HAMILTON BOARD OF HEALTH
AGENDA

Meeting #:	26-004
Date:	April 27, 2026
Time:	9:30 a.m.
Location:	Council Chambers Hamilton City Hall 71 Main Street West

Matt Gauthier, Legislative Coordinator (905) 546-2424 ext. 6437

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1. CALL TO ORDER

2. APPROVAL OF AGENDA

   (Added Items, if applicable, will be noted with *)

3. DECLARATIONS OF INTEREST

4. CEREMONIAL ACTIVITIES

5. APPROVAL OF MINUTES OF PREVIOUS MEETING

   5.1 February 23, 2026

6. DELEGATIONS

7. ITEMS FOR INFORMATION

   7.1 Communication Update respecting an Environmental Registry of Ontario posting related to ArcelorMittal Dofasco (City Wide)

   7.2 Communication Update respecting a Drug Alert – On-Going High Numbers of Paramedic Responses to Drug Poisonings (City Wide)

   7.3 Correspondence from Julie Mutis, Community Outreach Worker, Canadian Environmental Law Association, respecting a new report that highlights weaknesses in Ontario’s approach to getting lead out of school drinking water

7.4 Correspondence from the Office of the Chief Coroner, Ministry of the Solicitor General, respecting Implementation of Jury Recommendations

7.5 BOH26013

Peter Boris Centre Knowledge & Translation Projects Update (Outstanding Business List Item) (City Wide)

7.6 BOH26014

Heat-Related Illness Public Reporting (City Wide)

7.7 BOH26016

Program Update Series - Food Safety (City Wide)

This item will be preceded by a presentation.

8. ITEMS FOR CONSIDERATION

8.1 BOH26011

Food Advisory Committee Transition (City Wide)

8.2 BOH26012

Hamilton Public Health Public Beach Water Quality Monitoring at Binbrook Conservation Area (City Wide)

8.3 BOH26015

Evaluation of Hamilton Opioid Action Plan Initiatives (Outstanding Business List Item) (City Wide)

8.4 Amendments to the Outstanding Business List

a. Items Considered Complete and Needing to Be Removed

a. Alcohol Drug and Gambling Services Program and Peter Boris Centre for Addiction Research Knowledge Translation Projects Funding

Added: October 2, 2023 (Public Health Committee)
Address as Item 7.5 on today's agenda.

Members of the public can contact the Clerk’s Office to acquire the documents considered at this meeting, in an alternate format.

b. Hamilton Opioid Action Plan

Added: June 12, 2023 (Public Health Committee)
Address as Item 8.3 on today's agenda.

9. MOTIONS

9.1 Correspondence Concerning Provincial Actions Relating to the Opioid Crisis

10. NOTICES OF MOTION

11. BY-LAWS

11.1 005

To Confirm Proceedings of the Board of Health for the City of Hamilton Health Unit

12. ADJOURNMENT

Members of the public can contact the Clerk’s Office to acquire the documents considered at this meeting, in an alternate format.

BOARD OF HEALTH
FOR THE CITY OF HAMILTON PUBLIC HEALTH UNIT
MINUTES BOH 26-002

9:30 a.m.
Monday, February 23, 2026
Council Chambers (Hybrid)
71 Main Street West, Hamilton, Ontario

Present:	Councillors C. Kroetsch (Chair), C. Cassar, T. Hwang (Virtual), M. Tadeson and A. Wilson A. Joseph (Vice-Chair), A. Cheung (Virtual), D. Danko (Virtual), R. Janssen, C. Kirkby and R. Safi (Virtual)
Absent With Regrets:	Councillor N. Nann – Personal S. Adjekum

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1. CALL TO ORDER

Chair Kroetsch called the meeting to order at 9:30 a.m.

2. APPROVAL OF THE AGENDA

(Kirkby/Cassar)
That the agenda for the February 23, 2026, Board of Health, be approved, as presented.

CARRIED

3. DECLARATIONS OF INTEREST

There were no Declarations of Interest.

4. CEREMONIAL ACTIVITIES

There were no Ceremonial Activities.

5. APPROVAL OF MINUTES OF PREVIOUS MEETING

5.1 January 26, 2026

(Cassar/Safi)
That the minutes of the January 26, 2026, meeting of the Board of Health, be adopted, as presented.

CARRIED

6. DELEGATIONS

There were no Delegations.

7. ITEMS FOR INFORMATION

7.1 BOH26009
Orientation to Public Health Emergency Management (City Wide)

(Janssen/Kirkby)
That Report BOH26009, dated February 23, 2026, respecting the Orientation to Public Health Emergency Management (City Wide), be received.

CARRIED

8. ITEMS FOR CONSIDERATION

8.1 BOH26005
Board of Health Adoption of Code of Conduct (City Wide)

(Safi/Cassar)
(a) That Report BOH26005, dated January 26, 2026, respecting the Board of Health Adoption of Code of Conduct (City Wide), be received and the following recommendation, be approved:

(i) That the Board of Health ADOPT the City of Hamilton's Code of Conduct for Local Boards as its own Code of Conduct and that David Boghosian, the City's current Integrity Commissioner HAVE ALL THE POWERS AND DUTIES in respect of the Board of Health and its Code of Conduct as are provided for in the *Municipal Act, 2001*.

(b) That the Correspondence from David Boghosian, Integrity Commissioner, City of Hamilton, respecting the Code of Conduct for the Board of Health, be received.

Result: Motion CARRIED by a vote of 11 to 0, as follows:

ABSENT	-	Adjekum, Sarah	Citizen Member
YES	-	Cassar, Craig	Ward 12 Councillor
YES	-	Cheung, Andrew	Citizen Member
YES	-	Danko, Dawn	Educational Representative
YES	-	Hwang, Tammy	Ward 4 Councillor
YES	-	Janssen, Ryan	Citizen Member
YES	-	Joseph, Ameil	Citizen Member
YES	-	Kirkby, Chelsea	Citizen Member
YES	-	Kroetsch, Cameron	Ward 2 Councillor
ABSENT	-	Nann, Nrinder	Ward 3 Councillor

YES	-	Safi, Rami	Citizen Member
YES	-	Tadeson, Mark	Ward 11 Councillor
YES	-	Wilson, Alex	Ward 13 Councillor

8.2 BOH26010
2026 Annual Service Plan (City Wide)

Dr. Elizabeth Richardson, Medical Officer of Health, Julie Prieto, Director of Health Families & Chief Nursing Officer, Kevin McDonald, Director of Healthy Environments, and Melissa Biksa, Director of Epidemiology & Wellbeing, addressed the Board respecting Report BOH26010, 2026 Annual Service Plan (City Wide), with the aid of a PowerPoint presentation.

(Cassar/Janssen)
That Report BOH26010, dated February 23, 2026, respecting 2026 Annual Service Plan (City Wide) and the accompanying presentation, be received and the following recommendation, be approved:

(a) That the Chair of the Board of Health and the Medical Officer of Health BE AUTHORIZED and BE DIRECTED to submit the 2026 Annual Service Plan to the Ministry of Health, in keeping with the information outlined in Report BOH26010.

Result: Motion CARRIED by a vote of 11 to 0, as follows:

ABSENT	-	Adjekum, Sarah	Citizen Member
YES	-	Cassar, Craig	Ward 12 Councillor
YES	-	Cheung, Andrew	Citizen Member
YES	-	Danko, Dawn	Educational Representative
YES	-	Hwang, Tammy	Ward 4 Councillor
YES	-	Janssen, Ryan	Citizen Member
YES	-	Joseph, Ameil	Citizen Member
YES	-	Kirkby, Chelsea	Citizen Member
YES	-	Kroetsch, Cameron	Ward 2 Councillor
ABSENT	-	Nann, Nrinder	Ward 3 Councillor
YES	-	Safi, Rami	Citizen Member
YES	-	Tadeson, Mark	Ward 11 Councillor
YES	-	Wilson, Alex	Ward 13 Councillor

9. MOTIONS

There were no Motions.

10. NOTICES OF MOTION

There were no Notices of Motions.

11. PRIVATE & CONFIDENTIAL

There were no Private & Confidential Items.

12. BY-LAWS

(Hwang/Danko)
That Bills No. 26-003 and No. 26-004 be passed and the By-law, be numbered, be signed by the Chair and Secretary to read as follows:

003 A By-law to Establish Certain 2026 User Fees and Charges for Services, Activities or the Use of Property provided by Board of Health

004 To Confirm Proceedings of the Board of Health for the City of Hamilton Public Health Unit

Result: Motion CARRIED by a vote of 11 to 0, as follows:

ABSENT	-	Adjekum, Sarah	Citizen Member
YES	-	Cassar, Craig	Ward 12 Councillor
YES	-	Cheung, Andrew	Citizen Member
YES	-	Danko, Dawn	Educational Representative
YES	-	Hwang, Tammy	Ward 4 Councillor
YES	-	Janssen, Ryan	Citizen Member
YES	-	Joseph, Ameil	Citizen Member
YES	-	Kirkby, Chelsea	Citizen Member
YES	-	Kroetsch, Cameron	Ward 2 Councillor
ABSENT	-	Nann, Nrinder	Ward 3 Councillor
YES	-	Safi, Rami	Citizen Member
YES	-	Tadeson, Mark	Ward 11 Councillor
YES	-	Wilson, Alex	Ward 13 Councillor

13. ADJOURNMENT

There being no further business, the Board of Health was adjourned at 10:53 a.m.

Respectfully submitted,

Matt Gauthier
Acting Secretary
Office of the City Clerk

Councillor Cameron Kroetsch
Chair
Board of Health

COMMUNICATION UPDATE

TO:	Chair and Members Board of Health
DATE:	March 6, 2026
SUBJECT:	Environmental Registry of Ontario Posting related to ArcelorMittal Dofasco (City Wide)
WARD(S) AFFECTED:	City Wide
SUBMITTED BY: **SIGNATURE:**	Kevin McDonald, Director, Healthy Environments Division Hamilton Public Health

This communication update is to inform members of the Board of Health about opportunities to provide feedback and comments to the Environmental Registry of Ontario, related to environmental decision-making in Hamilton.

The catalyst for providing this update relates to correspondence to the Board of Health on February 24, 2026 by a community resident highlighting the opportunity for members of the Board of Health to submit comments to the registry regarding a proposal submitted by ArcelorMittal Canada MP Inc. and ArcelorMittal Canada Inc., operating as ArcelorMittal Dofasco G.P. (Environmental Registry of Ontario Number 026-0039). This correspondence can be found attached as Appendix “A” to this Communication Update.

Recognizing that the consultation period to receive comments about the proposal pre-dates the next meeting of the Board of Health on March 23, 2026, this update is being provided to share information about the Environmental Registry of Ontario and its intended purpose, ahead of the comment submission deadline of 11:59 p.m. on March 12, 2026.

The Environmental Registry of Ontario was established under the Environmental Bill of Rights, 1993, which recognizes that the people of Ontario have a right to a healthful environment and a responsibility to protect it. The Environmental Registry of Ontario is a type of ‘forum’ where public participation in decision-making about environmental laws, policies and instruments takes place.

Hamilton Public Health staff within the Health Hazards and Vector-Borne Diseases Program routinely monitor the Environmental Registry of Ontario for postings relevant to the City of Hamilton. Program staff submit comments to the Environmental Registry of Ontario that align with the program mandate under the Ontario Public Health Standards “To reduce exposure to health hazards and promote the development of healthy built

and natural environments that support health and mitigate existing and emerging risks, including the impacts of a changing climate".

Proposals that are posted to the Environmental Registry of Ontario are open to receive public comments for a minimum of 30 days, but typically allow 45 days before closing to comments. Program staff are aware of the current open Environmental Registry of Ontario posting regarding ArcelorMittall Dofasco G.P. (Environmental Registry of Ontario Number 026-0039) and will be submitting comments prior to the March 12, 2026, closure date.

Should members of the Board of Health have any questions related to the above information, or would like to know more about the Environmental Registry of Ontario commenting process, or specifically the ArcelorMittal Dofasco G.P. proposal (Environmental Registry of Ontario Number 026-0039), please contact Matthew Lawson, Manager, Health Hazards & Vector-Borne Diseases Program by email at matthew.lawson@hamilton.ca, or by phone at (905) 546-2424 Ext. 5823.

APPENDICES AND SCHEDULES ATTACHED

Appendix "A" to Board of Health Communication Update – (2026-03-06) Environmental Registry of Ontario Posting related to ArcelorMittal Dofasco

COMMUNICATION UPDATE

TO:	Chair and Members, Hamilton Board of Health Mayor and Members, City Council
DATE:	March 6, 2026
SUBJECT:	Drug Alert – On-Going High Numbers of Paramedic Responses to Drug Poisonings in Hamilton (City Wide)
WARD(S) AFFECTED:	City Wide
SUBMITTED BY: **SIGNATURE:**	Melissa Biksa Director, Epidemiology and Wellness Hamilton Public Health

This communication is to notify you that Hamilton Public Health issued a Drug Alert to community partners on March 6, 2026. Hamilton Public Health collaborates with community partners in monitoring surveillance data and qualitative reports from community providers about patterns of drug toxicity in the unregulated drug supply.

Drug Alerts are issued when Hamilton Public Health receives information about concerning trends in the community or a risk that has been identified with circulating substances. The goal of a Drug Alert is to notify community partners and protect members in the community who may be using unregulated substances from additional risk through encouraging them to take additional precautionary measures when consuming substances.

March 6, 2026 – Drug Alert: On-Going High Numbers of Paramedic Responses to Drug Poisonings in Hamilton

Since January 2026, persistent high numbers of paramedic responses to overdoses in Hamilton point to ongoing high risk in the community.

- High risk of opioid drugs contaminated with benzodiazepines and medetomidine causing heavy sedation, and reduced response to Naloxone; and,
- Reports of Crystal meth drugs contaminated with fentanyl, increasing the risk of unexpected opioid poisoning.

To view the Drug Alert – March 6, 2026, please visit the link below:
On-going High Numbers of Paramedic Responses to Drug Poisonings in Hamilton | City of Hamilton
(https://www.hamilton.ca/alert/going-high-numbers-paramedic-responses-drug-poisonings-hamilton)

Information about Hamilton Public Health community programs and services can be found at the link below:
Harm Reduction Services | City of Hamilton
(https://www.hamilton.ca/people-programs/public-health/alcohol-drugs-gambling/harm-reduction-services)

An alert poster is attached as Appendix "A" for distribution.

If you have any questions, or require additional information, please contact Melissa Biksa, Director, Epidemiology & Wellbeing Division, Hamilton Public Health at Ext. 6709 or melissa.biksa@hamilton.ca.

APPENDICES AND SCHEDULES ATTACHED

Appendix "A" to Board of Health Communication Update (2026-03-06) Drug Alert – On-Going High Numbers of Paramedic Responses to Drug Poisonings in Hamilton

Good Morning,

I am reaching out to share a report published today by the Canadian Environmental Law Association, which highlights the need for Ontario to modernize its nearly 20-year-old approach to protecting children in schools from being exposed to lead in drinking water.

O. Reg. 243/07, which sets minimum standards for testing, mitigating and communicating about lead in school water, is outdated, ineffective, and puts children's health at risk. Despite lack of change at the provincial level, **public health units can act now to ensure that lead testing and mitigation decisions are informed by the most up-to-date evidence.**

Please see attached the report **'F' for Effort: How Ontario is falling behind on getting lead out of school drinking water,** and a briefing note specific to the role that public health units play in protecting students from lead exposure. Also attached is a printable hand-out aimed at building capacity for parents and caregivers to advocate for better lead protections in schools.

Please feel free to reach out with any questions or comments about the material.

Best,

Julie Mutis (she/her/elle)

Community Outreach Worker/Travailleuse de sensibilisation communautaire

Canadian Environmental Law Association/

Association canadienne du droit de l'environnement

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DISCLAIMER:

Health Unit Options for Taking Action on Getting Lead Out of School Drinking Water

ISSUE: Ontario's regulations regarding lead in school drinking water are outdated, which is putting children's health at risk. Despite lack of change at the provincial level, public health units can act now to ensure that lead testing and mitigation decisions are informed by the most up-to-date evidence.

RECOMMENDED ACTION

1. **Recognize** that no amount of lead is safe, especially for children;
2. **Get the lead out** of schools by responding to lead exceedances with mitigation measure that will eliminate exposure;
3. **Share vital information** about school water quality by ensuring schools with known lead infrastructure test annually, and encouraging school boards to make water quality data more accessible.

BACKGROUND

- There is no safe level of lead. Scientists have not been able to find a level of exposure that is not linked to negative neurodevelopmental health outcomes.
- Ontario's regulation for lead in drinking water in schools is O. Reg. 243/07. It sets the legal limit for lead in drinking water to 10 parts-per-billion (ppb).
- O. Reg. 243/07 outlines mandatory lead testing and mitigation protocols, but local public health units can require schools to take stronger action and are consulted when schools apply for testing exemptions.
- In 2019, the federal government issued new guidance that reduced the maximum acceptable concentration of lead in water to 5ppb. Ontario is one of only two provinces and territories that have not adopted this updated guidance.

ACTION 1: Recognize that no amount of lead is safe

- In their 2019 guidance document, Health Canada recognizes that no amount of lead exposure is safe, especially for children.
- This means that even the 5ppb limit is not "safe," but is just a measurable target that can be used to help guide efforts to get lead levels in water as low as reasonably possible.
- Internal documents show the Ontario government staff agree that reducing the lead limit to 5ppb would be beneficial for the health of vulnerable groups, and the Auditory General has criticised the province for not providing transparency about their decisions on this issue.
- Elimination of lead exposure, not just compliance with regulation, should be the goal of all school drinking water interventions.

ACTION 2: Get the Lead Out

Local public health units can instruct schools on what action to take when a lead exceedance is found. CELA is calling on the provincial government to strengthen the required mitigation measures, but health units can protect student health *now* by implementing the following changes:

End the reliance on flushing:

- Research shows that lead levels can rise significantly just minutes or hours after flushing, meaning that flushing water through the tap in the morning does not guarantee safety throughout the day.
- In many cases, flushing interventions for specific taps are not permanent, meaning that the fixture can be returned to regular use in the future with no follow-up testing despite no action being taken to remove lead infrastructure.
- Public Health Units could adopt a similar approach to flushing as what is used in Quebec, wherein:
    - Flushing is only used as an intervention when the lead levels are not extremely high *and* when another intervention, such as replacement, filtration, or removal of the fixture from use, is not an option.
    - Signage is posted instructing students to flush the tap before each use, as opposed to once-daily.
    - Annual testing of fixtures using a flushing intervention is encouraged.

Prioritize Replacement and Filtration:

- Elimination of lead exposure should be the goal of interventions, and lead infrastructure replacement and filtration are the most effective ways to achieve this.
- Recognizing that schools have budget constraints, public health units could recommend that schools prioritize making some fixtures lead-free and closing fixtures that are not essential and cannot be corrected at this time.
    - It is preferable to take fixtures with known lead infrastructure out of use permanently than to allow them to re-open under a flushing regime, which may not be effective at protecting children from lead exposure.

ACTION 3: Share vital information

- Under O. Reg. 243/07, schools can apply for an exemption to annual testing if they have gone 24 consecutive months with no lead exceedances. In some cases, exempt schools can test as few as one tap every three years.
- Given that Ontario has not adopted the updated 5ppb limit on lead in drinking water, schools are being exempt from testing based on results that would spark mitigation action in the majority of other provinces and territories
- Public health units can use their role as experts in water safety to consult with schools seeking testing exemptions about negative impacts that this action could have on children's health.
- Public Health Units can encourage school boards to improve accessibility of lead testing records or to share exceedance notices. This will help ensure that the community is informed and will encourage discussions with students about the importance of following instructions about drinking water.
- Some Ontario school boards already make lead testing information available online, despite not being required to do so. This improves accessibility for caregivers that may not have the time to visit the school in-person to view physical records.

NEXT STEPS

- Read CELA's report ***'F' for Effort: Ontario is falling behind on getting lead out of school drinking water*****.**
- Review internal processes for providing lead mitigation instructions and consider if they:
    - Facilitate progress towards the goal of eliminating lead from schools
    - Are informed by the most up-to-date research and best practices
- Reach out to CELA with questions or comments about how local health units can protect children in schools from lead exposure and/or areas where the recommendations in this document can be improved.
- Discuss the need for stronger protections against lead in drinking water during conversations with the province.

Canadian Environmental Law Association
EQUITY. JUSTICE. HEALTH.

‘F’ for Effort: Ontario is falling behind on getting lead out of school drinking water

Preapred by:
Julie Mutis, Community Outreach Worker

Publication #1679
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Table of Contents:

Executive Summary Page 1

Lead Exposure and Children's Health Page 2

Lead Testing in Ontario Schools Page 2

Time to Modernize Ontario School Drinking Water Protections Page 5

Recognize that no amount of lead is safe Page 5

Prevent lead exposure Page 6

Clear communication about lead in school drinking water Page 10

Conclusion Page 12

Citations Page 13

Executive Summary

The Canadian Environmental Law Association (CELA) is calling on the province of Ontario to stop allowing children to be exposed to dangerous amounts of lead in school drinking water.

Lead has long been a known health hazard, but updated research shows that it is even more dangerous than previously thought. No amount of lead exposure is safe, and it can be particularly harmful to children's health.

In response to this new knowledge, the federal government and the majority of provinces and territories have changed course on how they approach the issue — shifting from a focus on limiting lead exposure to preventing it altogether.

Since 2019, all but two provinces and territories have adopted Health Canada's strengthened limit on lead in water of 5 parts-per-billion (ppb). Only Ontario and Saskatchewan allow levels to climb to the outdated 10ppb limit before acting.

Some regions have gone even further to protect children's health by seeking to identify and eliminate sources of lead in school drinking water. Transparent and detailed reporting from Quebec, which has emerged as a national leader in getting lead out of school drinking water, demonstrates how policies informed by modern research can be extremely effective in keeping lead exposure in school as low as possible.

Ontario, however, is stuck in the past.

This report shows that despite being one of the first provinces and territories to regulate lead in school drinking water back in 2007, Ontario students are still being exposed to lead today.

Ontario's nearly 20-year-old approach to addressing lead in school drinking water instructs schools to only act when lead exceeds the outdated 10ppb limit. A product of its time, the regulation also allows schools to use mitigation methods that only temporarily reduce lead exposure instead of working towards eliminating it.

No amount of lead exposure is safe and Ontario must update their approach to monitoring, responding to, and communicating about school water quality in a way that reflects the true risk to children's health, including:

1. **Recognize that no amount of lead is safe:** Strengthen the action threshold for lead in school drinking water from 10ppb to 5ppb;
2. **Get the lead out:** Respond to lead exceedances with solutions that will eliminate exposure instead of relying on ones that will only temporarily reduce it;
3. **Share vital information:** Provide accessible data about the state of school drinking water quality and the province's progress towards lead-free schools.

Lead Exposure and Children's Health

Lead is a toxic heavy metal that was commonly used in pipes prior to 1975, and plumbing solder and fixtures until the 1990s.[1] While lead has long been known to be hazardous to health, updated research shows that it is even more dangerous than previously known.

No amount of lead is safe and even low levels of exposure are linked to potentially life-altering impacts on children's brain development, including:

- Decreased IQ
- Decreased attention span
- Motor skill weaknesses
- Behavioural problems[1]

In response to this new understanding of the harms of lead, the government of Canada released updated guidance in 2019 recommending that lead levels in water be kept as low as possible and strengthening the recommended maximum acceptable concentration of lead from 10ppb to 5ppb.[1] Seven years later, Ontario is one of only two provinces and territories that have not adopted the 5ppb standard.[2-3]

This means that in too many of the institutions that are meant to equip the next generation with the knowledge and skills they need to succeed, Ontario's current laws and regulations allow children to drink water that could impair their ability to do so.

Lead Testing in Ontario Schools

In 2007, Ontario introduced O. Reg. 243/07, which required schools to test for, respond to, and report on lead levels in drinking water. Nearly 20 years later, Ontario students continue to be exposed to dangerous amounts of lead and the scope of the problem is likely being underreported.

At the time that O. Reg. 243/07 was developed, it was believed that consuming some water that contained at or below the limit of 10ppb of lead was not an "undue risk to health."[4] Based on this understanding, schools can be exempt from annual testing if their results are consistently below 10ppb.[5]

Despite the fact that the province has since internally recognized that there is no "safe" level of lead,[6] no action has been taken to rescind exemptions based on lead levels that are now understood to be harmful to health. This means that schools where the water would be considered unsafe to drink in most of the country are allowed to test as few as one tap every three years for lead.[5]

Each year, the province of Ontario releases school lead testing data to the public, but due to testing exemptions the results are likely an underrepresentation of the true scope of the problem.

The following rankings show which school boards and schools reported the highest number of lead tests that exceeded the Ontario 10ppb limit for lead and Health Canada's recommended limit of 5ppb.

School Board Ranking by # of Tests over 10ppb in 2024/25[7]

RANK*	SCHOOL BOARD	EXCEEDANCES	
		Over 10ppb	Over 5ppb
1	Ottawa Carleton District School Board	**104**	156
2	Dufferin Peel Catholic District School Board	**40**	85
3	Toronto District School Board	**30**	53
4	Peel District School Board	**23**	46
5	Grand Erie District School Board	**23**	45
6	Ottawa Catholic School Board	**22**	47
7	Conseil Scolaire de District Catholique des Aurores Boréales	**19**	24
8	Upper Canada District School Board	**19**	41
9	Durham District School Board	**15**	34
10	Hastings and Prince Edward District School Board	**15**	32

School Ranking by # of Tests over 10ppb in 2024/25[7]

RANK*	SCHOOL NAME	SCHOOL BOARD	EXCEEDANCES Over 10ppb	EXCEEDANCES Over 5ppb
1	Beaver River Public School	Durham District School Board	**15**	33
2	Val Des Bois	Conseil Scolaire de District Catholique des Aurores Boréales	**12**	14
3	Orleans Wood ES	Ottawa Carleton District School Board	**8**	8
4	Fallingbrook Community ES	Ottawa Carleton District School Board	**8**	9
5	Major Ballachey Publlic School	Grand Erie District School Board	**8**	13
6	St. Francis of Assisi Sep S	Dufferin Peel Catholic District School Board	**7**	9
7	Easthill Elementary School	Conseil Scolaire de District Catholique des Aurores Boréales	**7**	15
8	Sherwood Secondary School	Hamilton-Wentworth District School Board	**6**	11
9	Manor Park Public School	Ottawa Carleton District School Board	**5**	6
10	St. Kevin Sep S	Dufferin Peel Catholic District School Board	**5**	10

*Ranking inclusive of all public school boards, public school authorities, and the provincially-run Provincial and Demonstration Schools Branch, accounting for 83 individual boards/authorities. In places where the same number of tests over 10ppb were recorded, rank was determined based on test results and vulnerability of school population.

Total # exceedances may include multiple tests from the same tap and is inclusive of tests over, but not equal to, the respective limit as-per provincial testing methodology.

Time to Modernize Ontario School Drinking Water Protections

When Ontario introduced O. Reg 243/07, the province was a national leader in school water safety. Today, Ontario's failure to keep up with scientific knowledge has put us at the bottom of the class.

Since 2019, all but two provinces and territories have heeded Health Canada's guidance on the true dangers of lead and adopted the 5ppb limit. Some jurisdictions have gone even further to protect children's health by implementing evidence-informed policies that have been successful in working towards the goal of eliminating lead exposure in schools. It is time for Ontario to do the same.

No amount of lead exposure is safe, and Ontario must update their approach to monitoring, responding to, and communicating about school water quality in a way that reflects the true risk to children's health, including:

1. **Recognize that no amount of lead is safe:** Strengthen the action threshold for lead in school drinking water from 10ppb to 5ppb;
2. **Get the lead out:** Respond to lead exceedances with solutions that will eliminate exposure instead of relying on ones that will only temporarily reduce it;
3. **Share vital information:** Provide accessible data about the state of school drinking water quality and the province's progress towards lead-free schools.

1. Recognize that no amount of lead is safe

In 2007, it was believed that consuming water that contained at or below 10ppb of lead was not a significant health risk,[4] but today, research shows that there is no safe dose of lead, especially for children.[1] Ontario's regulations concerning lead in school drinking water must be changed to reflect this, starting with reducing our action threshold for lead from 10ppb to 5ppb.

Ontario should emulate the actions of other provinces and territories that have responded to new knowledge about the harms of lead with decisive action.

Health Canada's guidance was issued in March 2019, and by October of the same year Quebec became the first to adopt the 5ppb lead limit as part of a larger province-wide push to reduce children's exposure to lead.[8]

The province instructed schools to test all taps and fountains within the span of approximately 12 months, and new guidance was created about how to respond to lead exceedances when they were found.[9] Additionally, an inventory of all school drinking water fixtures was created in order to facilitate annual reporting on the number of taps and fountains that were not in compliance with the 5ppb standard for lead.[9]

In the interim, all untested fixtures could only be used after "flushing" before each use, wherein the tap is run for a certain amount of time to rid the system of water that could have been sitting in contact with lead plumbing.[9] In some cases, entire schools used bottled water until testing could be completed and effective solutions applied.[10]

Quebec's strong response is in stark contrast to Ontario, where, despite the fact that internal documents from the Ministry of Environment, Conservation and Parks say there is no "safe" level of lead exposure, no action has been taken to modernize O. Reg. 243/07 to reflect this.**

Ontario's lack of transparency around if or why no decision has been made on adopting the 5ppb limit on lead was critiqued by the Auditor General in March of 2025.[11] To date, no further information has been provided, even following a direct request for information by provincial policy makers.[12]

New knowledge about the true risk of lead exposure raises serious questions about if Ontario is doing enough to protect children in public schools. It is past time for Ontario to modernize O. Reg. 243/07 in a way that recognizes the true risk of lead exposure, and this must include adopting the 5ppb limit on lead in school drinking water.

2. Prevent Lead Exposure

In order to respond appropriately to the knowledge that no amount of lead exposure is safe, Ontario must modernize O. Reg. 243/07 in a way that prioritizes the elimination of lead sources.

Lead levels are often highest after water has been in contact with lead plumbing for an extended period of time. Instead of responding to this issue by prioritizing the replacement of lead infrastructure or installing filters to protect against lead exposure, O. Reg. 243/07 relies heavily on flushing, wherein the water is run through the entire plumbing system and at individual taps and fountains. The goal of this is to remove water that may have been in contact with lead plumbing for a prolonged period of time.

**Changes to O. Reg. 243/07 have been made since it was introduced in 2007, but do not address 2019 guidance from the federal government.

CELA's analysis of school water records suggests that the first and often only response when water fixtures exceed 10ppb of lead is to increase the flushing time at that specific tap or fountain.[13]

The problem with Ontario's reliance on flushing is twofold: it is ineffective in the short-term and has no impact on eliminating lead exposure in the long-term.

While flushing can reduce lead concentration for a short time, research shows that lead can return to dangerous levels just minutes or hours afterwards.[14-15] Flushing requirements can also last for as few as 24 months, at which time the fixture is returned to regular use without any permanent solution in place or even a follow-up test to assess the water quality.[16]

Lead Testing Need to Know

When testing a water fixture for lead, it is common for two samples to be taken:

Standing Sample: Water is collected after it has sat unused for an extended period of time, often a minimum of 6 hours. This test is meant to mimic what the water quality would be like if someone drank from a tap first thing in the morning.

Flushed Sample: This sample is collected after water has been run through the tap for a certain amount of time. This sample can represent the presence of lead in the plumbing system, as opposed to in fountain or tap components themselves.

Reliance on flushing is not consistent with the knowledge that no amount of lead is safe, and examples of how this plays out in Ontario schools paint a concerning picture, showing that compliance with O. Reg. 243/07 does not necessarily mean safety.

Case Study: Flushing failures in an Ottawa school***

When high lead levels were found at a water bottle filling station in an Ottawa elementary school, once-daily flushing was relied on to get the fixture back into compliance with O. Reg. 243/07.

This case study shows that despite evidence that flushing was ineffective at reliably reducing lead levels to below even the outdated 10ppb limit, the school was never required to take any further action.

Despite the application of O. Reg. 243/07, it is likely that young children are still being exposed to lead at this fixture today. Issues like this will continue to happen until O. Reg. 243/07 is updated to prioritize the removal of lead infrastructure and installation of filters.

Discovery of a lead exceedance:

In September of 2020, an Ottawa school tested a newly-installed water bottle filling station and found high levels of lead:

Standing Test: 136ppb
Flushed Test: 68.3ppb

Ottawa Public Health instructed the school to take the fixture out of use, flush water through it on a daily basis and conduct new tests.

The following four re-samples all exceeded the 10ppb limit on lead in drinking water, but it should be noted that these results could have been impacted by infrequent use of the entire plumbing system during school closures for the COVID-19 pandemic.

Filling Station Returned to Use:

In February of 2021, Ottawa schools reopened for in-person learning. Two compliant flushed samples were collected and the fixture was returned to use:

Flushed Resample 5: 2.61ppb
Flushed Resample 6: 6.48ppb

Second Exceedance:

Despite not being required to re-test the fixture, the water bottle filling station was tested in July 2022 and again exceeded the 10ppb limit on lead in drinking water.

Standing Test: 49ppb
Flushed Test: 12ppb

The school was instructed to take the filling station out of use, continue flushing, and conduct re-tests. This is despite the fact that a flushing intervention had already been in place when the exceedance was recorded.

Filling Station Returned to Use:

The fixture was returned to use after two compliant tests were submitted in August 2022:

Flushed Resample 1: 8ppb
Flushed Resample 2: 8ppb

As of December 2025, no further testing has been done on this water bottle filling station.

What does this case study tell us?

This case study highlights some of the glaring weaknesses in Ontario's outdated approach to mitigating lead exposure in schools:

1. **Water from this fixture would be considered unsafe in almost all other provinces and territories:** Only one of the 10 rounds of testing conducted at this filling station was below the 5ppb MAC for lead. No amount of lead is safe, but O. Reg. 243/07 allows children to continue being exposed to it at this fixture

2. **No long-term intervention has been put in place:** Flushing was the only intervention used, even though it was shown to not be effective. Given that O. Reg. 243/07 allows flushing interventions to end after as little as 24 months, it is possible that this water bottle filling station has been returned to regular use with no increased daily flushing time or requirement to re-test.

3. **Community members do not know about the risks:** The school was not required to tell community members about the lead exceedances, meaning that students and staff cannot make an informed decision about using this water fixture.

***Case study supported by documents acquired through FIPPA request A-2025-08405 and in correspondence with Ottawa Public Health and the Ottawa Carleton District School Board.

The weaknesses in Ontario's lead mitigation measures is even more evident when compared to Quebec, where the required responses to a lead exceedance are informed by the principle that no amount of lead exposure is safe.

In conjunction with the province's 2019 adoption of the 5ppb standard and campaign to test all school water fixtures, an updated mitigation guide was put in place that prioritizes the replacement of lead infrastructure where possible and the installation of filters when replacement is not feasible.[9]

Under this guidance, per-use flushing (as opposed to Ontario's once-daily approach) is the lowest-tier intervention and only used in situations where the flushed sample is under 5ppb, the fixture is a necessary water source, and a more effective solution is not immediately available.[9]

Quebec does not consider per-use flushing interventions to be a long-term solution and it is instead used in only the lowest-risk scenarios until more effective measures can be taken. Annual testing of such taps or fountains is encouraged.[18]

Temporarily reducing lead exposure is not good enough. In order to make real progress on protecting children's health, Ontario should follow the example of Quebec and shift our focus to permanently eliminating the risk of lead exposure in schools.

The province must modernize the lead mitigation measures in O. Reg. 243/07 to prioritize permanent or proven-effective solutions such as the replacement of lead infrastructure and use of filtration devices.

3. Clear communication about lead in school drinking water

Ensuring that information about lead in school drinking water is accurate and accessible is an important factor in building community trust, informing healthy decision-making and keeping the province accountable. Ontario is falling behind other provinces and territories when it comes to province-wide and community-specific transparency and communication.

Despite having collected nearly 20 years-worth of data, it is not possible to determine what real progress has been made to get lead out of school drinking water in Ontario since 2007.

In Quebec, a report about drinking water testing in public and private schools is published bi-annually in an accessible format that clearly demonstrates what progress is being made. This report includes a count of how many school taps and fountains are in compliance with the 5ppb standard, which keeps communities informed and the government accountable.

Quebec's consistent reporting has demonstrated the clear success of their approach to getting lead out of school drinking water. Since completing screening of all taps and fountains in the summer of 2021, 61 per cent of non-compliant taps in public school have been corrected.[19]

In contrast, the province of Ontario's approach to communicating about lead in schools includes releasing an annual spreadsheet of raw data[7] and providing a percentage of compliant tests taken as part of the Chief Drinking Water Inspector's annual report.[20]

Providing vital information as a raw data file creates barriers to accessibility for those who do not have the time or skills to analyse it. Additionally, the test results do not show how many or which fixtures have been tested, making it impossible to determine if a large number of exceedances at one school represents many non-compliant fixtures, or multiple tests on just a few taps or fountains. School officials have said this lack of specificity can create a "misleading," picture of water quality in specific schools.[21]

At the community level, Ontario schools are not required to inform the school community when lead exceedances are found or provide information about what steps are being taken to remedy the problem.

Other provinces and territories, including British Columbia[22], Quebec[9] and the Northwest Territories[23], have communication and reporting policies in place that are proportionate to the serious health risks associated with lead exposure. In all of these regions, community members are immediately notified when a lead exceedance is discovered and information is provided about what action is being taken.

This clear communication builds trust by demonstrating shared concern for children's health and supports healthy decision-making by initiating conversations at school and home about which water fixtures should and should not be used for drinking.

Lead in school drinking water is a serious public health issue and Ontario must update how they report on it to ensure that the information is accessible, accurate and clearly demonstrates what progress is being made towards the elimination of lead in school drinking water.

Conclusion

In the nearly 20 years since Ontario began addressing the issue of lead in school drinking water, our knowledge about the dangers of lead have changed, but our laws and regulations have not.

Despite privately acknowledging that there is no known "safe" level of lead exposure, the province has failed to change the way we test for, respond to, and communicate about lead in schools to reflect this reality.

Instead, Ontario students are allowed to drink water that would be considered unsafe in the majority of the country. We fail to make progress towards removing lead from schools by relying on ineffective and temporary mitigation measures, and there is no clear or accessible data about the state of school water quality or how it has changed over time.

The majority of other provinces and territories have responded to new scientific knowledge about lead with the seriousness it deserves by adopting the 5ppb limit on lead in drinking water and decisively working to eliminate lead exposure in schools.

It is past time that Ontario emulated this behavior and modernized their approach to getting lead out of school drinking water in ways that will ensure that our students have the same level of safety and opportunity that is enjoyed by children across the country.

Calls to Action

1. **Recognize that no amount of lead is safe:** Strengthen the threshold for lead in school drinking water from 10ppb to 5ppb;
    a. Rescind testing exemptions based on the 10ppb limit.
    b. Re-test all fixtures against the 5ppb limit.

2. **Get the lead out:** Respond to lead exceedances with solutions that will eliminate exposure instead of relying on ones that will only temporarily reduce it;
    a. Once-per-use flushing of fixtures with known lead content should be the lowest-tier approach and not considered a long-term solution.
    b. Solutions to fix points of lead exposure, such as replacement of lead infrastructure, installation of filters or removal of unnecessary fixtures from use, should be prioritized.

3. **Share vital information:** Provide accessible data about the state of school drinking water quality and the province's progress towards lead-free schools.
    a. Ensure that school communities have accurate and timely information about water quality in their school and action being taken to remedy problems.
    b. Create and annually report on an inventory of all school water fixtures in order to demonstrate the scope of the problem and progress made towards a lead-free future.

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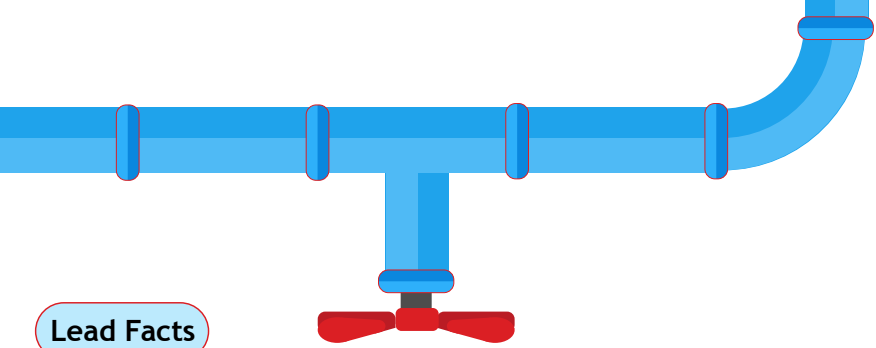
How You Can Help

Get Lead Out *of* School Drinking Water

Encourage the leaders in your school to speak up and take action!



Lead Facts

Lead can be found in tap/fountain parts and pipe solder in older infrastructure

There is **NO SAFE LEVEL** of lead. All exposure is linked to negative neurological health outcomes

Ontario's legal limit for lead in water is **twice** that of the federal government's guideline

In the last 5 years, **half of Ontario schools** have reported dangerous levels of lead in their water

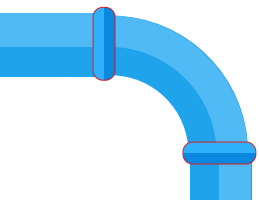
Health Impacts

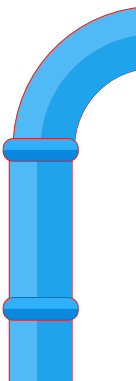
Children are particularly vulnerable to the harms of lead exposure

Even low levels of lead exposure are linked to:

- Decreased attention spans
- Lower IQ scores
- Behavioural problems
- Fine motor skill delays

Exposure to lead can have **life-long consequences**





Talking to School Leadership

Ontario's approach to preventing lead exposure in schools is outdated and ineffective. Your school's leadership may not know the facts, but you can help by explaining to them that ***"good enough" isn't good enough***.

WHEN THEY SAY	YOU SAY
We are in compliance with provincial water quality requirements.	The rules and regulations are outdated and not doing enough to keep kids safe. We need to get the lead out.
We flush water through the pipes every morning to remove water that was in contact with lead overnight.	That isn't enough to protect children. We need to prioritize removal and use more effective prevention measures.
It is the government's responsibility to regulate and enforce water safety measures.	I agree that the province needs to do more, but you also have the power to prevent the life-long health impacts of lead.

Requests to Your School Leaders

Learn

- Read CELA's report to learn about weaknesses in existing regulation
- Find out how much lead is in the water at schools under your jurisdiction

Advocate

- Pass a resolution calling on the province of Ontario to prioritize and fund the removal of lead from schools

Act

- Prioritize replacing lead-containing fixtures
- Where replacement isn't possible, install filters or, if necessary, flush water before each use
- Take mitigation action on taps that exceed the federally-recommended limit on lead

Canadian Environmental Law Association
EQUITY. JUSTICE. HEALTH.

www.cela.ca

For more information, contact: julie@cela.ca

Ministry of the Solicitor General

Office of the Chief Coroner
Ontario Forensic Pathology Service

Forensic Services and
Coroners' Complex
25 Morton Shulman Avenue
Toronto ON M3M 0B1

Telephone: (416) 314-4000
Facsimile: (416) 314-4030

Ministère du Solliciteur général

Bureau du coroner en chef
Service de médecine légale de l'Ontario

Complexe des sciences judiciaires
et du coroner
25, Avenue Morton Shulman
Toronto ON M3M 0B1

Téléphone: (416) 314-4040
Télécopieur: (416) 314-4060

January 23, 2025

Via email to each board of health

Office of Chief Medical Officer of Health, Public Health
BOARDS OF HEALTH
Ministry of Health | Ontario Public Service
777 Bay Street, 5th Floor
Toronto, Ontario M5G 2C8

Dear Boards of Health:

Re:	**Inquest into the death of:**	**Luke MOORE, died November 19, 2021** **Lorraine SHAGANASH, died November 20, 2021** **Lizzie SUTHERLAND, died November 21, 2021** **Mark FERRIS, died November 30, 2021** **Douglas TAYLOR, January 23, 2022**
	OCC Inquest File No.:	**Q2025-31**
	Date Inquest Jury Verdict & Recommendations Received:	**November 19, 2025**

The jury in the inquest into the death of Luke Moore, Lorraine Shaganash, Lizzie Sutherland, Mark Ferris, and Douglas Taylor has made recommendations which your organization may be in a position to implement. Please report back regarding your consideration to implement the recommendations relating to your organization by completing the attached chart, ***Responses to Jury Recommendations***. Responses to inquest recommendations will be made public. Therefore, your response should not contain personal identifiers with the exception of identifying the decedent.

We do request a response by **July 23, 2026,** however, the *Coroners Act* provides no authority for us to demand a response to a recommendation or set deadlines for a response. We do post responses publicly, and scrutiny of the responses has been growing. Public criticism may follow if a thoughtful response is not received in a timely manner.

A list of organizations requested to report back is provided.

We are pleased to provide you with a copy of the inquest jury verdict and recommendations. The presiding officer's verdict explanation will be sent when it becomes available.

I would like to explain the significance of inquests and consequent recommendations under the *Coroners Act*. An inquest is a public hearing conducted by a coroner (or a judge, or a retired judge or a lawyer) before a jury of five community members. Inquests are held for the purpose of informing the public about the circumstances of a death. An inquest does not find fault, blame or legal wrongdoing but rather examines the circumstances of one or more deaths and looks for lessons that can be learned from the death(s) that may contribute to a safer future for the living. Juries often make recommendations based on these learned lessons and, while they are not binding, it is hoped that implemented recommendations will prevent future deaths in similar circumstances.

Please provide us with the name and contact information of the individual leading your organization's response. If you feel any of the recommendations should be directed elsewhere, complete the attached ***Contact Information and Recommendation Referrals*** **form and forward** to occ.inquests.registraroffice@ontario.ca .

As noted above, inquest jury recommendations are not legally binding; however, we trust they will be given careful consideration for implementation and, if not implemented, that your organization provides an explanation.

Thank you for participating in this important process. Please contact me if you have any questions.

Sincerely,

David A. Cameron, MD, LLB, CCFP
Regional Supervising Coroner – Inquests

/eg

Attachments:
Responses to Jury Recommendations
List of Organizations Requested to Respond to Jury Recommendations
Contact Information and Recommendation Referrals

Responses to Jury Recommendations
BLASTOMYCOSIS Inquest Q2025-31

BOARDS OF HEALTH

RECOMMENDATION #:
27 – 28, 33, 48, 52

REC. #	ORGANIZATION'S RESPONSE

List of Organizations Requested to Respond to Jury Recommendations

BLASTOMYCOSIS Inquest Q2025-31

Hopital Notre-Dame Hospital

Ornge

Public Health Ontario (PHO)

The Ministry of Health

Northeastern Public Health (NEPH)

Indigenous Services Canada (ISC)

Constance Lake First Nation (CLFN)

Jane Mattinas Health Centre (JMHC)

Chief Counsel of Constance Lake First Nation

Ontario Health

Matawa First Nations Management Health Cooperative (MFNM)

Nishnawbe Aski Nation (NAN)

Ontario Telemedicine Network (OTN)

Boards of Health

Four Rivers Environmental Services Group (Four Rivers)

Canadian Institute of Health Research CIHR)

Ministry of Colleges, Universities, Research Excellence and Security

Ministry of Agriculture, Food and Agribusiness

Ontario Ministry of Agriculture, Food, and Rural Affairs (OMAFRA)
Office of the Chief Veterinary

College of Veterinarians of Ontario
Town of Hearst

Ministry of Natural Resources

Government of Ontario

Contact Information and Recommendation Referrals
Responses to Jury Recommendations
BLASTOMYCOSIS Inquest Q2025-31

BOARDS OF HEALTH

Part I: Contact Information

Name	Position Title
Email address	Telephone number

Part II: Referral

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

Recommendation Number	Organization Name & Address	Contact Name & Title

Forward to occ.inquests.registraroffice@ontario.ca

Office of the Chief Coroner

Bureau du coroner en chef

Verdict of Inquest Jury
Verdict du jury de l'enquête

Coroners Act - Province of Ontario
Loi sur les coroners - Province de l'Ontario

We the undersigned / Nous soussignés,

	of / de	Iroquois Falls, Ontario
	of / de	Kapuskasing, Ontario
	of / de	Iroquois Falls, Ontario
	of / de	Cochrane, Ontario
	of / de	Cochrane, Ontario

the jury serving on the inquest into the death(s) of / membres dûment assermentés du jury à l'enquête sur le décès de:

Surname / Nom de famille	Given Names / Prénoms	Aged / à l'âge de
Moore	Luke	43
Shaganash	Lorraine	47
Sutherland	Lizzie	56
Ferris	Mark	67
Taylor	Douglas	60

held at / tenue à Constance Lake, and virtual via Zoom, Ontario from / du October 15, 2025 to / au November 19, 2025

By / Par Doctor Michael B. Wilson Presiding Officer for Ontario / Président de séance pour l'Ontario

having been duly sworn/affirmed, have inquired into and determined the following:
avons fait enquête dans l'affaire et avons conclu ce qui suit:

Name of Deceased / Nom du défunt	Luke Moore
Date of Death / Date du décès	November 19, 2021
Place of Death / Lieu du décès	Hôpital Notre-Dame Hospital, Hearst, Ontario
Cause of Death / Cause du décès	Acute blastomycosis pneumonia
By What Means / Circonstances du décès	Natural

Name of Deceased / Nom du défunt	Lorraine Shaganash
Date of Death / Date du décès	November 20, 2021
Place of Death / Lieu du décès	Health Sciences North, Sudbury, Ontario
Cause of Death / Cause du décès	Blastomycosis pneumonia complicated by acute respiratory distress syndrome and multiorgan failure
By What Means / Circonstances du décès	Natural

Name of Deceased / Nom du défunt	Lizzie Sutherland
Date of Death / Date du décès	November 21, 2021
Place of Death / Lieu du décès	Hôpital Notre-Dame Hospital, Hearst, Ontario

Cause of Death / Cause du décès	Blastomyces dermatitidis, hepatitis, splenitis, and peritonitis
By What Means / Circonstances du décès	Natural

Name of Deceased / Nom du défunt	Mark Ferris
Date of Death / Date du décès	November 30, 2021
Place of Death / Lieu du décès	North Bay Regional Health Centre, North Bay, Ontario
Cause of Death / Cause du décès	Multi-organ failure due to respiratory failure due to blastomycosis pneumonia
By What Means / Circonstances du décès	Natural

Name of Deceased / Nom du défunt	Douglas Taylor
Date of Death / Date du décès	January 23, 2022
Place of Death / Lieu du décès	Hôpital Notre-Dame Hospital, Hearst, Ontario
Cause of Death / Cause du décès	Respiratory failure due to blastomycosis bilateral pneumonia
By What Means / Circonstances du décès	Natural

Original signed* by Foreperson /
Original signé* par le contremaître

**In-Person Inquests Only / Enquêtes en personne uniquement*

The verdict was received on / Ce verdict a été reçu le: November 19, 2025

Original signed* by jurors / Original signé* par les jurés

Doctor Michael B. Wilson

Presiding Officer's Name (Please print) /
Nom du président (en lettres moulées)

November 19, 2025

Date Signed / Date de la signature

Signature / Signature

We, the jury, wish to make the following recommendations: (see following page)
Nous, membres du jury, formulons les recommandations suivantes : (voir page suivante)

Office of the
Chief Coroner

Bureau du
coroner en chef

Verdict of Inquest Jury
Verdict du jury de l'enquête

Coroners Act - Province of Ontario
Loi sur les coroners - Province de l'Ontario

Inquest into the death(s) of:
L'enquête sur le décès de:

	Name of Deceased / Nom du défunt
	Moore, Luke
	Shaganash, Lorraine
	Sutherland, Lizzie
	Ferris, Mark
	Taylor, Douglas

JURY RECOMMENDATIONS
RECOMMANDATIONS DU JURY

INQUEST INTO THE DEATHS OF LUKE MOORE, LORRAINE SHAGANASH, LIZZIE SUTHERLAND, MARK FERRIS, AND DOUGLAS TAYLOR

Reconciliation and relationship building between Constance Lake First Nation, health care institutions, and public health organizations

1. Hôpital Notre-Dame Hospital ("NDH"), Ornge, Public Health Ontario ("PHO"), the Ministry of Health, Northeastern Public Health ("NEPH"), and Indigenous Services Canada ("ISC") should commit to Joyce's Principle, which aims to guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional, and spiritual health, including the recognition and respect of Indigenous people's traditional and living knowledge in all aspects of health.

2. NDH will collaborate with Constance Lake First Nation ("CLFN") to determine how NDH's commitment to following and implementing Joyce's Principle will be displayed and expressed to NDH patients, visitors, staff, volunteers, service providers, and anyone else entering the hospital (e.g., posters, signage).

3. ISC and the Ministry of Health in collaboration with and under the lead of CLFN Chief and Council and the Jane Mattinas Health Centre ("JMHC") will ensure that the funding and infrastructure available to CLFN, ensures the delivery of healthcare services that meet the needs of members of CLFN.

4. NDH, Ornge, PHO, and NEPH should create and publish on their websites, within six months of this verdict, a plan to implement the Truth and Reconciliation Commission ("TRC") Calls to Action 22 and 23 as applicable.

5. The Ministry of Health should create and publish on their websites, within six months of this verdict, a plan to implement the TRC Calls to Action 18, 22, and 23.

6. ISC should continue publishing initiatives and developments to implement the TRC Calls to Action 18 to 23.

7. NDH should collaborate with CLFN community members, Chief and Council and JMHC to prepare within three months of this verdict, an updated First Nations, Inuit, Métis and Urban Indigenous Health Workplan, that was prepared as required by the NDH Hospital Service Accountability Agreement for 2024-25 with Ontario Health. The updated Health Workplan will include concrete strategies to improve outcomes for CLFN members, and creating culturally safe access to health care services, programs to foster Indigenous engagement, and relationship building to improve Indigenous health. A copy of the Workplan will be provided to CLFN community, Chief and Council and the JMHC.

8. NDH, Ornge, PHO, NEPH, and ISC will, to the extent that it is not already being provided, ensure applicable personnel are receiving Indigenous Cultural Safety Training and training on trauma-informed care within 12 months of this verdict.
a) This training will include but not be limited to board members, senior leadership and management staff, health care providers, and allied health professionals. Frontline staff should have priority when implementing this training.
b) This training will include teaching on the history and culture of the First Nations and Indigenous communities to whom these agencies provide services and the contemporary experiences of those communities in the health care system, and cover topics such as anti-Indigenous racism, managing implicit bias, understanding how emotional prejudice impacts decision making, and mitigating the harmful impact of stereotyping on health outcomes.
c) This training should be mandatory and opportunities for ongoing learning on these topics should be provided on an annual basis or more frequently.

9. With respect to Indigenous Cultural Safety Training, NDH will:
a) Collaborate with CLFN and JMHC so that members of CLFN can be involved in the planning and delivery of Indigenous Cultural Safety Training and trauma-informed health care training.
b) In recognition that cultural safety is a core clinical skill, take steps to explore that the completion of this training be a condition for credentialing of locum physicians working at the hospital. This should include consulting with the Ministry of

Health about the requirements for physicians involved in the Emergency Department Locum Program ("EDLP"). NDH to provide updates about steps taken to explore adding Indigenous Cultural Safety Training as a condition for credentialing of locum physicians to the Blastomycosis Inquest Implementation Committee.

10. The Ministry of Health and/or Ontario Health should consider ways to support health care providers and public health professionals, including physicians, nurses, and allied health professionals working in northern and remote regions of Ontario, being able to take Indigenous Cultural Safety Training and trauma-informed health care training, including by providing additional funding.

11. The Ministry of Health should consider requiring all health regulatory colleges to make Indigenous Cultural Safety Training a mandatory requirement for all regulated health professionals. This training should incorporate teachings on a "two-eyed seeing approach" to health care that incorporates both Western and Indigenous ways of knowing and conceptions of well-being.

12. The JMHC, with the support and assistance of the Matawa First Nations Management ("MFNM") Health Cooperative and ISC where requested, should request and secure funding to employ two full-time Indigenous Patient Navigators.

13. NDH to allocate and maintain funding for at least one Indigenous Patient Navigator who will work at NDH. This position should be filled by a person who is Indigenous and has knowledge of and/or connections to the history and culture of CLFN. The job description and responsibilities for the Indigenous Patient Navigator role at NDH will be co-developed with CLFN Chief and Council or JMHC (as determined by CLFN).

14. NDH should make an existing multipurpose room at the hospital a traditional healing room for Indigenous patients and families. The space will be designed to facilitate the use of Indigenous medicines, including smudging, and accessing support from Elders and Traditional Indigenous Healers. The space should be designed with the CLFN community and be dedicated to the memory of Luke Moore, Lorraine Shaganash, Lizzie Sutherland, Mark Ferris, and Douglas Taylor.

15. NDH to create a policy stating that smudging is permitted at NDH and how requests to smudge are to be facilitated. The policy will be communicated to all staff, including part-time and contract staff (e.g., locum physicians and agency nurses), and to patients. To communicate this policy to patients, NDH to post clear signs in English, French, Cree, Ojibwe and Oji-Cree stating that smudging is permitted at NDH. This should be clearly stated on NDH's website as well. Posters will also be provided to the JMHC.

16. NDH should collaborate with CLFN to explore the potential availability of having a tipi and sacred fire on the grounds of the hospital and ways to incorporate traditional teachings at the site.

17. NDH and CLFN should explore more avenues for communication and relationship-building, including regular meetings and circles. A collaborative approach will be taken to determine Terms of Reference for meetings (if any), who will participate, frequency and location of meetings, and whether minutes will be kept. Informal opportunities for relationship building will also be explored.

18. NDH should take steps to share information with CLFN members about the emergency room triage system. The information to be shared and the ways it can be shared will be developed in partnership with the JMHC.

Emergency preparedness and response in Northern Ontario and First Nations communities

19. The Ministry of Health and/or Ontario Health should develop a Northern Ontario Emergency Response Team comprised of health care professionals and public health professionals who can provide surge capacity to northern and remote communities in Ontario during public health emergencies. The development of this team should include strategies to recruit Indigenous health care professionals to serve on the Emergency Response Team.

20.The Ministry of Health and/or Ontario Health should hold a debrief after any complex multi-jurisdictional outbreak of a disease of public health significance involving a First Nations or Indigenous community. This debrief should be held within six months of the outbreak being declared over and should include all local, provincial, and federal health institutions and agencies involved in the outbreak response. The First Nations community should be invited to participate and included in the planning and facilitation of the debrief.

21. NDH to continue to offer debriefing and provide mental health support services to all NDH staff, including those under contract i.e. locum physicians, agency nurses.

22. In appropriate circumstances, regarding the death of a patient, NDH will take steps to facilitate a debrief among individuals at NDH and other organizations involved in the clinical care of the deceased. The purpose of the debrief is to have an opportunity to discuss and identify any potential lessons learned.

23. NDH to review and update training provided to frontline health care providers to ensure that any health care providers who may be required to care for critical care patients can provide the best care possible if the patient cannot be transferred to a hospital with a higher level of care. This should include taking steps to arrange, wherever possible, for nurses employed by NDH to be registered for the C3 Concepts in Critical Care simulation course offered by Health Sciences North within one year of this verdict. The Ministry of Health should provide funding to NDH to permit such training.

24. The Ministry of Health should create an inventory of public health programs and services available to First Nation communities and compare the inventory to the Ontario Public Health Standards with the goal of identifying and improving access to public health services for First Nation community members. The Ministry of Health to share this inventory with ISC, and any applicable Tribal Council in relation to transferred communities.

25. CLFN, JMHC, and the MFNM Health Cooperative to inquire if there is an emergency response and evacuation plan in place for CLFN. If there is not, they should create such a plan in consultation with Nishnawbe Aski Nation ("NAN") and request that ISC provide any necessary support or assistance, if eligible, to develop an emergency response and evacuation plan.

26. CLFN, JMHC, and Matawa Tribal Council to consider applying for funding for the planning or training on emergency

preparedness and response, under ISC's Non-Structural Mitigation and Preparedness funding of the Emergency Management Assistance Program.

27. The Ministry of Health, local Boards of Health, and ISC to explore opportunities for relationship building among public health units and ISC, with a focus on responding to future public health emergencies in First Nation communities.

28. The Ministry of Health, local Boards of Health, applicable Tribal Councils, and ISC should meet to develop and establish clear roles and responsibilities, in response to future public health emergencies and outbreaks.

Indigenous representation in health care governance and institutions

29. NDH will create two permanent positions on its Board of Directors exclusively for members of CLFN, or individuals designated by CLFN. To promote and enable full CLFN participation in NDH governance, the hospital will take steps to:
a) Make amendments to its Board by-laws as necessary.
b) Change the list of qualifications on its website to remove that one of the qualifications for the CLFN Board Member is that the person be bilingual.
c) Consult with CLFN about holding some of the NDH Board meetings at Constance Lake First Nation.

30. Within two months of this verdict, the NDH Board to expand the portfolios of one or two current board members to include engagement and relationship building with CLFN. This expanded portfolio will include areas such as:
a) Engaging with CLFN Chief and Council about the implementation of the two board positions for CLFN members on the NDH Board of Directors. If agreeable to Chief and Council, this engagement may be done in part through attending and presenting on this board membership opportunity at the next possible Chief and Council meeting.
b) Support recruitment of CLFN members to the NDH Board of Directors through circulating postings for the position and engaging with community members interested in applying for the role.
c) Ensuring Chief and Council is updated about job positions at NDH to promote within their membership, attending CLFN in person to present on job opportunities, and offering support to community members interested in applying for such positions.

31. NDH and NEPH to explore ways to encourage and support Indigenous membership on their boards and advisory committees, including outreach opportunities with First Nation communities and urban Indigenous partners, coordinating with committee chairs or other people who are responsible for the appointment of members, and identifying and addressing existing or potential barriers to participation by First Nation communities.

32. NDH and CLFN to collaborate to arrange for in person community visits where youth and adults who are interested in working in hospital administration or the health care field can connect with hospital/health care professionals to learn about their work. NDH to also explore co-op placement, volunteer, and job shadowing opportunities for students from CLFN.

Information sharing between organizations responding to public health emergencies in First Nations communities

33. To support equitable, informed, and culturally respectful public health interventions and responses, the Ministry of Health should consider requiring local Boards of Health to collect race, ethnicity, and Indigenous identity data (where appropriate) for all diseases of public health significance, including blastomycosis. Data on Indigenous identity should be collected in partnership with Indigenous communities and aligned with OCAP data principles.

34. PHO, the Ministry of Health, and ISC should collaborate to establish a secure information sharing process (in alignment with OCAP data principles) among relevant public health agencies.

35. A trilateral table should be established for the First Nations Information Governance Centre. ISC and the Ministry of Health to engage in a process to explore and achieve the development of legislation, information sharing protocols, and/or a memorandum of understanding to address the collection, use, and disclosure of personal health information and personal information relating to members of First Nations communities and First Nations health data, including for research purposes, guided by OCAP principles. This process would include but not be limited to information sharing in times of a public health emergency and should include consultation with the Information and Privacy Commissioner of Ontario.

Addressing health human resource capacity in Northern Ontario

36. The Ministry of Health and/or Ontario Health should develop and implement a comprehensive strategy to ensure sustainable, full-time access to qualified health care providers and public health professionals, including physicians, nurses, and allied health professionals, in northern and remote regions of Ontario. At a minimum, the strategy will:
a) Include consultations with health care providers working in northern and remote regions of Ontario to better understand what support they need and what steps can be taken to implement these supports.
b) Prioritize placement of health care providers in facilities experiencing critical staffing shortages, including NDH.
c) Streamline recruitment processes and practices and remove administrative impediments to attract qualified candidates.
d) Provide targeted incentives (financial or otherwise) to encourage health care providers, including physicians, nurses, and allied health professionals, to work and remain in northern and remote regions of Ontario.
e) Explore ways to limit reliance on locum physicians and nursing agencies to provide health care services in northern and remote regions of Ontario.

37. The Ministry of Health and/or Ontario Health should develop and implement, in collaboration with Indigenous communities, including CLFN, a recruitment and retention strategy to attract, hire, and retain First Nations, Inuit, Métis and Urban Indigenous people pursuing careers as health care providers and/or public health professionals, particularly in northern and remote regions of Ontario.

38. To ensure continued funding and expand the availability of the Virtual Critical Care ("VCC") Program to guarantee 24/7 access to remote consultations and support, the Ministry of Health should consider the creation of a full-time, dedicated position responsible for providing VCC services.

39. The CritiCall Ontario Program to conduct an internal review to confirm removal of any administrative barriers to accessing health care, ensuring that patients can continue to access the urgent and emergent care they need as close to home as possible.

40. The Ministry of Health and/or Ontario Health should establish, allocate, and maintain funding for a dedicated nurse practitioner and/or family physician (general practitioner) position to deliver care to CLFN members on a regular basis. The Ministry of Health should consult CLFN and MFNM during the development of such a position and through the recruitment process to ensure their needs and views are considered.

41. To enhance and ensure consistent ground transportation services for CLFN members to and from health care services in Hearst and surrounding areas, including outside of weekday daytime business hours, during weekends and holidays. ISC and the Ministry of Health should consult CLFN to ensure that their specific needs are considered and addressed. Where necessary, the Ministry and ISC should seek, secure, and maintain any required additional funding to sustain these transportation services.

42. The Ministry of Health and/or Ontario Health should explore expanding the availability of virtual care services at the JMHC including through the Ontario Telemedicine Network ("OTN").

43. The Ministry of Health to work with the MFNM Health Co-operative and Northern Ontario School Medicine ("NOSM") University to provide stable funding to ensure the continuation of the Remote First Nations Stream and support its expansion into other communities such as CLFN.

Early identification, detection and treatment for blastomycosis

44. MFNM Technical Services and Four Rivers Environmental Services Group ("Four Rivers") should explore additional funding opportunities that may allow Four Rivers to continue its work related to blastomyces and blastomycosis in CLFN and other MFNM communities, including but not limited to research, ongoing environmental sampling and testing, public education, and the development of an early warning system that could integrate artificial intelligence to monitor, identify, and alert to trends in real-time.

45. For any research work related to blastomyces and blastomycosis, MFNM Technical Services and Four Rivers will work with CLFN within three months of this verdict to create a plan for:
a) Scheduling a meeting with the Canadian Institute of Health Research ("CIHR");
b) Identifying potential partnerships with Canadian universities;
c) Identifying potential Canadian professors and/or practitioners to supervise this research;
d) Establishing a sampling and research hub in CLFN; and
e) Outlining how the research will be conducted in alignment with OCAP principles.

46. MFNM and Four Rivers to explore with CLFN Chief and Council establishing a hub for blastomyces and blastomycosis research in CLFN. If such a hub is created, it should be community-led and governed.

47. Public health agencies (e.g., public health units, ISC, and First Nations health services providers such as Tribal Councils and community health centres, as applicable) should increase public education on symptoms and risk factors of blastomycosis, particularly in endemic areas. Messaging should be culturally safe, language-accessible, locally relevant, and developed in collaboration with First Nations communities (where appropriate) to incorporate local knowledge and lived experience, particularly regarding identifying potential environmental or activity-related risks.

48. To the extent that they are not already provided, PHO, the Ministry of Health, ISC, and local Boards of Health should, as appropriate to their mandates, provide education and resources to health care providers and public health professionals regarding diagnosis and treatment for blastomycosis, including, where appropriate, when to consider blastomycosis, aligned with current evidence, public health data, and clinical guidance.

49. PHO should explore acquiring access to the blastomyces urine antigen testing (a non-invasive adjunct to existing diagnostic methods for blastomycosis) in Ontario, with implementation to be led by PHO. Necessary funding should be secured and maintained by the Ministry of Health.

50. PHO should explore opportunities to increase access to clinical diagnostic methods for blastomycosis for Northern Ontario communities. Necessary funding should be secured and maintained by the Ministry of Health.

51. PHO to develop an Ontario Investigation Tool for blastomycosis to standardize information collected by public health agencies from cases of blastomycosis and support data entry and completeness in the provincial diseases of public health significance surveillance system (i.e., iPHIS). Consideration should be given to including questions specific to activities and interactions with the land reflecting the lived experience of members of First Nations communities.

52. The Ministry of Health to engage with the Ontario Ministry of Agriculture, Food and Agribusiness, and the Office of the Chief Veterinarian for Ontario and/or the Ontario Veterinary College to explore opportunities to review and analyze data on confirmed and clinical canid cases (e.g., in dogs) of blastomycosis in Ontario. Findings should be shared with PHO, local Boards of Health, ISC, and First Nation Tribal Councils as they may enable early warning for human cases.

53. NDH to incorporate education on blastomycosis in the hospital's orientation booklet for locum physicians working shifts at NDH. NDH and CLFN to collaborate in the preparation of a description of CLFN to be included in the hospital's orientation booklet for locum physicians.

54. The Ministry of Health should update the Exceptional Access Program ("EAP") to allow blastomycosis as an indication for coverage of posaconazole or isavuconazole in certain exceptional cases, where patients cannot tolerate itraconazole or voriconazole.

Transfer to higher levels of care from First Nations communities in Northern Ontario

55. The Town of Hearst should engage with CLFN, Ornge, and NDH to explore opportunities for joint advocacy for the purpose of attempting to secure public funding for the Hearst René Fontaine Municipal Airport (the "Hearst Aerodrome"), which may include funding for the following:
a) Runway improvements, such as a runway extension and/or the construction of an additional runway;
b) Upgraded runway lighting; and
c) Enhanced on-site weather observation capability at the Hearst Aerodrome.

56. The Town of Hearst to continue exploring opportunities to secure an anchor tenant (e.g., a commercial or not-for-profit enterprise) for the Hearst Aerodrome for the purpose of enhancing the likelihood of obtaining ongoing public funding for the Hearst Aerodrome. The Town of Hearst to also engage with NAN for its input on potential anchor tenants.

57.The Town of Hearst should ensure that currently available de-icing and anti-icing services remain available at the Hearst Aerodrome on request to air operators.

58. The Town of Hearst should ensure that the Hearst Aerodrome's current winter maintenance services remain available on request to medical evacuation air operators at all times.

59. The Town of Hearst should continue applying communication protocols with NDH for the purpose of promoting timely patient transfers through the Hearst Aerodrome.

60. The Town of Hearst should continue with initiatives to collect anonymized statistics from NDH regarding patient transfers from the Hearst Aerodrome for the purpose of supporting the Town of Hearst's ongoing efforts to secure public funding for the Hearst Aerodrome.

61. The Town of Hearst should engage with CLFN, NAN, Ornge, and NDH to discuss best practices regarding operations at the Hearst Aerodrome to promote safe and timely medical transfers. Engagement will commence with a meeting between these parties within 90 days of the close of the Inquest, at which meeting the parties will discuss and attempt to agree on the appropriate mode and frequency of future engagement.

62. The Ministry of Health and Ornge should collaborate with referring, transporting, and receiving health care settings on how to best provide consistent and clear messaging about triage processes and triage status of specific patients. This collaboration will include considerations for health care staff in how to communicate triage decisions to patients and their families.

63. The Ministry of Health should expedite the funding of Ornge's rotor-wing fleet expansion to enable Ornge to further enhance capacity and decrease response times in Northern Ontario, enabling better operationalization of Ontario's Life or Limb policy in Northern Ontario.

64.The Ministry of Health and Ornge should develop a mechanism for evaluating Ornge's needs for rotor-wing aircrafts on an annual basis to ensure ongoing fleet enhancements in between update cycles.

Oversight and accountability in health care delivery to members of First Nations communities

65. NDH should collaborate with CLFN and JMHC to create an accessible and trackable process for concerns/complaints, whether written or verbal, to be raised by CLFN members.

66. The Ministry of Health and Ontario Health should explore creating an Indigenous Patient Ombudsperson to receive and address health care complaints from First Nations or Indigenous patients. This office should be Indigenous-led with the goal of resolving complaints from First Nations patients arising from their experiences in Ontario's public hospitals.

Promoting holistic wellbeing for Constance Lake First Nation community members.

67. CLFN to continue providing JMHC staff with mental health and other supports when a state of emergency is in place.

68. MFNM Technical Services to work with CLFN to develop and implement a plan within six months of this verdict for ongoing biannual monitoring of the drainage ditches in CLFN, particularly on the eastern side of the community near Wilmot Lake. As part of this monitoring, drainage ditches will be maintained to ensure they remain properly graded and clear of organic materials that may create growth-promotive conditions for blastomyces. MFNM Technical Services and CLFN will continue to seek assistance from ISC, and ISC will provide support where appropriate.

69. MFNM Technical Services will work with CLFN to develop a plan for conducting comprehensive inspections of houses in CLFN for mold, and how they plan to remediate any mold found within three months of this verdict. ISC to respond to requests for assistance or support made by MFNM Technical Services and CLFN where appropriate.

70. ISC, CLFN, Matawa, Ontario's Ministry of Natural Resources, private industry partners, and any other identifiable stakeholders should:
a) Meet to identify steps that can be taken to address the growth of blue-green algae in Constance Lake;
b) Prepare a plan outlining those steps; and
c) Include in that plan a biannual inspection and review of the plan for blue-green algae remediation, within three months of this verdict.

71. Ontario's Ministry of Natural Resources and/or any responsible provincial ministry, and any private industry partners who contributed to the sawdust pile located at the entrance of the CLFN reserve, should work with CLFN to remove the sawdust pile.

72. MFNM Technical Services to provide CLFN Chief and Council reports of any inspection, investigation, and remediation of environmental health concerns in the CLFN community.

73. ISC should explore securing additional funding for the work outlined in recommendations 68-70 if funding is requested by MFNM Technical Services to implement these recommendations.

74.The Ministry of Health and ISC should explore providing sustained multi-year funding for Indigenous Health Transformation initiatives.

75. The Ministry of Health, ISC, NEPH, PHO, and CLFN should issue a formal endorsement of Indigenous health transformation as a collaborative process between ISC, the provinces and territories, and First Nations governments that supports First Nation communities' right to self-determination through the full control, design, delivery, and management of their own health services.

Implementation and reporting

76. NDH and CLFN will establish the Blastomycosis Inquest Implementation Committee to provide mutual accountability, exchange of knowledge, and to support both NDH and CLFN in implementing recommendations from this inquest.
a) The Blastomycosis Inquest Implementation Committee should include representatives of NDH executive leadership, the CLFN Chief or a Council member, the JMHC IPN(s) and, if they wish to participate, family members of Luke Moore, Lorraine Shaganash, Lizzie Sutherland, Mark Ferris, and Douglas Taylor.
b) The NDH CEO will report on the work of the Blastomycosis Inquest Implementation Committee in their monthly reports to the NDH Board.
c) The Blastomycosis Inquest Implementation Committee will provide public updates every six months, commencing May 15, 2026, on the status of implementation of each recommendation. NDH will publish the update on its website, and CLFN will publish the update on its website and the community's Facebook page.
d) NDH will explore opportunities to provide support to the Blastomycosis Inquest Implementation Committee, including access to internal resources for project management and communications.

77. Within 12 months of this verdict, NEPH, PHO and ISC will each prepare a status report on recommendations specific to public health matters addressed to them and provide a copy of this report to the Office of the Chief Coroner and to all parties with standing before the Inquest, and to NDH and CLFN to the attention of the Blastomycosis Inquest Implementation Committee.

Additional Funding

78. Province of Ontario, Government of Canada to provide funding to allow for the implementation of recommendations made in this inquest.

79. The Government of Ontario should consider establishing a legal fee reimbursement program for a First Nation to apply for certain costs of legal representation for an Inquest, in the interest of First Nation Access to Justice.

Hamilton Board of Health

Memorandum

To:	Chair and Members Hamilton Board of Health
Date:	April 27, 2026
Report No:	BOH26013
Subject/Title:	Peter Boris Centre Knowledge & Translation Projects Update **(Outstanding Business List Item)**
Ward(s) Affected:	(City Wide)

Information

This memo is to inform the Board of Health of the outcomes of two knowledge translation projects that were supported by the Alcohol, Drug & Gambling Program.

- **Brain Development, Gambling, and Gaming**
  In 2023, the Peter Boris Centre for Addiction Research and the Alcohol, Drug & Gambling Services program at Hamilton Public Health were funded by the Gambling Research Exchange Organization (GREO) to develop youth focused knowledge products to increase awareness about the connection between the brain, gaming and gambling. The project ran from November 2023 to November 2024. The project team included Peter Boris Centre for Addiction staff and students, Alcohol, Drug & Gambling Services program social work staff, youth outreach workers and an external animation company.

Four knowledge products intended for youth, service providers, clinicians, and parents were developed during this project. The knowledge products created were co-developed by youth and young adults, who were recruited through the HamOntYouth Steering Committee and the YMCA Youth Gambling Awareness Program. The knowledge products included a video and handout discussing young brains and video games, a clinical handout on gaming effects on young brains and a primer on brain connections and gaming. Knowledge products can be accessed at https://brainconnections.ca/. The funding grant did not include evaluation and to date these products have not been evaluated.

The project disseminated the materials through training to youth outreach workers with the Youth Gambling Awareness Program, through the Brain Connections web page, and two conference presentations.

- **Cannabis**

  In 2023, the Alcohol Drug and Gambling Services program supported the Peter Boris Centre for Addiction Research on a knowledge translation project. The project, titled Bud Talks, focused on sharing emerging research findings on cannabis in an accessible way to the general public. The project team included researchers, clinicians, a learning design specialist, and an external animation company. The project was completed on March 31, 2025.

  This project developed three knowledge products that focused on cannabis and older adults, cannabis use disorder and cannabis use among veterans. Knowledge products from this project can be accessed from https://cannabisresearch.mcmaster.ca/bud-talks/. Dissemination of these products included the above website, conference presentations, an e-learning module on the McMaster Optimal Aging Portal, and use by the Alcohol, Drug and Gambling Services clinical staff.

Overall, participation in these two projects supported the development of knowledge translation products to help youth, young people, older adults and the general public understand the risks associated with substance use and behaviours such as gambling and gaming. Throughout these two projects, the Alcohol, Drug and Gambling Services program were successful in collaborating with multi-disciplinary teams to develop and disseminate the products to clinicians, youth, older adults and the general public. The resource development was strengthened through purposeful co-development of resources with youth and young adults to enhance the utilization of the products. Looking ahead, health promotion around risks associated with gambling, gaming and cannabis continues to be relevant and will be a focus for the program and Hamilton Public Health moving forward.

Background

At its meeting on October 2, 2023 the Public Health Sub-Committee provided the following direction in response to Report BOH23034 – Alcohol Drug and Gambling Services Program and Peter Boris Centre for Addiction Research Knowledge Translation Projects Funding:

> (a) (iii) That staff be directed to report back to the Public Health Committee on what was learned from the project, at its conclusion.

With the submission of this memo, the item respecting Alcohol Drug and Gambling Services Program and Peter Boris Centre for Addiction Research Knowledge Translation Projects Funding, can be removed from the Board of Health Outstanding Business List.

Previous Reports Submitted

- **BOH23024** - Alcohol Drug and Gambling Services Program and Peter Boris Centre for Addiction Research Knowledge Translation Projects Funding

Appendices and Schedules Attached

Not Applicable.

Prepared by:

Susan Boyd, Manager, Alcohol Drugs & Gambling Services Program, Epidemiology & Wellness Division, Hamilton Public Health

Submitted and Recommended by:

Melissa Biksa, Director, Epidemiology & Wellness Division, Hamilton Public Health

Hamilton Board of Health

Memorandum

To:	Chair and Members Hamilton Board of Health
Date:	April 27, 2026
Report No:	BOH26014
Subject/Title:	Heat-Related Illness Public Reporting
Ward(s) Affected:	(City Wide)

Information

This memo is to inform the Board of Health that Hamilton Public Health is launching a publicly available heat-related illness dashboard for the 2026 heat season beginning May 4, 2026. This dashboard will be updated May through September 2026 and will continue annually during heat seasons. The dashboard will be hosted on the existing Public Health Heat Warnings & Heat-Related Illness webpage: https://www.hamilton.ca/people-programs/public-health/environmental-health-hazards/heat-warnings-heat-related-illness.

The dashboard is designed to help the public, community partners and Hamilton Public Health understand how heat is affecting community health in near real time, enabling more effective responses during periods of hot weather. It builds on experience gained through heat‑related illness monitoring that has been conducted within the Health Hazards and Epidemiology and Evaluation Programs over the past two heat seasons,

as described in Report BOH24005 Monitoring Heat-Related Deaths and Illnesses in Hamilton.

The dashboard will be updated weekly on Monday, or Tuesday if a statutory holiday falls on a Monday. However, when an extended heat warning is issued, the dashboard will be updated daily and continue for two additional days after the warning ends.

The dashboard will include three sections:

1. **Weekly Highlights**
   A weekly summary of key observations.
2. **Key Indicators**
   Weekly number of heat warning days, heat‑related paramedic calls, and heat‑related emergency department presentations prior to diagnosis.
3. **Interactive Graph and Data Table**
   This section will allow users to explore trends of heat-related illness indicators and heat-risk indicators in greater detail, including historical data from previous years.

Data tables will be accessible within the dashboard and will also be updated throughout the heat season on the City of Hamilton's Open Data Portal.

Quality improvement activities will be undertaken following the first full heat season of public reporting in 2026.

Previous Reports Submitted

- **BOH24005** - Monitoring Heat-Related Deaths and Illnesses in Hamilton

Consultation

Not Applicable.

Appendices and Schedules Attached

Not Applicable.

Prepared by:

Catherine Holtz, Manager, Epidemiology & Evaluation, Epidemiology & Wellness Division, Hamilton Public Health

Ruth Sanderson, Epidemiologist, Epidemiology & Evaluation, Epidemiology & Wellness Division, Hamilton Public Health

Submitted and Recommended by:

Melissa Biksa, Director, Epidemiology & Wellness Division, Hamilton Public Health

Hamilton Board of Health

Report for Information

To:	Chair and Members Hamilton Board of Health
Date:	April 27, 2026
Report No:	BOH26016
Subject/Title:	Program Update Series - Food Safety
Ward(s) Affected:	(City Wide)

Recommendations

a) That Report BOH26016, respecting Hamilton Public Health Food Safety Program Update, **BE RECEIVED** for information.

Key Facts

- The purpose of this report is to introduce the first of Hamilton Public Health's program update report series, which provides an overview of individual program areas;
- The series responds to Board of Health feedback asking for further information about public health programming and its reach and value, including how resources contribute to measurable outcomes and impacts in the Hamilton community;

- Report BOH26016 is the first program update in this series, and focuses on Food Safety.

Financial Considerations

Not Applicable.

Background

Not Applicable.

Analysis

Program Update Series Overview

Hamilton Public Health is introducing a program update series, with each update providing a focused overview of a single program area. These updates respond to the Board of Health's request for more information on Hamilton Public Health's programs and services, including how resources contribute to outcomes and community impact.

The program updates aim to:

- Outline the scope, reach, and value of Hamilton Public Health's programs;
- Demonstrate how public health resources are used to contribute to measurable outcomes and impacts in the Hamilton community; and,
- Support informed Board of Health oversight and decision making.

Program updates will be brought forward regularly, with timing adjusted as needed during the election and budget periods. They will follow a standardized structure and format that may be refined over time based on the Board of Health's feedback and emerging information needs.

Upcoming program updates will include Healthy Babies Healthy Children, Infection Prevention and Control, Immunization, and Child and Adolescent Services.

Report BOH26016: Food Safety Program Update

This report is the first in the series and is focused on Food Safety. The accompanying presentation outlines the Food Safety program's mandate, population health needs, priority populations, approach, relevant partnerships, resources, impact measures program performance, continuous quality improvement, and innovation initiatives.

Health Equity Data

Relevant health equity data are incorporated into the presentation accompanying Report BOH26016.

Legal Implications/Legislated Requirements

This report supports requirements under the Good Governance and Management Practices Domain of the Ontario Public Health Standards. It enhances Board of Health members' awareness and understanding of public health programs and related issues and trends.

Alternatives

Not Applicable.

Previous Reports Submitted

Not Applicable.

Consultation

- Finance & Administration, Hamilton Public Health

Appendices and Schedules Attached

Not Applicable.

Prepared by:

Konrad Lisnyj, Senior Project Manager, Planning & Competency Development, Healthy Families Division, Hamilton Public Health

Richard MacDonald, Manager, Food Safety Program, Healthy Environments Division, Hamilton Public Health

Submitted and Recommended by:

Kevin McDonald, Director, Healthy Environments Division, Hamilton Public Health

Program Update Series: Food Safety

Board of Health Meeting (April 27, 2026)

Report BOH26016

Hamilton Public Health

Healthy Environments Division

Food & Water Safety

Hamilton

Program Mandate

Ontario Boards of Health

- Comply with the Ontario Public Health Standards and Operational Standards
- Deliver a comprehensive food safety program to reduce the burden of foodborne illness by:
  - Preventing foodborne illness through inspections, education, and enforcement;
  - Reducing exposure to health hazards in food premises;
  - Ensuring safe food handling practices through education and certification; and,
  - Ensuring compliance with Food Premises Regulation 493/17.

Population Health

Enteric Disease Rate

Enteric disease rates in Hamilton have remained stable from 2015 to 2024, averaging about 266 cases per year.

Salmonella Rate

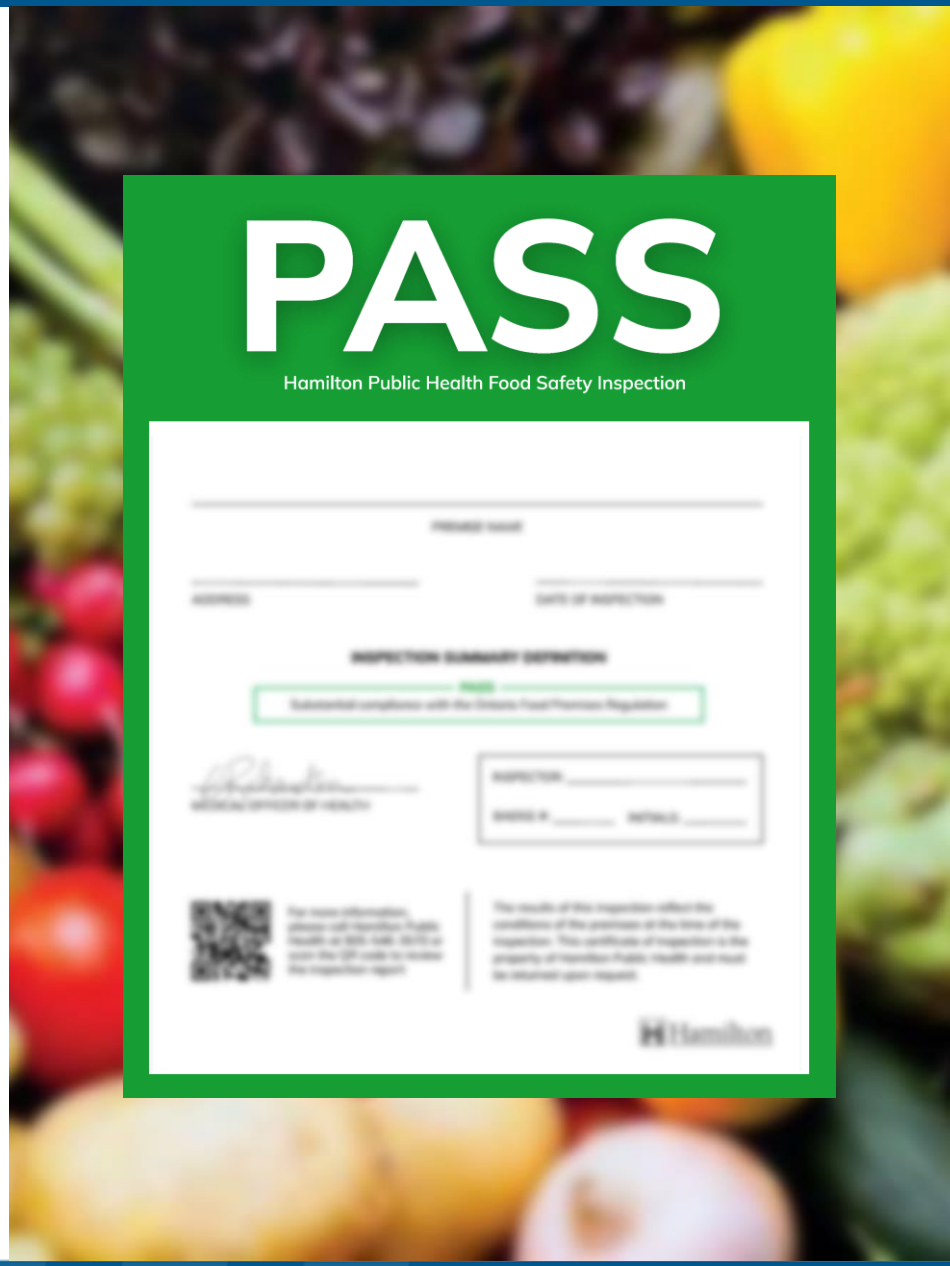
- Local salmonellosis rate declined by 37.2% from 2015 to 2024.
- In 2024, the local rate was 23.3% lower than the provincial rate.

Unreported Cases

- Only 9% of people with acute gastrointestinal illness in Canada sought medical care.
- An estimated 97,656 infectious gastrointestinal cases in Hamilton were unreported in 2024.

Program Approach

- Risk Based Inspection Frequency (High, Moderate or Low)
  - e.g., High risk inspected more often
- Routine and complaint inspections of food premises
- Progressive enforcement
  - Education, written orders, closures, fines or summons
- Suspect foodborne illness investigations
- Food Handler Training and Certification
- Health Inspection Disclosure On-site and Online



2025 Activity Highlights (Slide 1 of 2)

1

Total Food Premises

- 691 High-Risk
- 1,690 Moderate-Risk
- 1,123 Low-Risk

2

Food Premises Inspection Activity Levels

- 6,119 Routine Inspections
- 834 Re-Inspections

3

Food Handler Training and Certification

- 254 Registrants
- 209 Certificates Issued

2025 Activity Highlights (Slide 2 of 2)

4

Complaints and Service Requests

- 1,819 Responded and Resolved

5

Suspect Foodborne Illness

- 168 Investigations

6

Supporting Special Events

- 317 Events Risk-Assessed
- 80 Events attended by Public Health Inspectors
- 920 Inspections and Re-Inspections

Priority Populations

Individuals at greater risk of severe outcomes from foodborne illness include:

- Young children; and,
- Older adults.

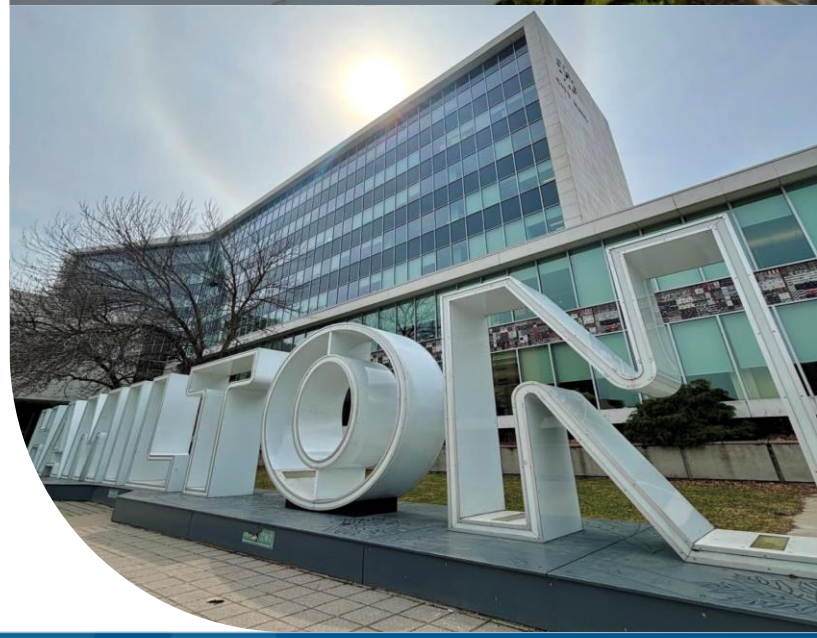
Public Health prioritizes food premises serving these populations, such as:

- Retirement & Long-term care homes
- Licensed Childcare Centers
- Childcare Nutrition Programs
- Hospitals and other institutional settings

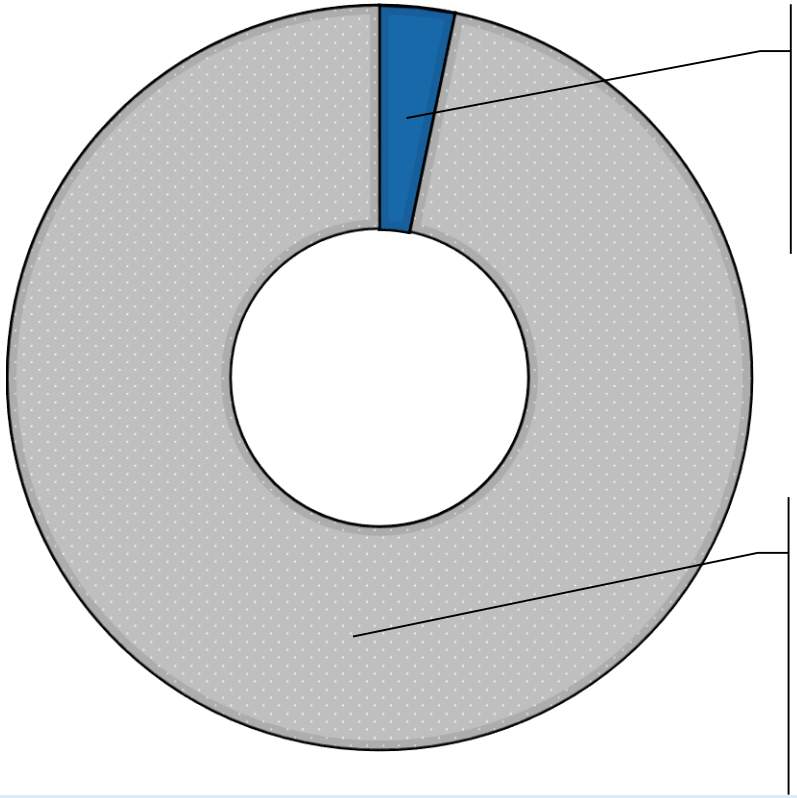
Total Facilities (2025):	Total Facilities Inspected (2025):
427	100%

Relevant Partnerships

- Canadian Food Inspection Agency
- Ontario Ministry of Health
- Public Health Ontario
- Ontario Ministry of Agriculture, Food and Agribusiness
- Central West Public Health Units
- City of Hamilton Licensing & By-Law Services
- City of Hamilton/Hamilton Water
- City of Hamilton Special Event Advisory Team (S.E.A.T)
- Local Boards of Education
- Various Community Groups



2026 Program Resources



Program
($2.2 M, 3%)

Hamilton
Public Health
($65.3 M,
97%)

Total Expenditure:
$2.2 Million (Gross)

Staffing:
15.5 FTE

2025 Impact Measures (Slide 1 of 3)

Routine Inspections

- 100% High, Moderate, Low Risk Inspections
- 6,119 Completed

Food Handler Certification

- 82% of Participants Certified
- 209 Certificates Issued

Suspect Foodborne Illness

- 100% Investigated Within 24-48 Hours
- 168 Completed

2025 Impact Measures (Slide 2 of 3)

Critical Infractions

23%

Total: 1,427
Routine Inspections

Non-Critical Infractions

40%

Total: 2,538
Routine Inspections

No Infractions

37%

Total: 2,286
Routine Inspections

2025 Impact Measures (Slide 3 of 3)

***Health Protection and Promotion Act* Closures**

Total: 25

Tickets Issued

Total: 33

Yellow Conditional

Total: 287

Continuous Quality Improvement and Innovation

Completed Improvements:

- Reduced overtime costs by scheduling staff for special events on weekends, resulting in significant savings.
- Implemented a software efficiency that supports improved food safety scoring.

Ongoing Innovations:

- Participating in the Continuous Improvement Collaborative on Food Premise Inspections with Public Health Ontario alongside other local public health agencies

“Strong food safety practices, supported by routine inspections, reduce the risk of foodborne illness, and build public confidence.”

- Public Health Agency of Canada

Thank You!

Hamilton Board of Health

Report for Consideration

To:	Chair and Members Hamilton Board of Health
Date:	April 27, 2026
Report No:	BOH26011
Subject/Title:	Food Advisory Committee Transition
Ward(s) Affected:	(City Wide)

Recommendations

a) That the Food Advisory Committee **BE DISBANDED**.

Key Facts

- Report BOH26011 provides an overview of the steps taken by Hamilton Public Health in response to City Council direction from its meeting on March 5, 2025 concerning the creation of Community Liaison Groups to replace previously supported Advisory Committees of Council;
- The inception of a Semi-Autonomous Board of Health for the city of Hamilton has resulted in a governance framework whereby Hamilton Public Health no longer supports Advisory Committees nor Community Liaison Groups for the purpose of advising City Council;

- Hamilton Public Health staff engaged in community consultation and a review of current community engagement models utilized by the City of Hamilton and Hamilton Public Health to inform this report;
- Hamilton Public Health staff previously served as liaison to the Food Advisory Committee of the Board of Health;
- The last official meeting of the Food Advisory Committee was September 20, 2022. The committee has not been operating since that time. The Committee has no active members;
- Hamilton Public Health utilizes several community engagement models to inform its programs and services through consideration and incorporation of networks, working groups, coalitions, and panels, as examples;
- Efforts to renew the City of Hamilton Food Strategy are presently underway, including targeted community engagement and the establishment of a food systems community table that will bring together “key” community stakeholders and partners to strengthen this collective effort; and,
- Given the current context and past history of the Advisory Committee model, the creation and installation of a Community Liaison Group is not warranted at this time.

Financial Considerations

Not Applicable.

Background

At its meeting on March 5, 2025, City Council approved General Issues Committee Minutes GIC 25-003, which provided the following direction to staff:

8.3 CM23025(b) Volunteer Advisory Committee Review (City Wide)

(a) That, based on municipal best practices, a new civic engagement model be applied that uses resident-led, staff facilitated community liaison groups of

volunteers with a clear ability to make their voice heard by Council, with each Division reporting back with tailored solutions, within one year, and that:

(xii) Public Health staff report back to the Public Health Committee on the creation of a community liaison group to replace the Food Advisory Committee to identify and inform, where appropriate, innovative community food security policies and programs that align with the vision and goals of the Hamilton Food Strategy, Hamilton Food Charter, and other City of Hamilton strategies; and that the 2024 approved budget currently assigned to the Food Advisory Committee be transferred to this Division to support this working group.

Analysis

Historical Background

On August 11, 2016, Hamilton City Council endorsed the Hamilton Food Strategy: Healthy, Sustainable, and Just Food for All (https://hamilton.ca/foodstrategy). The Hamilton Food Strategy is a 10-year strategy with a vision of “a city with a sustainable food system where all people at all times have economic and physical access to enough safe, nutritious food to meet their dietary needs and food preferences.” The Strategy is comprised of four goals, 14 recommendations and 46 actions across all food system elements (production, processing, distribution, access, consumption, and waste).

As part of the Hamilton Food Strategy 2016-2026, a Food Advisory Committee was established in 2016 with the mandate to “support and advise on the implementation of Hamilton’s Food Strategy, and the development of inclusive and comprehensive food-related policies and programs at the individual, household, and community/population level.” The Food Advisory Committee, a volunteer Advisory Committee to the Board of Health and City Council, was comprised of 13 to 18 voting volunteer members from across all components of the food system, as well as non-voting City Councillors (a maximum of two). The Advisory Committee was further supported by a Staff Liaison

from Hamilton Public Health who functioned as a system expert and supported member orientation, preparation of reports and correspondence, preparation and review of agendas and minutes, as well as provision of background information, advice, and context for implementation of priorities.

In September 2023, Report CM23025 was brought to the Audit, Finance and Administration Committee and a motion passed, to conduct a review of the existing 14 volunteer Advisory Committees. The motion included a pause on select existing volunteer Advisory Committees, the Food Advisory Committee being among that group.

In February 2025, Report CM23025(b) was brought to the General Issues Committee of City Council by staff in the Government Relations and Community Engagement Division that detailed the review process, findings, and recommended:

“That, based on municipal best practices, a new civic engagement model be applied that uses resident-led, staff facilitated community liaison groups of volunteers with a clear ability to make their voice heard by Council, with each Division reporting back with tailored solutions, within one year.”

Report CM23035(b) by the Government Relations and Community Engagement Division highlighted that the proposed alternative model employing Community Liaison Groups helped “to eliminate procedural challenges that may deter volunteer involvement, and [provided] a better opportunity for civic engagement”. The review also noted that other municipalities are adopting a range of civic engagement methods including task forces, working groups, and experts’ panels.

Community Engagement in Public Health

Community engagement is one of the foundational principles that guides the work of public health. This is outlined explicitly in the Ontario Public Health Standards, which list public engagement as a requirement within the Effective Public Health Practice Foundational Standard. Given the importance of community engagement, Hamilton Public Health recently released two resources to support community engagement work – Foundations of Community Engagement which outlines the framework and principles guiding this work and the Equity-Driven Engagement Toolkit which provides tools and

strategies to conduct community engagement and complements resources available through the City of Hamilton.

As stated in Foundations of Community Engagement, “in practice, community engagement can take many forms, depending on the goals, context, and populations involved. Broad-based engagement reaches out to the general public to raise awareness, gather input, or share information. Tailored engagement focuses on outreach to individuals and groups most directly affected by the decisions being made. This can include individuals experiencing or at risk of health inequities, current clients of Hamilton Public Health, and those facing barriers to accessing programs and services. Partnered or indirect engagement works through trusted community organizations and/or service providers who already have strong relationships with specific populations. This approach helps build trust, reduce barriers, and reach those who might otherwise be left out.”

Examples of Existing Community Engagement in Public Health

Within Hamilton Public Health, there are numerous examples of groups that Public Health convenes that include community representatives with the purpose of community engagement. These groups are each unique in terms of their purpose, membership, meeting frequency, and outcomes, but ultimately, each helps to inform and shape the work of Public Health, ensuring that programs, services and initiatives meet the needs of the community members impacted. In some cases, these groups work collaboratively to achieve shared goals and outcomes. Below are some examples:

- **Extreme Heat Working Group**

  This group, led by Hamilton Public Health, includes members of the Community Heat Response Committee, additional community groups, individuals representing equity deserving groups, environmental groups, and other entities with interest in this work. This working group meets twice annually to share updates, coordinate actions, and advise on the implementation of the Community Heat Response Strategy and extreme heat actions within the City’s Climate Change Impact Adaptation Plan.

- **Hamilton Breastfeeding Coalition**

  This well-established group includes a variety of members and healthcare organizations who work collaboratively to plan, implement, and evaluate infant feeding initiatives for families in Hamilton. While many members are community or healthcare organizations, individuals with lived experience may also join the group.

Community Engagement and Hamilton's Food Strategy

As outlined above, community engagement is central to the work of Hamilton Public Health. As such, Hamilton Public Health has several community engagement and collaborative models that it undertakes to inform its work and related strategies. Given this, the renewal efforts associated with the Hamilton Food Strategy does not warrant a unique approach, such as the creation of a Community Liaison Group.

As Hamilton Public Health engages in a revision and renewal of the Hamilton Food Strategy, it will develop a fulsome community engagement plan that includes members of the public as well as community organizations invested in the food system. This plan will be developed with support from staff from the City's Public Engagement team while aligning with Public Health's Foundations of Community Engagement and Equity-Driven Engagement Toolkit.

Given strong community support, Public Health intends to establish a food systems community table that will bring together community organizations from across the food system in Hamilton, on an on-going basis, to strengthen collaborative partnerships, share updates, and identify opportunities to enhance Hamilton's food system. This group would also serve to inform the renewal and implementation of the Hamilton Food Strategy.

Consultations and Results

The information within this report was supported by external community consultation in the form of a survey, focus group, and written feedback. Hamilton Public Health staff solicited input from 26 participants representing community organizations who were participating in a workshop related to the renewal of the Hamilton Food Strategy via a

survey. In addition, a focus group with participants from four community organizations and one written response, informed this report.

Feedback from the community confirmed the need for a community table related to Hamilton's food system. Currently, there exists a very limited number of community groups that bring together players from across the food system. One of these is the Greater Hamilton Food Collective that is focused on food insecurity, food equity, and advocacy. In the past, the Hamilton Food Literacy Network also existed for those organizations delivering food literacy programs in the community. However, this group has not convened consistently for the past two years due to lack of participants. There are also groups that are focused specifically on agriculture such as the Hamilton-Wentworth Federation of Agriculture and the Golden Horseshoe Food and Farming Alliance, the latter which serves a broader geography than just Hamilton.

Community members highlighted the need to bring together a diverse group of representatives from across the food system to focus on broader issues, share ideas, expand networks, and identify opportunities for collaboration. There was strong support for advising Hamilton Public Health on policies and programs that impact the food system as well as identifying gaps and emerging issues within the food system. Specific to the Hamilton Food Strategy, there was support for advising on the development and implementation of the Food Strategy.

Internally, the Food Strategy Interdepartmental Steering Team, Community Initiatives staff, and Legislative Coordinators were consulted.

Alternatives

An alternative recommendation is that Hamilton Public Health **BE DIRECTED** to convene a Food System Community Liaison Group.

This approach is not recommended as it does not align with Hamilton Public Health's existing community engagement and collaborative models that inform its work and allow for creation of a diversity of groups for engagement purposes based on individual

project need. Furthermore, with the inception of a semi-autonomous Board of Health for the City of Hamilton, this has resulted in a governance framework whereby Hamilton Public Health no longer supports Advisory Committees nor Community Liaison Groups for the distinct purpose of advising City Council.

Previous Reports Submitted

- **CM23025** – Voluntary Advisory Committee Review
- **CM23025(b)** – Voluntary Advisory Committee Review

Consultation

- Community Engagement, City Manager's Office
- Community Inclusion and Equity, City Manager's Office
- Legislative Services, Corporate Services
- Food Strategy Interdepartmental Steering Team members, City of Hamilton
- Affiliated Services for Children and Youth
- Growcer
- Greater Hamilton Food Share
- Hamilton Urban Core Community Health Centre

Appendices and Schedules Attached

Not Applicable.

Prepared by:

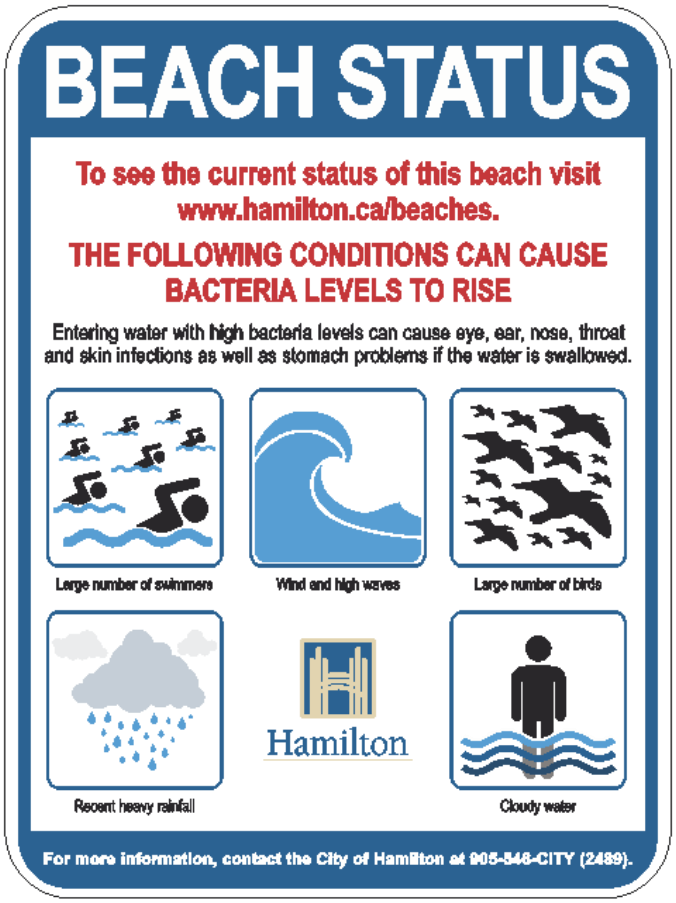
Heather Harvey, Manager, Chronic Disease Prevention, Healthy Environments Division, Hamilton Public Health

Submitted and Recommended by:

Kevin McDonald, Director, Healthy Environments Division, Hamilton Public Health

Permanent Beach Status Signs

Caption: A sign with the title “Beach Status”. It also contains the text “To see the current status of this beach visit www.hamilton.ca/beaches. The following conditions can cause bacteria levels to rise: entering the water with high bacteria levels can cause eye, ear, nose, throat and skin infections as well as stomach problems if the water is swallowed. Below the text are six symbols: multiple people swimming with the caption “large number of swimmers”, a wave with the caption “wind and high waves”, multiple bird silhouettes with the caption “large number of birds”, a rainy cloud with the caption “recent heavy rainfall”, a person standing in waves of different shades of blue with the caption “cloudy water”. The footer has the text “For more information, contact the City of Hamilton at 905-546-CITY (2489)”.



Hamilton Board of Health

Report for Consideration

To:	Chair and Members Hamilton Board of Health
Date:	April 27, 2026
Report No:	BOH26012
Subject/Title:	Hamilton Public Health Public Beach Water Quality Monitoring at Binbrook Conservation Area
Ward(s) Affected:	(City Wide)

Recommendations

a) That Hamilton Public Health **BE AUTHORIZED** to delegate public communication related to beach water quality and safety for Escherichia coli (E. coli) at the Binbrook Conservation Area beach to the Niagara Peninsula Conservation Authority commencing the Spring/Summer 2026; and,

b) That Hamilton Public Health **BE DIRECTED** to remove the onsite “Flip Signs” at all public beaches that indicate “safe” or “unsafe” for swimming, as depicted in Appendix “A”, and maintain the current permanent beach sign, as depicted in Appendix “B”.

Key Facts

- Reporting back to the Board of Health on the outcome of discussions between Hamilton Public Health and the Niagara Peninsula Conservation Authority regarding beach water quality testing and public swimming advisories at Binbrook Conservation Area Beach to ensure the continued protection of public health and effective inter-agency collaboration;
- Following a review of Ontario's legislative framework, legal opinions received, and applicable Program Standards, Hamilton Public Health staff will continue to deliver beach water quality testing and monitoring for long term water quality surveillance at all public beaches;
- Both Hamilton Public Health and the Niagara Peninsula Conservation Authority recognize the importance of consistent and clear public messaging regarding beach water quality and safety. Communication of beach water quality results will be transitioned to Niagara Peninsula Conservation Authority and will be maintained through public advisories, postings, and other communication methods to ensure the public receives timely and reliable information.

Financial Considerations

Not Applicable.

Background

At its meeting on July 28, 2025 the Board of Health provided the following direction via Motion:

9.1 Beach Water Quality Testing and Advisory Protocols at Binbrook Conversation Area - REVISED

(a) That Public Health Services be directed to engage in formal discussions with the Niagara Peninsula Conservation Authority to explore the feasibility, legal authority, and operational requirements for transitioning beach water quality

testing and public swimming advisories at Binbrook Conservation Area Beach from Hamilton Public Health Services to Niagara Peninsula Conservation Authority staff;

(b) That staff report back to the Board of Health with findings and recommendations no later than Q3 2025;

(c) That the report consider relevant legal opinions, service delivery models, operational impacts, communication strategies, public safety considerations, and opportunities for inter-agency collaboration; and,

(d) That the City Clerk forward a copy of this resolution to the Niagara Peninsula Conservation Authority Board of Directors for information.

Analysis

Historical Background

A question from the public in June 2020 concerning water quality at the Binbrook Conservation Area public beach identified conflicting messaging from Niagara Peninsula Conservation Authority and Hamilton Public Health. Hamilton Public Health issued an advisory that the beach was unsafe for swimming due to elevated Escherichia coli (E. coli) levels, while Niagara Peninsula Conservation Authority suggested the water was safe for swimming. To avoid public confusion, both organizations agreed to align messaging based on Hamilton Public Health's results and direction.

In June 2020, Niagara Peninsula Conservation Authority obtained a legal opinion, asserting that the responsibility for water testing at Niagara Peninsula Conservation Authority beaches rests with Niagara Peninsula Conservation Authority as the operator. In September 2020, Hamilton Public Health reviewed the legal opinion provided with City of Hamilton Legal Services and determined that it conflicts with the requirements of the *Health Protection and Promotion Act* and related Ontario Public Health Standards.

On April 2021, Hamilton Public Health and Niagara Peninsula Conservation Authority managers held a virtual meeting to discuss roles and responsibilities, Hamilton Public Health's beach water monitoring schedule, procedures for public communication during

adverse water quality events, the on-site notification process, and Hamilton Public Health developed fact sheets to support public messaging for Niagara Peninsula Conservation Authority patrons and visitors to the Binbrook Conservation Area.

On March 21, 2022, the Board of Health received Report BOH22004 from Hamilton Public Health recommending the discontinuation of on-site “Flip Signs” at all seven Hamilton-area public beaches. These signs are manually “flipped” by beach operators to indicate changes from “Safe for Swimming” to “Unsafe for Swimming”, as directed by Hamilton Public Health staff. The Board of Health did not support this proposed operational change, voting not in-favour of the recommendation in Report BOH22004 Public Beach Signage at the March 21, 2022 meeting.

Meetings were held between Hamilton Public Health and Niagara Peninsula Conservation Authority representatives on October 7, 2025, and January 7, 2026, to discuss Niagara Peninsula Conservation Authority’s request to assume operational responsibility for monitoring and testing beach water quality at the Binbrook Conservation Area effective spring/summer 2026.

The recommendations affirm Hamilton Public Health’s legislated authority and responsibility to monitor and test water quality under the *Health Protection and Promotion Act* and Ontario Public Health Standards.

Under the *Health Protection and Promotion Act*:

- **Section 2:**
  Establishes the purpose of public health programs to prevent disease and protect the health of the public.
- **Section 7(1):**
  Mandates that every Board of Health must comply with standards published by the Minister of Health.
- **Sections 41 and 42:**
  Grant Public Health Inspectors rights of entry and inspection to fulfil duties under the *Health Protection and Promotion Act* on behalf of the local Medical Officer of Health.

- **Schedule 12 of Regulation 553:**
  Areas Comprising Health Units designates the City of Hamilton as the jurisdiction for Hamilton Public Health, including Binbrook, Ontario.

The Ontario Public Health Standards include the Recreational Water Protocol, 2019 and Operational Approaches for Recreational Water Guideline, 2018, requires local Boards of Health to conduct surveillance, inspection, and public communication regarding the safety of public beaches.

The Recreational Water Protocol, 2019, defines “public beaches” broadly as any public bathing area accessible to the public, explicitly excluding only private residential beaches. Conservation Authority beaches are not exempt from this definition.

Hamilton Public Health operates a comprehensive Beach Water Quality Monitoring Program that includes:

- Routine sampling of all seven public beaches within the City of Hamilton, May to August annually;
- Public Health Inspector trainees conduct public beach water quality monitoring, testing, and reporting – supported by Certified Public Health Inspectors – in partnership with the Ontario Public Health Laboratory;
- The Ontario Ministry of Health fully funds the Public Health Inspector trainees working at Hamilton Public Health to a maximum of $30,000 annually;
- Public Health Ontario Laboratory conducts free analysis of Escherichia coli (E. coli) levels for public health units;
- Assessment of results based on geometric mean thresholds; and,
- Public posting and advisories indicating “safe” or “unsafe for swimming” or “closed”.

On-site “Flip Signs” are “flipped” by beach operators from “Safe for Swimming” to “Unsafe for Swimming” as directed by Hamilton Public Health staff. The Flip signage remains in place until water resample results are below established thresholds then are “flipped” back to “Safe for Swimming”. These signs direct the public to the City of

Hamilton website www.hamilton.ca/beaches or the Safe Water Hotline at (905) 546-2189 regarding current water quality status (see Appendix “A” to Report BOH26012).

The use of Flip Signs and Escherichia coli (E. coli) bacteriological sampling does not provide real time risk information to beach patrons. Water samples are collected and delivered to the Public Health Laboratory in Hamilton the same day for analysis. Public Health Laboratory typically provide results within 24 hours after receiving the sample. The culturing of water samples requires 24 hours to allow bacteria present in the sample to grow and multiply where they can be identified and measured by Public Health Laboratory. Given that water conditions can change rapidly, this time delay means that laboratory results may not reflect the actual quality of the water at the time that Hamilton Public Health communicates results to beach operators and post advisories.

Relying on a prolonged reporting timeline for laboratory analysis can misrepresent current risk level, and result in information communicated to the public potentially not being reflective of the current risk. For example, a water sample collected on a Monday may lead to a beach being posted as ‘unsafe’ on Tuesday afternoon based on adverse laboratory results, despite the possibility that water conditions may have improved since the time the sample was taken and current risk to patron’s is lower. This may result in patrons unnecessarily avoiding beach activities and may contribute to an unfavourable public perception of Hamilton’s public beaches. Conversely, a beach may remain unposted due to satisfactory results of a Monday water sample, even though water quality may have worsened since sampling occurred. In such cases, patrons may receive inaccurate information and a false sense of safety.

Permanent beach signage provided by Hamilton Public Health at Binbrook Conservation Area public will continue to inform patrons of risk factors which may contribute to elevated Escherichia coli (E. coli) bacteria levels (see Appendix “B” to Report BOH26012). This signage provides guidance on actions that patrons can take to reduce their risk, such as waiting 48 hours after a heavy rainfall before swimming. This will provide beach patrons with the information they need to assess environmental conditions that increase their risk of exposure. Hamilton Public Health will maintain its

website to direct the public to the Niagara Peninsula Conservation Authority website for current beach water quality information and continue to engage the community through social media and other communication methods.

In agreement with the Niagara Peninsula Conservation Authority, Hamilton Public Health is requesting authority to delegate Escherichia coli (E. coli) water quality communications for Binbrook Conservation Area public beach to the Niagara Peninsula Conservation Authority. Notwithstanding potential adverse events that pose a significant public health risk requiring Hamilton Public Health intervention such as a blue-green algae bloom, Hamilton Public Health will continue to manage beach closures by directing the Niagara Peninsula Conservation Authority to limit access and post signage in appropriate locations to reduce the risk of public exposure.

Beach water quality and safety remain a priority for Hamilton Public Health and the Niagara Peninsula Conservation Authority. This model serves to strengthen inter-agency collaboration and reduces the potential for conflicting messaging across the Niagara Peninsula Conservation Authority's watershed jurisdiction while providing reliable information to the public.

On October 31, 2025, the Ontario government announced plans to introduce legislation creating the Ontario Conservation Agency, a centralized body intended to streamline the provinces 36 conservation authorities into seven. It's unclear whether Niagara Peninsula Conservation Authority's jurisdictional boundaries will change or merge into a larger regional boundary. Niagara Peninsula Conservation Authority's roles and responsibilities for water-shed monitoring could potentially be re-evaluated or restructured during consolidation affecting local operations and partnerships.

Results of Consultations:

- **City of Hamilton Legal Services**
  Confirmed that the *Health Protection and Promotion Act* and Ontario Public Health Standards clearly assign beach water quality monitoring to Boards of Health.

- **Niagara Peninsula Conservation Authority:**
  Met with Hamilton Public Health October 7, 2025, and January 7, 2026, and both recognize the importance of consistent and clear public messaging regarding beach water quality safety and reporting.
- **Niagara Region Public Health:**
  Consultation held regarding current approach to beach water quality monitoring and reporting across Niagara Region.
- **Central West Ontario Environmental Health Directors and Medical Officers of Health:**
  Regarding current beach water quality monitoring within their respective jurisdictions.

Alternatives

Not Applicable.

Previous Reports Submitted

- **BOH22004** – Public Beach Signage

Consultation

- Legal Services, Corporate Services
- Niagara Peninsula Conservation Authority
- Niagara Region Public Health

Appendices and Schedules Attached

Appendix “A” to Report BOH26012: Flip Signs

Appendix “B” to Report BOH26012: Permanent Beach Status Sign

Prepared by:

Richard MacDonald, Manager, Healthy Environments Division, Hamilton Public Health

Submitted and Recommended by:

Kevin McDonald, Director, Healthy Environments Division, Hamilton Public Health

Flip Signs

Safe for Swimming Sign

Caption: A sign with the text “Safe Water Info Line 905-546-2189 www.hamilton.ca/beaches”, the logo for Hamilton Public Health Services, and a quick-response (QR) code.

Unsafe for Swimming Sign

Caption: Two signs. The first sign has the image of a swimmer in water, crossed out in the centre of a red circle, with the text “Warning”. The second sign has the text “Unsafe for swimming. Water Polluted due to high bacteria levels which may pose a risk to your health. Safe Water Info Line: 905-546-2189 www.hamilton.ca/beaches”, and a quick-response (QR) code

Hamilton Board of Health

Report for Consideration

To:	Chair and Members Hamilton Board of Health
Date:	April 27, 2026
Report No:	BOH26015
Subject/Title:	Evaluation of Hamilton Opioid Action Plan Initiatives **(Outstanding Business List Item)**
Ward(s) Affected:	(City Wide)

Recommendations

a) That the Secretary of the Board of Health **BE DIRECTED** to distribute a copy of this report to Council for their information.

Key Facts

- The purpose of this report is to share evaluation results from three Council-funded Hamilton Opioid Action Plan initiatives with the Board of Health;
- Evaluation results demonstrated that the Embedded Harm Reduction Pilot enhanced and expanded harm reduction services, principles, and practices within and across three men's emergency shelters;
- The YWCA Hamilton's Safer Use Space reduced the risks of accidental overdoses and provided basic health services and connections to social services,

healthcare, and treatment for women and gender-diverse individuals who use substances;

- Partial implementation of a local drug checking and surveillance system pilot has increased awareness of the local drug supply among people who use drugs and service providers; and,
- Full implementation of the drug checking and surveillance system pilot, including point-of-care drug testing, has been delayed due to changing legislation, limitations of available technology, available funding constraints, and finding an appropriate location for this service.

Financial Considerations

Not Applicable.

Background

At its meeting on June 12, 2023 the Public Health Committee provided the following direction, further amended by Council at its meeting on April 10, 2024:

Hamilton Opioid Action Plan (BOH23021) (City Wide) (Item 8.2)

(a) That the Hamilton Opioid Action Plan, attached as Appendix “A” to Report BOH23021, be approved;

(b) That the Public Health Services budgeted complement be increased by 1.0 FTE Health Strategy Specialist, with funding for the 2023 costs of $39,048 to come first from any Public Health Services levy funded surplus, then from the Public Health Services Reserve (112219), and that the 2024 operating cost of $116,760 be included in the 2024 Tax Operating Budget;

(c) That a one-year drug checking and surveillance system pilot be implemented in a manner satisfactory to the City Solicitor and that staff report back to the Public Health Committee in Q3 2024, at a cost of $118,000 to be funded in 2023, first from any Public Health Services levy funded surplus, then from

Public Health Services Reserve (112219), and that the 2024 operating costs of $60,000 be included in the 2024 Tax Operating Budget;

(d) That $667,000 be used to balance the current needs of our community by supporting an existing safe consumption site, bringing new harm reduction support to men's emergency shelters, and providing peer support to unhoused people who use substances, including those living in encampments, by initiating the following initiatives over the 2024-2025 budget years:

(i) By authorizing and directing the General Manager of Healthy and Safe Communities to implement an agreement in a form satisfactory to Legal Services for 12 months of bridge funding with the Young Women's Christian Association (YWCA) Hamilton for the Safer Use Space at a maximum cost of $300,000;

(ii) By authorizing the General Manager of Healthy and Safe Communities Services to implement a 12-month pilot for Embedded Harm Reduction in Men's Emergency Shelters at a cost of $300,000; and,

(iii) By authorizing the General Manager of Healthy and Safe Communities to fund Peer Support to support unhoused people who use substances, including those living in encampments, through a Call for Applicants at a cost of $67,000.

(e) That the cost of $667,000, as outlined in subsection (d), be funded through the Early Years System Reserve (112218), as approved by the 2024 Tax Operating Budget;

(f) That the General Manager, Healthy and Safe Communities Department or delegate be authorized and directed, on behalf of the City of Hamilton, to enter into, execute and administer all agreements and documents necessary to implement the initiatives outlined in subsection (d); and,

(g) That Public Health Services report back with an evaluation of the initiatives, including the perspectives of people with lived experience, no later than Q4 of 2025.

This report summarizes evaluations of these initiatives, and the evaluation report is available in Appendix “A” to Report BOH26015.

Analysis

Hamilton Opioid Action Plan Context

In November 2019, Council declared an opioid crisis in Hamilton after increases in opioid-related emergency department visits, deaths, and paramedic calls. During the COVID-19 pandemic, Hamilton continued to experience increases in opioid-related harms, observing a 221% increase in opioid-related deaths between 2016 and 2021. As part of the COVID-19 recovery, substance use remained a priority of Hamilton Public Health as well as the Hamilton Drug Strategy in 2023.

In February 2023, staff were directed by Council to convene local stakeholders, including people with lived and living experience, health, and drug policy experts, to develop an evidence-based harm reduction action plan to address high rates of opioid-related deaths. This plan was to consider how to implement safer use spaces and other evidence-based harm reduction strategies in Hamilton and in the houseless serving sector. In April 2023, Council also directed the Mayor to declare an emergency in the areas of opioids, mental health, and homelessness in Hamilton.

Staff brought this request to the Hamilton Drug Strategy for collaborative action and to develop a local opioid action plan. The Hamilton Opioid Action Plan was approved by the Hamilton Drug Strategy in May 2023 and presented to the Public Health Committee and Council in June 2023. The Hamilton Opioid Action Plan outlined 13 areas of immediate, medium-term, and long-term action. Municipal funds were approved for staffing support as well as implementing some of the actions, including a Drug Checking and Surveillance System Pilot at a cost of $178,000 and a Supervised Consumption Site Pilot in a men’s shelter at a cost of $667,000. To oversee the implementation of the Hamilton Opioid Action Plan, a working group under the Hamilton Drug Strategy – the Hamilton Opioid Action Table – was struck.

A Call for Applicants specific to the Supervised Consumption Site Pilot within men's emergency shelters was issued by the Housing Services division in August 2023, and no applications were received. Service providers shared that the call did not offer enough time or capital resources to undertake this pilot. The Good Shepherd Centres Hamilton (hereafter referred to as Good Shepherd), Mission Services of Hamilton Inc. (hereafter referred to as Mission Services), and the Governing Council of The Salvation Army in Canada (hereafter referred to as Salvation Army) subsequently proposed a 12-month harm reduction pilot project. The project would embed harm reduction supports in men's emergency shelters to support clients and build capacity within shelter staff at a cost of $607,270.

The proposal was shared with the Public Health Committee in January 2024. At that meeting, Public Health Committee and Council directed staff to take the proposal back to the Hamilton Opioid Action Table and the Hamilton Drug Strategy Steering Committee for further consultation and report back at the April 2024 Public Health Committee meeting. The Hamilton Opioid Action Table recommended funding an Embedded Harm Reduction Pilot, supporting the existing YWCA Hamilton Safer Use Space and a Peer Support program for unhoused people who use substances, including those living in encampments. These initiatives were approved by Council at the April 10, 2024 meeting.

Embedded Harm Reduction Pilot Program Summary

The Embedded Harm Reduction Pilot was informed by an existing outcome-based harm reduction program offered by Mission Services, which supported clients with employment, housing, familial reconciliation, treatment, and physical and mental health goals. The funding for the Embedded Harm Reduction Pilot Program was divided between Good Shepherd, Mission Services, and Salvation Army ($100,000 for each organization) for one year (October 1, 2024, to September 30, 2025). Funding was intended to expand and enhance harm reduction services, principles, and practices by integrating Embedded Harm Reduction Workers into the men's emergency shelter system.

Organizations reported that the program trained shelter staff, built partnerships that connected clients through referrals with health and social service providers, and fostered collaboration across the three men's emergency shelters. For clients, Embedded Harm Reduction Workers supported them with their goals, created new weekly harm reduction drop-in programs at each shelter, expanded existing harm reduction programs, and distributed Naloxone, safe injection, and safe inhalation supplies. Through the program, 176 drop-in groups were facilitated (39 groups at Good Shepherd, 87 groups at Mission Services, and 50 groups at Salvation Army), with each organization reporting working individually with 10 to 25 clients per month on average on their identified goals.

In the pilot evaluation, clients reported that the program helped to build trust, autonomy, and safety. Across two surveys conducted during the funding period by Mission Services (n=73 respondents), 95% of clients agreed that staff were non-judgmental, trustworthy, and met them where they were at. Across 11 interviews with 13 clients, clients shared they are using unused supplies more often and that they feel that staff are more understanding because of the program. Clients also shared that they are more comfortable approaching staff in case of an overdose, and that there have been improvements in how overdoses are responded to. This data highlights how the program contributed to enhanced shelter staff capacity – through both formal training and peer-to-peer learning – related to substance use. As one staff described, the program created "far more cultural change than expected in a short time frame."

Clients and staff reported many short-term outcomes, including that the funding created new programs, a safer shelter environment and more training for staff. However, longer-term outcomes, such as substantial changes related to housing or substance use, were acknowledged as difficult to achieve in a one-year funding period. Indeed, building rapport with clients was noted as something that takes time, with several staff describing how it can take a year or longer to do so. Mission Services shared that they learned that the program takes time before significant impacts can be observed. As one staff stated, "for something like this to work, we found you really must give it enough time. When working with a population that is often very slow to change, you are not

going to see those things right away." More information about the program and evaluation results can be found in Appendix "A" to Report BOH26015.

YWCA Hamilton Safer Use Space Program Summary

The $300,000 in funding allocated to YWCA Hamilton provided operational funding to their Safer Use Space for a one-year period (April 1, 2024 to March 31, 2025). As an Urgent Public Health Needs Site, the intended program outcomes included reducing the risks of accidental overdose, reducing strain on emergency medical services, providing basic health services, increasing access to unused drug use equipment, connecting people to social services, healthcare, and treatment, and providing space for people to connect with staff and peers. The program was evaluated through a review of program data, staff interviews, and a zine, which is a self-published magazine featuring art and text. The zine was created in collaboration with the people who access the space through a series of workshops. A copy of the zine that was created can be found on the YWCA Hamilton website https://ywcahamilton.org/programs-services/housing-services/low-barrier-health-care.

In the year of funding provided by the City of Hamilton, the Safer Use Space had 7,117 visits across 500 unique guests (i.e., approximately 20 visits per day). Within these visits, 1,599 visits were for supervised consumption, and 4,395 visits were for harm reduction. Additionally, 45 drug poisonings were reversed in the space. Emergency Medical Services was called six times during the funding period. The Safer Use Space also had 734 visits for wound care, 168 visits for reproductive care, and 186 referrals to healthcare providers during the year of funding. The evaluation results are available in Appendix "A" to Report BOH26015.

Peer Support Program Summary

The $67,000 in funding meant to provide peer supports to people who use substances, including those living in encampments, could not be used as intended. This funding was to be administered following a Call for Applicants. Before the call for applications could be completed, Hamilton's Encampment Protocol was rescinded on January 15, 2025, to be effective as of March 6, 2025. The program had not started when this decision was made and did not proceed, and the $67,000 that was designated for this initiative

remained in the Early Years System Reserve (11218). As such, Hamilton Public Health did not evaluate this initiative.

Drug Checking and Surveillance System Pilot Program Summary

The Drug Checking and Surveillance System Pilot has been partially implemented as originally presented in the Hamilton Opioid Action Plan. Through this funding, capital funds ($100,000) were approved to purchase a point-of-care testing device(s) that would support surveillance of the circulating drug supply and additional funds were provided to support a Drug Test Strip Kit Pilot, as described further below.

To date, capital funds have not been spent on a point-of-care testing device. In Canada, Fourier-Transform Infrared Spectroscopy (FTIR) is the benchmark point-of-care technology. Although this device can detect multiple substances in a drug sample, it is not as effective at detecting new or novel additives to the drug supply or detecting trace elements (i.e., below 5% of sample). This device also requires ongoing maintenance and specifically trained staff to accurately interpret results. These costs were not included in the one-time capital budget designated for this initiative. Additionally, this type of drug testing device is best used in a community location that is located with other services where individuals would be willing to provide samples for testing.

The advancement of this priority has been impacted by changes to provincial legislation. Point-of-care drug testing requires an exemption to handle and process the sample under the federal *Controlled Drugs and Substances Act*. With the passing of the provincial *Community Care and Recovery Act, 2024*, municipalities or local boards, such as the Board of Health, do not have the power to apply to Health Canada for an exemption to the *Controlled Drugs and Substance Act* for several purposes without the approval of the Minister of Health. While drug checking in not specifically referred to in the *Community Care and Recovery Act, 2024* legislation, the ability to apply for and acquire new exemptions under the *Controlled Drugs and Substances Act* remains unclear. The drug checking landscape continues to evolve, and Hamilton Public Health is exploring further opportunities and expansion of local enhanced drug checking and monitoring in 2026. Toronto’s Drug Checking Service is also currently expanding access

to unregulated drug market monitoring throughout the province; Hamilton has been one of the communities engaged in this expansion.

Drug Test Strip Kit Pilot Program Summary

Fentanyl test strip kits and xylazine test strip kits have been distributed by Hamilton Public Health and community partners since May 2024. The start of the Drug Test Strip Kit Pilot coincided with a one-time opportunity through the Ontario Harm Reduction Distribution Program to receive drug test strips free of charge for local distribution. Hamilton Public Health received 4,600 Xylazine and Fentanyl test strips and supporting supplies from the Ontario Harm Reduction Program. In addition, Hamilton Public Health acquired a total of 16,800 fentanyl and 16,800 xylazine test strip kits and supporting testing supplies with the $78,000 that was funded in 2023 and 2024 for the pilot.

The Drug Test Strip Kit Pilot was evaluated via a survey for people accessing test strip kits and through key informant interviews with service providers and people who use drugs. Between May 2024 and December 2025, 4,524 drug test strip kits were distributed, with nearly even distribution between fentanyl (51%) and xylazine (49%). Among people surveyed, 100% found test strips easy to use. Almost three-quarters of survey respondents (73%) shared test results with other people, most often with friends or people they know (70%). In addition, half of survey respondents (52%) shared that results change how they use drugs, including not using alone (21%), disposing of the drug (15%), and starting with a lower dose (9%). Service providers noted other benefits, including that kits are a good tool for health education and test results can be useful for informing overdose responses. More information about the evaluation is included within Appendix “A” to Report BOH26015.

Based on the evaluation results, an additional order for 5,400 test strips was made in November 2025 through available funds in the Mental Well-Being and Substance Use Program budget to allow for ongoing distribution of testing kits through Hamilton Public Health and community partners. Continued provision of drug test strip kits will be scoped within existing program resources and in line with information about the types of substances circulating from the local community as well as Toronto’s Drug Checking Service.

Health Equity Data

Hamilton Public Health uses many sources of evidence, including data, to understand health inequities. Descriptive statistics alone may not fully reflect community health and should be combined with research, lived experience, and organizational perspectives to gain a deeper understanding of health inequities. Data sources used to describe opioid-related harms in Hamilton include the Office of the Chief Coroner, Ministry of Health, Hamilton Paramedic Services, and local hospitals.

Information on opioid-related harms is shared through the Hamilton Opioid Information System Semi-Annual Update, most recently in December 2025 (see Report BOH25029). The next semi-annual update will be in June 2026.

The opioid crisis continues to disproportionately impact equity-deserving populations, including those who are unhoused, Indigenous, and racialized.[1,2] Indeed, the programs in this report were proposed to help address these impacts, including rates of death being substantially higher among people who are homeless (1,024.9 deaths per 100,000 people) compared to people residing in a private dwelling (16.1 deaths per 100,000 people).

Discussion

Since the initial approval of the Hamilton Opioid Action Plan, there have been changes to the local landscape that have implications on the medium and long-term actions identified in the Hamilton Opioid Action Plan and for continued local programs moving forward.

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[1] Alsabbagh W, Cooke M, Elliot S J, Chang F, Shah N-U-L, Ghobrial M. Stepping up to the Canadian opioid crisis: A longitudinal analysis of the correlation between socioeconomic status and population rates of opioid-related mortality, hospitalization, and emergency department visits (2000-2017). HPCDP Journal [Internet]. 2022 June. [cited 2025 Jul 28]; 42(6). DOI: 10.24095/hpcdp.42.6.01

[2] Laballey J, Kastor S, Valleriani J, McNeil R. Reconciliation and Canada's overdose crisis: Responding to the needs of Indigenous Peoples. CMAJ [Internet]. 2018 Dec 17 [cited 2025 Jul 28]; 190(50): E1466-E167. DOI: 10.1503/cmaj.181093

From a legislation perspective, the *Community Care and Recovery Act, 2024*, brought broader provincial restrictions to Consumption and Treatment Services sites, which had local implications as the only Consumption and Treatment Services site in Hamilton was required to close in April 2024 due to its proximity to a childcare centre. This legislation also limits the ability of municipalities and local boards to apply for exemptions under the federal *Controlled Drugs and Substances Act* for supervised consumption or decriminalization, and to seek federal funding from Health Canada for safer supply services. It also prevents municipalities and boards from supporting local agencies in applying for these programs and services. In June 2025, the *Protect Ontario Through Safer Streets and Stronger Communities Act* passed, which placed the onus on landlords to take reasonable measures to prevent drug-related activities (e.g., production, trafficking) from taking place on their properties. The *Safer Municipalities Act* was also passed in June 2025, which reinforced law enforcement's ability to address public consumption of substances and increased the penalties for people who "deliberately and continually" trespass. This law also provided specific enforcement tools to move encampments and address public consumption of substances.

Along with legislative changes, the epidemiological context has also evolved over the period of the Hamilton Opioid Action Plan. Opioid-related deaths have decreased locally since peaking in 2021 at 167 confirmed and probable deaths. Annual totals declined to 166 deaths in 2022, 150 deaths in 2023, and 129 deaths in 2024. As of November 30, 2025, there have been 81 confirmed or probable deaths in 2025. The decrease in opioid-related deaths has been observed in communities across Canada, with likely drivers noted as a changing drug supply, an increase in naloxone availability, and reduction in the at-risk population. An additional possible factor includes changes in consumption behaviour (example from injection to inhalation).

Opioid-related paramedic calls and emergency department visits remained relatively stable from 2023 to early 2025 but have seen increases beginning in May 2025. The average number of paramedic calls and emergency department visits are approximately double the 2024 average as of March 2026. Opioid-related hospitalizations have remained relatively stable.

Locally, early warning surveillance highlights that increases to paramedic calls are being driven in part by ongoing changes in the toxic unregulated drug supply. Toronto Drug Checking Services have reported an increased presence of veterinary tranquilizers in the opioid supply since late 2023, with medetomidine being the most present since March 2025. In the same period, the presence of benzodiazepine-related drugs has decreased, although early evidence in Q1 of 2026 suggests they are re-emerging. Two local drug alerts, February 5, 2026 and March 6, 2026, have been issued by Hamilton Public Health in Q1 of 2026. Community reports have identified increasing complexity in overdose response, including challenges related to prolonged sedation. These changes, coupled with other factors, are contributing to more complex overdose events requiring emergency response locally.

Moving forward, continuing to address the burden of substance use requires a comprehensive approach at all levels of government. From an investment perspective, the federal government, as part of the 2024 federal budget, provided funding to local municipalities and Indigenous communities through the Emergency Treatment Fund. The Emergency Treatment Fund was intended to fund programs to support emergency responses to address the ongoing substance use and overdose crises. Provincial investments that accompanied the *Community Care and Recovery Act, 2024* legislation have focused on treatment and abstinence-based programs, such as the Homeless and Addiction Recovery Treatment Hubs (HART) hub. The provincial priorities related to mental health and addiction continue to be guided through the province's Roadmap to Wellness.

Locally, Hamilton Public Health continues to work within its mandate as a Public Health Unit in the support of upstream substance use prevention and provision of harm reduction interventions. This includes harm reduction supply distribution, distribution of naloxone, local surveillance and operation of an Opioid Early Warning System and working with local partners and agencies to support a community-based response to substance use. The City of Hamilton has also been successful in receiving federal Health Canada funding on two Emergency Treatment Fund applications to support new and novel harm reduction outreach and programming. One project, run by the YWCA

Hamilton, supported the closure of existing Consumption and Treatment Services in Hamilton through outreach services and responding to drug poisonings in the community, as well as a focus on addressing gender-specific substance use related harms and connections to care. This project ran from January 1, 2025, to March 31, 2026. The second project is a collaborative project with Hamilton Public Health, Hamilton Paramedic Services, and community partners (Hamilton Social Medicine Response Team, Keeping Six, and Positive Health Network) to support individuals after a drug poisoning event when they are at higher risk of subsequent adverse outcomes through the coordination and dispatch of existing outreach health and social services. This project started in September of 2025 and will continue until the end of November 2026.

Moving forward, while legislation and investment changes have impacted the availability of some community-wide interventions that municipalities are able to implement, Hamilton Public Health will apply the lessons learned from these evaluations and continue to support planning for local initiatives to support collaborative community action on opioids, in addition to provision of mandated programs and services. Collaborative work will continue to be coordinated through established tables, including the Hamilton Drug Strategy and the Greater Hamilton Health Network's Harm Reduction & Treatment Working Group. Local resources, including the Greater Hamilton Health Network's Mobile and Outreach Service Map and Analysis (2024), will help inform planning, service alignment, and identification of gaps in outreach and care.

Consultations

City of Hamilton Housing Services staff were consulted to verify background information and program details.

City of Hamilton Finance and Administration staff were consulted to verify financial information for the funded initiatives.

Staff and leaders from each funded organization were consulted about the evaluation design and invited to participate in the evaluation. In all evaluations included in this

report, interview participants reviewed their transcript and agreed to have it included in the analysis. Organizations have also reviewed key messages shared in this report.

Alternatives

Options Should Board of Health not Wish to Approve Staff Recommendation(s):

Should the Board of Health not wish to approve the Recommendation, Council would not be made aware of the outcomes and evaluation.

Previous Reports Submitted

- BOH23021 – Hamilton Opioid Action Plan
  This report describes the Hamilton Opioid Action Plan and directed staff to evaluate funded initiatives.
- HSC24001/BOH23021(a) – Hamilton Opioid Action Plan: Embedded Harm Reduction Pilot
  This report introduces the Embedded Harm Reduction Pilot as presented to the Public Health Committee in January 2024.
- BOH25003 – Public Health Services Opioid Update
  This report provides an update on the current opioid situation and Hamilton Public Health's response as of February 2025.
- BOH25029 – Hamilton Opioid Information System Semi-Annual Update
  This report is the most recent semi-annual update on the Hamilton Opioid Information System, shared with the Board of Health in December 2025.
- BOH24015 – Update on the Hamilton Opioid Action Plan – June 2024
  This report provided an update on the progress made towards the Hamilton Opioid Action Plan, including the initiatives described in this report.
- BOH23008 – Opioid Emergency Response
  This report includes a summary of the opioid crisis response in Hamilton between 2017 and 2023.

Consultation

- Housing Services, Healthy and Safe Communities Department
- Finance & Administration, Hamilton Public Health

Appendices and Schedules Attached

Appendix “A” to Report BOH25015 – Hamilton Opioid Action Plan Initiatives Evaluation Report

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Hamilton Public Health

Hamilton Opioid Action Plan Initiatives Evaluation Report

Epidemiology & Evaluation

Appendix “A” to Report BOH25016

April 27, 2026

Hamilton

Table of Contents

Context 4
Embedded Harm Reduction Pilot 5
What is the Embedded Harm Reduction Pilot? 5
How was the Embedded Harm Reduction Pilot Evaluated? 5
What were the Impacts of the Embedded Harm Reduction Pilot? 6
Overall Impacts 6
Value of the Embedded Harm Reduction Worker 8
Facilitating Collaboration Across Men’s Emergency Shelters 8
Client-Reported Impacts 9
Program Model Lessons Learned 10
Evaluation Limitations 10
YWCA Hamilton’s Safer Use Space 11
What is the YWCA Hamilton’s Safer Use Space? 11
How was the YWCA Hamilton’s Safer Use Space evaluated? 11
What are the Impacts of the YWCA Hamilton’s Safer Use Space on Women and Gender-Diverse People who use Drugs? 12
Overall Impacts 12
Benefits of Co-Locating Safer Use Space and Carole Anne’s Place 13
Key Facilitators of the Safer Use Space 14
Evaluation Limitations 14
Drug Checking and Surveillance System Pilot 15
What is the Drug Checking and Surveillance Pilot? 15
What is the Drug Test Strip Kit Pilot? 15
How was the Drug Test Strip Kit Pilot evaluated? 16
What are the impacts of the Drug Test Strip Kit Pilot? 16
Overall Impacts 16
Test Strip Results Influence Drug Use Practices 17
Drug Test Strips Support Health Education 18
Opportunities to Improve the Program 18

Evaluation Limitations 19
Conclusion 19

Context

In February 2023, Hamilton Public Health staff were directed to convene local stakeholders, including people with lived and living experience as well as health and drug policy experts, to develop an evidence-based harm reduction action plan to address high rates of opioid-related deaths. In the direction to staff, Board of Health also directed that these consultations and action plan consider how to implement safer use spaces and other evidence-based harm reduction strategies in the City of Hamilton and in the houseless serving sector.

Staff brought this request to the Hamilton Drug Strategy for collaborative action and to develop a local opioid action plan. In June 2023, the Hamilton Opioid Action Plan was presented to the Public Health Committee and City Council. The plan outlined 13 areas of action, which would be led by the Hamilton Drug Strategy, and recommended areas for municipal investment to support implementation. This included funding for staffing support, a Drug Checking and Surveillance System Pilot ($168,000) and a Supervised Consumption Site Pilot at a men’s shelter ($667,000). This was approved by the Public Health Committee on June 12, 2023, and City Council on June 21, 2023. To oversee the implementation of the Hamilton Opioid Action Plan, a working group, called the Hamilton Opioid Action Table, was struck under the Hamilton Drug Strategy.

The Supervised Consumption Site Pilot was initiated by City of Hamilton Housing Services through a Call for Applicants, and no applications were received. The Hamilton Opioid Action Table then received a collaborative proposal submitted by three men’s emergency shelters – Good Shepherd, Mission Services, and Salvation Army – for a 12-month Embedded Harm Reduction Pilot. In addition to this proposal, the Hamilton Opioid Action Table put forward two additional recommendations to support funding for a current safer use space operating in the community, and to implement a peer support initiative as alternative strategies to utilize the approved $667,000 to support ongoing harm reduction programming in the community. These amendments were approved by City Council on April 12, 2024, and allocated $300,000 towards the Embedded Harm Reduction Pilot, $300,000 towards the YWCA Hamilton’s Safer Use Space, and $67,000 towards a Peer Support Program. At this time, Hamilton Public Health was also directed to evaluate these initiatives.

The purpose of this evaluation report is to describe each of the programs that received municipal investment, how they were implemented, and their impacts during the funding period. It is important to note that the Peer Support Program was meant to support unhoused people who used substances, including those living in encampments. Hamilton’s Encampment Protocol was rescinded prior to the program being launched. As such, the program did not proceed and is not included in this report.

Embedded Harm Reduction Pilot

What is the Embedded Harm Reduction Pilot?

The goal of the Embedded Harm Reduction Pilot was to enhance and expand harm reduction services, principles, and practices in men’s emergency shelters. The intention was that the program would bring flexible, timely, and consistent harm reduction services to clients and build capacity among shelter staff in harm reduction. The program aligned with the newly released Hamilton’s Emergency Shelter Standards, which committed housing service providers to a harm reduction approach.[1]

Funding for the Embedded Harm Reduction Pilot was divided evenly between Good Shepherd, Mission Services, and Salvation Army ($100,000 for each organization). The pilot was based on an existing Mission Services outcome-based harm reduction program, where Embedded Harm Reduction Workers support clients with goals focused on employment, housing, familial reconciliation, treatment, and physical and mental health. As such, Mission Services was responsible for sharing their program model with the other organizations and took a leadership role in reporting program data and convening the Community of Practice for staff involved in the pilot.

Funding was primarily allocated towards an Embedded Harm Reduction Worker position within each organization. The Embedded Harm Reduction Worker supported clients with individualized goals and plans, advocacy, safety planning, and referrals, as well as facilitating drop-in harm reduction groups and distributing harm reduction supplies. At each organization, Embedded Harm Reduction Workers also provided harm reduction resources, supports, and training to other shelter staff and contributed to a Harm Reduction Community of Practice that was established across the three men’s emergency shelters as part of the pilot.

How was the Embedded Harm Reduction Pilot Evaluated?

The evaluation used a case study design to examine whether and how each organization enhanced or expanded their harm reduction services, principles, and practices. A case study design was chosen because, although Mission Services had already implemented the program and shared their model, each organization adapted the program to their individual organizational context. Examining each organization allowed the evaluation to better understand each organization’s baseline and priorities

[1] Hamilton’s Emergency Shelter Standards are available here: https://www.hamilton.ca/sites/default/files/2025-02/PreventingHomelessness-Hamiltons-Emergency-Shelter-Standards-2025.pdf

to assess what changed over the funding period (October 1, 2024 to September 30, 2025).

Staff interviews were conducted at the program’s outset and conclusion to understand how the program was implemented and what the impacts were in each organization. The purpose of the program outset interviews was to assess the current state of harm reduction and the organization’s priorities for the funding period (October 1, 2024 to September 30, 2025). The purpose of the end-of-program interviews was to assess what changed and how the program was implemented in each organization. In total, 19 interviews were held with staff across all three organizations (eight interviews at the program’s outset and 11 interviews at the program’s conclusion). Questions about priorities were informed by Toronto Public Health’s “10 Points of Harm Reduction for Shelter Programs,” which proposes ten areas of harm reduction programming for shelters to adopt.[2] Interview participants included Embedded Harm Reduction Workers, supervisors, managers, and senior leaders, most of whom participated in both interviews.

Organizations were also encouraged to collect and report client feedback about the program. Mission Services conducted two surveys over the program’s funding period, which included 73 responses. Salvation Army conducted brief interviews with their clients, with 13 clients participating. These data were shared with Hamilton Public Health and results are included below.

What were the Impacts of the Embedded Harm Reduction Pilot?

Overall Impacts

The goal of the program was to expand and enhance harm reduction services, principles, and practices in men’s emergency shelters, with intended outcomes that included hiring an Embedded Harm Reduction Worker, distributing harm reduction supplies, facilitating drop-in groups, training shelter staff, and contributing to a community of practice across the three organizations. Organizations reported that the program trained shelter staff, built partnerships that connected clients with healthcare and social service providers, and fostered collaboration across the three men’s emergency shelters. For clients, the program created new weekly harm reduction drop-in programs, expanded existing harm reduction programs, contributed to improved relationships with staff, distributed Naloxone, safe injection, and safe inhalation

[2] Toronto Public Health’s “10 Points of Harm Reduction for Shelter Programs”: https://www.toronto.ca/wp-content/uploads/2021/06/9633-10PointShelterHarmReduction210528AODA.pdf

supplies, and led to improved outcomes related to the goals of the program (i.e., housing, employment, familial reconciliation, treatment, and physical and mental health).

Embedded Harm Reduction Workers worked with clients on goals that ranged from obtaining housing and employment to reducing use, practicing harm reduction and safety planning, attending recovery groups, pursuing opioid agonist therapy and other treatment, maintaining sobriety, improving wellness, regular wound care, taking medication, reconnecting with family, attending counselling, court support, and other goals. Embedded Harm Reduction Workers also led weekly groups in each organization. In total, through the program, 176 drop-in groups were facilitated (39 groups at Good Shepherd, 87 groups at Mission Services, and 50 groups at Salvation Army), with each organization reporting working individually with 10 to 25 clients per month on average.

“I know it has made a difference… Our Embedded Harm Reduction Worker has provided invaluable support to shelter residents and shelter staff. She has been directly involved in responding to drug poisonings and providing aftercare and support. She has provided education, referrals, advocacy, and community navigation to shelter residents and supported a number of individuals in connecting with health and treatment services.”

– Men’s Emergency Shelter Staff (Interview)

“It's hard to get more bang for your buck…We’re paying some salaries here and we're seeing the impact that it's having on all the clients, all of the programs, the staff. It’s hard to find something that has that low of a cost and that wide an impact.”

– Men’s Emergency Shelter Staff (Interview)

> “If I can get 24 homeless men in a group every Wednesday, from two to three, that's a positive…They don't use that hour. They don't use a half hour before two o'clock. Not because of me saying don't use, because they want to be part of this community.”
>
> – Men’s Emergency Shelter Staff (Interview)

Value of the Embedded Harm Reduction Worker

Having at least one frontline, dedicated full-time Embedded Harm Reduction Worker was seen as an essential facilitator for these impacts in addition to being one of the funded outcomes. As one staff described, “the Embedded Harm Reduction Worker’s presence in the shelter sends a clear message to residents that we are striving to offer a safer, more hospitable, and non-judgemental environment.” One staff provided a tangible example of the value of having an Embedded Harm Reduction Worker, “without the harm reduction pilot, I think it was harder to make referrals. There wasn’t someone in-house to direct people to. For detox, you’ll have to call multiple times. The Embedded Harm Reduction Worker is someone you can talk to right now, we can call together, and we can make a plan.” In addition to client support, the Embedded Harm Reduction Worker provided training to new staff, offered refresher training for current staff, responded to overdoses, followed up with clients after an overdose, and supported other staff when working with clients who use substances. Beyond holding these roles, having an Embedded Harm Reduction Worker as an additional staff on site was seen as another benefit.

Facilitating Collaboration Across Men’s Emergency Shelters

A key characteristic of the Embedded Harm Reduction Worker role is that they can support clients regardless of where they are living, for example, at their shelter, at another shelter, or in community. Alternatively, clients can choose to meet with a different Embedded Harm Reduction Worker if they move shelters while continuing with their same goals. This continuity and collaboration extended beyond frontline client support. As one staff noted, “it builds collaboration between the various agencies as we are approaching policies. For example, when we're talking at the Men's Emergency Shelter Coordinating Table, we can discuss best practices on how we engage together with working with our clients.” Staff at all organizations reported that the quarterly Community of Practice established as part of the program was valuable, since it allowed them to share ideas, learn from each other’s experience, and troubleshoot challenges.

Client-Reported Impacts

Supporting clients was another key outcome of the program, and clients reported higher levels of trust, autonomy, and safety because of the program. Across two surveys conducted during the funding period by Mission Services (n=73 respondents), 95% of respondents agreed that staff were non-judgmental, trustworthy, and met them where they were at. In addition, 88% of respondents agreed they were involved as much as they wanted to be in decisions about their services and supports, and 83% of respondents agreed that staff helped them develop a plan to reach their personal goals. Notably, 99% of clients agreed that they would recommend the service if a friend needed similar help. Salvation Army also conducted brief interviews with their clients about the impacts of the program. Across 11 interviews with 13 clients, clients shared they are using unused supplies more often and that they feel that staff are more understanding because of the program. Clients also shared that they are more comfortable approaching staff in case of an overdose, and that there have been improvements in how overdoses are responded to. These data highlight how the program contributed to enhanced shelter staff capacity – through both formal training and peer-to-peer learning – related to substance use. As one staff described, the program created “far more cultural change than expected in a short time frame.”

Clients and staff reported many short-term outcomes, including that the funding created new programs and a safer shelter environment and more training for staff. However, longer-term outcomes, such as substantial changes related to housing or substance use, were acknowledged as difficult to achieve in a one-year funding period. Indeed, building rapport with clients was noted as something that takes time, with several staff describing how it can take a year or longer to do so. Mission Services shared that they learned that the program takes time before significant impacts can be observed. As one staff stated, “for something like this to work, we found you really have to give it enough time. When you're working with a population that is often very slow to change, you're just not going to see those things right away.” Staff highlighted that system constraints can also affect longer-term outcomes, since they influence the supports that are available to clients. As one staff commented, if a client “can ultimately establish helping relationships that promote safety and reduce drug poisonings and opens up conversations about next steps and personal goals and aspirations – then we need to have resources and options available to offer them.” This participant expanded that, “the people we serve in shelter need options around treatment, care, ongoing support, and they need access to housing, adequate income, connection to community, safety so that they can maintain gains made.”

Program Model Lessons Learned

Two key lessons were learned through this evaluation. First, the pilot’s program model – that is, having dedicated staff focused on one objective – was seen as a good approach for addressing priorities in the men’s emergency shelter setting. As one staff commented, “we would use this model if we had something emerging… to gain intentionality, focus, strategic, outcome-driven cultural change and policy change… I don't think that was the intended design of the pilot to specifically create an organizational structure that we would utilize in the future, but I think it is an outcome that needs to be recognized.” Another staff expanded, “this pilot underscores my sense that embedded supports build global capacity in a program/organization.” This model could be considered for other priorities in the future.

Another lesson learned through the evaluation relates to how the program was adapted in each organization. It was not the intention of each program to replicate Mission Services’ program model – indeed, staff recognized that differences in organizational culture and approaches can be valuable for clients – though many elements of this model were implemented at Good Shepherd and Salvation Army. One of the key tenets of Mission Services’ model is that the Embedded Harm Reduction Worker role is delineated from shelter support and housing case management functions. All organizations recognized the value of this distinction since it allows the Embedded Harm Reduction Worker to foster safety and trust when working on goals with clients. Although this separation was not always possible in practice, it remains a helpful consideration when shaping future harm reduction roles in similar settings.

Evaluation Limitations

As discussed, the program was based on an existing model that each organization adapted to their context. These adaptations led to differences in program implementation that make it challenging to assess the overall impact of the program across the three organizations. As such, the case design was chosen since it is useful for exploring organizational impacts and contextual factors that affected implementation. With a longer program timeline, capturing other perspectives more consistently (e.g., hearing from program clients, shelter residents, and community partners) would have strengthened the evaluation. Further, an extended program timeline would have allowed the evaluation to better explore and capture longer term client outcomes, such as changes in housing or substance use.

YWCA Hamilton’s Safer Use Space

What is the YWCA Hamilton’s Safer Use Space?

The YWCA Hamilton’s Safer Use Space is a supervised consumption site located within Carole Anne’s Place, a low-barrier overnight drop-in for unsheltered women and gender-diverse individuals. The Space is an Urgent Public Health Needs Site established through an exemption from Health Canada and has been open since April 2022. The Safer Use Space is run in partnership with Keeping Six and the Hamilton Social Medicine Response Team (HAMSMaRT).

The $300,000 in funding allocated to YWCA Hamilton provided operational funding to their Safer Use Space for a one-year period (April 1, 2024 to March 31, 2025). In addition to supervised consumption and providing harm reduction supplies, onsite services are available through partnerships, such as withdrawal management and support, Rapid Access Addiction Medicine, and wound care and other nursing supports. People accessing the Safer Use Space are also connected with supports available at Carole Anne’s Place.

How was the YWCA Hamilton’s Safer Use Space evaluated?

As an Urgent Public Health Needs Site, the Safer Use Space already collects and reports quantitative data. As such, this evaluation was designed to complement these program data by documenting key characteristics of the Safer Use Space and its impacts. To do this, nine interviews were conducted with current and former staff, peers, and partners of the Safer Use Space. In addition, a zine was created with people who use the space to further explore the Safer Use Space’s impacts.[3] A zine is a self-published magazine featuring art and text, and the Safer Use Space had previously published a zine about the program. Three zine workshops were held between November 2024 and March 2025. Workshops focused on the guiding questions, “What does the Safer Use Space mean to you?” and “What is your fondest memory of the Safer Use Space?”. Staff from the YWCA Hamilton and Hamilton Public Health supported each workshop. The zine was shared back with people who use the Safer Use Space for their review and reflection in February 2026. In total, 20 individuals participated in the zine workshops and 14 people attended the reflection event. Minor changes were made to the zine following this event based on participant feedback. The

[3] YWCA Hamilton’s “Safer Use Space Zine”: https://ywcahamilton.org/programs-services/housing-services/low-barrier-health-care

YWCA Hamilton also shared program data with Hamilton Public Health, and these data are included within the zine.

What are the Impacts of the YWCA Hamilton’s Safer Use Space on Women and Gender-Diverse People who use Drugs?

“Whenever I come here, I know I will get what I need. A snack, supplies, someone to talk to. I know if I come here, I don’t have to use alone. It has been good for me.”
– YWCA Hamilton Participant (Zine)

“When people are using in a calm space, and can take the time to prepare, and can get juice, it’s not that the overdoses experienced outside the space are now in the Safer Use Space, it’s that we disrupted the pattern. People can sit down, they don’t have to use fast, they can test out a new batch and use a little bit. The total number of drug poisonings that would be responded to by staff has been made much, much lower.”
– YWCA Hamilton Staff (Interview)

Overall Impacts

The intended outcomes of the funding were to reduce the risks of accidental overdose, reduce strain on emergency medical services, provide basic health services such as wound care, increase access to unused drug use equipment, connect people to social services, healthcare, and treatment, and provide space for people to connect with staff and peers. In the year of funding provided by the City of Hamilton, the Safer Use Space had 7,117 visits across over 500 unique guests (i.e., approximately 20 visits per day). In total, there were 1,599 visits for supervised consumption, 734 visits for wound care, and 4,395 visits for harm reduction. The Safer Use Space also had 168 visits for reproductive care, 186 referrals to healthcare providers, and 20 referrals to detox.

Critically, 45 drug poisonings were reversed in the space, and there have never been any deaths in the space. One piece of art in the zine also reflects on this key function of the Safer Use Space by listing people who they know that have passed because of a drug poisoning. As the art piece states, “if we had more spots, less names.” The zine’s cover photo further expands, “Every life saved is another chance for us to save ourselves. Every time we get a second chance is a possibility to start living.”

Data from other supervised consumptions sites across Canada reinforce how the Safer Use Space can reduce risk of accidental overdose and strain on emergency medical services. From April 1, 2024 to March 31, 2025, across Canada, supervised consumption sites had 559,922 visitors and responded to 7,993 overdoses (i.e., approximately one overdose per every 82 visits).[4] For the same period, the Safer Use Space had 7,117 visits and responded to 45 drug poisonings (i.e., approximately one overdose per every 158 visits). Similarly, the Safer Use Space made fewer calls to emergency services and police services when compared to data from other supervised consumption sites across Canada.

Impacts reported by participants include and extend beyond harm reduction, including how the space facilitates connection with staff and peers. Clients who use the space reported a high level of trust with staff and peers and that they felt safe and supported within the space and when accessing services as part of Carole Anne’s Place. As one zine contributor summarized, the Safer Use Space is “a warm friendly place to safely use. It has been such a relief knowing I had a safe clean place to go whenever to get “gear”, harm reduction, wound care, a snack, or a place to use, this place was there for me.” Another zine participant described how the Safer Use Space “is a community. Just knowing this place is here, day or night, even on holiday days – it means a lot to me.”

Benefits of Co-Locating Safer Use Space and Carole Anne’s Place

Having the Safer Use Space as part of Carole Anne’s Place assisted with fulfilling one of the program outcomes to connect people to social services. Through Carole Anne’s Place, people who use the Safer Use Space can be connected to supports including overnight shelter, meals, access to showers and basic needs, low barrier healthcare, systems navigation and shelter referrals, counselling, justice support, and advocacy. Further, staff commented that having the Safer Use Space as part of Carole Anne’s Place means there were fewer service restrictions, which leads to better client outcomes. As one staff described, “a lot of people are going to be using substances in

[4] Health Canada. Supervised consumption sites: dashboard [Internet]. Ottawa (ON): Government of Canada; 2025 Sep 19 [cited 2026 Feb 20]. Available from: https://health-infobase.canada.ca/supervised-consumption-sites/

shelters, so when you have a space where people can use and it’s not against the rules then it means that people have a much better shot of succeeding in the program.”

Having safe consumption within Carole Anne’s Place was noted by the participants to improved client safety, which also contributes to reducing strain on emergency medical services. As one interview participant described, “we get to be with people from start to finish, so if they were to experience a drug poisoning, we know exactly what happened. We can respond better, and it is a less stressful and traumatic response.” At the time of data collection, it was noted there had not been a drug poisoning in the adjacent Carole Anne’s Place since the Safer Use Space opened.

Key Facilitators of the Safer Use Space

Across zine participants and staff interviews, the Safer Use Space itself was often highlighted. As one zine participant said, the Safer Use Space “is inviting – you feel comfortable here.” A staff participant expanded, “people really appreciate a non-clinical environment. We have so much art in the room, and people will come in with things that they think are beautiful and want to give them to the space.” Peers and staff also contribute to this experience. As one participant shared, “Staff make you feel safe and calm…They care to listen to our story and see us as people and treated us as such.” Another participant described, “the peers help provide a more personal connection; they have helped establish trust… the experience and connection is authentic, genuine.” Having the Safer Use Space as part of Carole Anne’s Place has also contributed to better relationships between staff and clients since the Safer Use Space opened. As one staff explained, “The way we can be much more open with each other has improved the way that staff and clients can relate to each other… Staff aren’t watching over you to surveil you, but because they care about you.”

The Safer Use Space is also tailored to the people that Carole Anne’s Place serves. Staff noted they can offer gendered health programming in the space, including a focus on reproductive health or menopause and substance use. In addition, the Safer Use Space is a place where “women can also come and take a break from their partner or living outside with this program. Women are safer from gender-based violence, since they are at a higher risk when substance affected.” These aspects of the Safer Use Space were seen as important components that contribute towards the program’s outcomes, and reduce the harms related to drug use that are experienced by women and gender-diverse individuals.

Evaluation Limitations

Workshops and the reflection event were designed to be welcoming and appreciative spaces, held within the Safer Use Space and supported with food and a participant

incentive. These activities occurred in the evening before the Safer Use Space opened to ensure participation was voluntary and to allow more people to be present in the space at one time. This also meant that participation was likely limited to people at the YWCA Hamilton that evening. However, the Safer Use Space can be accessed overnight by women and gender-diverse individuals regardless of whether they are accessing the YWCA Hamilton. In addition, the creative nature of the zine method required participants to feel comfortable with the activities and sharing their perspectives in this way. As a result, some experiences of the Safer Use Space may not be represented in the zine.

Drug Checking and Surveillance System Pilot

What is the Drug Checking and Surveillance Pilot?

The goal of Drug Checking and Surveillance Pilot was to provide information to Hamilton Public Health, community partners and individuals who are using substances about the toxic unregulated drug supply. The Drug Checking and Surveillance System Pilot has not yet been fully implemented. Capital funds ($100,000) were designated to purchase a point-of-care testing device(s) that would support surveillance of the circulating drug supply and additional funds were provided to support a Drug Test Strip Kit Pilot. To date, capital funds have not been spent on a point-of-care testing device and this option continues to be explored by Hamilton Public Health and community partners.

What is the Drug Test Strip Kit Pilot?

The objectives of the Drug Test Strip Kit Pilot were to increase community access to harm reduction tools and increase community awareness and knowledge of the unregulated drug supply. Fentanyl and xylazine test strips were selected for distribution after conducting a survey with people with lived and living experience, who identified these substances as of interest in the local drug supply. Drug test strips are a harm reduction tool made available to help people who use drugs check whether a drug contains a single substance (e.g., fentanyl or xylazine). This knowledge can be used to make informed decisions about their use of the drug that was tested. They are not intended to be used as a surveillance tool to understand the local drug supply, and individuals who use test strips are not expected to report their results.

Fentanyl test strip kits and xylazine test strip kits have been distributed by Hamilton Public Health and community partners since May 2024.The start of the Drug Test Strip Kit Pilot coincided with a one-time opportunity through the Ontario Harm Reduction

Distribution Program to receive drug test strips free of charge for local distribution. Hamilton Public Health received 4600 xylazine and fentanyl test strips and supporting supplies from the Ontario Harm Reduction Program. Hamilton Public Health acquired a total of 16,800 fentanyl and 16,800 xylazine test strip kits and supporting testing supplies with the funds that were made available, at a total cost of $78,030.80. An additional order for test strips was made in November 2025 to allow for ongoing distribution of testing kits through funds were available in the Mental Well-Being and Substance Use Program budget. Of the acquired kits, approximately one-third of the test strip kits remain and continue to be distributed by Hamilton Public Health and community partners.

The program began in May 2024 within Hamilton Public Health before being expanded to other community organizations. Each kit can test five drug samples, and includes test strips (five), soap wipes, micro-scoops, mixing cups or cookers, and sterile water ampules, as well as an instruction sheet developed by Hamilton Public Health. Clients are provided with information about how to use the test strip kits, the benefits and limitations of the tests, and harm reduction education. Service providers are trained through a “Train the Trainer” model, where a subset of staff from community organizations are trained by Hamilton Public Health. These staff train other staff within their organizations.

How was the Drug Test Strip Kit Pilot evaluated?

The evaluation included a survey for people accessing test strip kits and key informant interviews. It was initially proposed to conduct the surveys in-person through Hamilton Public Health’s Van Needle Syringe Program and an online survey that could be accessed through a quick response QR code on the kits. However, online survey uptake was low, and it was challenging to conduct surveys on busy Van shifts. Another key distributor of test strip kits, Positive Health Network, agreed to administered paper surveys. In total, 38 survey responses were received, most of which were collected by Positive Health Network. In addition, nine interviews were conducted with staff from Hamilton Public Health and community organizations that distribute the test strip kits. These interviews focused on how the pilot was going (i.e., successes, challenges, opportunities, and recommendations) and observed impacts of the program.

What are the impacts of the Drug Test Strip Kit Pilot?

Overall Impacts

The intended outcomes of the program were to increase community access to harm reduction tools and increase community awareness and knowledge of the unregulated

drug supply. With respect to access, between May 2024 and December 2025, three Hamilton Public Health programs and 13 community partners have distributed 4,524 drug test strip kits to individuals in the community. Kits were nearly evenly distributed between fentanyl (51%) and xylazine (49%), with over half of survey respondents (59%) reporting using both kit types. Survey respondents reported various testing frequencies for increasing their knowledge of the unregulated drug supply, with 32% testing whenever they had a new batch/supply, 29% testing every time, and 29% testing sometimes. Among people surveyed, 100% found test strips easy to use.

Test Strip Results Influence Drug Use Practices

Clients reported changes in behaviour based on test strip results. Nearly three-quarters of survey respondents (73%) share test results with other people, most often with friends or people they know (70%), in turn increasing awareness and knowledge of the unregulated drug supply. In addition, half of survey respondents (52%) shared that results change how they use drugs, including not using alone (21%), disposing of the drug (15%), and starting with a lower dose (9%). These results align with the literature on test strip kits and behaviour change. For example, a study in British Columbia found that 27% of individuals reported safer or more positive behaviour changes after fentanyl was detected,[5] and a rapid review by Public Health Ontario reported that fentanyl test strip use led to increased risk reduction behaviours among 45.2% to 100% of participants.[6] Clients also expressed appreciation for the program in survey responses.

Drug test strips contributing to increased awareness and behaviour changes are important to note in the context of toxicology reports from confirmed accidental opioid-related deaths in Hamilton. Between Q1 2023 and Q1 2025, fentanyl was identified in 83.2% of opioid-related deaths, while 4.4% of deaths from the same period have involved xylazine.[7] In addition, toxicology reports note that stimulant(s) were frequently involved in opioid-related deaths. The most common combinations were cocaine and fentanyl (51.2%) and methamphetamine and fentanyl (41.7%). One of the benefits

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[5] Klaire, S., Janssen, R. M., Olson, K., Bridgeman, J., Korol, E. E., Chu, T., Ghafari, C., Sabeti, S., Buxton, J. A., & Lysyshyn, M. (2022). Take□home drug checking as a novel harm reduction strategy in British Columbia, Canada. International Journal of Drug Policy, 106, 103741. https://doi.org/10.1016/j.drugpo.2022.103741.

[6] Ontario Agency for Health Protection and Promotion (Public Health Ontario). (2024). Test strips for drug checking. https://www.publichealthontario.ca/-/media/Documents/T/24/test-strips-drug-checking.pdf?rev=ca581112e55d4303aaa6d24e96553ced&sc_lang=en.

[7] Hamilton Board of Health Report BOH25029 “Hamilton Opioid Information System Semi-Annual Update (September 20, 2025): https://pub-hamilton.escribemeetings.com/filestream.ashx?DocumentId=476495

identified from clients and service providers was that drug test strips are useful to test stimulants, such as cocaine and methamphetamine, for fentanyl contamination. This is a benefit that is also noted in the literature.[8]

Drug Test Strips Support Health Education

Service providers noted several benefits of test strip kits. One service provider explained, “this is a good way to talk about the uncertainty of the drug supply… It’s a nice opportunity for health teaching.” This improved engagement has other benefits. As one service provider described, “I think it is helping with reducing stigma, I believe it is bringing out those open conversations.” Knowing more about the drug supply, and how this knowledge may change an overdose response, was seen as another benefit. As a service provider summarized, “knowing what is in the drug supply helps us teach people about the presentation and how the response might change.”

Opportunities to Improve the Program

One limitation of test strip kits is that they only test for one substance, which is a challenge given the toxic drug supply and a drug supply that is constantly changing. Service users and providers suggested that test strips for benzodiazepines, medetomidine, nitazene, and ketamine would be helpful. As the drug supply continues to evolve and change, so does the availability and utility of the drug test strip available. In addition, from Q1 2023 to Q1 2025, 48% of opioid toxicity deaths in Hamilton involved one or more unregulated benzodiazepines, further suggesting that there may be utility in having other drug test strips available.

Two comments were also received from survey respondents about test strip kits not always being available. While it is difficult to know what specifically affected availability for these participants, test strip kits have many components, and, at times, Hamilton Public Health may not have enough kits ready for pickup. Additional staff have been supporting kit making to help mitigate this challenge, but it is an important consideration should other drug test strip kits be explored, especially those that have different components (e.g., benzodiazepines). Both clients and service providers also expressed wanting to know what other drugs might be in each sample and the composition of tested drugs. This suggests that there remains opportunity to explore additional models of drug checking such as a point-of-care device and/or options to access mass

[8] Reed, M. K., Roth, A. M., Tabb, L. P., Groves, A. K., & Lankenau, S. E. (2022). “I probably got a minute”: Perceptions of fentanyl test strip use among people who use stimulants. International Journal of Drug Policy, 92, 103147. https://doi.org/10.1016/j.drugpo.2021.103147

spectrometry, which is better able to identify trace substances and novel/emerging substances in a sample than Fourier Transform Infrared (FTIR) point-of care testing.

Evaluation Limitations

Relative to the number of drug test strip kits distributed, survey completion was low. This is not surprising given both the nature of the intervention and the survey modalities available. Drug testing is brief and may occur discreetly, and accessing an online survey can present barriers for participants while paper-based survey collection was not always feasible. In future implementations of similar surveys, providing a small incentive may help increase survey completion.

Conclusion

Overall, these Hamilton Opioid Action Plan initiatives achieved their objectives and demonstrated positive outcomes. These three initiatives were funded through the Hamilton Opioid Action Plan and further shaped through consultation with the Hamilton Drug Strategy Steering Committee, the Hamilton Opioid Action Table, community partners responsible for implementation, and the people who participated in them. The reported impacts of these programs – enhanced harm reduction supports in men’s emergency shelters, 45 reversed drug poisonings, and changes in substance use behaviours informed by drug test strip results – demonstrate the value of designing, implementing, and evaluating programs in partnerships with community members and the organizations that serve them. As one staff member reflected about the Embedded Harm Reduction Pilot, “the program is valuable. It has helped save lives. It has helped people feel seen, and heard, and supported.” Moving forward, continued collaboration with community organizations and through the Hamilton Drug Strategy will continue to be essential to reducing the harms associated with substance use in Hamilton.


Hamilton

BOARD OF HEALTH

M O T I O N

Board of Health: April 27, 2026

MOVED BY MEMBER R. JANSSEN…….

SECONDED BY MEMBER C. KIRKBY…….

Correspondence Concerning Provincial Actions Relating to the Opioid Crisis

WHEREAS the average number of monthly opioid-related paramedic responses in Hamilton has more than doubled in the eleven months following the provincially-mandated closure of Hamilton's consumption and treatment service (CTS) relative to the eleven months prior to the CTS closure (an average of 61 monthly calls between May 2024 – March 2025, increasing to an average of 130 monthly calls between May 2025 – March 2026) – and whereas other municipalities that saw provincially mandated CTS closures are reporting a similar trend;

WHEREAS in 2023 the City of Hamilton declared a crisis for mental health, addictions, and homelessness based in part on key indicators that included loss of life, prevalence and impact, and having met or exceed its municipal mandate – and whereas those same indicators have only worsened in the intervening years;

WHEREAS health and social service partners in Hamilton have, through various Public Health consultation bodies and in other collaborative forums, articulated that the situation respecting the provision of health and social care for people who use opioids is untenable and worsening; specifically with respect to poisonings and deaths, and the vicarious trauma associated with providing care for this population;

WHEREAS the Ministry of Health accepted the Auditor General's 2024 finding that the Ministry's most recent Opioid Strategy, published in 2016, is outdated and does not address increased risks and needs, even with the Ministry's new HART Hubs model;

WHEREAS Public Health Canada's 2025 report on the decline in opioid-related deaths in Canada articulates that one of the three likely drivers for the reduced number of opioid-related deaths is a 'declining population at risk,' specifying that "population declines are in part because many lives were lost over previous years;"

WHEREAS reports from the Association of Municipalities of Ontario and Maytree suggest that Ontario is currently spending half of what is needed to end chronic homelessness, including deeply affordable non-market housing units with wrap-around supports where necessary; and

WHEREAS the current Ontario Public Health Standards implicate Public Health in achieving improved health and quality of life, reduced morbidity and mortality, and reducing health inequalities among population groups.

THEREFORE BE IT RESOLVED:

(a) That the Board of Health **DIRECT STAFF** to write a letter, to be signed by the Board of Health Chair, to the Premier of Ontario, Minister of Health, Associate Minister of Mental Health and Addictions, and all local Members of Provincial Parliament, that includes:

    (i) Any Public Health data and analysis to date of the impact of the closure of Hamilton's CTS, including public health data related to the toxicity of the drug supply in Hamilton;

    (ii) A summary of known solutions to the opioid crisis that are under direct Provincial jurisdiction, including:

        (1) A clear, current, and accountable Provincial strategy for addressing the current drivers of the opioid crisis;

        (2) Improved access to the full continuum of care, including evidence-based harm reduction initiatives such as CTS;

        (3) Increased investment in housing with supports;

        (4) Improved access to opioid agonist therapy (OAT), including injectable OAT for severe, treatment-refractory opioid use disorder, alongside comprehensive services (i.e. primary care, counselling, etc.); and

        (5) Enhanced investments in direct service provision for substance use and mental health supports in the healthcare system.

(b) That staff **BE DIRECTED** to request feedback from the Hamilton Opioid Working Group, who are involved both in direct service provision and in coordinating a local response to the opioid crisis, when drafting the letter.

Bill No. 005

BOARD OF HEALTH FOR THE CITY OF HAMILTON HEALTH UNIT

BY-LAW NO. BOH 26-005

To Confirm the Proceedings of the Board of Health for the City of Hamilton Health Unit at its meeting held on April 27, 2026.

THE BOARD OF HEALTH FOR THE CITY OF HAMILTON HEALTH UNIT ENACTS AS FOLLOWS:

1. That the actions of the Board of Health for the City of Hamilton Health Unit at its meeting held on the 27th day of April 2026, in respect of each motion, resolution and other action passed and taken by the Board of Health at its said meeting, is, hereby adopted, ratified, and confirmed.

2. That the Chair of the Board of Health, officials of the Board of Health and Hamilton Public Health are hereby authorized and directed to do all things necessary to give effect to the said action or to obtain approvals where required, and except where otherwise provided, the Chair and the Secretary of the Board of Health are hereby directed to execute all documents necessary in that behalf.

PASSED this 27th day of April 2026.

C. Kroetsch	M. Trennum
Chair	Secretary