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May 13, 2020

Hon. Christine Elliott, Deputy Premier and Minister of Health  
College Park, 5th Floor  
777 Bay Street  
Toronto, ON M7A 2J3

Mr. Matthew Anderson  
Chief Executive Officer  
Ontario Health

Dear Hon. Minister Elliott and Mr. Anderson:

**Re: Ontario's Clinical Triage Protocol for Major Surge in COVID Pandemic**

We write further to the Open Letter dated April 8, 2020 and which was delivered to Premier Doug Ford, Minister of Health, Christine Elliott, and Minister of Accessibility, Raymond Cho. As you will recall, the Open Letter raised grave concerns regarding the Ontario Clinical Triage Protocol for Major Surge in COVID Pandemic<sup>1</sup> (the “Triage Protocol”), authored by Ontario Health, dated March 28, 2020 but never publicly released.

On April 21, 2020, ARCH Disability Law Centre, amongst other recipients, received a response from the Ontario Government. The Government’s letter, undated, stated that the Ministry of Health directed Ontario Health to consult with the Ontario Human Rights Commission (OHRC), as well as key human rights and community experts. In response, ARCH delivered a letter to Ontario Health on April 22, 2020 requesting additional information regarding any consultations, and requesting that a clear statement be made

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<sup>1</sup> Ontario Clinical Triage Protocol for Major Surge in COVID Pandemic, March 28, 2020 [Triage Protocol].

rescinding the March 28, 2020 draft Triage Protocol. ARCH continues to await a response from Ontario Health.

While ARCH welcomes the Government's direction to Ontario Health to consult, little has been made public about the consultations, including the format of consultations, the timeline surrounding consultations, the groups – aside from the OHRC – that will be consulted, and when a finalized version of the Triage Protocol can be expected.

A further concern is that, despite stating that the current version of the Triage Protocol is a draft, the Government has taken no action to clearly withdraw the draft to ensure that it is not implemented should the medical system become overburdened whilst Ontario Health conducts consultations.

Notwithstanding the Government's assertion that the Triage Protocol is undergoing consultation, ARCH is not aware of any such consultation nor has ARCH received any revised draft. ARCH strongly encourages input from communities of persons with disabilities through a formal and inclusive consultation process, and that any revised version of the Triage Protocol be made widely available to allow for a more fulsome and effective consultation. In the meantime, because time is of the utmost essence in the present circumstances, ARCH is taking this opportunity to provide its own submissions on the issues that must be addressed and resolved in any (newly) drafted Triage Protocol.

To note, ARCH recognizes that health care workers need a pragmatic and practical approach to assist them in making extremely difficult decisions in allocating critical care resources during this pandemic. However, as a collection of United Nations experts have made clear, "*The scarcity of resources ... should never be a justification to discriminate against certain groups of patients*"<sup>2</sup>. It is imperative that any critical care protocol developed by the Ontario Government, or any of its agencies, be founded upon human rights laws and principles, including the recognition that every person has an equal right

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<sup>2</sup> No exceptions with COVID-19: "Everyone has the right to life-saving interventions" – UN experts say, Press Release, March 26, 2020. Available: [https://www.ohchr.org/EN/NewsEvents/Pages/NewsSearch.aspx?MID=SR\\_Disabilities](https://www.ohchr.org/EN/NewsEvents/Pages/NewsSearch.aspx?MID=SR_Disabilities)

to life-saving intervention and the right to be free of discriminatory denial of health care, including persons with disabilities.<sup>3</sup>

In its current version, the Triage Protocol is in conflict with the rights of persons with disabilities pursuant to the Ontario *Human Rights Code*,<sup>4</sup> the *Charter of Rights and Freedoms* (the *Charter*),<sup>5</sup> and the United Nations' *Convention on the Rights of Persons with Disabilities*.<sup>6</sup> For the purposes of this brief, the discussion that follows focuses primarily on the *Charter* violations. The analysis then turns to the administrative and implementation considerations the Government must put in place to ensure that any critical care protocol does not infringe upon the rights of persons with disabilities. To conclude this brief, ARCH makes several recommendations that we urge the Ministry of Health, Ontario Health and any other organization that may be involved in drafting, to consider when re-drafting the Triage Protocol.

### **The Triage Protocol Violates the Charter**

Any critical care protocol or health care scheme the Government chooses to put into place must comply with the *Charter*.<sup>7</sup> The Triage Protocol, and the tools it relies on to determine a patient's prioritization in receiving critical care, must be considered through this lens.

In particular, the Triage Protocol states that allocation of critical care resources is dependent, in part, on the basis of the 9-point Clinical Frailty Scale (CFS).<sup>8</sup> The points range from Very Fit (score of 1) to Terminally Ill (score of 9), by taking into account disability-related factors such as activity levels<sup>9</sup> and the requirement for assistance in completing activities, as well as the use of mobility devices by some persons with

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<sup>3</sup> *Convention on the Rights of Persons with Disabilities*, 30 March 2007, 2515 UNTS 3 at 70, Can TS 2010 No 8 (entered into force 3 May 2008, ratified by Canada 11 March 2010), at Article 25 [CRPD].

<sup>4</sup> RSO 1990, c H.19 [Code]

<sup>5</sup> The Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11 [Charter].

<sup>6</sup> CRPD, *supra* note 3.

<sup>7</sup> *Canadian Doctors for Refugee Care v Canada (Attorney General)*, 2014 FC 651 para 506; see also generally, *Eldridge v British Columbia (Attorney General)*, 1997 CanLII 327 (SCC) [Eldridge].

<sup>8</sup> Triage Protocol, *supra* note 1 at 6.

<sup>9</sup> Score 4 on the Clinical Frailty Scale, for example, deems someone who feels tired during the day as being vulnerable; persons with disabilities such as lupus and muscular dystrophy fall within this CFS category since one of the manifestations of their disability is fatigue.

disabilities, the ability to walk with assistance, and/or the use of a support person for personal care or finances. As will be demonstrated below, the inclusion of the CFS in the Triage Protocol violates the rights of persons with disabilities, pursuant to sections 15, 7, and 12 of the *Charter*.

Further, the Triage Protocol specifically identifies at least four different categories of disabilities, including cognitive disabilities and “advanced or moderate” neurodegenerative diseases including Parkinson Disease, Amyotrophic Lateral Sclerosis, and Metastatic Malignant Disease. Persons with these disabilities may in some stages of their disability be deprioritized from receiving critical care.

These tools, on their face and/or in application, do not comply with the *Charter*.

#### Section 15 of the *Charter*: Right to the Equal Protection and Equal Benefit of the Law without Discrimination

The Triage Protocol violates the right of persons with disabilities to be equal before and under the law, and to have equal protection and equal benefit of the law without discrimination, contrary to section 15 of the *Charter*. The “animating norm” of section 15 is substantive equality,<sup>10</sup> which responds to the reality that “persistent systemic disadvantages have operated to limit the opportunities available to members of certain groups in society and seeks to prevent conduct that perpetuates those disadvantages.”<sup>11</sup>

In addition to identifying specific disabilities for the deprioritization for critical care, the Triage Protocol draws a clear distinction for critical care on the basis of a CFS score. Persons who score higher on the CFS will be deprioritized from receiving critical care. Persons with disabilities are more likely to score higher on the CFS score, because of their general disability-related care needs and reduced activity levels. Meanwhile, a person without a disability is less likely to receive a high CFS score – it is only persons with disabilities who will fall within this scope. In this way, the CFS draws a clear distinction between persons with disabilities and abled-bodied persons.

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<sup>10</sup> See *Withler v Canada*, 2011 SCC 12 and *Andrews v Law Society of British Columbia*, [1989] 1 SCR 143.

<sup>11</sup> *Kahkewistahaw First Nation v Taypotat*, 2015 SCC 30 at para 17.

It is widely recognized that healthcare systems tend to be structurally and systemically ableist.<sup>12</sup> Historically, and due to this, persons with disabilities have been denied equal access to health care<sup>13</sup> on the basis of stereotypes and the erroneous notion that disability is a flaw inherent in the individual.<sup>14</sup> The crux of the issue is in the often subconscious devaluing of the lives of persons with disabilities by medical practitioners.<sup>15</sup> This subconscious devaluing stems from the tendency of ableist quality of life presumptions to seep into medical practitioners' decision-making process. These inequities persist today, and the pandemic has significantly exacerbated these disparities and erected further barriers; this includes the Triage Protocol which creates a decision-making framework built upon an ableist approach to disability. This is despite the fact that persons with disabilities may be particularly vulnerable<sup>16</sup> to COVID-19.

Interestingly, the Triage Protocol purports to be guided by the principle of fairness.<sup>17</sup> However, without contemplating substantive equality, the principle of fairness in the Triage Protocol is illusory at best. In this circumstance, fairness is understood as the treatment of all patients on an equal and fair basis by using clinically-relevant criteria to allocate resources. The Triage Protocol, however, fails to understand the difference between formal and substantive equality, and fails to appreciate the lived experience of persons with disabilities in their interactions with the medical system.

The inclusion of the guiding principles in the Triage Protocol leads to the very errors warned against by the Special Rapporteur on the Rights of Persons with Disabilities. As the Special Rapporteur stated, the health care sector has a tendency to reduce ethical debates "to an application of rules to situations in an oversimplified and legalistic manner, without a critical reflection of the role of human rights in bioethics and the power dynamics under which decisions are made."<sup>18</sup> The inclusion of the guiding principles in

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<sup>12</sup> Katie Savin & Laura Guidry-Grimes, *Confronting Disability Discrimination During the Pandemic*, April 2, 2020 available: <https://www.thehastingscenter.org/confronting-disability-discrimination-during-the-pandemic/>.

<sup>13</sup> Eldridge, *supra* note 7.

<sup>14</sup> Eldridge, *ibid* at para 56.

<sup>15</sup> United Nations General Assembly, Report of the Special Rapporteur on the rights of persons with Disabilities, A/HRC/43/41, 17 December 2019, available: <https://undocs.org/en/A/HRC/43/41> ["Report of the Special Rapporteur"].

<sup>16</sup> Savin & Guidry-Grimes, *supra* note 12.

<sup>17</sup> Triage Protocol, *supra* note 1 at 3.

<sup>18</sup> Report of the Special Rapporteur, *supra* note 15, at 6.

the Triage Protocol, including the principle of fairness, is formalistic and fails to consider all the ways in which fairness is eroded by the treatment of persons with disabilities within the healthcare system.

Many persons with disabilities will be deprioritized and at risk of being denied access to critical care simply because the CFS deems them “severely frail” on the basis of their use of a mobility device, having a support person assisting them with activities of daily living, or having one of the disabilities identified by the Triage Protocol. These characteristics are not, as a rule, relevant to the person’s health status nor their overall mortality in the face of COVID-19. These same persons may very well be viable candidates for critical care despite the fact that they need assistance for daily living and personal care and/or use a wheelchair.

Persons with disabilities are not one homogenous group and the grouping of persons with disabilities into pre-determined categories of disability pre-empts and denies individual assessment to determine their need for critical care. For example, the Triage Protocol groups persons with cognitive disabilities<sup>19</sup> into one group, ignoring the fact that persons with cognitive disabilities can include persons labelled with intellectual disabilities, persons with developmental disabilities, persons with dementia, persons with acquired brain injuries, persons with fetal alcohol syndrome, etc. This kind of decision-making lends itself to the reliance upon labels, which can be laden with stereotypes and value judgments as to the quality of the patient’s life. This has the detrimental impact of denying a patient of individual assessment, which is necessary to ascertain their individual needs.<sup>20</sup>

In this respect, the Triage Protocol clearly has the effect of reinforcing, perpetuating, or exacerbating the disadvantage experienced by persons with disabilities. By deprioritizing persons from receiving care, the Triage Protocol, relying on the CFS, disconcertingly

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<sup>19</sup> The Triage Protocol uses “cognitive impairments,” which is not human rights language. For the purposes of this document, however, and to ensure clarity, the term “cognitive disabilities” is used throughout.

<sup>20</sup> See, for example: *British Columbia (Superintendent of Motor Vehicles) v British Columbia (Council of Human Rights)*, 1999 CanLII 646 (SCC) and *British Columbia (Public Service Employee Relations Commission) v BCGSEU*, 1999 CanLII 652 (SCC).

mimics the historical treatment of persons with disabilities in the medical system of isolation and exclusion, and being subject to ableist norms and value judgments about their quality of life. These criteria rely on damaging assumptions about persons who require assistance with aspects of daily living as having a lesser quality of life. This devalues the lives of persons with disabilities.

It is imperative that decisions about who receives critical care should be made using objective, individualized clinical criteria directly associated with mortality risks of COVID-19. Decisions must not be based on stereotypes or assumptions about a person's disability, the value of quality of their life due to their disability, or longer term mortality rates that are not directly related to COVID-19.

#### Section 7 of the Charter: Right to Life and Security of the Person

The inclusion of the CFS in the Triage Protocol and the identification of specific categories of disabilities violates the rights of persons with disabilities to life and security of the person in a manner not in accordance with the principles of fundamental justice, contrary to section 7 of the *Charter*.

The effect of the Triage Protocol violates the rights of persons with disabilities to life. Persons who use mobility devices,<sup>21</sup> those who use support persons for daily living tasks and personal care,<sup>22</sup> those who walk with assistance,<sup>23</sup> or those who have a disability that is expressly identified, are more likely to be deprioritized from receiving critical care and are more likely to experience negative health outcomes, up to and including death.

Persons with disabilities who use mobility devices or walk with assistance include those who were born with disabilities or acquired them at a young age, such as persons with cerebral palsy, congenital amputations or who have survived childhood cancers. Persons who need assistance for daily living tasks can include persons labelled with intellectual disabilities who are able to live in the community with assistance from support workers.

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<sup>21</sup> Scoring a 7 on the CFS, see Triage Protocol, *supra* note 1, at 10.

<sup>22</sup> Scoring a 5, 6, or 7 on the CFS, see Triage Protocol, *ibid*.

<sup>23</sup> Scoring a 6 on the CFS, see Triage Protocol, *ibid*.

The use of the CFS inappropriately labels persons with these characteristics as “frail” which then deems them less likely to receive critical care when they most need it.

In identifying specific disabilities, the Triage Protocol invites the application of labels and value judgments to the quality of life of persons with disabilities. Instead of objective and individualized assessment, these labels and value judgements then become the starting point for assessing a patient’s likely morbidity.

The inclusion of the CFS and the identification of specific disabilities also violates persons with disabilities’ right to security of the person, contrary to section 7. In particular, knowing that they may be deprioritized or denied access to critical care has caused persons with disabilities psychological distress, and creates a disincentive to seek medical care, putting their security and their community at risk. Persons with disabilities are already experiencing the disproportionate effects of the COVID-19 virus,<sup>24</sup> and are more susceptible to the virus depending on the nature of their disability. The Triage Protocol means they must now endure the very real scenario that they may be denied critical care resources, at least in part, because they use a mobility device, require assistance with daily living tasks or require the assistance of a mobility device to walk.

This use of the CFS is overbroad, arbitrary and not in accordance with the principles of fundamental justice. This is especially true considering the purposes for which the CFS was designed and developed: for physicians to use in treating elderly patients.<sup>25</sup> It is accepted that the CFS has not been widely validated in populations younger than 65 years of age or for persons with disabilities.<sup>26</sup> Moreover, the CFS does not distinguish between frailty and disability, making it wholly inappropriate to apply to a subset of the population that has long-term disabilities, some of which may be progressive in nature.

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<sup>24</sup> CBC News, *COVID-19 death toll at Ontario long-term care homes nears 1,000, hospitalizations on the rise*, May 3, 2020 available: <https://www.cbc.ca/news/canada/toronto/ontario-sunday-covid-19-police-memorial-death-total-1.5553859>

<sup>25</sup> Rockwood K, Song X, MacKnight C, Bergman H, Hogan DB, McDowell I, Mitnitski A. A global clinical measure of fitness and frailty in elderly people. *CMAJ*. 2005 Aug 30;173(5):489-95; also see: <https://www.dal.ca/sites/gmr/our-tools/clinical-frailty-scale.html>

<sup>26</sup> National Health Service, Specialised Clinical Frailty Network, *Frailty and Covid-19*, available: <https://www.scfn.org.uk/clinical-frailty-scale>

In fact, several jurisdictions have already recognized the error in including the CFS in their Triage Protocols and have remedied their error by removing the CFS from any COVID-19 protocols and committed to an individualized assessment of each patient. We direct the Government's attention, for example, to the United Kingdom,<sup>27</sup> where the use of the CFS has been challenged and the government has conceded the problematic nature of the CFS for the purposes of allocating critical care resources.<sup>28</sup> The Government and Ontario Health are encouraged to heed these lessons learned in other jurisdictions.

#### Section 12 of the *Charter*: Right Not to be Subjected to any Cruel and Unusual Treatment

The Triage Protocol violates persons with disabilities' right to be free from cruel and unusual treatment, contrary to section 12 of the *Charter*. The CFS and the identification of specific disabilities intentionally targets an already vulnerable, disadvantaged and marginalized group in society that is more than likely to have been, or will be, impacted by the very virus to which this Protocol responds. This is demonstrative of treatment that is cruel and unusual.

The Triage Protocol draws a distinction between persons with disabilities and persons without disabilities for the purposes of allocating critical care resources in a manner that outrages the standards of decency. Again, we point to the disability-related need for assistance to walk as a marker of "frailty" according to the CFS. This is problematic and neglects the human-rights approach and understanding of disability. The effect of the inclusion of the CFS and identifying specific disabilities is to create a two-tiered access to critical care: one for persons with disabilities and one for persons without disabilities.

It is well established that persons with disabilities are entitled to access health care on an equal basis; this violation of the right to equal access, and by extension to ensure that the

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<sup>27</sup> Hodge, Jones & Allen, News Release, *NICE Amends COVID-19 Critical Care Guideline After Judicial Review Challenge*, March 31, 2020 available: <https://www.hja.net/press-releases/nice-amends-covid-19-critical-care-guideline-after-judicial-review-challenge/>

<sup>28</sup> The Government's attention is also directed to the states of Alabama, Tennessee and Washington in the United States for similar legal challenges to the identification of specific disabilities to be excluded or deprioritized from receiving critical care. Available: [https://adap.ua.edu/uploads/5/7/8/9/57892141/al-ocr-complaint\\_3.24.20.pdf](https://adap.ua.edu/uploads/5/7/8/9/57892141/al-ocr-complaint_3.24.20.pdf) and <http://thearc.org/wp-content/uploads/2020/03/2020-03-27-TN-OCR-Complaint-re-Healthcare-Rationing-Guidelines.pdf>

human dignity of persons with disabilities is not degraded, cannot be justified in light of the fact that society is currently battling a pandemic.

There is little doubt that the treatment of persons with disabilities, in accordance with this Triage Protocol, would be unacceptable to a large segment of the population, violates public standards of decency and propriety and, overall, shocks the general conscience. In short, the approach adopted by the Triage Protocol deprioritizes persons with disabilities and prioritizes persons without. In effect, this leads to cruel and unusual treatment of persons with disabilities *because they have a disability*.

The current version of the Triage Protocol is drafted in a manner as to call for a clinical assessment of the chance of survival that is *comparative* rather than *individualized*. The removal of critical care from a person with a disability who has a reasonable chance of survival in order to provide it to another patient who, by virtue of not having a disability, is deemed to have a better chance of survival<sup>29</sup> also amounts to cruel and unusual treatment. It is clear that the Triage Protocol does not explicitly state that persons with disabilities will be deprioritized or removed from receiving critical care in order for a person without a disability to receive it. However, the cumulative effect of including the CFS, the identification of specific disabilities in the exclusion chart, and the subconscious value-judgments inherent in the health care system that permeate the decisions made pursuant to the Triage Protocol, lead to a eugenic-adjacent approach to the pandemic. This is a clear violation of section 12 of the *Charter*.

### **Administrative and Implementation Precautions**

The Government must take a number of active measures to ensure that persons with disabilities are not deprioritized in receiving critical care and to ensure that ableism is not perpetuated in emergency and critical care response measures. Without these active steps, the issues that stem from the current Triage Protocol will continue to have devastating consequential effects on persons with disabilities.

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<sup>29</sup> See for example, Triage Protocol, *supra* note 1, a 6, Exclusion Criteria Chart section (J), Triage Levels 1, 2 and 3.

It is imperative that the Government is accountable and transparent throughout the development and implementation of the Triage Protocol. The Triage Protocol must include oversight and accountability mechanisms that are effective and timely to ensure that systemic safeguards are in place and operational throughout any period of implementation.

The current Triage Protocol was drafted without any known and public consultation undertaken by the Ministry of Health or by Ontario Health with communities and/or organizations of persons with disabilities who will be disproportionately impacted by the Triage Protocol.

It is beyond a shadow of a doubt that persons with disabilities are disproportionately impacted by COVID-19 and it is equally certain that the current Triage Protocol disproportionately impacts persons from various disability communities. As such, any direction by the Ontario Ministry of Health to Ontario Health to consult with key groups *must* include consultations with persons with disabilities specifically identified in the Triage Protocol. Any consultation conducted without affected persons with disabilities is ineffective and is more than likely to result in another Triage Protocol that infringes upon the rights of persons with disabilities, rights that are protected provincially, federally and internationally.

The Canadian Human Rights Tribunal has recognized the ways in which greater consultation with persons with disabilities may prevent similar discriminatory practices from occurring again in the future.<sup>30</sup> The Ministry of Health and Ontario Health are encouraged to heed this finding and embark on as broad as a consultation as possible by inviting persons with disabilities identified in the Triage Protocol to a seat at the consultation table.

Furthermore, under the *CRPD*, engagement with persons with disabilities is required in the development of law and policy, unless there is no disproportionate effect on them.<sup>31</sup>

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<sup>30</sup> *Hughes v Elections Canada*, 2010 CHRT 4 at para 79.

<sup>31</sup> United Nations Committee on the Rights of Persons with Disabilities, *General comment No 7 (2018) on the participation of persons with disabilities, including children with disabilities, through their representative organizations, in the implementation and monitoring of the Convention*, 9 November 2018, CRPD/C/GC/7, available:

The preamble explains that “persons with disabilities should have the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them”.<sup>32</sup>

In addition, article 4(3) elaborates that in the development of legislation and policies that affect persons with disabilities, State parties “shall closely consult with and actively involve” them through “representative organizations”.<sup>33</sup> This participation is also informed by the concept of intersectionality, to capture the lived experience of persons with disabilities who may experience particular impacts because of a combination of identities.

## **Recommendations**

In light of the concerns raised above, ARCH makes the following recommendations to the Ministry of Health, Ontario Health and any affiliated authors of the Triage Protocol:

- (a) Remove any reliance on the Clinical Frailty Scale to make decisions about critical care allocation from the Triage Protocol as it is in violation of the *Charter*,
- (b) Remove any reference to specific disabilities as exclusion criteria from the Triage Protocol for the purposes of critical care allocation as it is in violation of the *Charter*,
- (c) In order to address the inherent inequities and ableism in the health care system, and the discriminatory effects of the Triage Protocol, it is imperative that the Triage Protocol include a clear statement of non-discrimination on the basis of disability;
- (d) In order to address the inherent inequities and ableism in the health care system, and the discriminatory effects of the Triage Protocol, it is imperative that the Triage Protocol include a clear statement of the duty to accommodate persons with disabilities in the delivery of critical healthcare services;
- (e) Develop oversight and accountability mechanisms through consultation with persons with disabilities. These may include any and all of the following or

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[https://tbinternet.ohchr.org/\\_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD/C/GC/7&Lang=en](https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CRPD/C/GC/7&Lang=en) at para 19 [General Comment No 7].

<sup>32</sup> CRPD, *supra* note 3, Preamble.

<sup>33</sup> CRPD, *ibid*, Art 4(3).

additional measures as appropriately adapted: systemic measures such as a timely and ongoing process to review and re-evaluate the implementation of the Triage Protocol to address any disproportionate impacts on persons with disabilities, the creation of an oversight committee that includes persons with disabilities, the collection of disability-specific and socio-demographic data and the public release of that data; and individual accountability measures such as a timely and effective process for immediate review of decisions with due process protections (such as reasons for decisions), the provision of advocacy support, and the provision of rights advice to individuals and their families of all available recourses; and

- (f) Any consultation undertaken by the Government, by Ontario Health, or any other Government ministry or agency for the purposes of drafting a critical care protocol in response to a health crisis must ensure that persons, or representative groups of persons, who will be disproportionately impacted by said protocol are consulted.

Sincerely,  
**ARCH DISABILITY LAW CENTRE**



**Robert Lattanzio**  
Executive Director

Cc: Raymond Cho, Minister of Accessibility  
Todd Smith, Minister of Children, Community and Social Services  
Renu Mandhane, Ontario Human Rights Commissioner