pertaining to Board organizational operations, be it program or budget, is the responsibility of the Medical Officer of Health/Chief Executive Officer. This is supported by legislation.

The public must be assured that qualified medical personnel are assessing their health needs and that the Board will act on such advice.

The Medical Officer of Health/Chief Executive Officer should be someone with clear skills and professional competenciesly recognized as being professionally sound in the area delivery of health protection services and delivery of health oriented promotion programs. They must also have the senior administrative and management skills to be an active chief administrator of the organization.

They must be fully aware of the management task and be prepared to be fully involved. This is not an academic stance. The Medical Officer of Health, as Chief Executive

Officer of the Board, must be~~come~~ a good manager as well as being a good public health professional.

The Medical Officer of Health is responsible for the development and execution of all approved health programs and the quality and effectiveness of the ~~health unit~~organization's managerial results. They are accountable to the Board for their actions and have~~s~~ direct communication with the Board.

Associate Medical Officers of Health must have sufficient skills to execute all the responsibilities of the Medical Officer of Health/Chief Executive Officer in absence, incapacity, or vacancy of the former.

Board of Health Manual
Public Health Sudbury & Districts

Policy

Category
Board of Health Structure & Function

Section
Ethical Practice

Subject
Ethical Practice of Public Health

Number
C-IV-10

Approved By
Board of Health

Original Date
January 16, 2003

Revised Date
~~June 20, 2019~~September 17, 2026

Review Date
September 1~~7~~9, 202~~6~~4

Purpose

Principles of the Ethical Practice of Public Health

1) Public health should address principally the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes.

2) Public health should achieve community health in a way that respects the rights of individuals in the community.

3) Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members.

4) Public health should advocate and work for the empowerment of ~~disenfranchised community~~individuals and communities experiencing inequities ~~members~~, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.

5) Public health should seek and use the information, evidence, and knowledge needed to implement effective policies and programs that protect and promote health.

6) Public health institutions should provide communities with the information they have that is needed for decisions on policies or programs and should obtain the community's consent for their implementation.

7) Public health institutions should act in a timely manner on the information they have within the resources and the mandate given to them by the public.

8) Public health programs and policies should incorporate ~~a variety of~~ approaches that ~~anticipate and~~promote cultural humility and cultural safety while respecting diverse values, beliefs, ~~and~~ cultures, and ways of knowing within ~~in~~ the community.

9) Public health programs and policies should be implemented in a manner that most enhances the physical and social environment.

10) Public health institutions should protect the confidentiality of information that can bring harm to an individual or community if made public. Exceptions must be justified on the basis of the high likelihood of significant harm to the individual or others.

11) Public health institutions should ~~ensure the professional competence of their employees.~~foster professional practice excellence by supporting the ongoing competence, professional development, and reflective practice of their employees.

12) Public health institutions and their employees should engage in collaborations and affiliations in ways that build the public's trust and the institution's effectiveness.

Approved by the Sudbury & District Board of Health on June 20, 2002 (57-02)

Board of Health Manual
Public Health Sudbury & Districts

Information Sheet

Category
Public Health System

Section
~~Provincial~~Organization of Public Health in Ontario

Subject
~~Ministry of Health and Office of the Chief Medical Officer of Health~~Public Heath Institutions

Number
D-I-10

Approved By
Board of Health

Original Date
January 16, 2003

Revised Date
September 1~~7~~9, 2026~~4~~

Review Date
September 1~~7~~9, 2026~~4~~

Information

Ministry of Health

~~The Ministry of Health is the provincial government body to whom b~~Boards of health are primarily responsible to the Ministry of Health. ~~It~~ The Ministry is charged with ~~the responsibility~~ of administering such legislation as the *Health Protection and Promotion Act*, the *Health Insurance Act*, the ~~*Commitment to the Future of Medicare Act*, the~~ *Public Hospitals Act,* and *Immunization of School Pupils Act*.

The role of the Ministry of Health in the organization and operation of boards of health is ~~well~~ established in the *Health Protection and Promotion Act*, which defines its responsibilities~~, in regard to such matters as changes in health unit by-laws, financing, inspection, construction of facilities, etc~~.

Chief Medical Officer of Health

The Office of the Chief Medical Officer of Health is the Ministry's primary liaison with boards of health and staff of local public health agencies. The function of the Office of the Chief Medical Officer of Health is to promote good health, to monitor the health status of Ontarians and to control the spread of disease. It does this in part through ~~financial~~ support and ~~expert advice to~~ collaboration the ~~34~~ local public health ~~units~~ agencies or boards of health which ~~conduct~~ deliver local programs and, in part, by developing ~~its own~~ province-wide programs. ~~The Office of the Chief Medical Officer of Health is equally concerned with preventing disease, by measures ranging from better sanitation to vaccinations for school children and provides funding for local official health agencies in these areas.~~

As part of its mandate, the Office of the Chief Medical Officer of Health has broad responsibilities to support the Minister of Health. Furthermore, it is responsible for ~~informing~~ working with other branches within the government on public health issues, and liaising with other provinces, territories and the federal government regarding public health in Ontario.

Public Health Ontario

Public Health Ontario (PHO) is a centre for specialized research and knowledge of public health, specializing in the areas of infectious disease, infection control and prevention, health promotion, chronic disease and injury prevention, and environmental health. An arms-length agency, it supports the Chief Medical Officer of Health and provides expert scientific leadership and advice to government, local public health, and front-line health care workers. Its responsibilities include the provision of specialized public health laboratory services to support timely health surveillance, support of infection control and provision of communicable disease information as well as assistance with emergency preparedness (e.g. provincial outbreak of pandemic influenza, local outbreaks).

Association of Local Public Health Agencies

The Association of Local Public Health Agencies (alPHa) is the provincial representative body for boards of health and local public health agency management across Ontario. Membership includes board of health members, medical and associate medical officers of health, and senior public health managers. The Association of Local Public Health Agencies has a mandate to, through a strong and unified voice, advocate for public health policies, programs and services on behalf of member local public health agencies in Ontario.

alPHa is governed by a Board of Directors, which provides strategic direction to the Association, and is led by a Chief Executive Officer, who is responsible for the day-to-day operations. Representatives on the alPHa Board include seven members from the Boards of Health (BOH Section) and seven members from the Council of Ontario Medical Officers of Health (COMOH). The balance of the alPHa Board is composed of one representative from each of the seven Affiliate organizations which include

- Ontario Association of Public Health Nursing Leaders (OPHNL)
- Association of Ontario Public Health Business Administrators (AOPHBA)
- Association of Public Health Epidemiologists in Ontario (APHEO)
- Association of Supervisors of Public Health Inspectors of Ontario (ASPHI-O)
- Health Promotion Ontario (HPO)
- Ontario Association of Public Health Dentistry (OAPHD)
- Ontario Dietitians in Public Health (ODPH)

The Association conducts regular meetings of its Board of Health Section and Council of Medical Officers of Health to discuss issues particular to their positions. The alPHa Advocacy Committee meets regularly to discuss action plans for Association Resolutions, as well as emerging issues raised by members, public, government or media. This committee is designed to give opportunity for wider participation in alPHa business by interested health unit staff.

Ontario Health

Ontario Health is an agency created by the Government of Ontario with a mandate to connect, coordinate, and modernize the province's health care system. Ontario Health oversees health care planning and delivery across the province to build a person-centered health care system.

The following are some organizations that are part of Ontario Health:

- Cancer Care Ontario
- eHealth Ontario
- HealthForceOntario Marketing and Recruitment Agency
- Ontario Health Quality Council (operating as Health Quality Ontario)
- Health Shared Services Ontario
- Ontario Telemedicine Network
- Trillium Gift of Life Network
- CorHealth Ontario

As well, the health system support functions are provided by six Ontario Health regions (formerly Ontario's Local Health Integration Networks):

Ontario Health region	Former Local Health Integration Network (LHIN)
North East	North East
North West	North West
East	Central East South East Champlain
Central	Central Central West

	Mississauga Halton
	North Simcoe Muskoka
Toronto	Toronto Central
West	South West
	Hamilton Niagara Haldimand Brant
	Waterloo Wellington
	Erie St. Clair

The work of Ontario Health includes

- measuring and reporting on how the health system is performing
- overseeing the delivery and quality of clinical care services, including cancer, renal, cardiac, palliative, mental health and addictions services
- managing funding and accountability for parts of the health system
- creating provincial digital and virtual services that will give patients and health care providers more complete health information
- delivering organ and tissue donation and transplantation services
- setting quality standards and developing evidence-based guidelines to improve clinical care

Federal Public Health Institutions

The **Public Health Agency of Canada (PHAC)** is the federal agency responsible for advancing public health in Canada. Its work focuses on promoting health, preventing and controlling infectious and chronic diseases and injuries, preparing for and responding to public health emergencies, and strengthening collaboration across governments and partners. PHAC also serves as a national focal point for public health science, surveillance, policy, and emergency preparedness. PHAC does not have any authority over the public health system in Ontario.

The **Chief Public Health Officer of Canada (CPHO)** is the federal government's lead public health professional. The CPHO provides advice to the Minister of Health and the President of PHAC, works with provincial, territorial, and international partners on public health matters, and reports annually to Parliament on the state of public health in Canada. During public health emergencies, the CPHO helps provide national public health leadership, advice, and communication to support the health of people in Canada.

Public Health Interest Associations

The **Canadian Public Health Association (CPHA)** is the independent national voice and trusted advocate for public health in Canada. Founded in 1910, CPHA is a national, independent, not-for-profit association that champions health equity, social justice, and evidence-informed decision-making. CPHA works to influence public policy, connect diverse communities of public health practice, and advance initiatives that improve health and well-being for all people and communities in Canada.

The **Ontario Public Health Association (OPHA)** is a non-partisan, non-profit organization that brings together a broad spectrum of groups and individuals concerned about people's health. OPHA's members come from various backgrounds and sectors, from the various disciplines in public health, health care, academic, non-profit to the private sector. They are united by OPHA's mission of providing leadership on issues affecting the public's health and strengthening the impact of people who are active in public and community health throughout Ontario. This mission is achieved through professional development, information and analysis on issues effecting community and public health, access to multidisciplinary networks, advocacy on health public policy and the provision of expertise and consultation.

Board of Health Manual
Public Health Sudbury & Districts

Procedure

Category
Board of Health Proceedings

Section
Board of Health Meetings

Subject
Preparation & Distribution of the Agenda Package

Number
E-I-11

Approved By
Board of Health

Original Date
February 26, 1990

Revised Date
September 179, 20264

Review Date
September 179, 20264

Process
An agenda is to be prepared by approximately the second Tuesday of the month. It should contain, along with the following items, in order of appearance, date, time and place of meeting for distribution of the agenda package to the Board members the second Thursday of the month.

1) Call to Order

This is when the Chair calls the attention of all present at the meeting that the meeting is now to commence.

2) Roll Call

A dated Attendance Register (Roll Call) is completed at the meeting, with the Chair announcing the names as listed and the Board members responding. Notation is made on the roll call as to whether the Board member is present, in person or virtually, or absent.

3) Declaration of Conflict of Interest

This is asked by the Chair of the Board and provides an opportunity for members to declare a conflict and the general nature of the conflict of interest (as per C-I-16). At the time of the meeting, or as soon as possible afterwards, the member shall file a written statement of the interest and its general nature, if not already declared in the Annual Conflict of Interest Declaration form.

See Procedure C-I-16.

4) Delegations/Presentations

Topics for the staff presentations are identified via the Board agenda planner and proposed by the MOH/CEO. Presentations by external delegation are listed here as well. List the title of the presentation on the agenda, as well as the ~~staff~~ presenter name(s), title(s) and ~~division~~affiliation(s).

5) Consent agenda

The consent agenda is a single item that includes all items that the Board of Health would normally approve with little or no discussion, and which involve no decision-making. The consent agenda is introduced by a motion.

The consent agenda may include, but is not limited to, items such as Board or standing committee minutes, the report of the Medical Officer of Health/Chief Executive Officer, routine financial reports, correspondence and information items.

Items for clarification or for which a board member has a question are normally requested before the meeting.

After introduction of the consent agenda motion, the Chair shall then invite discussion on any item(s) set forth in the consent agenda motion. Any member who wishes to discuss any item(s) set forth in the consent agenda motion shall so advise the Chair, following which

- the item(s) for discussion shall be separated from the consent agenda motion and moved to the regular agenda as an item to be discussed
- the remainder of the consent agenda motion shall be voted on;

Items of the consent agenda that were moved to New Business shall be discussed there and at the conclusion of the discussion

- if no amendments have been proposed to any item(s), the Chair shall call for a vote on each separated motion; or
- if amendments have been proposed to any item(s):
    - each amendment shall be voted on separately without further amendment or debate; and
    - the Chair shall call for a vote on each item, as amended.

i) **Minutes of Previous Board Meeting**
~~These are distributed as part of the agenda package prior to the meeting.~~

ii) **Business Arising from Minutes**
~~Items are listed on the Agenda that require follow-up from previous minutes.~~

iii) **Standing Committees**
~~These are the minutes and Committee Chair's report from any committees established by the Board. These can include unapproved minutes to ensure timely communication to the Board.~~

iv) **Report of Medical Officer of Health/Chief Executive Officer**
Program and service highlights are submitted by the Division Heads to the Secretary two weeks prior to a scheduled Board meeting as per the document "Schedule of Reporting at Board Meetings" located within the EC terms of reference which can be found in the General Administrative Manual.

The purpose of the Report is to provide the Board with an update on issues relating to public health concerns and to public health programs and services as per Section 67 (1) of the *Health Protection and Promotion Act* (1990). The report will also include periodic reports to the Board on the status of compliance with the required obligations under the other statutory requirements.

v) **Correspondence**
~~These are items received through other health units or organizations relating to public health matters.~~

vi) **Items for Information**
~~These are general public health materials, i.e., newsletters, shared for the Board's information.~~

6) New Business

These items are listed and are derived from items that are of interest/concern requiring discussion, direction, or approval.

7) Addendum

This is a separate agenda prepared and made available (if required) at the beginning of the Board meeting and contains information items that have arisen during the time the agenda was made available and before the Board meeting. A motion is prepared to deal with items on the addendum.

8) In Camera

See By-Law 04-88 and Procedure F-111-10 regarding matters to be discussed in-camera.

A motion is prepared for the Board to begin in-camera proceedings and should specify the reason for going in camera.

Motion to go in-camera can also be included under New Business where a specific item requires a closed discussion.

9) Rise and Report

A motion is prepared for the Board to rise and report from the in-camera proceedings.

10) Announcements

Provides an opportunity for the Board Chair, MOH or Board members to share reminders, announcements, etc.

11) Adjournment

A motion is prepared to announce the conclusion of the meeting.

Once the agenda package has been prepared, the Board of Health Chair and the ~~Board Secretary meets with the~~ Medical Officer of Health/Chief Executive Officer ~~to~~ will review ~~and confirm its relevant~~the agenda ~~items~~ prior to its distribution. ~~The Board of Health Chair is given an opportunity to comment on the draft agenda.~~

~~See E-I-12 Procedure related to the distribution of the agenda package.~~

~~One print package is required for the Board of Health minute binder and one extra agenda package is to be kept on hand should anyone require it at the meeting.~~

Three business days before the Board meeting (typically on the Monday of the week of the Board meeting unless there is a holiday), Communications staff posts the agenda package to the Public Health Sudbury & Districts website and shares a link with the news media informing them of the meeting. The MOH office shares the agenda package with constituent municipalities electronically.

Any questions related to the agenda package ~~is~~ are to be directed to the Board Secretary.

Per the records classification, the Board agenda packages have a permanent preservation. The electronic agenda package is deemed the official record and a print copy is maintained for archival purposes. .

See Procedure E-I-15 for preparation of a closed meeting agenda

Board of Health Manual
Public Health Sudbury & Districts

Policy

Category
Board of Health Proceedings

Section
Board of Health Meetings

Subject
Minutes and Motions

Number
E-I-13

Approved By
Board of Health

Original Date
November 15, 2007

Revised Date
September 175, 20262

Review Date
September 179, 20264

Purpose
Board of Health minutes and motions will be maintained. These minutes will serve as a Record of meeting, as per the *Municipal Act, Section 239, Subsection (7)*:

> A municipality or local board or a committee of either of them, shall record without note or comment all resolutions, decisions, and other proceedings at a meeting of the body, whether it is closed to the public or not. 2006, c. 32, Sched. A, s. 103 (3).

Board of Health Minutes
Once the regular Board meeting minutes are have been prepared and reviewed, the Secretary to the Board of Health distributes electronic copies of unapproved minutes to the Board of Health members, Senior Management Executive Committee members and constituent municipalities for their information. Unapproved minutes are distributed for information purposes only and do not constitute the official record of the meeting until

approved. The unapproved minutes are made available for staff to view. ~~The unapproved minutes are posted for staff to view.~~

All meeting minutes, whether ~~it be a closed or~~ from a public or closed meeting, ~~are~~ shall be approved, with or without amendment, at the next ~~subsequent~~ meeting of the originating committee. Once approved by the Board of Health, the Board ~~minutes~~ agenda packages are posted on the Public Health Sudbury & Districts website for a period of ~~four~~ one year~~s~~.

The Board minutes and motions are filed for permanent preservation. Effective January 2027, the electronic version is considered the official record for permanent preservation, with a paper copy as a back-up~~.~~

Minutes of Standing Committees of the Board

Unapproved Board Standing Committee minutes are ~~shared~~ provided ~~with~~ to the Board ~~members~~ of Health for information ~~at~~ within the next regular Board ~~meeting~~ agenda package under Reports of Standing Committees.

Closed Minutes

Approved closed-session minutes shall be retained as confidential records and shall not be publicly disclosed except as required by law.

~~If~~ Where closed-session minutes ~~of a closed meeting~~ are circulated in print for approval or information, they ~~are~~ shall be copied on colored paper and distributed and retrieved at the meeting.

Where closed-session minutes are circulated electronically, access shall be restricted to authorized individuals and managed in accordance with applicable records management, privacy, and information security requirements.

~~If they are circulated electronically at or prior to the closed session, they are removed from the system at the end of the meeting.~~

Board of Health Manual
Public Health Sudbury & Districts

Procedure

Category
Board of Health Proceedings

Section
Board of Health Meetings

Subject
Minutes and Motions

Number
E-I-13

Approved By
Board of Health

Original Date
February 26, 1990

Revised Date
September ~~19~~17, 202~~6~~4

Review Date
September 1~~7~~9, 202~~6~~4

Process

Board of Health Meeting Minutes

All items listed on the Agenda in order of appearance, should be addressed in the minutes even if it is only to indicate no action/discussion or tabled for information. It should contain a brief, succinct synopsis of any discussion that takes place and the conclusions reached. Specific reference to an individual should be avoided, other than that of "the Chair", "Board Members", etc. The comments should not be so brief that anyone years after would not be able to determine the theme of the discussion as the minutes are classed as permanent documents.

Closed session minutes are taken by the Recording Secretary. In the event the Recording Secretary is excused from the closed session, the Chair or designate must document the proceedings. Closed session minutes of the Board must be approved in a subsequent closed meeting of the Board.

Board of Health closed session materials, that may include the previous in-camera minutes, will be made available electronically as non downloadable and non printable, no less than three business days and no more than one week prior to the scheduled Board of Health meeting with a closed session. The in-camera agenda package, that may include the previous in-camera minutes, will be removed immediately following the meeting. Once approved, the minutes of the closed sessions must be retained by the Recording Secretary.

See Policy E-I-~~14~~ 13 regarding Board minutes~~Posting/Circulation Board of Health approved and unapproved minutes~~. Minutes of previous meetings constitute part of the Agenda Package.

See Procedure E-I-12 regarding Distribution of the Agenda Package.

Effective January 2027, the electronic version of the minutes and motions are considered the official record for permanent preservation, with a paper copy as a back-up

~~Once approved, original minutes are filed for permanent preservation and properly labeled in a binder along with the supporting documentation, i.e. attendance register (once photocopied and forwarded to Payroll for disbursements of per diems, mileages, etc.), addendum and any information distributed at the Board meeting.~~

The Board Chair and Recorder signs the approved minutes at the next regularly scheduled meeting.

Standing Committee Minutes

These are also a brief, succinct synopsis of events that transpire during the meeting. Motions that are prepared for the meeting can relate only to items which the Committee may deal with on their own (e.g. election of committee Chair, procedural matters). All other items should be listed as recommendations and presented as a motion to the Board for approval as the Committee may not approve an item, only recommend that the Board approves the item, save and except when the Board Executive Committee assumes governance of the Board when regular board meetings are not scheduled.

See Policy E-I-14 Posting/Circulation Board of Health approved and unapproved minutes. Minutes of previous meetings constitute part of the Agenda Package.

Committee minutes for the Board and Board Standing Committee minutes should indicate the presiding Chair~~person~~ for that meeting and be signed off by that Chair~~person~~ and the ~~Recording~~ Board Secretary.

Closed session minutes of Board Standing Committees such as the Board Executive Committee are taken by the ~~Recording~~ Board Secretary. In the event the ~~Recording~~ Board Secretary is excused from the closed session, the Chair or designate must document the proceedings. Closed session minutes must be approved in a subsequent closed meeting of the originating standing committee.

Board of Health closed session materials, that may include the previous in-camera minutes, will be made available electronically as non-downloadable and non-printable, no less than three business days and no more than one week prior to the scheduled Board Standing Committee meeting with a closed session. The in-camera agenda package, that may include the previous in-camera minutes, will be removed immediately following the meeting. Once approved, the minutes of the closed sessions must be retained by the Recording Secretary.

Motions

Motions are prepared as listed on the agenda in advance of the meeting. They are then numbered in sequence at the top right-hand corner (i.e. 1 of 12, 2 of 12, etc.) as they are distributed amongst the Board members upon their arrival prior to the start of the Board meeting for a Mover and a Seconder. Motions can therefore, be put in order and made available to the Chair for reference and approval at the meeting as they appear on the agenda.

Motions – Closed Meeting

> Before holding a meeting or part of a meeting that is to be closed to the public, the board shall state by resolution the fact of the holding of the closed meeting and the general nature of the matter to be considered at the closed meeting.

Motions - Open Meeting

> A meeting shall not be closed to the public during the taking of a vote.

Exception

> A meeting may be closed to the public during a vote if the vote is for a procedural matter or for giving directions or instructions to officers, employees or agents of the municipality, local board or committee of either of them or persons retained by or under a contract with the municipality or local board.

After the meeting, motions are then numbered in conjunction with the other motions (i.e. 25-90, 26-90, etc.) with the last two digits signifying the year in which the motion was presented and approved. The numbering of motions for the Board and Standing Committee will be distinct. Once properly numbered and also included on an electronic master list, they then become a part of the master list of **all** motions that are available through the office of the Secretary to the Board. A summary of program-related motions is also available on the Public Health Sudbury & Districts website.

Motions are filed in the Board motion binder for permanent preservation.

Board of Health Manual
Public Health Sudbury & Districts

Procedure

Category
Board of Health Proceedings

Section
Board of Health Meetings

Subject
Preparation of a Closed Meeting ~~Agenda~~

Number
E-I-15

Approved By
Board of Health

Original Date
June 15, 2017

Revised Date
September 17~~9~~, 2026~~4~~

Review Date
September 17~~9~~, 2026~~4~~

Process
A closed meeting (also referred to as an in-camera meeting) is a meeting or portion of a meeting that is not open to the public.

Entering into a Closed Meeting & Maintenance of Records

Except as described in this procedure, all Board of Health meetings are open to the public.

The *Municipal Act* applies to local boards or committees of local boards. Per the *Municipal Act* S.239 (2), a meeting or part of a meeting may be **closed** to the public under conditions as prescribed in the Act.

As per section 239 (3), a meeting or part of a meeting shall be closed to the public if the subject matter being considered is,

(a) a request under the *Municipal Freedom of Information and Protection of Privacy Act*, if the council, board, commission or other body is the head of an institution for the purposes of that Act; or

(b) an ongoing investigation respecting the municipality, a local board or a municipally-controlled corporation by the Ombudsman appointed under the *Ombudsman Act*, an Ombudsman referred to in subsection 223.13 (1) of this Act, or the investigator referred to in subsection 239.2 (1). 2014, c. 13, Sched. 9, s. 22.

As per section 239 (3.1), a meeting may be closed to the public if the following conditions are both satisfied:

1. The meeting is held for the purpose of educating or training the members.

2. At the education or training meeting, no member discusses or otherwise deals with any matter in a way that materially advances the business or decision-making of the council, local board or committee. 2006, c. 32, Sched. A, s. 103 (1).

Before holding a meeting or part of a meeting that is to be closed to the public, a municipality or local board or committee of either of them shall state by resolution,

(a) the fact of the holding of the closed meeting and the general nature of the matter to be considered at the closed meeting; or

(b) in the case of education or training sessions, the fact of the holding of the closed meeting, the general nature of its subject-matter and that it is to be closed under article 239 subsection 3.1 of the *Municipal Act*.

Copies of Board records in the possession or under the control of the Secretary to the Board may be made available to members of the public and shall be processed in accordance with the General Administrative Manual (GAM) policy for information requests. Payment of the costs of photocopying shall be in accordance with Public Health Sudbury & Districts fee schedule.

Municipal Freedom of Information and Protection of Privacy Act does not apply to a record of a meeting closed under subsection (3.1). 2006, c. 32, Sched. A, s. 103 (3) of the Municipal Act.

In the event that Public Health Sudbury & Districts receives a complaint relating to a closed Board of Health meeting, Public Health Sudbury & Districts will utilize the services of the Ombudsman Ontario as the investigator when required in accordance with s.239 of the Municipal Act.

The Secretary to the Board of Health will ensure that members of the press covering Board meetings have access to relevant information.

Closed Meeting Agenda

A closed agenda ~~is to~~ shall be prepared and reviewed and the agenda package made ~~visible~~available ~~electronically for~~ to Board members ~~via BoardEffect~~ no less than three

working days and no more than one week ~~prior~~ before ~~to the~~ a scheduled Board of Health meeting ~~with~~ that includes a closed session. ~~The in-camera agenda package will be removed immediately following the meeting.~~

The closed agenda should contain, along with the following items, in order of appearance, date, time and place of meeting to begin closed meeting proceedings once the in-camera motion is passed for the Board.

1) Review of Agenda / Declaration of Conflict of Interest

This is asked by the closed meeting Chair (position held by the Vice-Chair of the Board) and provides an opportunity for members to announce a conflict (as per C-I-16). A declaration of conflict of interest will eliminate that individual from any discussion on that topic. These will be recorded in the minutes.

2) Approval of In-Camera Minutes of Previous In-Camera Meeting

These are distributed as part of the closed meeting agenda package.

3) New Business

These items are listed and are derived from items that are of interest/concern.

See By-Law 04-88 and Procedure F-111-10 regarding closed matters to be discussed.

Closed-session items shall relate only to matters that satisfy the legislative and by-law requirements for consideration in a closed meeting.

Each closed-session agenda item shall identify the applicable Municipal Act closed-meeting exception authorizing consideration of the matter in camera.

Where a matter discussed in closed session requires a Board decision in open session, the agenda shall identify the proposed motion for consideration following the Board's rise and report from the closed session:

~~Any motions listed on the agenda of a closed meeting should include a notation:~~

MOTION for consideration out of camera:

Upon returning to open session, the Board shall report, where appropriate, the general nature of matters considered in closed session and any directions provided, while maintaining confidentiality requirements.

~~The Board will entertain a motion to rise and report from the in-camera proceedings.~~

Access to the in-camera agenda package by Board members shall be removed following the meeting. Official records shall be retained in accordance with Board records retention requirements.

Once the in-camera agenda package has been prepared, by the Board Secretary, ~~meets with~~ the the Board Chair and the Medical Officer of Health/Chief Executive Officer ~~and subsequently with the or the Board Chair to~~ will review ~~and confirm its relevant agenda items~~it prior to disribution.

A print package is required for the confidential Board of Health closed meeting binder.

See E-I-11 and E-I-13 ~~and E-I-14~~ related to the distribution of the closed meeting minutes, motions as well as the ~~posting and~~ circulation of closed meeting minutes.

Board of Health Manual
Public Health Sudbury & Districts

Policy

Category
Communication

Section
Confidentiality

Subject
Freedom of Information

Number
F-III-10

Approved By
Board of Health

Original Date
May 23, 1991

Revised Date
~~June 16, 2016~~September 17, 2026

Review Date
September 1~~7~~9, 202~~6~~4

Purpose
The Board of Health supports the general right of the public to obtain access to local government records. This access shall at all times be governed by the provisions of *The Municipal Freedom of Information and Protection of Privacy Act*.

Pursuant to Section 3, subsection (2) of the *Municipal Freedom of Information and Protection of Privacy Act* (MFIPPA), R.S.O. 1990, c.M.56, which allows the members elected or appointed to a board that is an institution under the Act to designate in writing an individual to act as head of the institution for the purposes of the Act, the Board of Health for the Sudbury and District Health Unit designates the Medical Officer of Health/Chief Executive Officer as head for the purposes of MFIPPA. In circumstances where the MOH/CEO is unable to act these powers are delegated to the Associate Medical Officer of Health, in the first instance, and to the Director, Corporate Services, in the second instance.

The Board recognizes that the *Personal Health Information Protection Act* establishes rules for the collection, use, disclosure and confidentiality of an individual's personal health information. Requests for Personal Health Information shall be accessed and processed in accordance with the *Personal Health Information Protection Act*.

The Board recognizes that the *Regulated Health Professions Act* requires regulated professionals including Physicians and Surgeons, Dental Surgeons, Dental Hygienists, Nurses, and Dietitians to protect the confidentiality of information.

Board of Health Manual
Public Health Sudbury & Districts

By-Law

Category
Board of Health By-Laws

Section
By-laws

Subject
By-law 04-88: Board of Health Proceedings

Number
G-I-30

Approved By
Board of Health

Original Date
June 23, 1988

Revised Date
~~February 20, 2025~~September 17, 2026

Review Date
September 17~~February 20~~, 202~~5~~6

To Regulate the Proceedings of the Board of Health

~~The Board of Health for the Sudbury and District Health Unit enacts as follows:~~

Interpretation

1. In this By-law:

   a) "Act" means the *Health Protection and Promotion Act*. S.O. Ontario, Chapter 10 as amended;

   b) "Board" means the Board of Health for the Sudbury and District Health Unit

   c) "Chair" means the person presiding at the meeting of the Board;

d) “Chair of the Board” means the chair elected under the *Act*, which reads:

At the first meeting of a board of health in each year, the members of the board shall elect one of the members to be chair and one to be vice-chair of the board for the year.

e) “Committee” means a committee of the Board, but does not include the Committee of the Whole;

f) “Committee of the Whole” means all the members present at a meeting of the Board sitting in Committee;

g) “Council” means the Council of any constituent municipality;

h) “Meeting” means a meeting of the Board;

i) “Member” means a member of the Board;

j) “Quorum” means a majority of the members of the Board who are present at a Board meeting;

k) “Secretary” means the Secretary of the Board of Health.

l) "Absences" means a Board member who is not present at a Board meeting for the purpose of establishing quorum and has not provided notice of their absence or provided their regrets.

General

2. As per section 49. (2) of the Health Protection and Promotion Act, the Board shall have no fewer than three and no more than thirteen municipal members. R.S.O. 1990, c. H.7, s. 49 (2). In addition, the Lieutenant Governor in Council may appoint one or more persons as members of the board of health as long as the number of Lieutenant Governor in Council appointees are fewer in number that the municipal members of the board of health. R.S.O. 1990, c. H.7, s. 49 (3).

   Where a vacancy occurs in a Board of Health by the death, disqualification, resignation or removal of a member, the person or body that appointed the member shall appoint a person forthwith to fill the vacancy for the remainder of the term of the member.

3. In all the proceedings at or taken by this Board, the following rules and regulations shall be observed and shall be the rules and regulations for the order and dispatch of business at the Board, and in the Committee thereof.

4. Except as herein provided, the rules of order of the Parliament of Canada, Bourinot shall be followed for governing the proceedings of this Board and the conduct of its members.

5. A person who is not a member of the Board or who is not a member of the council shall not be allowed to address the Board except upon invitation of the Chair subject to written request to the Secretary at least two weeks prior to the scheduled meeting.

6. Persons who have not requested in writing to address the Board may address the Board provided two-thirds of the Board are in agreement.

7. No persons shall smoke in the buildings or on the premises owned or leased by the Board of Health.

Convening a Regular Meeting

8. Regular monthly meetings shall be held at a date and time as determined by the Board which is normally the 3rd Thursday of the month at 1:30 p.m. with the exception of March, July, August and December when regular Board meetings are not scheduled.

   It is expected that commitments to regularly scheduled Board meetings be honoured by the Board members.

   The Board may, by resolution, alter the time, day or place of any meeting.

   Board members are expected wherever possible to attend meetings in person.

   Subject to any conditions or limitations in the Health Protection and Promotion Act and/or the Municipal Act, a member who participates in an open meeting through electronic means is deemed as present and counted for the purpose of establishing quorum. All members present, either in-person or members participating electronically, will have full participation, including voting rights. Further, electronic participation is also permitted for a meeting which is closed to the public.

   The electronic means will enable the member to hear and to be heard by the other meeting participants. Normal board of health meeting rules and procedures will apply with necessary modifications arising from electronic participation.

Convening a Special Board Meeting

9. A special meeting shall not be summoned for a time which conflicts with a regular meeting or a meeting previously called of (participating) council(s) or municipality(s).

   A special meeting may be called by the Chair of the Board of Health.

   The Secretary shall summon a special meeting upon receipt of a signed petition of the majority of Board members, constituting a quorum, for the purpose and at the time mentioned in the petition.

Notice of Meetings

10. The Secretary shall give notice of each regular and special meeting of the Board and of any Committee to the members thereof and to the heads of divisions concerned with such meeting.

    The notice shall be accompanied by the agenda and any other matter, so far as is known, to be brought before such meeting.

    The notice shall be provided to each member no later than one week prior to the day of the meeting.

    Lack of receipt of the notice shall not affect the validity of holding the meeting or any action taken thereat.

    The notice for calling a special meeting of the Board shall state the business to be considered at the special meeting and not business other than that stated in the notice shall be considered at such meeting except with the unanimous consent of the members present and voting.

    The public is made aware of regular board meetings or board committee meetings through the Public Health Sudbury & Districts website as per the *Municipal Act*, 238 subsection 2.1

Preparation of the Agenda

11. The Secretary, in conjunction with the Medical Officer of Health/Chief Executive Officer, shall have prepared for the use of members at the regular meetings the agenda as follows:

    - Call to Order
    - Roll Call
    - Declaration of Conflict of Interest
    - Delegations/Presentation
    - Consent agenda *which normally shall include*:
        - Minutes of Previous Meeting
        - Business Arising from Minutes
        - Report of Standing Committees
        - Report of the Medical Officer of Health/Chief Executive Officer
        - Correspondence
        - Items of Information
    - New Business
    - Addendum
    - In-Camera
    - Rise & Report
    - Adjournment

Delegation is placed on the agenda only when a request is received for a delegation to appear. Procedure to accept a delegation is as follows:

Where a delegation wishes to have any policy matter considered by the Board of Health, a letter shall be addressed to the Board Secretary and the letter shall

- be printed, typewritten or legibly written;
- clearly set out the matter at issue and the request made of the Board of Health
- be signed with the name of the writer and contain the mailing address, street address and telephone number of the writer.

Written delegation requests should be received prior to 12:00 noon the second Monday of the month prior to a regularly scheduled Board of Health meeting.

Delegations will be recorded and the recording made available to the public.

12. For special meetings, the agenda shall be prepared when and as the Chair of the Board may direct or, in default of such direction, as provided in the last preceding section so far as is applicable.

13. The business of each meeting shall be taken up in the order in which it stands upon the agenda, unless otherwise decided by the Board.

Commencement of Meetings / Quorum

14. As soon as there is a quorum after the hour fixed for the meeting, the Chair of the Board, or Vice-Chair or person appointed to act in their place and stead, shall take the chair and call the members to order.

15. If the person who ought to preside at any meeting does not attend by the time a quorum is present, the Secretary shall call the members to order and a presiding officer shall be appointed by majority vote to preside during the meeting or until the arrival of the person who ought to preside.

16. If there is no quorum within 15 minutes after the time appointed for the meeting, the Secretary shall call the roll and take down the names of the members then present, and the meeting shall then adjourn until such time as quorum is available.

17. Upon any member directing the attention of the Chair to the fact that a quorum is not present, the Secretary, at the request of the Chair, shall within three minutes following such request, record the names of those members present and advise the Chair, if a quorum is, or is not, present.

Rules of Debate and Conduct of Members at the Board

18. The Chair shall preside over the conduct of the meeting, including the preservation of good order and decorum, ruling on points of order and deciding all questions relating to the orderly procedure of the meetings, subject to an appeal by any member to the Board from any ruling of the Chair.

19. Each deputation will be allowed a maximum of one speaker for a maximum of 10 minutes, but a member of the Board may introduce a deputation in

addition to the speaker or speakers. Normally, a deputation will not be heard on an item unless there is a report from staff on the item or upon agreement of two-thirds of the Board present.

The Board shall render its decision in each case within seven days after deputations have been heard.

20. When a member finds it impossible to attend any meeting, the onus is upon the member to advise the Secretary prior to the holding of such meeting of his/her/their wishes with respect to items on the agenda or matters appearing therein in which he is vitally interested.

    Three consecutive absences by a member of the Board of Health will be reviewed by the Chair, following which notification will be forwarded to the appropriate municipality or council.

    Board members who are elected or appointed representatives of their municipalities shall be bound by the rules of attendance that apply to the councils of their respective municipalities. Failure to attend without prior notice at three consecutive Board meetings, or failure to attend a minimum of 50% of Board meetings in any one calendar year will result in notification of the appointing municipal council by the Board chair and may result in a request by the Board for the member to resign and/or a replacement be named.

    Board members appointed by the Lieutenant Governor-in Council are answerable to the Board of Health for their attendance. Failure to provide sufficient notice of non-attendance at three consecutive meetings or failure to attend a minimum of 50% of Board meetings without just cause may result in a request by the Board for the member to resign.

21. If the Chair desires to leave the chair for the purpose of taking part in the debate or otherwise, the Chair shall call on another member to fill his/her/their place until he/she/they resumes the Chair.

22. Every member, prior to speaking to any question or motion, shall respectfully address the Chair.

23. When two or more members ask to speak, the Chair shall name the member who, in his/her/their opinion, first asked to speak.

24. A member may speak more than once on a question, but after speaking shall be placed at the foot of the list of members wishing to speak.

    No member shall speak to the same question at any one time for longer than ten minutes except that the Board upon motion therefore, may grant extensions of time for speaking of up to five minutes for each time extended.

25. Subject to this section, no member may ask a question of the previous speaker except with the consent of such previous speaker and then only to

clarify any part of the previous speaker's remarks and such question shall be stated concisely.

When it is a member's turn to speak, before speaking he may ask questions of the Medical Officer of Health/Chief Executive Officer or Secretary, in order to obtain information relating to the report or clause in question and, with the consent of the speaker, other members of the Board may ask a question of the same official.

A member's question shall not be ironical, rhetorical, offensive, contain epithet, innuendo, satire or ridicule, be trivial, vague or meaningless, or contain questions and answers.

26. Any member may require the question or motion under discussion to be read at any time during the debate, but not so as to interrupt a member while speaking.

27. A member shall not

- speak disrespectfully of the Reigning Sovereign, any member of the Royal Family, the Governor-General or a Lieutenant-Governor;
- use offensive words or unparliamentary language at the Board meetings;
- disobey the rules of the Board or decision of the Chair of the Board, on questions of order or practice or upon the interpretation of the rules of the Board;
- leave his/her/their seat or make any noise or disturbance while a vote is being taken and until the result is declared; or
- interrupt a member while speaking except to raise a point of order.

28. In case any member persists in a breach of the foregoing section after having been called to order by the Chair, the Chair shall without debate put the question, "Shall the member be ordered to leave his seat for the duration of the meeting?"

If the Board votes in the affirmative, the Chair shall order the member to leave his/her/their seat for the duration of the meeting.

If the member apologizes, the Chair, with the approval of the Board, may permit him/her/them to resume his/her/their seat.

Questions of Privilege and Points of Order

29. A member who desires to address the Board upon a matter which concerns the rights or privileges of the Board collectively, or of himself/herself/themself as a member thereof, shall be permitted to raise such matter of privilege. A breach of privilege is a wilful disregard by a member or any other person of the dignity and lawful authority of the Board. A matter of privilege shall take precedence over other matters. When a member raises a point of privilege, the Chair shall use the words "Mr./Mrs. _____ state your point of privilege".

While the Chair is ruling on the point of privilege, no one shall be considered to be in possession of the floor.

30. When a member desires to call attention to a violation of the rules of procedure, he shall ask leave of the Chair to raise a point of order and after leave is granted, he shall state the point of order with a concise explanation and then not speak until the Chair has decided the point of order.

    Unless a member immediately appeals to the Board, the decisions of the Chair shall be final.

    If the decision is appealed, the Board shall decide the question without debate and its decision shall be final.

31. When the Chair calls a member to order, the member shall immediately cease speaking until the point of order is dealt with then he shall not speak again without the permission of the Chair unless to appeal the ruling of the Chair.

Motions and Order of Putting Questions

32. A motion for introducing a new matter shall not be presented without notice unless the Board, without debate, dispenses with such notice by a majority vote and no report requiring action of the Board shall be introduced to the Board unless a copy has been placed in the hands of the members at least one day prior to the meeting, except by a majority vote, taken without debate.

33. Every motion presented to the Board shall be written.

34. Every motion shall be deemed to be in possession of the Board for debate after it is presented by the Chair, but may, with permission of the Board, be withdrawn at any time before amendment or decision.

35. When a matter is under debate, no motion shall be received other than a motion

    - to adopt,
    - to amend,
    - to defer action,
    - to refer,
    - to receive,
    - to adjourn the meeting, or
    - that the vote be now taken.

36. A motion to refer or defer shall take precedence over any other amendment or motion except a motion to adjourn.

    A motion to refer shall require direction as to the body to which it is being referred and is not debatable.

A motion to defer must include a reason and a time period for the deferral and is not debatable.

37. When a motion that the vote be now taken is presented, it shall be put to a vote without debate, and if carried by a majority vote of the members, the motion and any amendments thereto under discussion shall be submitted to a vote forthwith without further debate.

    A motion relating to a matter not within the jurisdiction of the Board shall not be in order.

38. Only one amendment at a time can be presented to the main motion and only one amendment can be presented to an amendment, but when the amendment to the amendment to the amendment has been disposed of, another may be introduced, and when an amendment has been decided, another may be introduced.

    The amendment to the amendment, if any, shall be voted on first, then if no other amendment to the amendment is presented, the amendment shall be voted on next, then if no other amendment is introduced, the main motion, or if any amendment has carried, the main motion as amended shall be put to a vote.

    Nothing in this section shall prevent other proposed amendments being read for the information of the members.

39. When the question under consideration contains distinct propositions, upon the request of any member, the vote upon each proposition shall be taken separately.

40. After the Chair commences to take a vote, no member shall speak to or present another motion until the vote has been taken on such motion, amendment or sub-amendment.

41. Every member eligible to vote at a meeting of the Board, when a vote is taken on a matter, shall vote therein unless prohibited by statute; and, if any member eligible to vote at a meeting persists in refusing to vote, he shall be deemed as voting in the negative.

42. If a member disagrees with the announcement by the Chair of the result of any vote, he may object immediately to the Chair's declaration and require that the vote be retaken.

43. When a member eligible to vote at a meeting requests a roll call vote, all members eligible to vote, unless prohibited by statute, shall vote in alphabetical order with a call for the Chair's vote to be the last taken. A roll call vote and the names of those who voted for and against the resolution shall be noted in the minutes unless the Board is in-camera. The Secretary shall announce the results of the vote.

44. Any member, including the Chair, may propose or second a motion and all members including the Chair shall vote on all motions except when disqualified by reasons of interest or otherwise; a tie vote shall be considered lost. When the Chair proposes a motion, he shall vacate the chair to the Vice-Chair during debate on the motion and reassume the chair following the vote.

45. After any matter has been decided, any member who voted therein with the majority may move for a reconsideration at the same meeting or may give notice of a motion for reconsideration of the matter for a subsequent meeting in the same year, but no discussion of the question that has been decided shall be allowed until the motion for reconsideration has carried, and no matter shall be reconsidered more than once in the same year. For the purposes of this section, the word “year” shall mean the period from January 1st to December 31st in the same year.

Adjournment

46. A motion to adjourn the Board meeting or adjourn the debate shall be in order, except:

- when another member is in possession of the floor;
- when it has been decided that the vote be now taken; or,
- during the taking of a vote;

but no second motion to the same effect shall be made until after some intermediate proceedings have taken place.

47. Every communication intended to be presented to the Board must be fairly written or printed and must not contain any impertinent or improper matter and shall be signed by at least one person.

48. Every such communication shall be delivered to the Secretary before the commencement of the meeting of the Board.

Secretary for the Board

49. It shall be the duty of the Secretary

- to attend or cause an assistant to attend all meetings of the Board;
- to keep or cause to be kept full and accurate minutes of the meetings of all the Board meetings, text of by-laws and resolutions passed by it; and
- to forward a copy of all resolutions, enactments and orders of the Board to those concerned in order to give effect to the same.

Appointment and Organization of Committees

50. At the first meeting in any year, the Board shall appoint the members required by the Board to one standing committee responsible for overall Board operations~~s~~.

a. This committee will provide advice to the Board regarding appointments to other standing committees.

~~50.~~b. Upon receipt of this advice, the Board will proceed with appointments to all other standing committees.

51. The Board may appoint committees from time to time to consider such matters as specified by the Board.

~~51.~~a. The standing committee responsible for overall Board operations will typically provide advice to the Board as to membership of these committees.

Conduct of Business in Committees

52. The rules governing the procedure of the Board shall be observed in the Committees insofar as applicable.

53. It shall be the duty of the Committee

- to report to the Board on all matters referred to them and to recommend such action as they deem necessary;
- to report to the Board the number of meetings called during a year, at which a quorum was present, and the number of meetings attended by each member of the Committee; and
- to forward to the incoming Committee for the following year any matter undisposed.

54. The procedures of the Board with respect to

- incurring of liabilities and paying of accounts;
- contacts and expenditures;
- petty cash;
- tenders and quotations;

shall be in accordance with By-law 01-88: Management of Property and 01-93 Signing Authority, Financial Administration, and Procurement

Corporate Seal

55. The corporate seal of the Board shall be in the form impressed herein and shall be kept by the Chief Executive Officer or the Secretary of the Board.

Execution of Documents

56. The ~~Board may at any time and from time to time, direct the~~ manner in which and the person or persons who may sign on behalf of the board and affix the corporate seal to any particular contract, arrangement, conveyance, mortgage, obligation, or other document or any class of contracts, arrangements, conveyances, mortgages, obligations or documents shall be in

accordance with By-law 01-93: Signing Authority and Financial Administration.

Duties of Officers

Chair and Vice-Chair

57. At the first meeting of a board of health in each year, the members of the board shall elect one of the members to be chair and one to be vice-chair of the board for the year.

~~57.~~58. The Chair of the Board shall

- preside at all meetings of the Board;
- represent the Board at public or official functions or designate another Board member to do so;
- be ex-officio a member of all Committees to which he has not been named a member;
- perform such other duties as may from time to time be determined by the Board or required by the Ontario government.

~~58.~~59. The Vice-Chair shall have all the powers and perform all the duties of the Chair of the Board in the absence, incapacity, or vacancy ~~or disability~~ of the Chair of the Board, together with such powers and duties, if any, as may be from time to time assigned by the Board.

When undertaking the duties outlined above, the Vice-Chair shall be paid, in lieu of his/her/their regular Board member per diem, a fee as stipulated in Board of Health policies.

60. In the absence, incapacity, or vacancy of both the Chair and the Vice-Chair, the most senior sitting Board member shall become the Acting Chair until the next meeting of the Board of Health.

Where multiple Board members have equal seniority, Board members may decide among themselves by consensus.

If consensus cannot be achieved, the Secretary or designate will implement a random number generator to select between Board members.

All Board members will either be invited to observe the random selection or be shared a recording of it.

61. At the next meeting of the Board of Health, the Board will elect an Acting Chair who will continue to fulfil the duties of the Chair until either the Chair or Vice-Chair can resume fulfillment of them.

62. When undertaking the duties outlined above, the Acting Chair shall be paid, in lieu of his/her/their regular Board member per diem, a fee as stipulated in Board of Health policies.

~~59.~~63. The Vice-Chair shall preside during in-camera sessions.

~~60.~~64. When it is moved and carried that the Board recess and go in-camera, the Chair shall vacate the Chair and the Vice-Chair shall preside over the Board sitting as a Committee of the Whole.

Board of Health in-camera matters shall be as per F-III-10 Freedom of Information.

The Vice-Chair shall report the proceeding to the Board and a motion of concurrence shall be voted upon.

65. In the absence of the Vice-Chair, the Chair or the person presiding over the open meeting shall designate another Board member to fulfil the duties of the Vice-Chair during the Board sitting as a Committee of the Whole.

Amendments

~~61.~~66. Any provision contained herein may be repealed, amended or varied, and additions may be made to this by-law by a majority vote to give effect to any recommendation contained in a Report to the Board and such Report has been transmitted to members of the Board prior to the meeting at which the Report is to be considered, but otherwise no motion for that purpose may be considered, unless notice thereof has been received by the Secretary two weeks before a Board meeting and such notice may not be waived and in any even no bill to amend this by-law shall be introduced at the same meeting as that at which such report or motion is considered.

Medical Officer of Health

~~62.~~67. The Board of Health may institute arrangements with the Medical Officer of Health to continue to provide medical officer of health services to Public Health Sudbury & Districts during periods of leave so as to ensure that the requirements of the governing legislation continue to be met, and such that no compensation above that provide in the existing employment agreement is paid to the Medical Officer of Health.

The Medical Officer of Health, wherever possible, will advise the Board of Health Chair if such arrangements constitute an absence or inability to act of the Medical Officer of Health as per Section 69(1) of the Health Protection and Promotion Act;

Activation of an Acting MOH appointment will be delegated to the MOH with the MOH providing notice of the Acting Appointment to the Board of Health Chair. If the MOH is unable to activate an Acting MOH appointment the

activation will be done by the Board of Health Chair. The Acting Medical Officer of Health must provide written consent to the appointment.

Per Section 68(2) of the HPPA, where the office of the MOH is vacant or the MOH is absent or unable to act, the Associate MOH of the board shall act as and has all the powers of the MOH.

Dismissal of Medical Officer(s) of Health or Associate Medical Officer of Health

~~63.~~68. Per Section 66 of the HPPA, a decision by the Board of Health to dismiss a Medical Officer of Health or an Associate Medical Officer of Health from office is not effective unless:

- the decision is carried by the vote of two-thirds of the members of the Board; and
- the Minister consents in writing to the dismissal.

The Board of Health shall not vote on the dismissal of a Medical Officer of Health or Associate Medical Officer of Health unless the Board has given the officer:

- reasonable written notice of the time, place and purpose of the meeting at which the dismissal is to be considered;
- a written statement of the reason for the proposal to dismiss the officer; and
- an opportunity to attend and to make representation to the Board at the meeting.

MOH/CEO, Associate MOH, and Divisional Director Meeting Notice and Attendance

69. The MOH/CEO is entitled to notice of and to attend each meeting of the Board of Health and every committee of the board, but the Board may require the MOH/CEO withdraw from any part of a meeting at which the Board of a committee of the board intends to consider a matter related to the remuneration or the performance of the duties of the MOH/CEO.

70. The Associate Medical Offices of Health and divisional directors are invited to attend all Board meetings and committee meetings, and are also invited to attend all in camera meetings and closed the public meetings with the following exceptions:

a. An item of discussion concerns the remuneration or performance of the individual, directly or indirectly;

b. An item of discussion concerns the performance of another staff member;

c. The individual has a conflict of interest related to an item of discussion;

d. The person presiding over the meeting determines that staff should not attend;

~~64.~~e. The MOH/CEO directs staff not to attend.

~~General~~Inclusive Interpretation

~~65.~~71. In this by-law, words importing the singular number of the masculine gender ~~only~~ shall be interpreted to include ~~more person, parties or things of the same kind than one and females as well as males and the converse~~multiple persons, and/or to include persons of any gender, as relevant.

Enacted and passed by the Board of Health, Sudbury & District Health Unit this 23rd day of June 1988.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 26th day of February 1990.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 23rd day of May 1991.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 29th day of June 1992.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 22nd day of April 1993.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 28th day of April 1994.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 27th day of April 1995.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 23rd day of May 1996.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 28th day of May 1998.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 22nd day of April 1999.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 25th day of May 2000.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 22nd day of February 2001.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 17th day of October 2002.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 17th day of June 2004.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 15th day of November 2007.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 18th day of November 2010.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 16th day of February 2012.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 20th day of February 2014.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 15th day of October 2015.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 16th day of June 2016.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 15th day of June 2017.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 21st day of September 2017.
Revised and passed by the Board of Health, Public Health Sudbury & Districts this 21st day of June 2018.
Revised and passed by the Board of Health, Public Health Sudbury & Districts this 16th day of April 2020.
Revised and passed by the Board of Health, Public Health Sudbury & Districts this 17th day of September 2020.
Revised and passed by the Board of Health, Public Health Sudbury & Districts this 18th day of November 2021.
Revised and passed by the Board of Health, Public Health Sudbury & Districts this 15th day of September 2022.
Revised and passed by the Board of Health, Public Health Sudbury & Districts this 19th day of September 2024.

Board of Health Manual
Public Health Sudbury & Districts

By-Law

Category
Board of Health By-Laws

Section
By-laws

Subject
By-law 01-93 Signing Authority, Financial Administration, and Procurement

Number
G-I-40

Approved By
Board of Health

Original Date
April 22, 1993

Revised Date
~~February 20, 2025~~September 17, 2026

Review Date
September 17~~February 20~~, 202~~65~~

The Board of Health for the Sudbury and District Health Unit enacts as follows:

1. In this by-law
   a) "Act" means the *Health Protection and Promotion Act*~~. *S.O. Ontario, Chapter 10*~~*R.S.O. 1990, c H.7* as amended;

   b) "Board" means the Board of Health for the Sudbury and District Health Unit

   c) "Banking Authority" means the authority to change organizational arrangements with a financial institution, including incurring financial obligations, modifying agreements or accounts, and providing instructions respecting such arrangements.

d) "Document Execution Authority" means the authority to legally bind the corporation through the signing or execution of contracts, agreements, leases, and other legal documents on behalf of the Board.

e) "Financial Approval Authority" means the authority, within the Board's financial administration framework, to approve expenditures, purchases, procurements, and other financial commitments or obligations.

2. All matters related to the financial affairs of the Board shall be the responsibility of the Medical Officer of Health/Chief Executive Officer, with delegation as deemed appropriate.

3. Nothing in this By-law limits or alters any authority, duty, or responsibility of the Medical Officer of Health under the Act or any other applicable legislation.

~~2.~~ **Banking**

~~3.~~4. The Board will maintain a formal list of names, titles and signatures of those individuals who have ~~signing~~ banking authority.

~~4.~~5. ~~Signing~~ Banking authorit~~yies~~ shall be restricted to

- ~~a.~~ the Chair of the Board of Health
- b. the Medical Officer of Health/Chief Executive Officer
- ~~c.~~ Associate Medical Officer of Health
- ~~d.~~ the Director, Corporate Services

6. Two signatures or authorizations from the above list shall be required to exercise banking authority, including

a. Opening, closing, and modification of accounts,

b. The addition, removal, or modification of officers with banking authority,

c. Establishing agreements relating to banking services, cash-management products, or financial institution services, and

d. Borrowing money, obtaining credit, establishing or amending lines of credit, granting security, providing guarantees, or otherwise creating debt obligations on behalf of the Board.

7. The Medical Officer of Health/Chief Executive Officer shall establish policies and procedures governing the release of funds from Board accounts, including requirements respecting

a. Financial Approval Authority;

b. Procurement approvals;

c. Segregation of duties;

d. Electronic payment controls; and

e. Financial oversight and accountability.~~on each cheque.~~

~~5.~~ **Financial Administration**

~~6.~~8. The Director, Corporate Services, under the direction of the Medical Officer of Health/Chief Executive Officer, is hereby authorized on behalf of the Board to

- a. deposit or negotiate or transfer to the bank or trust company (but only for the credit of the Board) all or any cheques, promissory notes, bills of exchanges or orders for payment of monies;
- b. receive all paid cheques and vouchers and to arrange, settle, balance and certify all books and accounts between the Board and the bank or trust company;
- c. sign the bank's or trust company's form of settlement of balances and releases;
- d. receive all monies and to give acquittance for the same; and
- e. invest excess or surplus funds in interest-bearing accounts or short-term deposits.
- f. sign all required documents for, and cause to be filed with the appropriate governmental authority, (i) the renewal of the PUBLIC HEALTH SUDBURY & DISTRICTS master business license and (ii) the notice of change when new directors and/or officers are appointed.

~~7.~~9. The Director, Corporate Services, under the direction of the Medical Officer of Health/Chief Executive Officer, shall

- a. prepare and control the annual budget under the jurisdiction of the Board for submission to the Board;
- b. prepare financial and operating statements for the Board in accordance with established Ministry policies indicating the financial position of the Board with respect to the current operations;
- c. act as custodian of the books of account and accounting records of the Board required to be kept by the laws of the province;
- d. in conjunction with the Auditor, arrange for an annual audit of all accounting books and records;
- e. report to the Board on all financial and banking matters initiated by the Chief Executive Officer;
- f. shall reconcile all balances with all constituent municipalities and appropriate ministries upon receipt of final year end settlements; and
- g. perform other duties as the Board may direct.

- **Financial Approvals**

10. The Medical Officer of Health/CEO may approve any expenditure up to $250,000, and may delegate all or part of that Financial Approval Authority.
11. The Medical Officer of Health/CEO and the Board Chair must jointly approve any expenditures exceeding $250,000 up to $2,000,000.
12. The Medical Officer of Health/CEO may delegate their co-approval to the Associate Medical Officer of Health or to the Director of Corporate Services.
13. The Board Chair may delegate their co-approval to the Vice-Chair or to the Chair of the Finance Standing Committee.
14. The Board of Health must approve any expenditures greater than $2,000,000.
15. For the purposes of this bylaw, expenditure includes the total financial commitment under an agreement, including renewal options where known.
16. The Board of Health Chair will ~~have oversight over expenses made independently~~review and approve expenditures incurred directly by the Medical Officer of Health/Chief Executive Officer ~~(e.g.,~~ including expense reimbursement claims, corporate credit/purchase card ~~use~~expenditures, travel expenses, and other ~~reimbursement claims)~~expenditures for which the Medical Officer of Health/Chief Executive Officer would otherwise be the approving authority.

Procurement

17. The Medical Officer of Health/Chief Executive Officer shall establish and maintain procurement policies and procedures governing the acquisition of goods, services, consulting services, construction, and other procurements undertaken by the Board.
18. The procurement policies and procedures established under section 1 shall include, at a minimum
    a. rules governing actual, potential, and perceived conflicts of interest in procurement activities;
    b. requirements for the segregation of procurement duties for procurements with a value exceeding $15,000;
    c. an Approval Authority Schedule establishing authority limits for procurements and expenditures, provided that no procurement with a value exceeding $2,000,000 shall proceed without approval of the Board;
    d. requirements for competitive procurement processes or use of vendor-of-record arrangements for procurements with a value exceeding $25,000;
    e. requirements that procurements with a value exceeding $150,000 be conducted through an open competitive procurement process, or through an established vendor-of-record arrangement;
    f. requirements to ensure fairness, transparency, accountability, and value for money in procurement activities; and
    g. such other requirements as may be necessary to ensure compliance with applicable legislation, trade agreements, and Board policies.

19. All procurements undertaken on behalf of the Board shall comply with the procurement policies and procedures established pursuant to this By-law.

Document Execution

20. A Director may execute an agreement on behalf of the Board where
    a. the agreement relates solely to the programs, services, or operations within the Director's division;
    b. the agreement is within an approved budget and within the Director's Financial Approval Authority;
    c. the agreement is either
        i. a renewal, extension, amendment, or replacement of an existing agreement that does not substantially alter its purpose or obligations; or
        ii. a new agreement using a form, template, or terms approved by the Board, the Medical Officer of Health/Chief Executive Officer, or the Director of Corporate Services; and
    d. the agreement does not
        i. create obligations for another division;
        ii. provide for the collection, use, disclosure, or sharing of personal information beyond that contemplated by an existing agreement or approved template; or
        iii. require execution by the Director of Corporate Services or the Medical Officer of Health/Chief Executive Officer under this By-law.
21. The Director of Corporate Services may execute an agreement on behalf of the Board where
    a. the agreement supports corporate operations;
    b. the agreement relates to finance, banking, insurance, facilities, technology, purchasing, procurement, or other corporate administrative functions; and
    c. the agreement is within the Director's Financial Approval Authority.
22. The Medical Officer of Health/Chief Executive Officer may execute any agreement within their Financial Approval Authority and shall execute
    a. agreements involving the collection, use, disclosure, or sharing of personal information where such activities are not addressed through an existing agreement or approved template;
    b. agreements establishing strategic partnerships or collaborative arrangements with external organizations;
    c. agreements establishing obligations affecting multiple divisions and involving programmatic, strategic, or operational commitments beyond routine corporate administration;
    d. agreements that fall outside approved templates or standard terms; and

e. any agreement that is not otherwise delegated under this By-law.

23. The Board shall approve

a. collective bargaining agreements;

b. any agreement that is required by legislation, regulation, or Board policy to receive Board approval before execution;

c. borrowing, debt instruments, and credit facilities that are not already authorized through the annual budget, a prior Board resolution, or existing banking arrangements;

d. acquisition or disposition of real property;

e. agreements creating an ownership interest in a corporation, partnership, or joint venture; or

f. incorporation, creation, or acquisition of a subsidiary.

24. The Director of Corporate Services or Medical Officer of Health/CEO may exercise the document execution authority of a director.

25. The Medical Officer of Health/CEO may exercise the document execution authority of the Director of Corporate Services.

26. A director may delegate document execution authority to another director in writing, specifying the scope and effective period of delegation.

~~8.~~27. The Medical Officer of Health/CEO may delegate document execution authority to the Associate Medical Officer of Health in writing, specifying the scope and effective period of delegation.

Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 22nd day of April 1993.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 28th day of April 1994.
Reviewed and passed by the Board of Health, Sudbury & District Health Unit this 27th day of April 1995.
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Revised and passed by the Board of Health, Sudbury & District Health Unit this 21st day of June 2018.
Revised and passed by the Board of Health, Sudbury & District Health Unit this 19th day of September 2024.

Board of Health Manual
Public Health Sudbury & Districts

~~Policy~~Information Sheet

Category
Board of Health Administration

Section
Hiring of Professional Staff

Subject
Hiring of Medical Officer of Health, Associate Medical Officer of Health, and Professional Staff

Number
I-IV-10

Approved By
Board of Health

Original Date
November 23, 1995

Revised Date
September 1~~7~~9, 2026~~4~~

Review Date
September 1~~7~~9, 2026~~4~~

Purpose

Medical and Associate Medical Officers of Health

The Board of Health is bound by the *Health Protection and Promotion Act (HPPA)*, R.S.O. 1990 with respect to the hiring of a full-time Medical Officer of Health (MOH) or Associate Medical Officer of Health (AMOH). The current version of the Ministry of Health's Policy Framework on Medical Officer of Health Appointments, Reporting, and Compensation further outline the steps for the appointments of Medical Officers of Health and Associate Medical Officers of Health and the requirements for acting Medical Officers of Health. Appointment of a MOH, AMOH and Acting MOH is an important obligation of a board of health under the HPPA.

Acting Medical Officer of Health

Pursuant to section 68(2) of the *HPPA*, in the absence, incapacity, or vacancy of the Medical Officer of Health, the Associate Medical Officer of Health becomes the Acting Medical Officer of Health.

Pursuant to section 69, if both the Medical Officer of Health and the Associate Medical Officer of Health are absent, incapable, or vacant, the Board of Health must appoint an Acting Medical Officer of Health observing the same requirements as for hiring a full-time Medical Officer of Health.

Professional Staff

The Board of Health is bound by the *Health Protection and Promotion Act*, R.S.O. 1990, with respect to the hiring of Professional Staff.

Board of Health Manual
Public Health Sudbury & Districts

Procedure

Category
Board of Health Administration

Section
Performance Management

Subject
Performance Appraisal of MOH/CEO

Number
I-VI-10

Approved By
Board of Health

Original Date
June 16, 2016

Revised Date
~~June 21, 2018~~September 17, 2026

Review Date
September 17~~9~~, 2026~~4~~

Process

- Performance appraisals are conducted on an annual basis, unless otherwise specified by the Board Chair, and are the responsibility of the Board Chair.
- A survey tool that permits respondent anonymity will be used to seek feedback from all Board of Health members and positions that report directly to the MOH/CEO. The Board Chair may specify additional survey respondents (e.g. external partners, other employees).The survey tool will explicitly seek input relative to the current position description. The survey tool will be administered by the Executive Assistant to the MOH/CEO/Board Secretary.
- The compiled feedback will be shared with the Board of Health Executive Committee members and the MOH/CEO.
- The Board Chair will conduct the performance appraisal meeting with the MOH/CEO after appropriate consultation with the Board of Health Executive Committee. The *Performance Mapping Mutual Action Plan* forms will be used as per Public Health Sudbury & Districts General Administrative Manual forms.

- Information regarding the work and conduct of the MOH/CEO is referred to when preparing the performance appraisal and all relevant successes and performance issues are included in the performance appraisal from the entire review period.
- ~~The factors evaluated during the appraisal are the MOH/CEO's quality of work, work habits, and interpersonal relations. Each appraisal is thoroughly discussed to point out both areas of successful performance and areas that require improvement or are unacceptable.~~
- The evaluation is intended to be participatory in nature.
- The MOH/CEO signature on the completed performance appraisal shall be part of the completed document. The signature signifies that the appraisal has been completed and discussed. It does not necessarily imply agreement with the appraisal. Should the MOH/CEO wish to provide additional comments to their performance appraisal, they shall do so and these comments will be appended to the performance appraisal being placed in the personnel file.
- The original performance appraisal (plus any additional comments) will be filed in the personnel file located in the Corporate Services Division.
- A copy of the performance map is provided to the MOH/CEO.
- The Board shall be informed once the performance appraisal process is completed.

BOARD OF HEALTH MANUAL

MOTION:

THAT the Board of Health approve the Manual as presented on this date;

THAT the Board of Health adopt the amendments to the following bylaws:

- **By-Law 04-88 concerning proceedings of the Board of Health**
- **By-law 01-93 concerning signing authorities and financial matters**

AND THAT the Board of Health adopt new titles (“subject”) for each By-Law as outlined in the Briefing Note..

« Annual performance and financial reports

2025 Year-in-Review: Lasting Ripples of Impact

2024 Financial Report

2024 Year-in-review: Connecting the dots

Home » About » Annual performance and financial reports » Financial Report 2025

Financial Report 2025

In 2025, Public Health Sudbury & Districts strengthened its focus on the work that matters most for community health. Operating within a challenging fiscal environment and growing community needs, the agency focused resources on activities with the greatest potential to improve health outcomes and strengthen communities. This included vaccination, the control of infectious diseases, and engaging with our diverse communities. Additionally, to build sustainability at a time when funding does not keep pace with inflation, the agency made initial investments towards technology-driven efficiencies and a strengthened workforce.

Collaboration also played an important role. Throughout the year, Public Health worked with key partners to improve health and well-being across our large and diverse service area. For example, Public Health developed multiple partnerships to support oral health, including collaborating with Wikwemikong Health Centre to co-design and plan culturally-appropriate dental screening clinics for children. Beyond oral health, partnerships also supported environmental health initiatives, including work with the City of Greater Sudbury to develop an adverse air quality response plan. Public Health also collaborated with co-leads from Shkagamik-Kwe Health Centre and Sudbury District Restorative Justice, as well as other community partners, to advance Planet Youth Up North in the Greater Sudbury and La Cloche areas, supporting its implementation around local community needs.

Popular links

Measles self-assessment tool

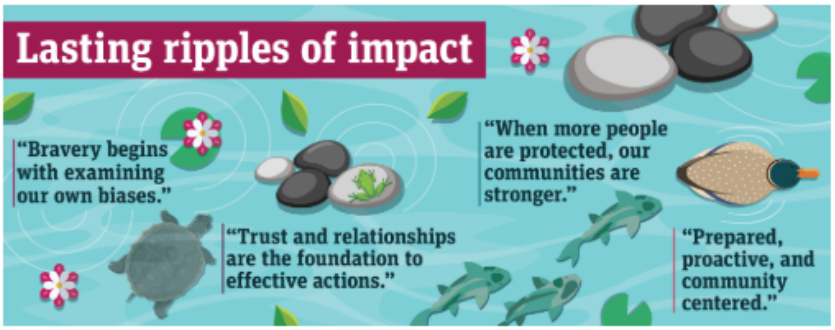
Strategic Plan: 2024-2028

Food handler training

How to report vaccinations

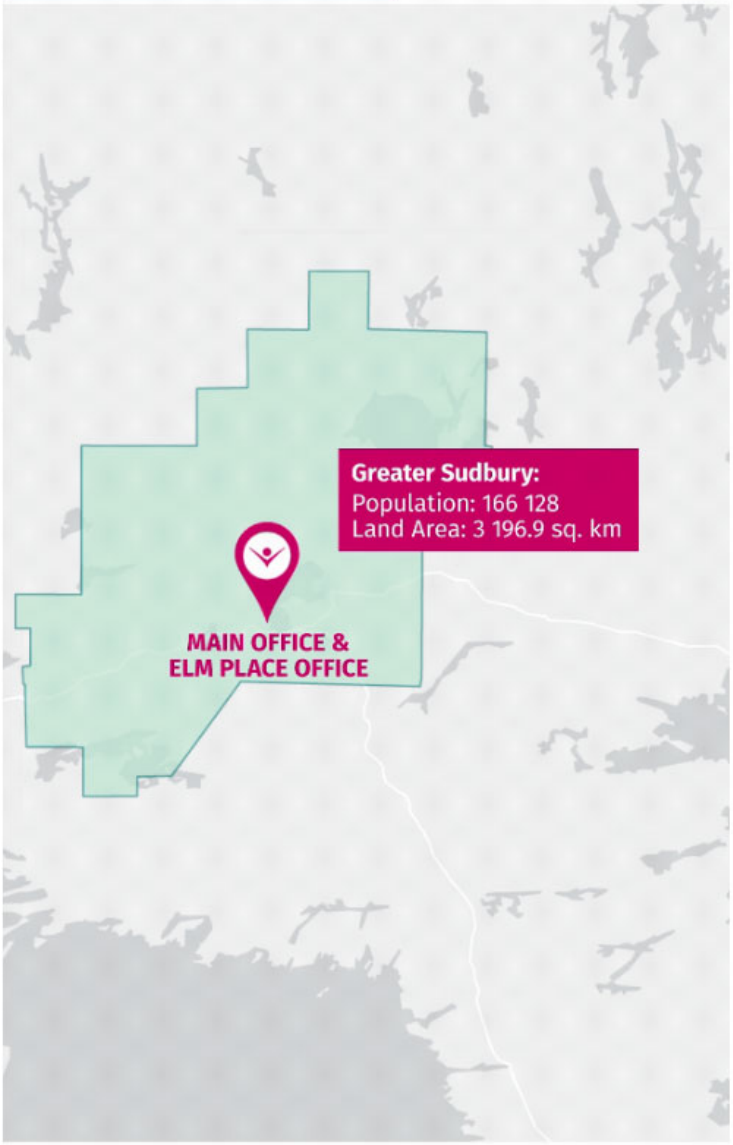
Positive space

How did we do today?



The value of strong partnerships was made evident during the measles outbreak in 2025. Through preparedness, timely action, in-person presence in communities, and strong collaboration with health care partners and community leaders, Public Health protected children and supported families. These efforts reflected the need for a trusted, local, and community-centred public health system. This and other examples of Public Health's work and impact are highlighted in the *2025 Year-in-Review: Lasting Ripples of Impact*. The financial information presented in this report demonstrates how resources were used to achieve meaningful results and deliver lasting impact for the people and communities we serve.

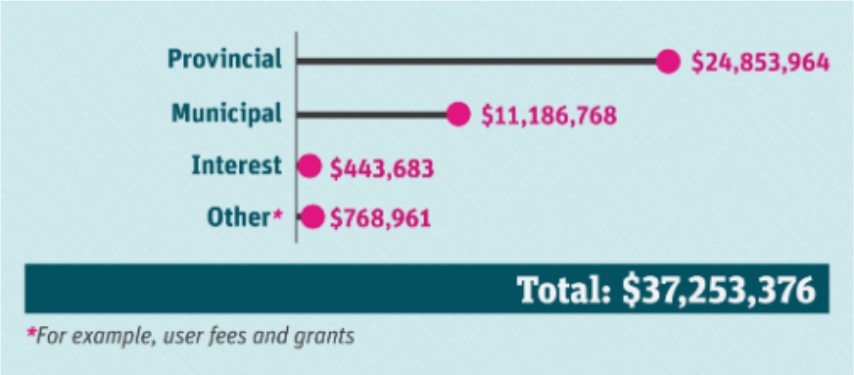
Communities we serve



Source: Statistics Canada. 2022. Census Profile. 2021 Census. Statistics Canada Catalogue number 98-316-X2021001. Ottawa. Released February 9, 2022.

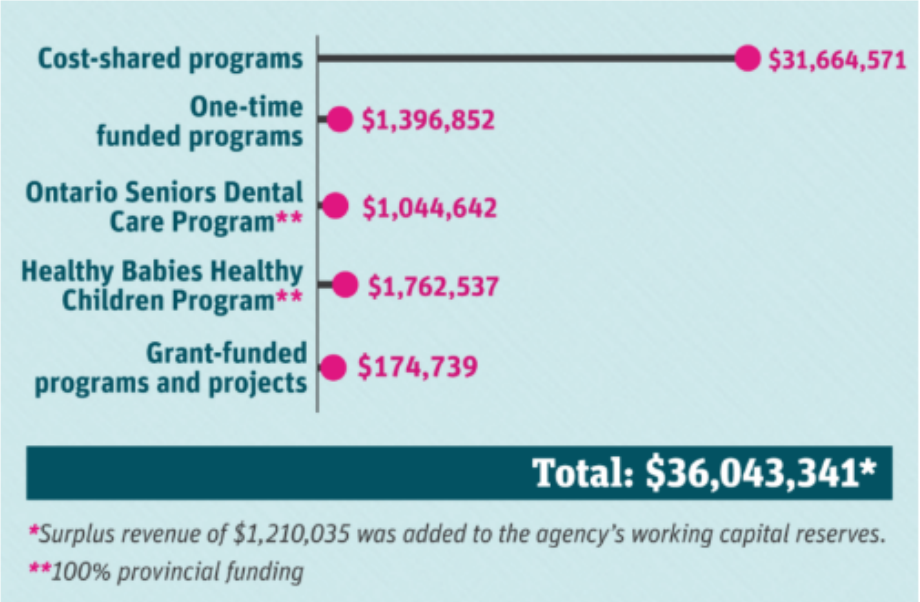
Public Health Sudbury & Districts covers a land area of 46 167.2 km^2 and operates within the Anishinabek and Cree territories. The service area is subject to the Robinson-Huron Treaty and Treaty 9 to the north.

Revenue sources:



Operating expenses:

Although the provincial government's policy is to fund 75% of cost-shared expenditures, the actual provincial funding received in 2025 covered only 62.3% of Public Health Sudbury & Districts' cost-shared expenditures, which put an additional burden on municipalities to make up the rest.



Detailed information is available in the 2025 Audited Financial Statement (PDF, 346 KB) (English only).

This item was last modified on September 2, 2026

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« Rapports annuels sur le rendement et les rapports financiers

Bilan de l'année 2025 : Effets d'entraînement durables

Bilan de l'année 2024 : établir les liens

Rapport financier 2024

Rapport financier 2025

En 2025, Santé publique Sudbury et districts a mis davantage l'accent sur le travail le plus important pour la santé communautaire. Vu le contexte financier où il évoluait et les besoins croissants à l'échelle locale, l'organisme a concentré ses ressources sur les activités pouvant le mieux améliorer les résultats en santé et renforcer les collectivités. Cela incluait la vaccination, le contrôle des maladies infectieuses et l'interaction avec nos diverses collectivités. De plus, pour assurer la durabilité à une époque où le financement ne suit pas l'inflation, l'organisme a investi initialement dans les économies axées sur la technologie et le renforcement de la main-d'œuvre.

La collaboration a également joué un rôle important. Tout au long de l'année, Santé publique a travaillé avec des partenaires clés pour améliorer la santé et le bien-être dans sa zone de service, vaste et variée. Par exemple, le bureau a créé une série de partenariats pour favoriser la santé buccodentaire, notamment en collaborant avec le Wikwemikong Health Centre pour concevoir et planifier des cliniques de dépistage dentaire culturellement adaptées pour les enfants. Les partenariats ont également permis de soutenir des initiatives de santé environnementale, et de dresser un plan d'intervention en cas de mauvaise qualité de l'air de concert avec la Ville du Grand Sudbury. Santé publique a également collaboré avec les coresponsables du Shkagamik-Kwe Health Centre et de Justice réparatrice du

Liens populaires

Rougeole : Outil d'auto-évaluation

Plan stratégique 2024–2028

Santé sexuelle : dépistage, traitement, et autres services

Comment déclarer les vaccins

Espace positif

Comment a été notre service aujourd'hui?

district de Sudbury, mais aussi d'autres partenaires communautaires, pour faire progresser Planète Jeunesse Sudbury-LaCloche dans les régions du Grand Sudbury et de LaCloche, en appuyant sa mise en œuvre en fonction des besoins de la population locale.

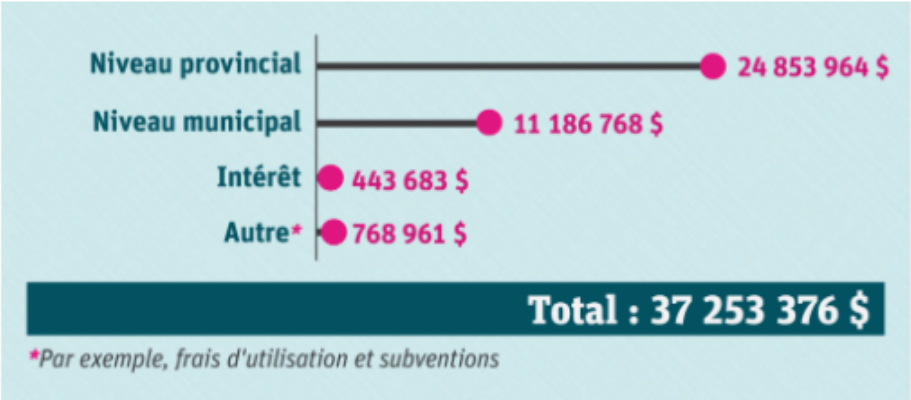
En 2025, l'épidémie de rougeole a mis en évidence la valeur de solides partenariats. Par sa préparation, son action rapide, sa présence dans les communautés et sa solide collaboration avec des partenaires en soins de santé et des responsables communautaires, Santé publique a protégé les enfants et soutenu les familles. Ces efforts reflétaient la nécessité d'un système de santé publique fiable, local et à caractère communautaire. Le *Bilan de l'année 2025 : Effets d'entraînement durables* les met en évidence, en plus de donner d'autres exemples du travail et de l'influence de Santé publique. L'information financière qui se trouve dans le présent rapport démontre comment les ressources ont permis d'obtenir des résultats probants et d'agir de façon durable sur les gens et les collectivités que nous servons.

Les communautés que nous servons

Source : Statistique Canada, 2022. Profil du recensement. Recensement de 2021. Numéro de catalogue de Statistique Canada 98-316-X2021001. Ottawa. Publié le 9 février 2022. Mis à jour le 17 août 2022.

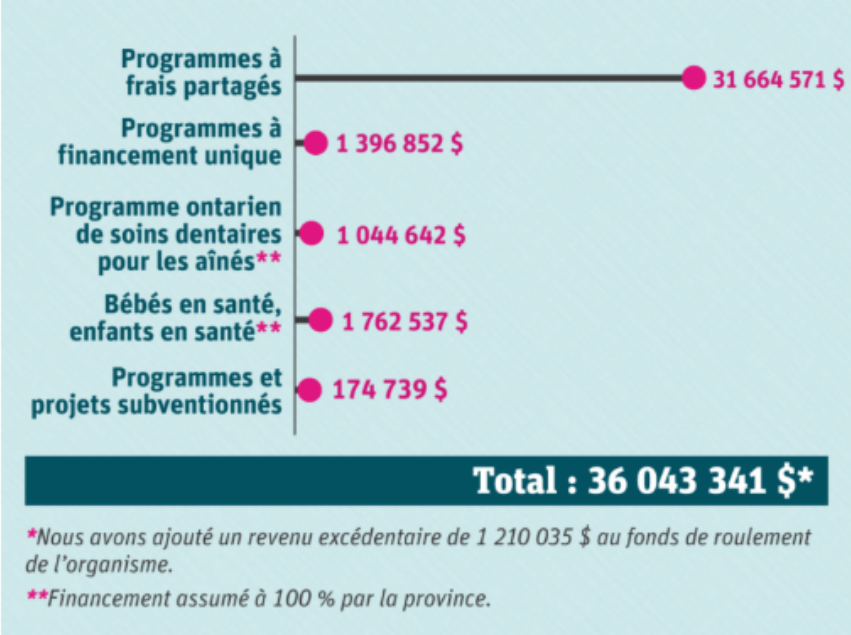
Santé publique Sudbury et districts couvre une superficie de 46 167,2 km² et exerce ses activités sur les territoires des Anichinabés et des Cris. Le Traité Robinson-Huron et le Traité nº 9 au nord englobent la zone de service.

Sources de revenus :



Dépenses de fonctionnement :

Bien que le gouvernement provincial ait pour politique de financer 75 % des coûts partagés, les fonds réellement reçus en 2025 ont couvert seulement 62,3 % des dépenses à frais partagés que Santé publique Sudbury et districts a engagées. Les municipalités ont ainsi dû porter le fardeau supplémentaire d'assumer le reste.



L'information détaillée se trouve dans les états financiers audités de 2025 (PDF, 346 Ko) (seulement en anglais).

Dernière modification : 2 septembre 2026

Partager la page :

ADDENDUM

MOTION: THAT this Board of Health deals with the items on the Addendum.

ADJOURNMENT
MOTION: THAT we do now adjourn. Time: _____