SUBMISSIONS MADE TO THE WALKERTON COMMISSION ON BEHALF OF OPSEU RE: PART I (B)

PALIARE ROLAND ROSENBERG ROTHSTEIN LLP
Barristers and Solicitors
Commerce Court West
Suite 4900
Toronto, Ontario
M5L 1J3

Ian J. Roland
Tel: (416) 862-4319
Donald K. Eady
Tel: (416) 862-4321
Rob Centa
Tel: (416) 862-4640
Fax: (416) 862-7661

Solicitors for the Ontario Public Service Employees Union.

INTRODUCTION

1. The Ontario Public Service Employees Union (OPSEU) is a trade union with approximately 100,000 members. OPSEU represents 50,000 employees working directly for the provincial government in the Ontario Public Service (OPS). OPSEU also represents employees who work in the broader public service (including funded agencies such as public health units and hospitals), community colleges and the private sector.

2. OPSEU represents all non-management and non-engineering staff at the Ministry of the Environment (MOE) or about 928 employees of a ministry total of 1,384. OPSEU also represents all non-management staff at the Ontario Clean Water Agency (OCWA), or 563 employees of the agency's total of 691. OPSEU also represents non-management employees of the Bruce-Grey/Owen Sound Health Unit.

3. The Commissioner granted OPSEU limited standing in the Walkerton Inquiry. OPSEU did not have full standing in Part IA of the Inquiry. The Commissioner granted OPSEU special standing in respect of certain OPSEU members called as witnesses during Part IA. The Commissioner granted OPSEU full standing during Part IB as part of the Bargaining Unit Coalition, which also included CUPE Local 225 and the Professional

Engineers and Architects of the Ontario Public Service (PEGO). This grant of standing was limited to those issues affecting provincial government employees.[1]

4. These submissions are not comprehensive. They do not address many of the difficult questions the Commissioner must answer. These submissions, instead, focus on issues that affect provincial government and public health unit employees. The submissions are designed to reflect the scope of the OPSEU's standing and to highlight issues of particular concern to OPSEU members. OPSEU hopes the submissions assist the Commissioner.

5. OPSEU submits that the evidence demonstrates that certain policies, procedures and practices of the Government of Ontario had a significant effect on both the causes of the *E. Coli* contamination in the Walkerton water supply and the scope and scale of the outbreak that caused hundreds of people in the Walkerton area to become ill and several of them to die in May and June 2000.

6. These submissions will address the following points:

[1] The Honourable Dennis R. O'Connor, Ruling on Standing and Funding.

a) the scale of the budget cuts imposed by the Government of Ontario between fiscal years1995-1996 and 2000-2001, the corresponding reduction in staff levels over the same period, and the effect of these cuts on the day-to day work experiences of the staff in the Owen Sound District Office;

b) the weaknesses in the MOE training program including the lack of advanced level training for staff monitoring municipal water supplies, the generally low level of training provided, and the misallocation of resources to human resource and management training at the expense of technical training;

c) the Government of Ontario's failure to respond meaningfully to the warnings issued by front-line staff in the MOE regarding the risks associated with the budget cuts and staff reductions, the privatization of the routine testing of drinking water samples, the failure to strengthen the Ontario Drinking Water Objectives (ODWO) and the general risks posed by weakening the state capacity to protect the environment; and

d) the small operational scale and lack of expertise of the Walkerton Public Utilities Commission in contrast to the expertise of the Ontario Clean Water Agency, which has operated the Walkerton water system since May, 2000.

BUDGET CUTS

7. There is no doubt that the government has dramatically reduced the Ministry of the Environment's budget and staff levels. Between 1995-96 and 1997-98 the government cut the Ministry's budget by just under half.[2]

[2] This figure excludes the reductions to water and sewage grant programs. Exhibit 330F, Tab 2, page 1, INQDOCNO 1023459.

Between 1995, and March 31, 2000 the MOE headcount dropped from 2208 to 1374.[3]

8. The reductions in staff and budget levels diminished the effectiveness of the MOE in many ways. Some of the government's policies, procedures and practices that caused the Walkerton disaster were developed to facilitate such reductions; others were developed because of such reductions. For this reason, it is important to describe briefly the scale of the reductions.

Budget Estimates And Actual Expenditures

9. From 1995-96 to 1999-2000 the government significantly reduced the approved budget for the MOE. The table below details the MOE's final authorized budget and its actual expenditures per year from 1990-91 to 1999-2000.[4]

[3] These numbers exclude the effect of OCWA. The 1995 number includes energy functions. Exhibit 309 Headcount, Ministry of the Environment 1991-2000, page 3. See also Testimony of Brian Gildner April 26, 2001, page 137 ff.
[4] Note: the 1993-94 to 1996-97 values include both Environment and Energy budget/expenditures. Exhibit 330F, Tab 27. All figures $millions.

	Operating		Capital		Total	
Year	Budget	Actual	Budget	Actual	Budget	Actual
1990-91	369	367.5	281.6	277.8	650.6	645.3
1991-92	414.7	407	322.6	202.5	737.3	710.5
1992-93	451.1	437.6	318.9	304.7	770	742.3
1993-94	351.9	342.2	219.1	214.3	571	556.5
1994-95	269.6	268.3	75.8	74.3	345.4	342.6
1995-96	224.1	296.2	130.2	118.5	354.3	414.7
1996-97	182.3	178.1	202	200.9	384.3	379
1997-98	167.9	164.4	124.2	90.1	292.3	254.5
1998-99	169.4	169.2	60.2	44	229.6	213.2
1999-2000	182.6	179.7	231.1	197.5	413.7	377.1

All figures in $Millions

10. These cuts affected the Ministry in many ways, perhaps most dramatically through the significant staff reductions.

STAFF REDUCTIONS

11. The government and the MOE count staff in many different ways. Regardless of the method chosen, it is clear that there are many fewer staff working for MOE today than there were five or ten years ago.

12. One method of counting staff is "headcount."[5] Brian Gildner, Organizational Development Consultant, Human Resources Branch, MOE created a document setting out the MOE Headcount from 1991-2000.[6] That document demonstrates that there were almost one thousand fewer "warm bodies" at the MOE in 2000 than in 1991. According to Exhibit 309, the total MOE headcount, excluding OCWA or, more precisely excluding Utility Operations and Project Engineering, from 1991 to 2000 is as follows:

1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
2306	2378	2358	2371	2208	2065	1663	1494	1418	1374

13. Another method of calculating staff strength is to examine the number of funded positions within the Ministry. As set out in the table below, between

[5] Headcount represents the number of staff on payroll at a given time. It includes all classified, unclassified crown and SMG staff. It does not include staff on leave or Long Term Income Protection. Numbers from 1994 to 1998 includes energy functions.
[6] Exhibit 309.

1995-96 and 2000-01 the number of funded positions decreased by 929 positions or 22% of the total:[7]

	1995-1996	1996-1997	1997-1998	1998-1999	1999-2000	2000-2001	Change 1995-96 to 2000-01	
							#	%
MOE	2,430	1,905	1,648	1,509	1,529	1,501	(929)	(38%)
Operations Division	961	795	706	692	739	741	(220)	(22%)

EFFECT OF BUDGET CUTS

14. The Ministry of Environment suffered a significant loss of qualified and experienced staff between 1995 and 2000. Mr. Jenkins testified that the closure of the MOE Regional Laboratories in 1996 meant that the Ministry lost a number of experienced scientists and water quality experts such as Gary Palmateer, Dr. Arthur Ley and others.[8] Mr. Jenkins also testified that the layoffs and privatizations meant a loss of expertise to the Ministry and a loss of institutional memory.[9]

[7] Exhibit 330F, Tab 15 page 3 of document; INQDOCNO 1014633.The 1995-96 values include the Energy staff (approximately 115 staff) that were transferred to the Ministry of Energy Science and Technology in 1998-99.
[8] ODWO Panel, May 10, 2001, page 347.
[9] ODWO Panel, May 10, 2001, pages 297, 320 – 322.

15. In addition, Mr. Brian Gildner, an Organizational Development Consultant with the Ministry of Environment was asked:

> Q. And this is in an era where there have been a number of cutbacks of scientific people, the Ministry is losing a lot of expertise and experience: you would agree with me?
>
> A. Right. And that was the next one, not only cutbacks but retirements on top of that. [10]

Finally, Mr. Jenkins was asked:

> Q. Is it your view that the privatizations that took place, the staff lay-offs and the budget cutbacks have significantly compromised the ability of the Ministry to protect the public interest by providing safe drinking water?
>
> A. In my opinion, it definitely compromised, whether or not significantly I don't know, but yes, in my opinion it did compromise the Ministry's abilities. [11]

16. The atmosphere of cutbacks, downsizing and privatization meant that the Ministry of Environment was incapable of responding to the public health challenges raised by the cutbacks, downsizing and privatization themselves.

17. Many witnesses testified on the effects of the budget cuts and staff reductions on their day-to-day work experiences in the Owen Sound office. Phil Bye testified that the government reduced staff through a variety of means including an early retirement package known as Factor

---

[10] Transcript of Brian Gildner, April 26, 2001, page 154.

[11] ODWO Panel, May 10, 2001, page 299.

80.[12] These reductions caused the Ministry to lose many years of valuable technical and scientific expertise. There appeared to be no corresponding effort to replace this loss of expertise. This expertise would have been of great assistance to the MOE as it attempted to cope with the pressures of budget reductions and shifting priorities.

18. Phil Bye testified that the workload in the Owen Sound District had certainly increased over time.[13] John Earl identified the following factors as contributing to the increased workload in the Owen Sound office:

> Involvement in a larger set of program areas, more requests from individuals in the private sector for complaints or assistance…responses to various issues, increasing inspection points as set out in out annual work plans….we dedicate a certain portion of our man years per office towards various inspection programs. Certainly work generated through our ORIS system with occurrence reports.

19. From 1997 onward Mr. Bye felt that his office was very busy and that people were working very hard.[14] Larry Struthers describe the office as "short staffed" indicated that they had a lot of work and they "could have used more help." [15] John Earl commented that there were two vacancies

[12] Where the sum of an employee's age and years of service equal 80, an employee can retire with a more generous pension than would be the case without the plan. See Testimony of Phil Bye, November 13, 2001, page 40 ff.
[13] Testimony of Phil Bye, November 13, 2000, page 137.
[14] Testimony of Phil Bye, November 13, 2000, page 139.
[15] Testimony of Larry Struthers, October 26, 2000, page 178.

within the office staff complement that increased the workload for everyone else.[16]

20. Although Mr. Bye testified that the increased demands did not have any practical implications for the Owen Sound offices communal water system files, he accepted that the shift that occurred in 1997 affected the ability of the environmental officers to undertake their work the way they had in the past.[17] Specifically, the introduction of the Delivery Strategies and the "significant decrease in the time allocated to water matters" made proactive investigations and inspections of communal water treatment plants a much lower priority.[18]

21. The Commission heard evidence from several MOE staff each of whom had some responsibility for the Walkerton PUC at various times. The staffing responsibility at the MOE for the Walkerton PUC changed frequently in the period leading up to the disaster. This staff turnover, combined with the shifting duties and responsibilities described above, created a situation where no single person dealt with the Walkerton PUC over time. This lack of continuity hampered staff in their attempts to deal effectively with the PUC.

---

[16] Testimony of John Earl, October 30, 2000, page 129 – 130.

22. John Earl testified that more staff and resources would have permitted the Owen Sound office to have taken a more proactive approach with the Walkerton PUC:

> Q. And do you think if you had more staff and time, for example, you may have reviewed the 1998 inspection report for Walkerton after you received the results in April?
>
> A. If I had some – if the office had substantially more staff and time, yes, sir.
>
> Q. Okay and what about, you were saying more staff and time being proactive in seeing people. Do you think you may have visited the Walkerton staff if you had – not the Walkerton staff, the Walkerton PUC if you had more time and staff?
>
> A. Yes, and that was a more common practice back in the 70s , for instance, when we didn't have the same workload, yes, sir.[19]

23. Other witnesses supported the value of proactive visits to water treatment plants. Larry Struthers confirmed that it would have been prudent for someone to go out to Walkerton to sample the water to determine to determine the amount of chlorine in the system rather than continuing merely to correspond with Mr. Koebel.[20] Proactive action by MOE with respect to Walkerton was made more difficult due to budget cuts and staffing reductions.

24. Finally, OPSEU submits that staff and budget reductions caused a reduction in the frequency of inspection for municipal water treatment plants. Commencing in 1996-97, the government extended the inspection

---

[17] Testimony of Phil Bye, November 13, 2000, page 140, 142
[18] Testimony of Phil Bye, November 13, 2000, page 139.
[19] Testimony of John Earl, October 31, 2000, page 70 – 71.

cycle to once every four years.[21] This ensured that MOE staff would inspect each plant less frequently and reduced the visible presence of MOE staff at the water treatment plants.

RECORD KEEPING AND COMPUTER DATABASES

25. Many witnesses remarked that the Ministry seemed incapable of providing timely access to reliable records and data. Mr. James Merritt testified that the Ministry was "data rich and knowledge poor" in the sense that it had the information but much of it was not computerized or accessible. [22]

26. Dr. Schnyder testified that he was unaware of a Ministry of Environment agreement with the Ministry of Health to share data and test methods and to create a database. Dr. Schnyder testified that he was not aware of the agreement (which was entered into before he assumed his position as Director of the Laboratory Services Branch) and that while there was some work done on the test methods, nothing was done about sharing data or the creation of a database. Dr. Schnyder testified that the Ministry did not have the resources to spend on the creation of a shared database.[23]

---

[20] Testimony of Larry Struthers, October 26, 2000, pages 149 - 150.
[21] Exhibit 287A, Tab 1, page 26.
[22] Transcript of James Merritt, April 12, 2000, page 49.
[23] Testimony of Dr. Schnyder, May 7, 2001, pages 23 – 28.

27. Dr. Helen Demshar from the Ministry of Health confirmed that the joint Ministry of Environment and the Ministry of Health database was never developed because of “time and funds and changing of staff and a variety of things”. [24]

28. Gary Horsnell’s proposals to create a database of water test results was ignored and his views were treated as if he was an external stakeholder rather than a long service employee.

29. Patricia Lachmaniuk testified that the privatization of the laboratories created data reliability and comparability problems with the Drinking Water Surveillance Program. Furthermore she testified that the privatization of the laboratories meant that the Ministry was unable to do trend analysis of the data. [25]

30. Michelle Zillinger also testified that if she had access to a database of water test results and chlorine residuals results from the Walkerton water system she would have been better able to understand what was going on with respect to Walkerton’s water system. [26]

---

[24] Transcript of Ministry of Health Panel, May 8, 2001, page 330.
[25] ODWO Panel, May 10, 2001 pages 152 - 155.
[26] Transcript of Michelle Zillinger, November 6, 2000, page 66.

31. James Schmidt also testified that a database of both municipal and private water systems would assist Public Health Units in their ability to monitor and track adverse water results. [27]

32. The creation of accessible and useable data bases and records may seem trivial when viewed against some of the larger issues raised by this Commission. However, the evidence indicates that the Government's failure to create and maintain databases of water test results impaired the ability of those on the ground to do their job. Such a database would have allowed employees dealing with the Walkerton water system to see adverse trends more clearly and would have alerted them to emerging problems with the system. It also would have allowed MOE or Health Unit staff to monitor changes recommended in the various inspection reports.

33. Several witnesses commented that it would have been helpful to have access to such information when making decisions about Walkerton.[28]

TRAINING

34. The Government of Ontario adopted training policies, procedures and practices that contributed to the Walkerton Water tragedy.

[27] Transcript of James Schmidt, December 15, 2000, page 280.
[28] Transcript of Phil Bye, November 13, 2000, pages 54 – 59; Transcript of John Earl, October 31, pages 80 – 83; Transcript of Michelle Zillinger, November 7, 2000, pages 53 – 57.

35. The Commissioner heard evidence that a number of environmental officers in Owen Sound were not aware that strains of E. Coli can cause serious illness and death in humans. For example, John Earl and Larry Struthers testified that, at the time of the disaster they were not aware that E. Coli could cause death.[29]

36. Ministry staff should have been provided with up-to-date training on the risk unsafe drinking water poses to human health. The lack of comprehensive technical training, particularly for more senior employees, resulted from government policies, procedures and practices that under-emphasized the importance of ongoing training, the reduced resources available for training, and shifted the remaining resources away from technical training toward management and human resource focused training.

37. The government was aware that "MOE Operations Division Staff required "ongoing training and development in areas such as health and safety, professional, technical, information technology and business skill to effectively carry out their job functions."[30]

---

[29]Testimony of John Earl Transcript, Volume 8, page 15; see also Transcript April 26 2001, page

38. Moreover, the government knew that additional training of remaining staff would be required to address the significant reductions in staffing and operating budgets in the mid-1990s. The "Guideline for Preparing the Operations Division Staff Training and Development Plan" concluded that additional training was required to offset the following:

1. the loss of a number of highly skilled staff who had generally been appointed to the OPS since the late 1980s;
2. the loss of a significant number of skilled and experienced staff often as a result of early retirement incentives;
3. the inability to effectively reinvigorate the Ministry and replace lost expertise due to hiring constraints;
4. the loss of experienced staff, often with a very high level of technical expertise to outside employers; and
5. changes in approaches to program delivery.[31]

39. Front-line staff echoed this concern and told the government that they needed a comprehensive staff training and development plan.[32] However, the Commissioner heard evidence that the government did not implement an adequate training program.

---

176 - 177. Testimony of Larry Struthers, October 26, 2000, pages 38 – 39.

[30] Exhibit 307, Tab 5, p. 1 of the document.

[31] Exhibit 307, Tab 5, page 2 of the document, also at Transcript, April 26, 2001, pages 49 - 50.

[32] Exhibit 283, Tab 7; see also Transcript, April 26, 2001, page 53.

40. In 1986 the government developed a course called Drinking Water Treatment for Environmental Officers. It was a four-day course that covered bacteriology, disinfection, the role of the Medical Officer of Health, filtration, coagulation, flocculation, and other treatment methods.[33] The course was offered only five times between 1986 and 1997 and reached a mere 91 MOE staff.[34] Between 1997 and May 2000 the Ministry of the Environment did not run the course because "enrollment for the course did not warrant delivery at that time."[35]

41. However, this course was not designed for the staff of the Owen Sound office. The government designed the course for "new personnel and less experienced staff who are responsible for monitoring municipal and private water supplies."[36] The course was not designed for environmental officers who had many years of experience doing inspection.[37] In fact, in May 2000 there was no advanced level training program for drinking water inspectors.[38] In May 2000 there was no formal training offered to MOE Operations Division staff in respect of new chlorination techniques or new technologies.[39]

[33] Testimony of Brian Gildner, Transcript April 26, 2001, page 25.
[34] Testimony of Brian Gildner, Transcript April 26, 2001, page 27.
[35] Idem.
[36] Testimony of Brian Gildner, Transcript April 26, 2001, page 68.
[37] Testimony of Brian Gildner, Transcript April 26, 2001, page 68 - 69.
[38] Testimony of Brian Gildner, Transcript April 26, 2001, page 69.
[39] Testimony of John Earl, October 31, page 18-19; Testimony of Brian Gildner April 26, 2001, page 180 - 181

42. This omission resulted from government policies, procedures and practices that failed to fund training programs adequately, and emphasized human resources and business training at the expense of technical training for front-line staff.

43. In 1994 the government noted that training expenditures in the MOE had decreased significantly since 1991 primarily due to constraints imposed on staff travel and accommodation expenditures.[40] In 1990-91 the ministry spent approximately 6.6% of its total ODOE on training, development, and conferences. By 1994 such spending had fallen to 3.2% of ODOE, a decrease much more dramatic than that of the Ministry ODOE as a whole.[41] In 1991-92 the Ministry provided a total of 2014 training days for 461 participants.[42] By 1998-99 that number had plummeted to 799 training days (for 357 participants) before rebounding slightly to 925 training days (but for only 277 participants) in 1999-2000.[43]

---

[40] Exhibit 307, Tab 12 "Backgrounder on Training Development and Certification Activities – Ministry of Environment and Energy" page 1 of the document.
[41] Exhibit 307, Tab 12 "Backgrounder on Training Development and Certification Activities – Ministry of Environment and Energy" page 4 of the document.
[42] Exhibit 307, Tab 17, page 2 of the Tab.
[43] Idem.

44. In March 1995, the Human Resources Branch of the Ministry noted that the number of technical training days had decreased by approximately 35% since 1990.[44] The Human Resources Branch identified three reasons for the reduction: restricted travel budgets precluded staff traveling to Toronto for technical training; budget constraints reduced the number of staff that could attend conferences; and the limited training programs available to staff.[45]

45. Mr. Gildner explained that the reduction in the number of gross training days was misleading since the number of MOE staff declined significantly between 1991-92 and 1999-2000. This fact would partially account for the decreased number of training days offered by the Ministry. To illustrate this point, Mr. Gildner calculated the annual ratio of Training Days to the population of the Ministry (excluding OCWA). These numbers show that the ratio stood at 0.84 in 1990-91, peaked at 1.46 in 1995-96 (largely because of the Compliance Policy training) and slid to 0.56 in 1998-99 and 0.67 in 1999-2000.

46. There is no doubt that the government laid off many MOE employees during this period. However, as early as 1994 the Ministry recognized that “the demand for technical training is expected to increase as a result of

[44] Exhibit 307, Tab 16, page 3 of the document; Testimony of Brian Gildner, April 26, 2001, pages 94 - 95.
[45] Idem.

reorganizations, increasing workloads and higher expectations of client groups.” [46] The need for training dramatically increased following the significant budget cuts and staff reductions from 1995 to 1998. Instead, the Ministry offered only two-thirds as many days of training per employee in 1998-99 as it did in 1990-91.

47. In summary, the government provided too little technical training to its employees during a period of structural upheaval and increasing workloads. Front-line staff lacked the necessary tools for their struggle to protect the environment with diminished resources.

48. The evidence of the environmental officers from the Owen Sound office shows the inconsistency of training from one employee to another. They had varying levels of training when it came to the inspection of water treatment plants and the Ontario Drinking Water Objectives, ranging from receiving training in the 1970s to the 1980s.[47]

---

[46] Exhibit 307, Tab 12, Backgrounder on Training Development and Certification Activities – Ministry of Environment and Energy” page 1 of the document; see also Testimony of Brian Gildner April 26, 2001, page 93.

[47] See Testimony of John Earl, October 31, 2000, page 18; Testimony of Michelle Zillinger, November 7, 2000, page 9; Exhibit 397, Tab 18, page 1.

49. However, in addition to providing too little training, the government offered the wrong kind of training by adopting a policy of emphasizing Human Resources among its offerings. In 1994-95 for example, the MOE announced that "the training priority for this and coming years will be Human Resources and Management Training."[48] In March 1999, the Human Resources Branch commented that it had made its training program more balanced by shifting the focus away from technical training:

> in the past few years, the focus of training has shifted from being almost exclusively technical in nature to a more balanced approach providing employees with opportunities to develop not only their technical skills, but also their management, human resources and professional skills.[49]

50. OPSEU submits that the government's emphasis was anything but balanced. In 1998-1999, excluding training provided to municipalities and the private sector, the Ministry provided training to 4223 participants. 1058 participants received either Environmental Officer training or Technical Training. 3165 participants engaged in Management Training, Professional Development, or Career Management Training. Mr. Gildner agreed that there is nothing in the Human Resources or Management training program that is related to skills development of Environmental Officers.[50]

---

[48] Exhibit 307, Tab 12, Backgrounder on Training Development and Certification Activities – Ministry of Environment and Energy" page 1 of the document.
[49] Exhibit 307, Tab 3, INQDOCNO 1055552, page 2 of the document.
[50] Testimony of Brian Gildner, Transcript April 26, 2001, page 207

51. OPSEU submits that a 3:1 ratio of Human Resources and Management training to Technical Training is unacceptable. The MOE did not offer the Owen Sound staff an advanced course on water safety. This lack of training left the MOE Owen Sound staff without the awareness of issues they needed to properly guide their response to the emerging circumstances in Walkerton. OPSEU submits that two specific government policies, procedures and practices contributed to this difficulty: First, because of cutbacks in spending, the government offered too few training opportunities to its staff; second, the Ministry skewed its training priorities in favour of Human Resources and Management Training at the expense of technical training.

FRONT-LINE ADVICE IGNORED

52. The government cannot say that it was not warned about the dangers inherent in its approach to the Ministry of the Environment. Front-line staff warned the government about the risks posed by significant budget cuts, privatization, and staff reductions. In particular, front-line staff warned the government about the dangers of privatizing the routine testing of drinking water samples, the need to toughen the ODWOs, and the dangers posed by a general weakening of the state capacity to protect the environment.

Privatizing The Routine Testing Of Water Samples

53. The Government of Ontario contributed significantly to the cause of the Walkerton Water tragedy by deciding, in 1996, to privatize the routine testing of water samples. Prior to 1996, the Ministry of Health laboratory located in Palmerston did testing of Walkerton water samples. After September 1996, municipalities were no longer able to use Government laboratories for routine testing but were required to contract with private laboratories for this service.

54. It is submitted that the decision to privatize the routine testing of water samples was driven by budget constraints and ideology without consideration for public health. The Ministry of Environment did not do any cost benefit analysis to determine whether the privatization of the water testing service would adversely affect public health.[51] There was no public consultation and no significant internal consultation with respect to the decision to privatize routine water testing. The internal consultation done by Dr. Schnyder indicates that the Ministry of Health and the Operations Division of the Ministry of Environment were opposed to the privatization of routine water testing. [52]

[51] Testimony of Dr. Schnyder, May 7, 2000, page 222.
[52] Testimony of Dr. Schnyder, page 100, and page 224.

55. Internal government documents indicated concern with the quality of analytical data from private sector laboratories.[53] The initial internal government documents indicated that privatization of routine water testing could be safely accomplished within a 2 to 3 year timeframe. In 1996, municipalities were given approximately 2 months to contract with private laboratories to conduct routine water testing. Dr. Schnyder testified that there were risks in moving so quickly but he was overruled. [54]

56. Moreover, other options such as increasing fees charged by the Ministry to the municipalities were proposed by Ministry of Environment officials but were never pursued by senior Ministry officials.[55]

57. Regulatory requirements and laboratory accreditation issues were not fully considered by Government in its haste to privatize routine water testing. Dr. Schnyder testified that the failure to make laboratory accreditation mandatory was due in part to a general distaste on the part of the Government for new regulations.[56] The Ministry of Environment did not keep an inventory of private laboratories [57]and only 6 private laboratories were accredited at the time of privatization [58]

[53] Testimony of Dr. Bern Schnyder, May 7, 2001, page 49.
[54] Testimony of Dr. Bern Schnyder, May 7, 2001, page 49.
[55] Testimony of Dr. Schnyder, May 7, 2001, page 213.
[56] Testimony of Dr. Bern Schnyder, May 7, 2001, pages 84 - 85.
[57] Testimony of Dr. Bern Schnyder, May 7, 2001, page 115 and page 126.
[58] Testimony of Dr. Bern Schnyder, May 7, 2001, page 104.

The Notification Function

58. With respect to the Walkerton situation, the evidence indicates that until September 1996, the local Public Health Unit would receive water test results (both adverse and clear) directly from the Ministry of Health laboratory located in Palmerston, Ont. Therefore until September 1996, Mr. Schmidt (the public health inspector for the Walkerton area) received every test result submitted by the Walkerton Public Utilities Commission ("PUC"). In fact, the Walkerton PUC used water-sampling bottles provided by the local Public Health Unit and the Health Unit would courier the samples to the Palmerston laboratory on behalf of the PUC. In addition, the evidence indicates that prior to 1996, the Owen Sound office of the Ministry of the Environment also received copies of the Walkerton water test results.

59. The decision to privatize the routine water testing was not accompanied by a corresponding change in the notification protocol. The 1994 version of the Ontario Drinking Water Objectives ("ODWOs") required the MOE or MOH laboratory to report results to the local office of the Ministry of Environment and the local Public Heath Unit. Prior to May 2000, the ODWOs were not amended to require the private laboratories to report adverse water test results to the local Public Health Unit (or Medical Officer of Health). When public sector laboratories were in the business of

routine water testing, it was safe to assume that public servants were aware of their duty to report adverse water results to the proper authorities. Indeed, it is clear that the Ministry of Health laboratory did report adverse results to the MOE and to Mr. Schmidt of the local Health Unit.

60. It is also clear that after 1996, that the various laboratories doing the water tests for Walkerton did not continue to report adverse results to Mr. Schmidt as the MOH Palmerston laboratory had done prior to 1996 because there was no legal requirement to do so.

61. It is respectfully submitted that the Government knew about the notification problem but did nothing about it. There were concerns expressed Minister to Minister and by officials in the Ministry of Health with respect to the notification issue. Yet nothing was done. Correspondence from private laboratories indicates that there was real confusion about who was to be notified of an adverse water result.

62. Furthermore, even the accreditation program (mandatory or voluntary) imperiled the notification of public health officials because of the requirements of client confidentiality that are part of the accreditation procedure.

63. This concern about the notification protocol was raised within the Ministry of Environment and the Ministry of Heath. However, nothing was done until after the Walkerton tragedy.

Front Line Staff Out Of The Loop

64. The effect of privatization of routine water testing was to disrupt a longstanding system that:

    a) ensured that the laboratories undertaking routine water testing knew what they were doing and had the proper equipment and staff to produce reliable and timely results;

    b) had an institutional memory and an understanding of local conditions;

    c) had an understanding of the ODWOs and other legal requirements regarding water and testing of water; and

    d) had a clear understanding of who to notify in the face of an adverse water result.

65. Therefore, the privatization of routine water testing weakened the ability of the system to respond to adverse water quality results. In the Walkerton situation, the privatization of water testing results effectively took Mr. Schmidt out of the loop.

66. The evidence strongly suggests that the Government's decision to privatize routine water testing represents the triumph of the Common Sense Revolution over public health concerns and contributed to the Walkerton tragedy.

Evidence Of Stella Couban

67. The testimony of Stella Couban reinforces two of the themes that emerged during the evidence at the inquiry. First, front line staff warned the government repeatedly of the dangers of privatizing routine laboratory testing of water samples. Second, the Red Tape Commission's desire to "change the regulatory culture" within the Ministry of the Environment acted as an effective barrier to new regulations that would impose a burden on the private sector.

68. On January 16, 1997, John Tooley, area supervisor for the Belleville area office, wrote to Stella Couban asking for her advice for an upcoming Health Unit meeting.[59] Tooley sought the advice of legal counsel to the Ministry of the Environment in preparation for a discussion on the notification of adverse bacteriological results as outlined in section 4.1.3 of the ODWO. Tooley needed assistance because he felt that the private laboratories were not reporting test results that indicated deteriating, poor, and unsafe results:

> "the problem is we have no guarantee that "the laboratory will immediately notify the MOEE district officer (sic) who …". In fact, I can almost guarantee that the laboratory does not notify the district manager in the vast majority of cases. The number of deteriorating, poor and unsafe results have dropped dramatically since our labs do not do the analysis.

[59] Exhibit 412, INCDOCNO: 1083549.

69. This email makes clear that front-line MOE staff realized that with the privatization of routine water testing, the MOE and MOH were no longer receiving adverse test results. This was precisely the issue that the Minister of Health Wilson asked Minister of the Environment to deal with.[60]

70. Ms. Couban's reply to Mr. Tooley is evidence of the effect of the Red Tape Commission on regulatory development within the Ministry of the Environment. Ms. Couban wrote to Mr. Tooley that there were three direct means by which the Ministry could ensure that it received appropriate notification.[61] The third option, although it has been blacked out, appears to be suggest the creation of a new regulatory requirement for private laboratories to report adverse results to either the Ministry of the Environment or the Ministry of Health or both. However, Ms. Couban advised Mr. Tooley that such a regulation was a non-starter:

> In terms of this option, I am not sure whether the concept of a regulation imposing a new requirement is even a starter with the current regime and its interest in lessening or reducing the amount of regulatory control.

71. Ms. Couban reached her opinion based on her review of several key government documents including the terms of reference of the Red Tape

[60] See Exhibit 310D Tab 7.
[61] Exhibit 412, page 2, INQDOCNO:6018723

Commission[62], "Reforming Environment and Energy Regulation in Ontario, Responsive Environmental Protection, A Consultation Paper"[63] and the "Final Report of the Red Tape Commission"[64].

72. Ms. Couban noted that one of the goals of the red tape review process was to "change the culture" of regulation within the Ministry of the Environment.[65] Having reviewed these documents, Ms. Couban concluded that it would have been difficult to convince the government to adopt a new regulation imposing a reporting requirement on the private sector, which may also have implications for the front line staff of the Ministry of the Environment.

73. It is important to note that Ms. Couban believed her colleagues throughout the legal services branch shared her opinion.[66] Ms. Couban discussed her opinion with Jim Jackson the senior solicitor within the ministry.[67] At no point did anyone tell Ms. Couban that her advice was incorrect or inappropriate.

---

[62] Exhibit 398, Tab 18: Testimony of Stella Couban, July 4, 2001, page 315
[63] Exhibit 398, Tab 27; Testimony of Stella Couban, July 4, 2001, page 321
[64] Exhibit 398, Tab 29; Testimony of Stella Couban, July 4, 2001, page 330
[65] Testimony of Stella Couban, Transcript, July 4, 2001, pages 334 - 335
[66] Testimony of Stella Couban, Transcript, July 4, 2001, page 343
[67] Testimony of Stella Couban, July 4, 2001, page 342

74. Ms. Couban identified three reasons why this particular regulation was a "non-starter" first, it was a new regulation. Second, it was a regulation that would have resource implications for the Ministry of the Environment front line staff. Third, it was a regulation imposing a new requirement on the private sector.[68] Ms. Couban also noted that none of the 11 regulations passed in the year in which she gave her advice had all three elements listed above.[69]

ONTARIO DRINKING WATER OBJECTIVES (ODWOS)

75. The ODWO revision process can only be described as painfully slow and *ad hoc*. The evidence indicates that it was only after the Walkerton tragedy that the revision process received the necessary political commitment.[70] Prior to the Walkerton tragedy, the ODWO revision process was stalled, stymied and delayed in part, it is submitted, because of the Government of Ontario's distaste for additional regulatory or policy requirements.

76. The evidence indicates that the Drinking Water Coordinating Committee was aware of the notification protocol issue (the fact that private laboratories were not notifying the Ministry or the local Public Health Unit) yet no final determination on this issue was made by the Government until

---

[68] Testimony of Stella Couban, July 4, 2001, page 345
[69] Testimony of Stella Couban, July 4, 2001, page 376

after the Walkerton tragedy.[71] Others also raised this issue, yet nothing was done.[72] Mr. Brodsky from the Ministry of Health raised the issue with the Drinking Water Coordinating Committee.[73] This issue was again raised in the correspondence between Minister Wilson and Minister Sterling in late 1997.[74] This issue was also raised in late 1999 and early 2000 through correspondence to the Minister. [75]

77. Tony Edmonds began working on a guide for municipalities that may have assisted water operators to understand the reporting requirements. On the front page of the copy of the document provided to the Commission, it states that:

> This draft document was prepared to offer guidance to municipalities and their analytical labs after downloading of testing. It is incomplete because of lack of resources. [76]

78. There is no question that this issue was raised and that it was raised as a direct result of the privatization of the routine water testing in 1996. It is respectfully submitted that nothing happened on the notification issue because the Government of Ontario was engaged in the Red Tape Commission process. This process was designed to decrease the

---

[70] Transcript of the ODWO Panel, May 10, 2001, page 270.
[71] ODWO Panel, May 10, 2001, page 130.
[72] ODWO Panel, May 10, 2001, page 231.
[73] ODWO Panel, May 10, 2001, page 247.
[74] ODWO Panel, May 10, 2001, pages 258 - 259.
[75] ODWO Panel, May 10, 2001, page 214.
[76] Exhibit 311 C, Tab 13.

regulatory burden rather than increase it. The best evidence that supports this submission is that while the Drinking Water Coordinating Committee spent approximately 5 years discussing and debating potential amendments to the ODWOs, nothing material to the events in Walkerton happened. After Walkerton, the Drinking Water Standards were in place in months.

79. As the ODWO Panel pointed out, the post-Walkerton process used to develop the Standards was top-down, adequately resourced and politically driven.[77]

80. It is interesting to note that the two processes which created and then solved the notification problem were politically driven. The privatization of routine water testing created the notification problem and the evidence indicates that the privatization was a key government priority which was implemented with some 2 months notice to the end users (notwithstanding expert advice that the privatization should be phased in over 2 or 3 years). The problems created by this political action (the notification and accreditation issues) were left to languish, bouncing between Ministries, between committees and within the bureaucracy. It was only when the Government was forced to turn its mind to water issues as a direct result of the Walkerton tragedy, that action was taken.

81. Did this lack of political will or inaction lead to the events that caused the Walkerton tragedy? It is respectfully submitted that it did. Had there been a clear and binding notification procedure, then it is likely that the local MOE office and the local Public Health Unit office in Walkerton would have had critical, relevant and timely pieces of information that may have allowed them to fix the water system before May, 2000 or at least would have allowed the Medical Officer of Health to issue the Boil Water Advisory earlier than he did.

GENERAL STATE CAPACITY

82. OPSEU submits that many of the operational shortcomings discussed above reflect a general decline in the state's capacity to protect the environment. The decline in capacity is evidenced by: the privatization of routine water training; understaffing; lack of training; lack of response to front-line advice, and the chilled regulatory culture.

83. OPSEU warned the government early in its mandate that strong enforcement of environmental laws is a key factor in promoting public health. The evidence shows, however, that enforcement activities diminished after 1995.

---

[77] ODWO Panel, May 19, 2001, pages 147 – 149.

84. In a press conference held on September 19, 1995, OPSEU President Leah Casselman urged the government to continue to enforce environmental laws and not to go soft on environmental crime.[78] Ms. Casselman warned the government that laying off environmental officers responsible for enforcing environmental laws and regulations designed to ensure safe drinking water would jeopardize the health of Ontario residents. Enforcing environmental laws, she added, promoted public health.

85. Linda Stevens, Deputy Minister government, made the Premier's office and senior civil servants aware of OPSEU's position. She circulated OPSEU's press release and information package to Guy Giorno (Premier's Office), and several senior public servants: Rita Burak (Cabinet Office), Michele Noble (Management Board), Michael Gourlay (Ministry of Finance), and Jan Rush (Cabinet Office).[79]

86. Premier Harris testified that he took the OPSEU concerns seriously.[80] However, despite OPSEU's warning, and the warning contained in the business plan, the government went ahead with its program. This led to a

---

[78] Exhibit 398, Tab 7, page 3; INQDOCNO 6120195.

precipitous decline in the environmental law enforcement activity between 1995 and 1998 as set out in the table below:

ANNUAL ENFORCEMENT SUMMARY CALENDAR YEARS 1992-2000[81]

ACTIVITY	1992	1993	1994	1995	1996	1997	1998	1999	2000
Assigned Investigations	1,502	1,605	1,452	1,372	821	874	1,046	1,159	1,121
Prosecutions Initiated	322	289	289	170	128	142	208	368	318
Charges Laid	2,158	1,570	1,640	1,045	758	951	805	1,216	1,796
Individuals Charged	305	280	280	158	110	102	159	225	635
Companies Charged	220	175	186	125	104	130	270	410	441
Cases with Convictions	266	211	237	188	121	136	137	284	285
Individuals convicted	426	248	362	255	182	205	105	138	316
Companies Convicted	352	246	284	218	148	225	183	274	273
Number of Fines	686	464	551	387	273	262	390	583	727
Fines Imposed	$3.4	$2.1	$2.4	$2.9	$1.2	$955k	$864k	$1.5	3.0

[79] Exhibit 398, Tab 7, page 1.
[80] Testimony of Michael Harris, June 29, 2001, page 213.
[81] Exhibit 302, Tab 10.

87. The September 19, 1995 press conference was not the only warning OPSEU provided to the government. On January 9, 1997, OPSEU released "Nothing Left to Cut: A field report on the activities of the Ontario Ministry of Environment and Energy."[82] This paper described how government cuts were affecting the Ministry's ability to monitor and protect surface water and ground water.[83]

THE GOVERNMENT KNEW OF THE RISKS BEFORE IMPLEMENTING THE CUTS

88. The government knew that implementing cuts of the magnitude proposed would create risks to human health and the environment. Ministers Elliott and Sterling described these risks as manageable. However, neither pointed to a single document that could be described as a risk-management analysis. OPSEU submits that the government simply concluded that the risks were "acceptable" not "manageable."

89. Sheila Willis identified that staff and budget cuts in the MOE could increase risks to public health and the environment in a series of memos

[82] Ex. 304, Tab 1.
[83] See also Testimony of Investigations and Enforcement Panel, Transcript, April 24, 2001, pages 176 - 188.

to senior staff within the Ministry including Richard Dicerni and Linda Stevens.[84]

90. Most importantly, however, the 1996 Business Plan recognized that implementing the plan and its reductions would create risks for the environment and public health.[85] Minister Elliott and Deputy Minister Stevens nevertheless signed the Business Plan, which was designed to cut $203.8 million from the budget. They recognized and identified the following "key impacts" resulting from the Business Plan: [86]

> The Ministry's proposed strategies for change may have the following key impacts:
>
> …
>
> - The Ministry's presence in some communities will be substantially reduced as a result of the reduction in front-line staff and the elimination of one regional office, one district office, four sub-offices, and the closure of three regional laboratories.
>
> - The Ministry's ability to monitor and assess environmental change and give early warning of long-term serious threats, **ensure compliance** with environmental standards and regulations, and **develop policy and programs** in response to emerging environment and energy issues will be reduced as a result of:

[84] See Exhibit 330C, Tab 3; Exhibit 330D, Tab2; Exhibit 330D Tab 4;
[85] Exhibit 330E, Tab1; INQDOCNO 1075690.
[86] Idem at page 22 of the document.

- the closure of some air monitoring stations;
- reduced acid rain/urban toxic/Great Lakes deposition monitoring and analysis;
- the elimination of inspections of closed waste sites and reduction in proactive inspections of industries;
- **a reduction in policy and program development and research activities**;
- **a reduction in the Ministry's scientific and technical expertise; and**
- **delays in developing standards and in providing expert advice on risks of water and soil contamination.**

- The public may perceive that the government's ability to protect Ontario's environment has been substantially reduced.

- **The risk to human health and the environment may increase as a result of improper or illegal actions which are neither detected, nor controlled through orders and prosecutions as a result of decreased compliance and enforcement activities**.

…

- The level of front line service will be reduced as a result of slower response times to complaints, a focus on compliance activities rather than providing assistance with abatement actions and less information available to respond to enquiries, **and reduced technical assistance to municipalities seeking to optimize water and sewage treatment facilities.**

- **Greater reliance in Ontario on the private sector for analytical testing services**.

- Approximately 750 staff will be let go over the next two years.

91. OPSEU submits that the risks identified in the Business Plan materialized. As set out above, many of the risks of the Business Plan became the reality of government.

92. By early 1998 even the Ministry of the Environment agreed that its functions "have experienced diminished capacity" and that "the bottom line is that the risk of failure of achieving the Ministry's core business [has] increased."[87]

93. A document prepared for Minister Sterling in 1998 notes:

> It is difficult to find a direct mapping of the budget reductions to impacts on the environment. While none of the businesses and functions used to manage the environment (monitoring, research, assessment, etc.) have been eliminated, all have experienced diminished capacity and reshaping. In general terms, this translates into:
>
> - Reduced capacity to monitor air and water issues;
>
> - Reduced scientific and research capacity to support standards development and direction setting; and

[87] Exhibit 330F, Tab2, page 2 of the document; INQDOCNO 1023459.

- Reduced capacity to engage in partnership programs with businesses, municipalities and individuals which assist in compliance.

The bottom line is that the risk of failure of achieving the Ministry's core businesses is increased.

…

Even though the Ministry has attempted to protect front line delivery resources, budget cuts of these magnitudes have had a detrimental impact on the ability of the Ministry to deliver front line services. Examples include:

- Reduction in the number of front-line delivery offices…

….

- **Reduction in the promotion of pro-active initiatives** such as Pollution Prevention by front-line staff is for companies to achieve compliance with environmental requirements, not the promotion of initiatives which go beyond compliance.

94. In OPSEU's submission, the bottom line is that government cutbacks to MOE budgets and staff levels contributed to the disaster in Walkerton.

THE SMALL OPERATIONAL SCALE AND LACK OF EXPERTISE OF THE WALKERTON PUBLIC UTILITIES COMMISSION

95. The small operational scale and lack of focussed drinking water expertise of the Walkerton Public Utilities Commission contributed to the events of May 2000. Other submissions will undoubtedly provide detailed discussions of the operational deficiencies of the

PUC and certain of its staff. These submissions will briefly contrast certain structural aspects of the PUC with the Ontario Clean Water Agency, the provider which replaced it.

96. PUC staff did have some standard operational procedures, and did receive some intermittent advice and assistance from a consultant and through the Ontario Municipal Waterworks Association. (See generally Douglas Burns, November 9, page 186 - 216). There was some training and the treatment regime was a "typical" one, with existing equipment in "relatively good condition", consistent with other municipalities (Marc Ethier, October 17, page 13 and 28). However, the PUC was not part of any larger organization. It was a small group of individuals, who had many operational responsibilities in addition to water treatment plant operations (Frank Koebel, December 6, pages 114 – 118), Drinking water received only part time attention. There were major deficiencies in drinking water training and general knowledge (See generally Frank and Stan Koebel, December 6 and 18). There were also shortcomings in equipment. The deficiencies most directly related to the onset of the contamination of Walkerton's drinking water were the following:

a. Well #5 being vulnerable to contamination, which vulnerability was left unrectified until an occurrence of

overwhelming contamination (Burns, pages 127 – 128 and Dr. Robert Gillham, February 28, page 131)

b. The lack of the continuous chlorine residual analysis needed to detect that occurrence (Stan Koebel, December 18, pages 157 – 158).

c. The lack of the alarm system needed to bring that occurrence to the attention of staff (Ethier, October 17, page 19).

d. A lack of the operator training and expertise needed to proactively identify and remedy the operational deficiencies.

e. A lack of the operational expertise needed to respond to the occurrence by taking the needed step of shutting down Well #5 (Dr. Peter Huck, February 28, 2001, page 213).

97. At any number of times, the PUC , the town and the province could have engaged in individual attention to each of these specific deficiencies. They could also have addressed the overall lack of operational scale and expertise by employing an organization able to systematically avoid those deficiencies.

98. That operator was readily available. OCWA's mandate includes the operation and maintenance of municipal water and waste water facilities. In that capacity it is the water treatment plant operator for a large number of small Ontario municipalities. It operates those plants on a hub and cluster system with area operations management. It employs Standard Operational Procedures that exceed regulatory requirements. Its staff operate under an Environmental Management System designed to ensure quality

performance. The organization has industry leading training and its staff are fully trained (Brian Gildner, June 7, pages 135 – 136). Physical plant standards are supervised by a Specialized Operational Standards and Optimization group. Remote plant operations are monitored through an integrated information technology system called Outpost #5 (See generally, Marc Ethier, October 17, 2000, pages 7 – 15 and January 18, pages 196 - 197). OCWA's "substantial institutional capacity" was demonstrated by the rapid and extensive remediation effort undertaken in the town of Walkerton itself (Ethier, January 19, pages 11 – 12).

99. If OCWA had been operating the Walkerton water treatment plant throughout, that may well have made a crucial difference. There can be no certainty in such an assertion but it is worth reviewing what would likely have occurred if OCWA had been given the contract to run the Walkerton PUC prior to the events of the spring of 2000.

100. OCWA would likely have taken a series of steps, outlined below. Each of these steps might individually have been sufficient to alter events. Cumulatively, they establish the difference that the alternate operator would have made:

- First, OCWA operational procedures would have been automatically put into place, without regard for the standards of the prior operator. (Ethier, October 17, page 68). OCWA's Standard Operating Procedures and would have been implemented (Ethier, October 17, page 69), This would minimally have resulted in the installation of continuous chlorine monitoring (Ethier, October 17, pages 70 – 71). That monitoring would have been connected to OCWA's information system, which includes an alarm that would have turned Well #5 off automatically and alerted staff about the situation (Ethier, October 17, page 33, January 18, page 99 and Huck, February 28, 2001, page 245).

- Second, OCWA would have applied its Environmental Management System to the Walkerton water works. The Operational Standards and Optimization Section would have required a full review of the water supply system (Ethier, January 19, 2001, pages 70 – 71) which would have involved an assessment of critical points, including the vulnerable circumstances of Well #5. Those circumstances might very well have been rectified.

- Third, in the very unlikely event Well #5 had remained in operation without improvement and without the necessary chlorine residual analysis in place, there would have been an assessment of what was required to comply with the MOE chlorination bulletin 65-W-4 in respect of automatic chlorine residual analysis, given the vulnerability of Well #5.

- Fourth, there would have been a full response to 1998 MOE inspection report.

- Fifth, the adverse water samples in the spring of 2000 revealing the "significant deterioration of water quality in Well #5" (Burns, January 17, page 178) would have been more fully analyzed and more thoroughly responded to by OCWA staff, fully trained in the significance of such results, the risks they posed to human health and the necessary remedial response. This response would have been supervised by Operations Management for the area.

101. In sum, it is OPSEU's submission that if OCWA had been the water provider for Walkerton in May 2000, the tragic events of that month might very well have been averted.

CONCLUSIONS

102. It is respectfully submitted that Government policies, practices and procedures contributed to the Walkerton tragedy.

103. The Government of Ontario pursued a budget cutting and privatization agenda without regard for public health and safety. The Government drastically reduced the Ministry of Environment's budget and staff complement. The Government reduced training budgets, failed to replace qualified technical, scientific and other staff, and failed to create needed databases. The Ministry was understaffed and under equipped to properly perform its program responsibility.

104. The Government was warned that the budget reductions and privatization agenda would create increased risks to the environment. They assumed that these risks were manageable. Clearly Walkerton demonstrates that the risks were either unmanageable or that the Government was not capable of managing these risks.

105. The Government privatized the laboratories without any evidence that this would benefit the public. The Government then failed to ensure that the appropriate regulations, guidelines or policies were put in place to account for the fact that MOE or MOH laboratories were no longer doing the routine water testing in the Province.

106. The evidence indicates that this Government, for ideological reasons, cared more about reducing the regulatory burden on the private sector than it did in ensuring that private laboratories reported adverse results to the proper authorities.

107. This ideological fervour interfered with the Government's ability to ensure that the public had necessary access to safe drinking water.

108. This Government was warned on numerous occasions by its own staff, by OPSEU, by environmental groups and by others that it was going too far; that there was "Nothing Left to Cut". The Government ignored the advice of its critics but more importantly it ignored the advice of its employees in a number of critical areas. Unfortunately Walkerton was the result.

Doc. 473880